Fairfax-Falls Church CSB Fiscal Oversight Committee Virtual Meeting

Will be held electronically due to the COVID-19 pandemic

March 18, 2021, 4:00 p.m.

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Meeting ID: 991 7119 9253 • Passcode: 211046

MEETING AGENDA

Agenda Item	Facilitator
1. Meeting Called to Order	Jennifer Adeli
2. Roll Call and Audibility	Jennifer Adeli
3. Preliminary Motions	Jennifer Adeli
4. Matters of the Public	Jennifer Adeli
5. Amendments to the Meeting Agenda	Bettina Lawton
6. Review of November 12th Meeting Minutes	Jennifer Adeli
7. Administrative Operations Report	Daryl Washington
8. Clinical Operations Report A. Time to Treatment B. Quarterly Data Reports	Lyn Tomlinson
9. Financial Status A. Modified Fund Statement B. Variable Revenue Report	Jessica Burris
10. HR Update A. Position Status	Daryl Washington
11. Open Discussion	
12. Adjourn	

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CSB Fiscal Oversight Committee
Virtual Meeting Minutes
November 12, 2020

Members in Attendance:

In-Person: Chair, Jennifer Adeli; Karen Abraham; Bettina Lawton; Andrew Scalise; and Sandra Slappey

Audio Bridge: Captain Derek DeGeare; Ken Garnes; and Daniel Sherrange

Staff: Daryl Washington; Jessica Burris; Michael Neff; and Lyn Tomlinson

1. Summary of Information Shared/Decisions:
   The meeting was called to order at 4:05 p.m.

2. Review of meeting minutes
   The October 15, 2020 meeting minutes were offered for review. Recognizing no revisions were forthcoming, Sandra Slappey made a motion to approve the minutes as presented, which was seconded and approved.

3. Administrative Operations Report
   Michael Neff directed attention to the handout included the meeting materials and provided an overview the highlights which include:
   A. Efforts to prepare for data migration by the *MAX* Team include closing cases and correction to team/program assignments. Additionally, demonstrations of the potential new EHR in 13 areas are anticipated to begin soon in support of a signed contract by the end of 2020.
   B. It was clarified that the possible participation in a value-based purchasing pilot includes the involvement of a second CSB. The five HEDIS (Healthcare Effectiveness Data and Information Set) outcomes include follow up to care at seven and at thirty days, two medication adherence measures and re-admittance for behavioral healthcare. Mr. Neff further reported he anticipates that future healthcare contracts will be value-based as a means of achieving healthcare savings.
   C. The development and implementation of the business partner model with Human Resources is designed to increase responsiveness and effectiveness in the agency.

4. Clinical Operations Report
   Lyn Tomlinson provided an overview of time to treatment acknowledging that wait times have not improved since the last report. Efforts to reduce wait times include:
   - Recruiting clinicians from all locations to provide telehealth regardless of the client's 'base' site,
   - Clinicians in youth programs will provide services to clients identified as young adults,
   - Merging some Intensive Outpatient groups to increase capacity for clinicians to provide services one-on-one.
   - Highlighting the 11 vacancies in outpatient services, Ms. Tomlinson noted that if all positions were filled, there would be no wait times related to a lack of staffing. It was confirmed that new hires typically take an average of six weeks post-hire before clients are assigned.

- Attention was directed to the (SUD) Substance Use Disorder Residential Waiting List included in the meeting materials. It was clarified that, due to COVID and physical distancing, there have been reductions to bed space including at Crossroads and New Generations (long term residential), A New Beginning (intermediate stay residential) and at Cornerstones and at Detox (Medical Detoxification services).
- It was clarified that while waiting for outpatient or residential services, there are ongoing engagement efforts that include telephonic outreach, peer resources, recovery meetings, emergency services, CrisisLink, support groups, crisis stabilization, mobile crisis, and Revive! classes.

5. Financial

   Jessica Burris provided the financial update with an overview of the modified fund statement and fiscal notes. Other highlights included:

   - An ongoing initiative to develop management reports for Service Directors that will allow for management of their service area budgets is nearing completion. Implementation planning includes education, business intelligence tools, and a pilot group for input and refinement of broader implementation.
   - October variable revenue exceeded target, partially attributed to an unanticipated increase in referrals.
   - Offering a reminder of proposed development of financial reports, this effort is ongoing with delivery of draft reports expected at the December 2020 meeting.

6. Human Resources (HR) Update

   Michael Neff provided the HR update, noting the vacancies as of Nov. 9, 2020 numbered 89. The ongoing challenges with recruitment and retention remained a primary topic of interest and discussion, some highlights of which include:

   - Revision to the current Vacancy Breakeven Point (VBP) of 89 to 79 has been requested of DMB (Department of Management and Budget) with a reply pending.
   - Acknowledging the high number of staff turnover, an outreach project to define and address reasons has been launched starting with Support Coordination.
   - Plans to address anticipated retirements include weekly monitoring of retirement eligibility reports. Additionally, planning meetings are scheduled with retirement eligible staff at about 12 months prior to eligibility date.

7. Open Discussion

   Daryl Washington reported that Linda Mount and Jessica Burris have initiated an analysis of Substance Use Disorder (SUD) Residential Treatment service delivery going back three years to identify the cost for each program. Additionally, Lyn Tomlinson, Michael T. Lane, Director of Individual and Family Affairs, and Daryl Washington will be scheduling talking sessions with SUD clients and staff. Although this process will not be completed, an update will be provided at the December CSB Board meeting.

Noting no further discussion was forthcoming, the meeting was adjourned at 5:20 p.m.

CSB Fiscal Oversight Committee
Virtual Meeting Minutes
November 12, 2020

Action Items/Responsible Party Required Prior to Next Meeting:

Issues to Communicate to CSB Board:
Update on the SUD Treatment Services data collection

Agenda Items for Next Meeting:
Draft Financial Reports

Next Scheduled Fiscal Oversight Committee meeting
Thursday, December 10, 2020, 9:30 am
Pennino Building, 12011 Government Center Pkwy, Fairfax, VA
Suite 836A

_____ _____

Date Approved Clerk to the Board

STEP-VA Comprehensive Update: February 2021

Because so many aspects of STEP-VA implementation were put on hold due to COVID-19 pandemic, instead of requesting a 6 month update survey from each CSB this February, we will provide you with this comprehensive update on the status of the STEP-VA project. The 6-month phase 2 check-ins will resume in August, 2021 to be included in the 2021 legislative report.

Needs Assessment Results and Cross-STEP Updates

The results of the 18-month statewide needs assessment indicated primary findings that cut across STEPs to focus on broader system issues and improvements. The Needs Assessment had a total of 7 key findings and 11 recommendations. Further, our response to the 2019 JLARC CSB funding report was put on hold while the statewide Needs Assessment was completed.

Behavioral Health Index Equity (BHIE) Workgroup:

A workgroup comprised of CSB/BHA executive directors and DBHDS program, finance, data, contracting, and other administrative staff was formed and met six times over a 12 month period in 2020 and early 2021. The workgroup came to consensus recommendation regarding short term solutions to support the ongoing implementation of STEP-VA, including the use of a needs-based funding formula. The short term needs based formula is as follows:

45% population in poverty + ALICE + 25% BHI + 20% uninsured rate at CSB measured two ways [10% each] + 10% rurality indicator = share of funding

****note: the importance of using this formula in the context of an agreed upon "floor" for funding, to ensure that small CSBs receive enough funding to implement the base services required was agreed upon as well.***

The majority of recommendations set out a longer-term strategy to decrease the overall number of funding streams from DBHDS to CSB/BHAs (currently over 90) and a process to support first steps to modernize both our funding and performance frameworks as well as our data exchange. By first focusing on achieving transactional data exchange and unique identifiers, we can then set more

ambitious goals such as cost-of-care models and shared reimbursement structures. The final report will be distributed soon.

Workforce initiatives: Needs Assessment results highlighted significant workforce issues, which have unfortunately been further exacerbated by COVID-19. In general, these related to position-based demands (paperwork, regulations, acuity/schedule) and salary/compensation not being competitive with private sector positions that required less paperwork and had fewer regulations. Successful workforce initiatives must consider both sides of this situation. Regarding paperwork, we have identified the following areas for further exploration of their feasibility. As you know, these are complicated issues with multiple offices and agencies involved and we will likely not be successful in achieving all of these. But, we are committed to clearly evaluating the feasibility and acceptability of each of these proposals which at face value are consistent with feedback from the Needs Assessment.

Paperwork reduction requests received by DBHDS and currently under review:

1	Decrease DLA-20 to every 6 months for all clients
2	No longer require DLA-20 for SUD only clients due to overlap with ASAM (still require for co-occurring)
3	No longer require quarterly review; move to 6 month review and ISP update
4	Fully integrate DBHDS and DMAS CNA requirements
5	Review paperwork requirements at each level of care with co-occurring lens and align requirements across MH and SUD

Regarding salary alignment, the idea of a statewide salary study was discussed in 2020. We have not pursued this at this time at DBHDS. A statewide workforce survey is in development in cooperation with MH/SUD council currently. We were thrilled to see the advocacy of VACSB for Behavioral Health Loan Repayment and believe this is an important avenue for workforce support.

Core Performance Outcomes: The importance of core performance outcomes that span across all program areas was highlighted by the Needs Assessment as well as both JLARC studies. It is not feasible for CSBs to achieve integration with the broader Medicaid system and work with 6 MCOs while also maintaining performance metrics for each historical DBHDS program. We have been working with Quality and Outcomes (Q&O) Committee to review historical performance outcomes in the performance contract as well as STEP-VA metrics. Currently, we are on track to have approximately 5 core metrics identified by July, 2021. The ultimate framework/estimate would be to achieve 10-12 core performance metrics. We hope to have Virginia/CSB system specific metrics (~5-6) as well as priority HEDIS measures (~5-6) once we achieve data and reporting upgrades described below. The idea is that some core metrics (e.g., DLA-20, engagement) could be evaluated for different programs and populations to serve multiple purposes. It is important to note that specific DBHDS programs (e.g., ACT, Permanent Supportive Housing, Jail Diversion, etc.) will retain their own individualized performance metrics. Initial measures being reviewed include Same Day Access measures, substance use engagement, continuity of care after state hospital discharge, and DLA-20 score improvements. Relatedly, consistent with a set of core performance metrics, a core description of the STEP-VA scope of services in a single document and associated updates to the performance contract is needed and DBHDS has begun drafting this documentation.

Data and Reporting upgrades: The vision for STEP-VA can only be achieved with a modernized data approach. Not only is this needed for quality and accountability, but also for us to better identify system

improvements regarding access and consistency. The primary investment needed is on the DBHDS side to transition to an EHR based data extract and software to replace the functions of CCS3 and little CARS. DBHDS has taken initials steps for internal approval and will soon engage with DMC to initiate planning. In order to ensure that modern structures invested in at DBHDS can interface with all EHRs at the CSBs, we will need to gather information to ensure that resources are provided to CSBs that would need a technical upgrade in order to interface with a modern, transaction-based data solution.

Billing and reimbursement improvements: The transition to carved-in behavioral health services and six MCOs drastically impacted business procedures for the CSBs. Unfortunately, due to the data limitations described above and lack of data integration with DMAS, DBHDS has had limited success in providing the support needed to identify areas of improvement for reimbursement practices. There were initial discussions in 2020 regarding the initiation of a statewide contractor to work with CSBs in this domain; however, given competing demands and COVID-19 impacts, CSBs indicated the preference was not to pursue at this time although still remains an idea for consideration. If the CSBs are interested in working with a contractor for this purpose, there is funding available to pursue this through DBHDS, please communicate back to us via VACSB.

Training and Clinical Quality: The Needs Assessment also recommended a statewide contract focused on evidence based practice and clinical quality improvement, however, as with billing and reimbursement improvements, these recommendations were made prior to COVID-19. We have been impressed with the significant investments in training in evidence based practices that the regions have achieved with self-directed planning over the last two years. We would like to continue allocating $1.5 million in outpatient funding (FY 20) towards training, and continue the regional approach launched with those funds. Additional 'set asides' within other steps (Service Members, Veterans, and Family Members, for example) can augment these funds. A subgroup of the Quality and Outcomes (Q&O) committee has recently formed which will be a critical partner in planning. This subgroup, led by Stacy Gill (ED, Goochland-Powhatan CSB), is advising on issues related to learning management systems, and what would be the best way to manage trainings that are to be statewide.

The most pressing training needs from our perspective regard continuation of DLA-20 training, ongoing ASAM training, and new trainers needed for the statewide children's mobile crisis training curriculum. We envision set asides from STEP VA funding would support the development of regional training infrastructure (e.g. outpatient services, SMVF, etc) (more on that below), as well as the new required block grant crisis set-aside.

In order to meet the upcoming, significant and on-going needs regarding training under STEP-VA, we request further structuring the initiative as follows:

1) Each region with at least .5 or 1 FTE regional training coordinator
2) Each region with at least 1.0 FTE regional trainer

With the upcoming required mobile crisis trainings for both adults and children, there will be an on-going need to have dedicated regional trainers. In summary, in the short term, these new requirements can be supplemented by additional block grant dollars being received by Virginia, but planning should begin now to ensure that over the next two years the infrastructure described is invested in using these outpatient training dollars. Initial focus of state-sponsored trainers, regardless of funding stream, will be DLA-20 and children's mobile crisis.

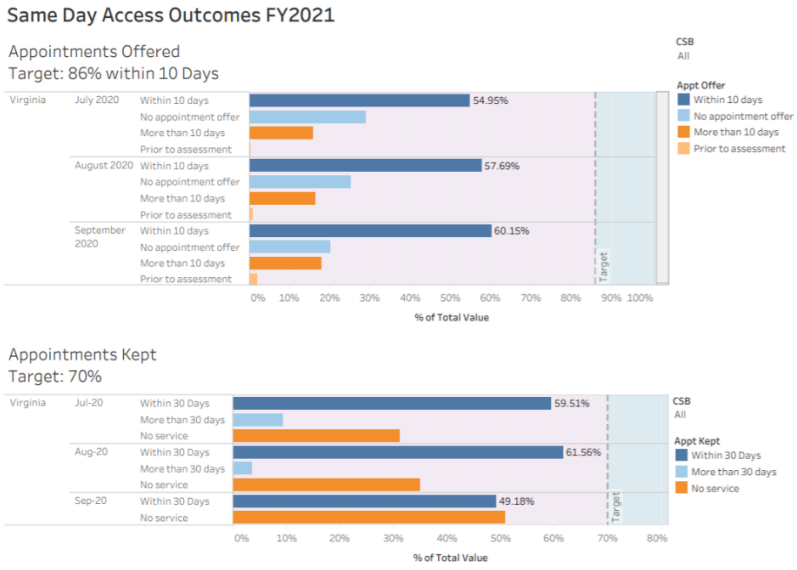
Infrastructure Funding: $3.2 million is provided in the 2022 budget for CSBs to build infrastructure needed for the implementation of STEP-VA. This will not cover all of the above stated infrastructure needs across the system. DBHDS will assess the costs associated with any CSB EHR upgrades needed to interface with a modern data system in the coming months. The remaining dollars can be disbursed either using a needs based formula, which would mean a small amount of funding for each CSB, or in a two step approach, where high needs CSBs are first identified and then funding is distributed among those CSBs who need the infrastructure funding the most. DBHDS seeks VACSB input into this determination so that decisions for planning can be made by May, 2021.

Individual Step Updates

Same Day Access

All CSBs continued providing SDA throughout the COVID-19 pandemic, with a focus on transitioning to telehealth platforms, and calibrating processes to ensure that services were also continuously available for individuals without access to telehealth while maintaining staff safety. Innovations included drive up services, two-room approaches, and more.

Data Management Committee (DMC) as well as a subgroup focused on data quality has been working to improve data quality around Same Day Access metrics. The goal is to implement any behavioral changes, CSB guidance, DBHDS quality checks, and shared understanding of any remaining limitations of the data in its current status by July, 2021. The status of the data currently is reflected below. We plan to make this information available to CSBs on a refreshed data dashboard beginning in FY22. As you can see, the capture of "appointment offered" remains an issue (and we understand that this is not a data element captured for any other purpose or captured as part of typical business procedures). The appointment kept measure has fewer identified data issues, and as can be seen, at a state-wide level, we are close to meeting the target of 70%, which is extremely promising.



Primary Care Screening

Early in the pandemic, we released guidance on the implementation of this STEP that supported CSBs to focus on clinical need when determining primary care screening services. Further, we expanded the window for 2020 screenings from 12 months to an 18 month window. In determining clinical need for a primary care screen, factors to consider include whether the individual has a primary care physician (PCP) and whether they have had a recent visit with their PCP. The completion of metabolic screens for individuals prescribed antipsychotic medication is a more pressing clinical issue, and it is our understanding that most CSBs have continued to see these clients in person, even if less frequently, as clinically indicated.

Little did we know the pandemic would still be having major impacts on in-person services a year later. Clinically, our guidance remains the same: primary care screens should be prioritized for individuals without connections to primary care, all clients should be connected to primary care and followed to ensure successful connections, and metabolic screens remain highly important for individual prescribed antipsychotic medications, with best practice considered to be screening at each maintenance appointment (approximately every 3 months). With more advanced data capture, we would pursue measuring this more closely, but unfortunately, the limits of CCS3 and continuing impediments associated with the pandemic make it very difficult to clearly identify these processes when they are being determined based on clinical need. Thus, we are relying on CSBs to continue to evaluate their internal data for quality improvement. At the state level, we continue to monitor the number of screens completed each month. This is a key area we hope to improve with improvements to the DBHDS-CSB data relationship.

Outpatient Services

Outpatient service offerings have grown significantly with the $15 million investment, including over 100 new positions across outpatient provider types, broadening specializations within CSBs across adult SMI, adult SUD, and child and family services, innovative retention and recruitment efforts, and a range of training and development initiatives. Outpatient services is also a STEP where additional funding is expected for fiscal year 2022.

Based on the BHI formula above, allocations of the remaining $6.9 million in outpatient funding would be as follows. It is important to note that a base allocation is a key part of the formula; since a base had been applied with the original funding, this could be interpreted two ways. The numbers below do not provide a *new* base for the $6.9 million, but instead distribute the $6.9 million according to the formula considering the original base allocation as the base. Chart 1 has estimated allocations for the $6.9 million in one column and then the total ongoing outpatient allocation would be (inclusive of the fully allocated $15,000,000). Final decisions regarding funding for outpatient services will be made in late April, so ensure that any input is provided back to DBHDS by March for consideration in this funding process. Please send input via VACSB. Please also note that baseline measures for trauma training/EBP use will be integrated into the end of year block grant report and collected for baseline measurement this June/July.

CSB/BHA	Additional Allocation (of $6.9 million)	Total Outpatient Allocation
Alexandria CSB	$176,799	$455,784
Alleghany Highlands CSB	$61,872	$390,187
Arlington County CSB	$204,045	$483,030
Blue Ridge Behavioral Healthcare	$198,435	$585,815
Chesapeake Integrated Behavioral Healthcare	$166,101	$513,996
Chesterfield County CSB	$139,237	$423,272
Colonial Behavioral Health	$80,707	$364,742
Crossroads CSB	$122,761	$470,656
Cumberland Mountain CSB	$155,647	$483,962
Danville-Pittsylvania Community Services	$106,351	$454,246
Dickenson County Behavioral Health Services	$60,101	$388,416
District 19 CSB	$214,709	$602,089
Eastern Shore CSB	$82,741	$430,636
Fairfax-Falls Church CSB	$482,976	$796,261
Goochland-Powhatan CSB	$60,886	$448,266
Hampton-Newport News CSB	$214,824	$498,859
Hanover County CSB	$61,853	$390,168
Harrisonburg Rockingham CSB	$160,588	$508,483
Henrico Area MH and DS	$269,261	$597,576
Highlands CSB	$129,770	$413,805
Horizon Behavioral Health	$231,874	$579,769
Loudoun County CSB	$193,691	$506,976
Middle Peninsula-Northern Neck CSB	$144,958	$532,338
Mount Rogers CSB	$146,128	$494,023
New River Valley Community Services	$207,071	$554,966
Norfolk CSB	$257,783	$605,678
Northwestern CSB	$233,026	$620,406
Piedmont CSB	$159,433	$507,328
Planning District One Behavioral Health Services	$134,836	$463,151
Portsmouth Department of Behavioral Healthcare Services	$106,768	$454,663
Prince William County CSB	$323,220	$680,785
Rappahannock Area CSB	$269,874	$657,254
Rappahannock-Rapidan CSB	$147,130	$495,025
Region Ten CSB	$223,044	$570,939
RBHA	$244,471	$572,786
Rockbridge Area CSB	$77,508	$425,403

Southside CSB	$104,501	$432,816
Valley CSB	$154,150	$438,185
Virginia Beach CSB	$261,080	$608,975
Western Tidewater CSB	$154,795	$483,110

Total outpatient allocations would range from about $364,000-$796,000. Additional guidance will be forthcoming regarding planning for these additional funds.

Crisis Services

Crisis Services is the most complex STEP of STEP-VA. We continue to be grateful for your honest feedback as well as grace in working through the complexities of an integrated cross-disability, highly accessible, state-wide crisis system. We remain committed to this vision, and believe Virginia is poised to be the first state to successfully build this in the public sector while integrating existing safety net structures and private providers of crisis services into a statewide Crisis Now model. The private sector providers will also play a role in partnering to provide crisis services in coordination with the regional hubs. We acknowledge that there have been miscommunications and difficulties along the way, and are grateful that we have arrived at a mutually agreeable shared vision and are now taking steps to bring this to life. The key components and their status are:

Statewide shared infrastructure for data capture, tracking, and dispatch of mobile crisis:

Request for Proposals has been posted for this technological infrastructure.

9-8-8 Implementation: Federal law now requires that 9-8-8 is available July 16, 2022, and Virginia plans to integrate 9-8-8 implementation with broader crisis system transformation. Virginia was recently awarded a 9-8-8 implementation planning grant, which will begin with forming a 9-8-8 coalition in the coming months.

Regional call center operators:

a description of the call center operations has been reviewed in STAC and the parameters document and draft funding structure have been shared with the regions. Funds for call center staff will be available beginning July 1, 2021. If your region has not solidified a plan or vision for operating as a call center, it is time to do so now. We also urge you to consider creative solutions including partnering or subcontracting with existing NSPL call centers in Virginia and considering cross-regional collaborations to ensure efficiency where it makes sense.

Specialized child mobile crisis services:

regions continue to build their child hubs and teams. Please ensure that your teams will be ready to bill Medicaid December, 2021. As you know, a statewide 36-hour training curriculum is in development that will be required of all providers of STEP-VA. This training will assist with developing the workforce to have the skills and core base competencies needed to provide child and adolescent mobile crisis services and allow for greater uniformity of services across the state to expand consistent service delivery and dispatch. Each module will be six hours and will cover the following topics: safety, screening/assessment, family dynamics, trauma, intellectual and developmental disabilities and de-escalation. Currently, there is an expectation through the draft medical necessity criteria that all crisis providers (private and public) will be required to participate in the statewide training to ensure continuity and consistency. There will be a request forthcoming for trainer nominations to ensure that we have trainers in the curriculum in each region. As part of the new MHBG crisis set-aside, there is potential funding for trainer positions, and we believe that having current

staff, such as supervisors, to be trained as trainers, in addition to devoted training positions would be the best path forward.

Adult mobile crisis services: Partial funding for adult mobile crisis services will be available July 1, 2022. All teams funded through STEP-VA will be managed by the regional hubs. Parameter document and draft budget were distributed through STAC for completion and submission by March 19, 2021

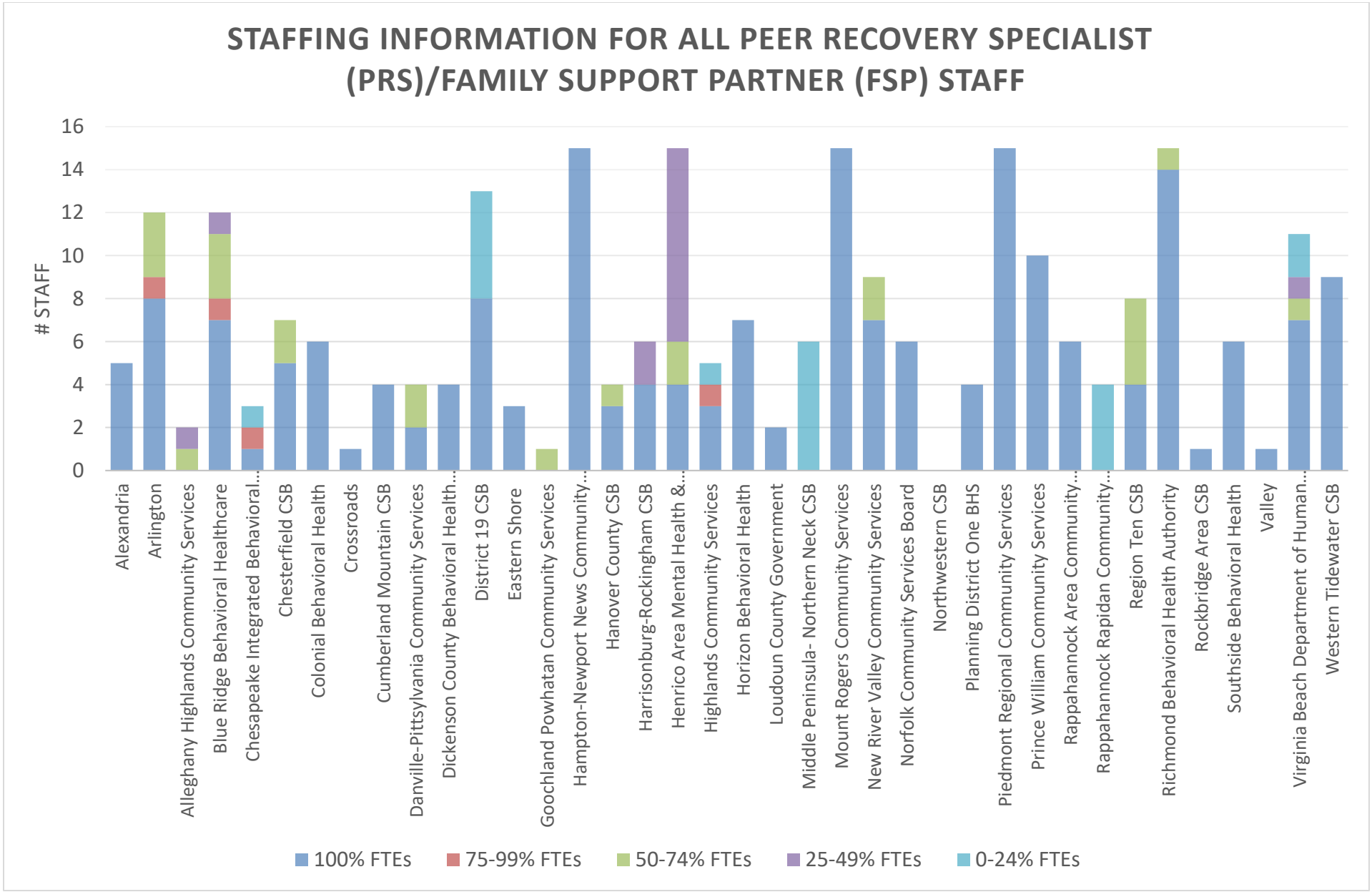
Crisis integration*:* A comprehensive plan for integration will be developed following the implementation of the call center and dispatch leveraging community providers to ensure comprehensive coverage throughout the regions. A comprehensive plan for integration of crisis services refers to the long-term alignment of the community systems' current system to align with national best practices, create low and no barrier entries to crisis services (i.e. no wrong door, easy access), and eventual leveraging and blending of funds across current traditional disability-specific funding lines to create a comprehensive system that supports people in their own communities, focuses on trauma informed care, and meets individual needs regardless of disability or diagnosis. Plan elements would include, for example, timeline, funding considerations, workforce capacity needs and gaps, and policy, Code and regulatory considerations, and timeline.

Marcus Alert: Although the addition of the Marcus Alert requirements added complexities to the STEP-VA crisis implementation, we believe this is a unique opportunity to critically analyze and enhance the design of our crisis system to focus on equitable access, racial disparities, and coordination with law enforcement from a racial equity perspective while the system is still in development. We remain focused on building upstream mobile crisis services without law enforcement as the key feature of our crisis system, and believe that the Marcus Alert requirements are complementary to this goal. Statewide coverage by STEP-VA mobile crisis will partially meet the Marcus Alert community coverage requirements, although we understand that localities/catchment areas will also be investing in co-responder models and other programs. It is important to note that even if your area invests in a co-responder model, crises that can be managed by STEP-VA crisis services need to be diverted to the behavioral health system to ensure equal access to least restrictive services. A comprehensive array of crisis services is a robust continuum with structures and protections at the state, regional, and local level, with flexibilities extended to ensure coordination between systems, and the Marcus Alert is an opportunity for each locality to engage with a systems perspective on planning and integration.

Peer and Family Support

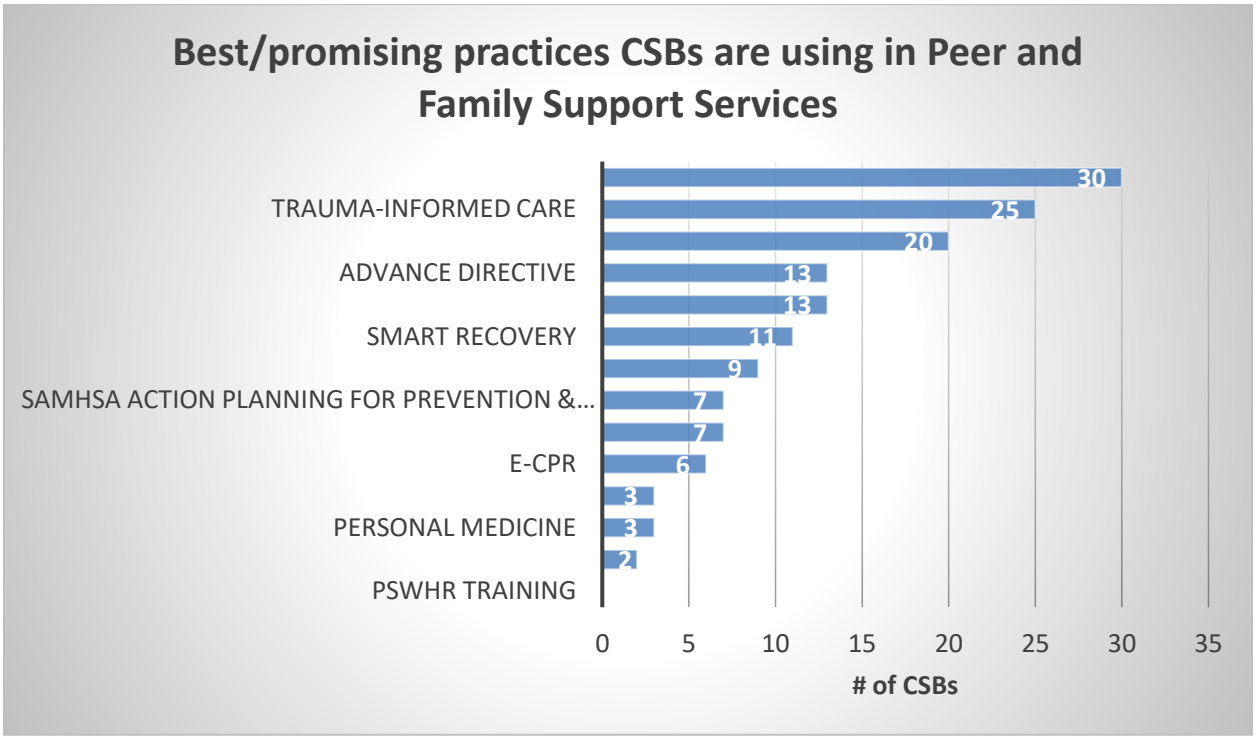
Funding initially allocated to this STEP was frozen due to COVID-19 pandemic, and we are glad that this funding is re-allocated for fiscal year 2022. Due to the funding freeze, instead of providing a funding plan, you each completed a needs assessment survey to provide us with insight into your current peer services and needs for expansion. Some of these survey results are summarized below. Funding for this STEP will begin July, 2021. Information about disbursements and requirements will be formalized by April, 2021.

Until this current fiscal year, direct capturing and reporting of services specifically offered by Peer Recovery Specialists or Family Support Partner staff was largely missed by our community service data systems. The chart below allows us to gauge the landscape of how these staff are distributed across CSBs.


STAFFING INFORMATION FOR ALL PEER RECOVERY SPECIALIST (PRS)/FAMILY SUPPORT PARTNER (FSP) STAFF
STAFF
16
14
12
10
8
6
4
2
0
Alexandria
Arlington
Alleghany Highlands Community Services
Blue Ridge Behavioral Healthcare
Chesapeake Integrated Behavioral...
Chesterfield CSB
Colonial Behavioral Health
Crossroads
Cumberland Mountain CSB
Danville-Pittsylvania Community Services
Dickenson County Behavioral Health...
District 19 CSB
Eastern Shore
Goochland Powhatan Community Services
Hampton-Newport News Community...
Hanover County CSB
Harrisonburg-Rockingham CSB
Henrico Area Mental Health &...
Highlands Community Services
Horizon Behavioral Health
Loudoun County Government
Middle Peninsula- Northern Neck CSB
Mount Rogers Community Services
New River Valley Community Services
Norfolk Community Services Board
Northwestern CSB
Planning District One BHS
Piedmont Regional Community Services
Prince William Community Services
Rappahannock Area Community...
Rappahannock Rapidan Community...
Region Ten CSB
Richmond Behavioral Health Authority
Rockbridge Area CSB
Southside Behavioral Health
Valley
Virginia Beach Department of Human...
Western Tidewater CSB
100% FTEs
75-99% FTEs
50-74% FTEs
25-49% FTEs
0-24% FTEs

In total, there are 257 PRS and FSP staff reported by the 38 CSBs responding to the survey. The dark blue bars represent how many of those are full-time 100% FTEs. Full-time FTEs strongly outweigh part-time staff and comprise about 77% of all PRS/FSP staff. CSBs range in having anywhere from 0 to 1 staff to 15 staff in these roles.

The following chart identifies what types of best practices are used by the CSBs to support this service area. WRAP (wellness recovery action plan), Trauma-Informed Care, and Permanent Supportive Housing were the most popular items selected amongst the list provided.

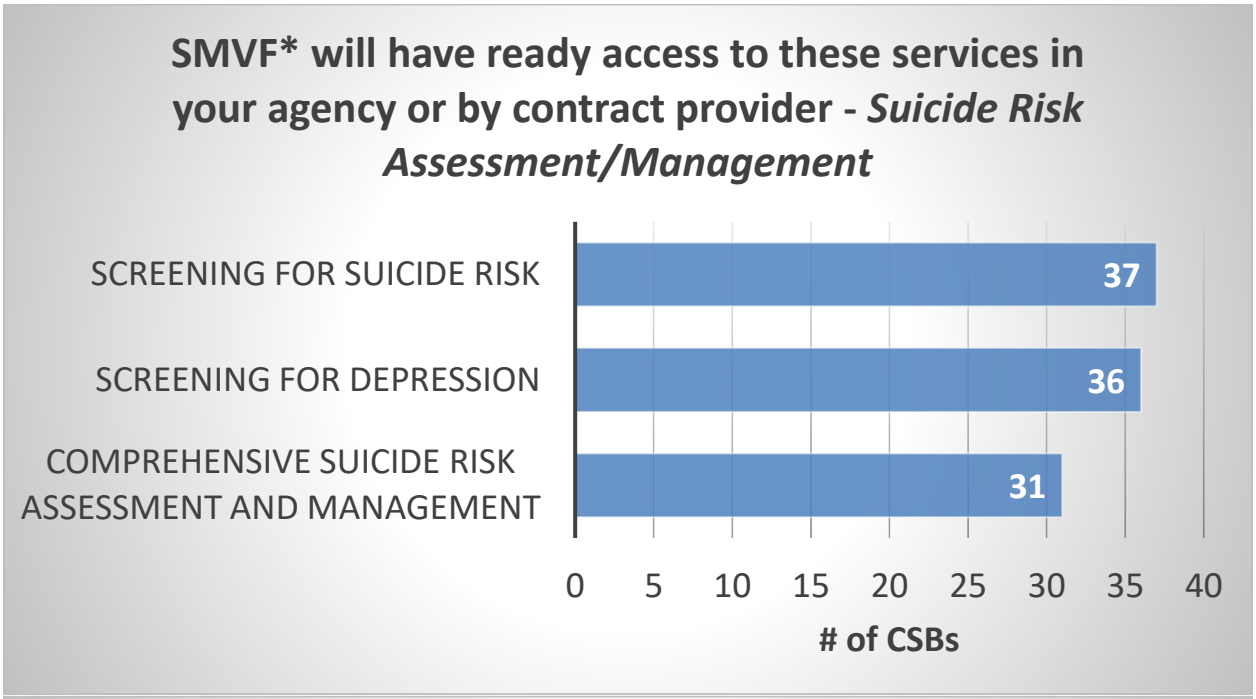


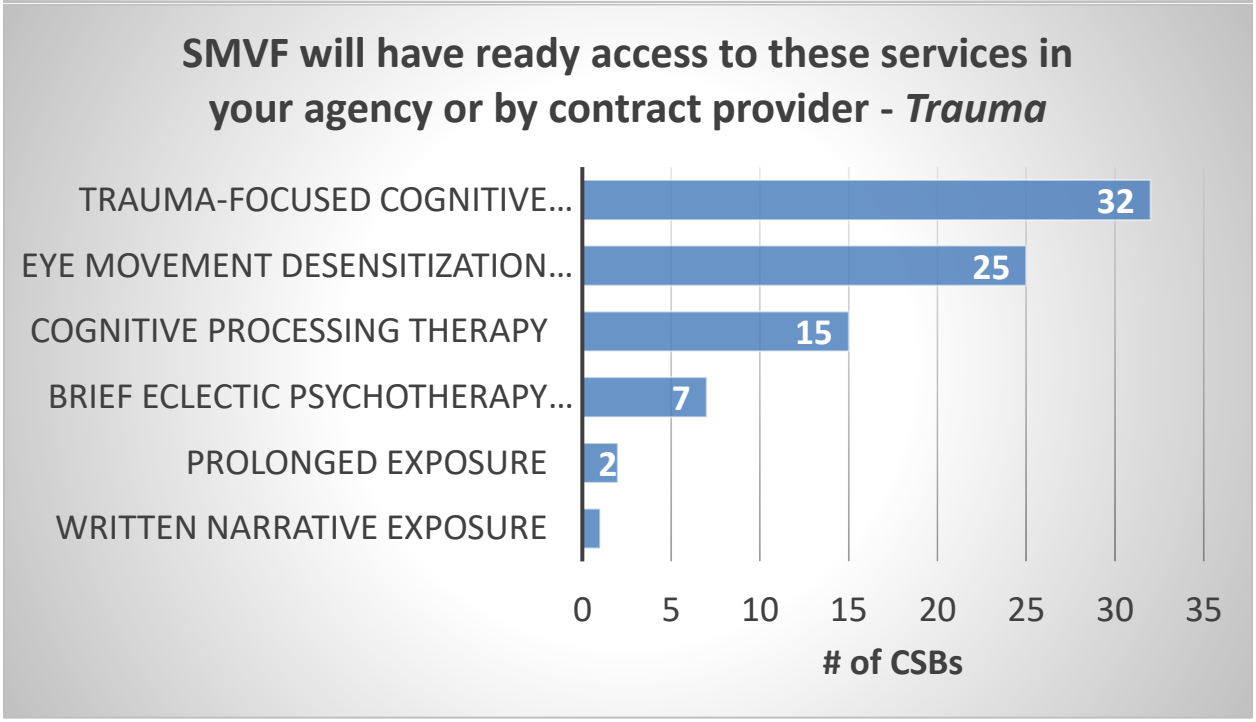
Service Members, Veterans, and Family Members (SMVF)

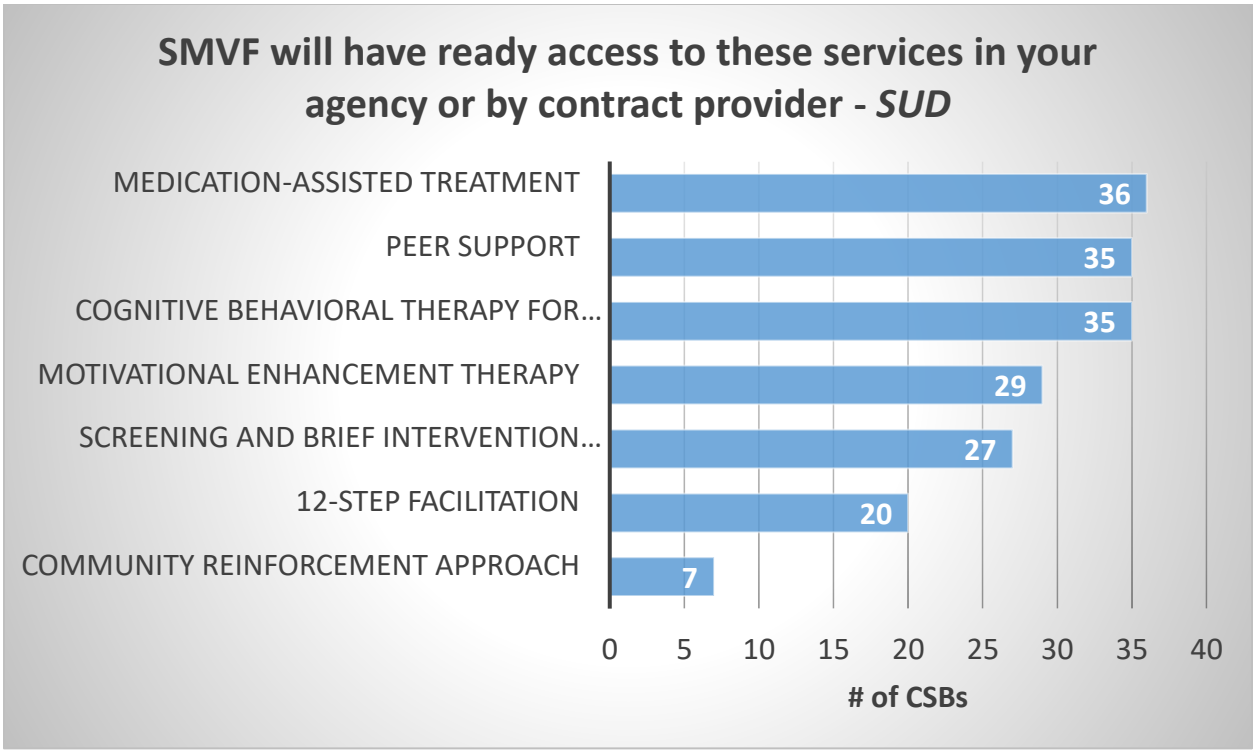
Similar to Peer and Family Support, this funding was initially frozen but has been reallocated for fiscal year 2022. Results of the needs assessment will be utilized to inform additional planning and centers on four key components as established by the work group throughout 2019-2020: 1) Clinical service enhancements; 2) Regional navigators/coordinators; 3) Lock and Talk Program Support and Development; and 4) Training and Capacity Building. DBHDS experienced a loss with the departure of Brandi Jancaitis, but we are happy the Commonwealth has retained her in an important role at Department of Veterans Services. Funding for this STEP will begin July, 2021 and will apply both regionally (Regional Navigators; Lock and Talk; Training and Capacity Building) and CSBs (Clinical Service Enhancements). Information about disbursements and requirements will be formalized by April, 2021.

CSBs recently responded to a survey to identify current infrastructure to support this STEP and what is required to progress to implementation of this STEP. Some of the findings below illustrate CSB's current

ability to offer services to SMVF individuals recommended by the Department of Defense and Veterans Health Administration.





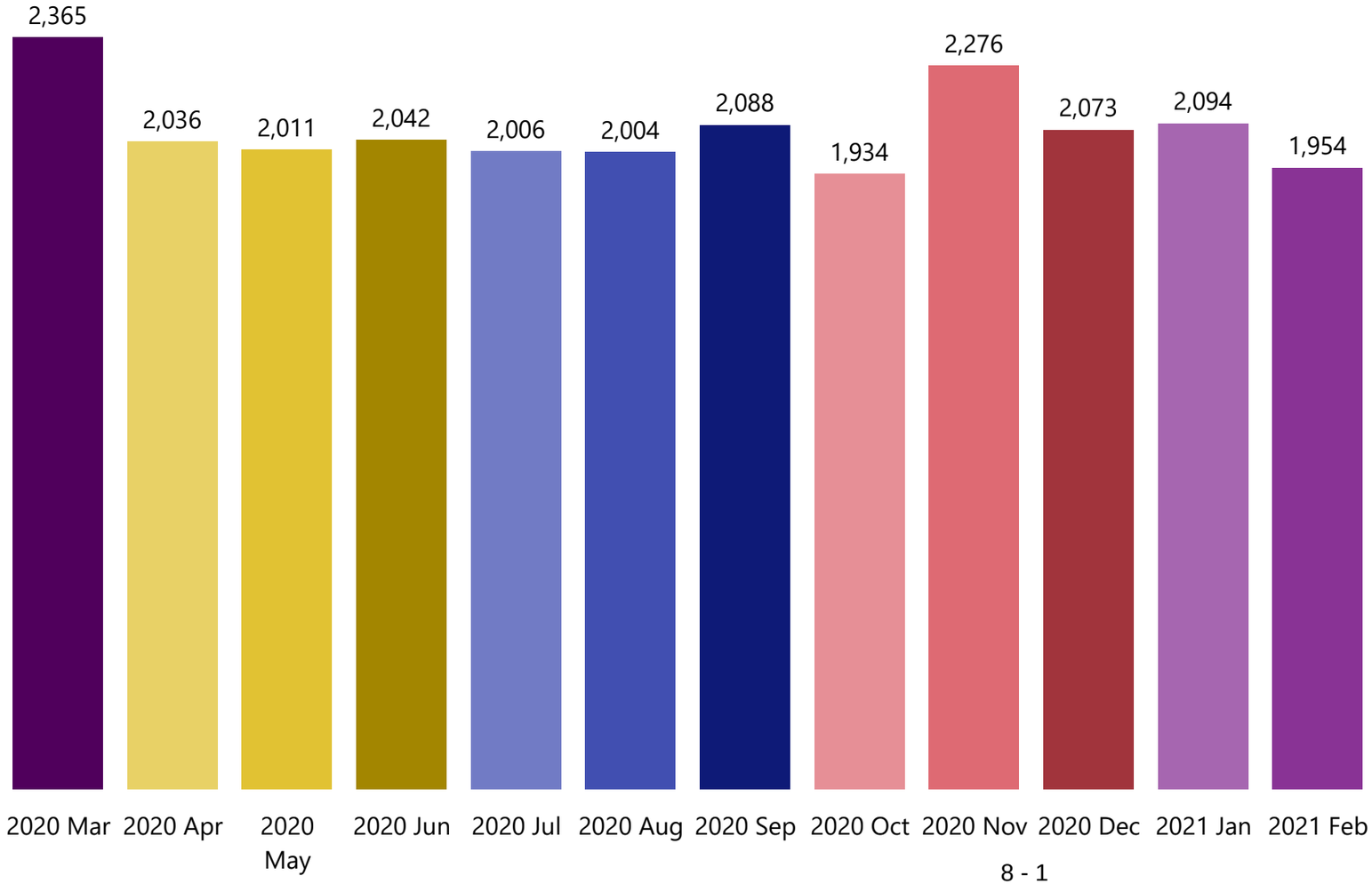


Case Management, Care Coordination, and Psychiatric Rehabilitation

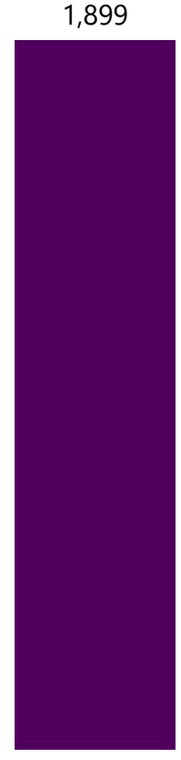
The implementation of the final three STEPs of STEP-VA is expected during the 2023-2024 biennium. Results of the needs assessment emphasized the importance of pivoting plans to focus on Medicaid integration for sustainability and long-term success, given important systems changes such as Medicaid expansion and carve-in of behavioral health services that have transpired since STEP-VA was originally designed. DBHDS recommends the integration of STEP-VA implementation for these STEPs with the Behavioral Health Enhancements process through Virginia Medicaid. Due to the timelines and approvals needed regarding any further progress on the BH Enhancements project, we do not have a specific update at this time, outside of our general plan to seek integrated implementation during the 2023-2024 biennium.

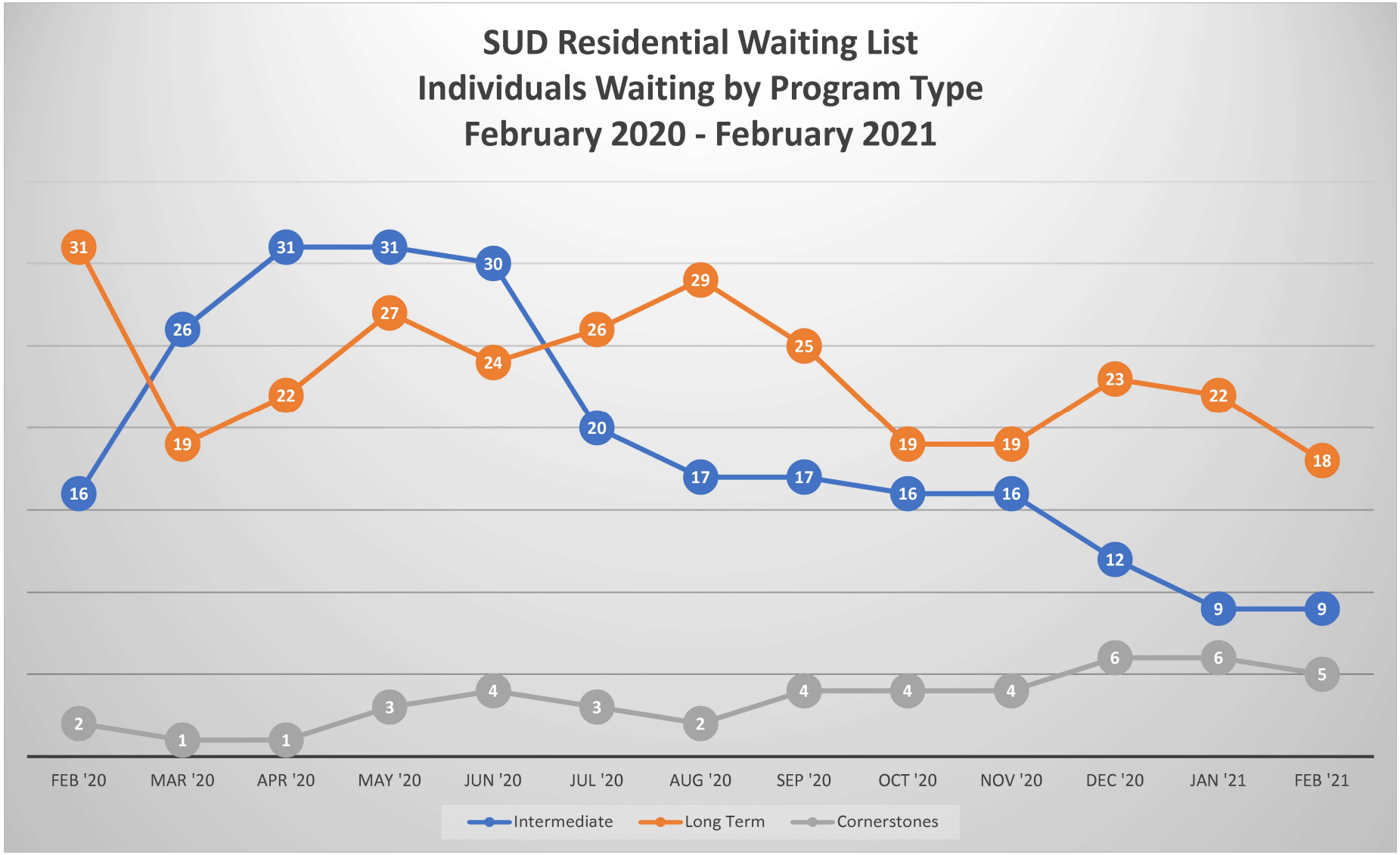
Agency Wide - Average Clients Served per Day

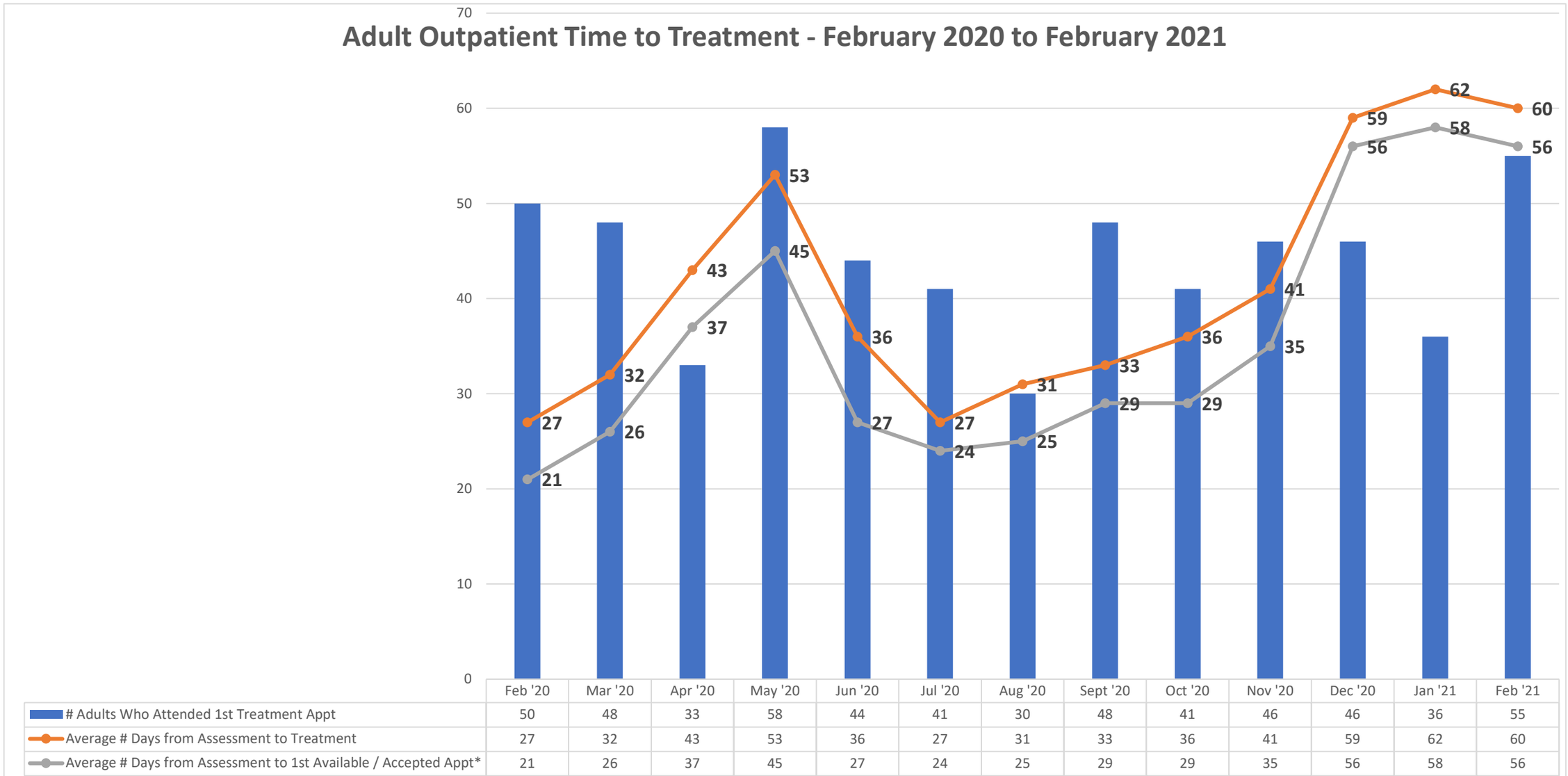
Excludes Emergency & Residential



Current Month (week ending)



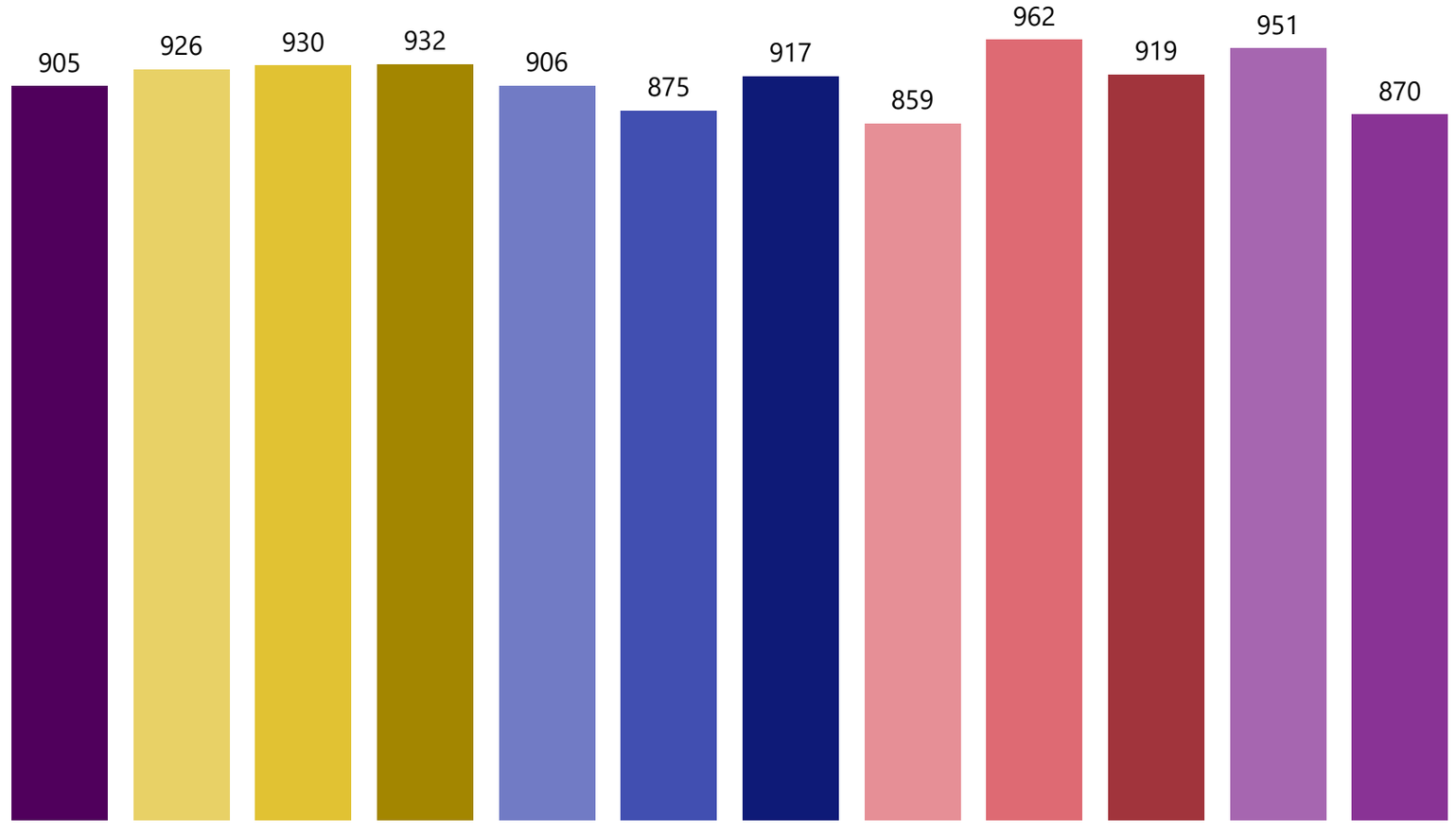

SUD Residential Waiting List
Individuals Waiting by Program Type
February 2020 - February 2021
31
26
31
31
30
20
17
17
16
16
12
9
9
19
22
27
24
26
29
25
19
19
23
22
18
2
1
1
3
4
3
2
4
4
4
6
6
5
FEB '20
MAR '20
APR '20
MAY '20
JUN '20
JUL '20
AUG '20
SEP '20
OCT '20
NOV '20
DEC '20
JAN '21
FEB '21
Intermediate
Long Term
Cornerstones

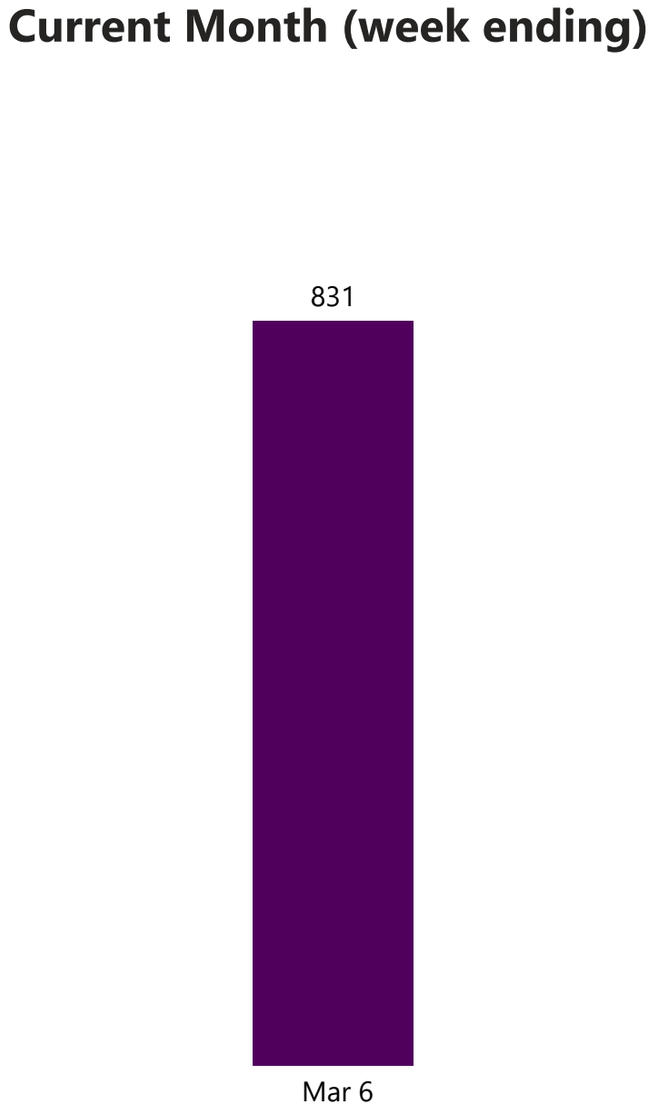


	Feb '20	Mar '20	Apr '20	May '20	Jun '20	Jul '20	Aug '20	Sept '20	Oct '20	Nov '20	Dec '20	Jan '21	Feb '21
# Adults Who Attended 1st Treatment Appt	50	48	33	58	44	41	30	48	41	46	46	36	55
Average # Days from Assessment to Treatment	27	32	43	53	36	27	31	33	36	41	59	62	60
Average # Days from Assessment to 1st Available / Accepted Appt*	21	26	37	45	27	24	25	29	29	35	56	58	56

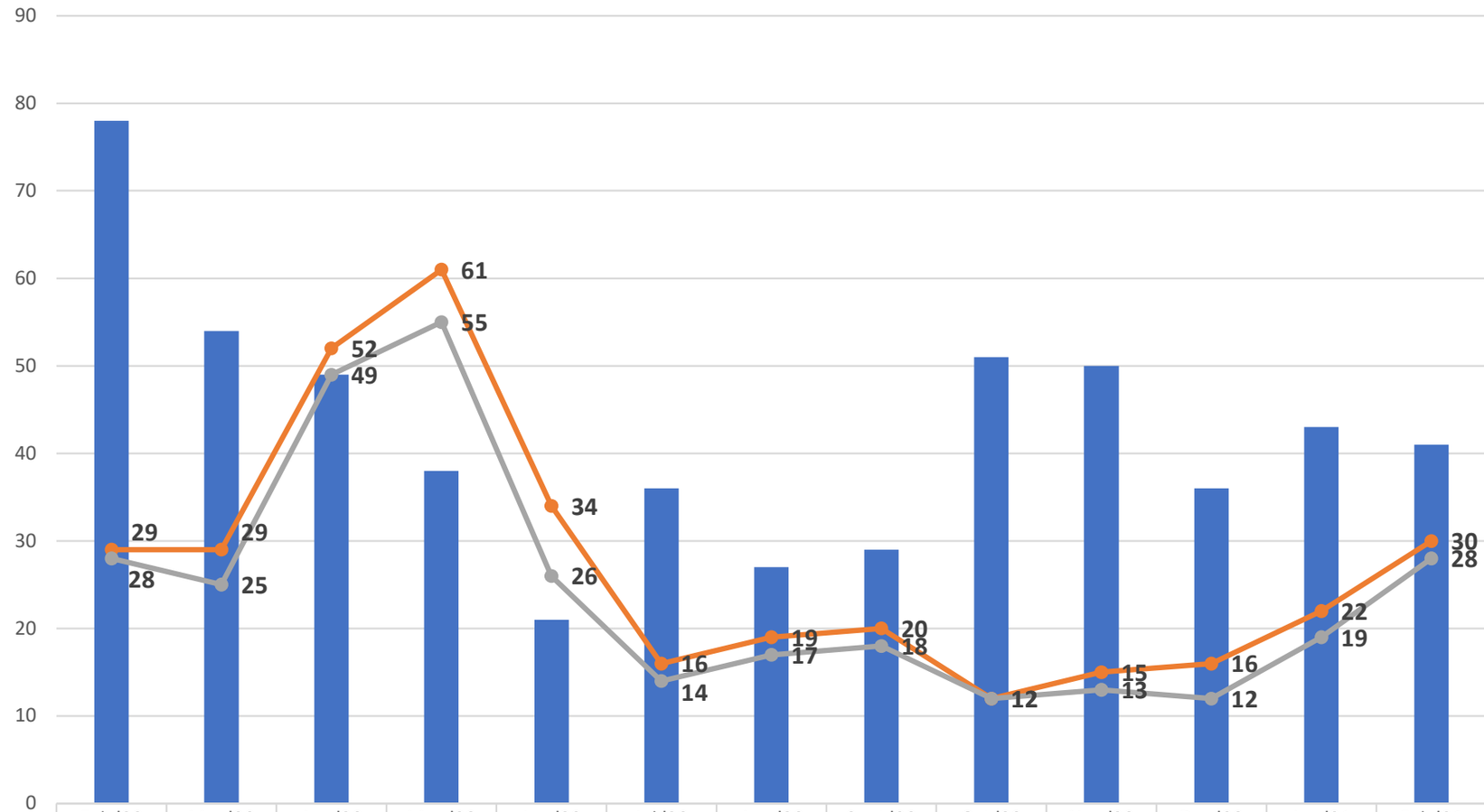
***Average number of days from Assessment to Date of First Available Appointment (if known) OR from Assessment to Date of First Accepted Appointment**

BH Outpatient - Average Clients Served per Day



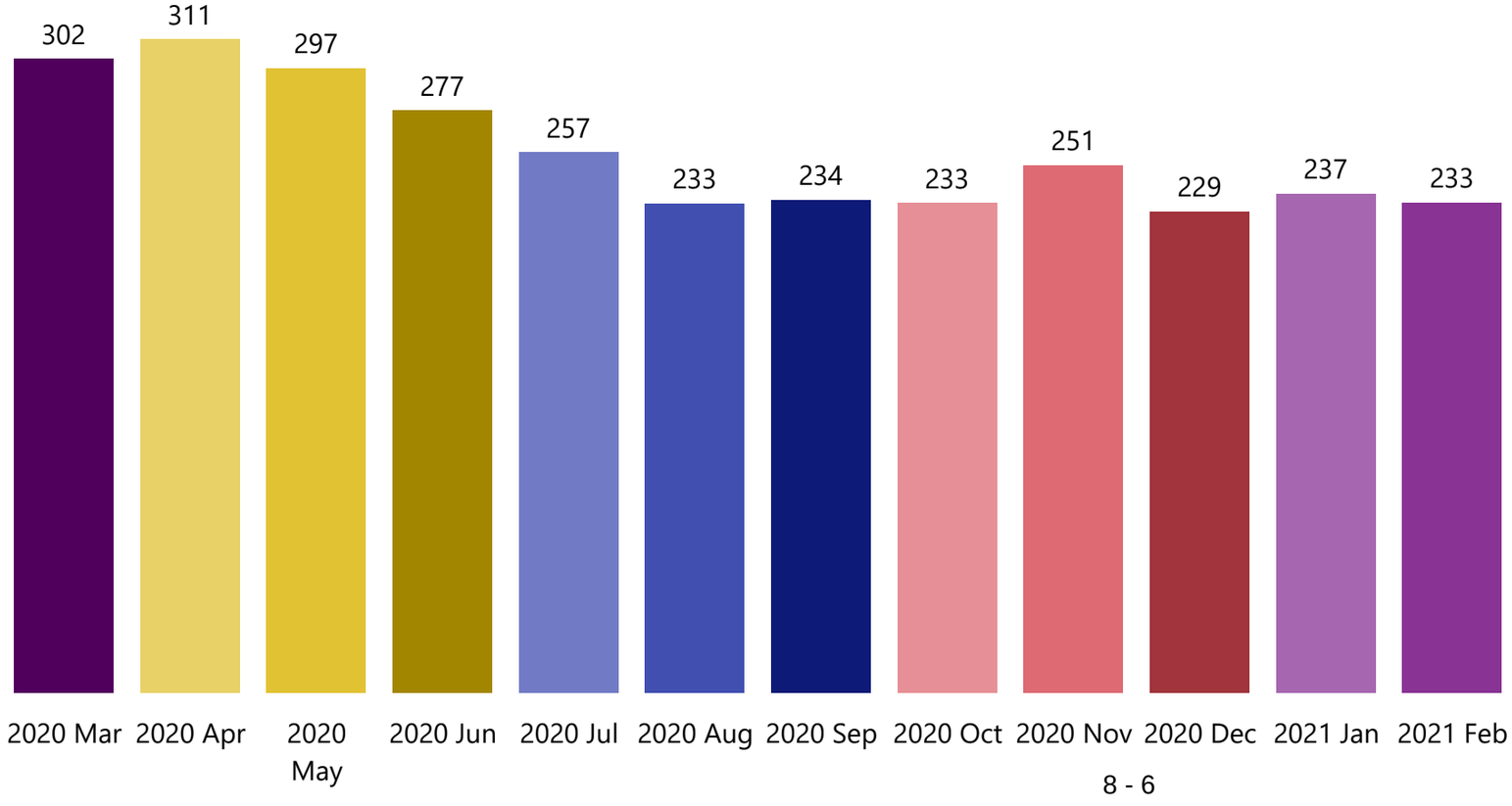


Youth Outpatient Time to Treatment - February 2020 to February 2021



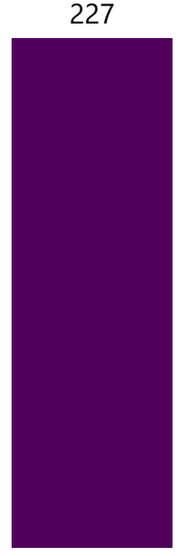
	Feb '20	Mar '20	Apr '20	May '20	Jun '20	Jul '20	Aug '20	Sept '20	Oct '20	Nov '20	Dec '20	Jan '21	Feb '21
# Youth Who Attended 1st Treatment Appt	78	54	49	38	21	36	27	29	51	50	36	43	41
Average # Days from Assessment to Treatment	29	29	52	61	34	16	19	20	12	15	16	22	30
Average # Days from Assessment to 1st Available / Accepted Appt*	28	25	49	55	26	14	17	18	12	13	12	19	28

Youth Outpatient - Average Clients Served per Day

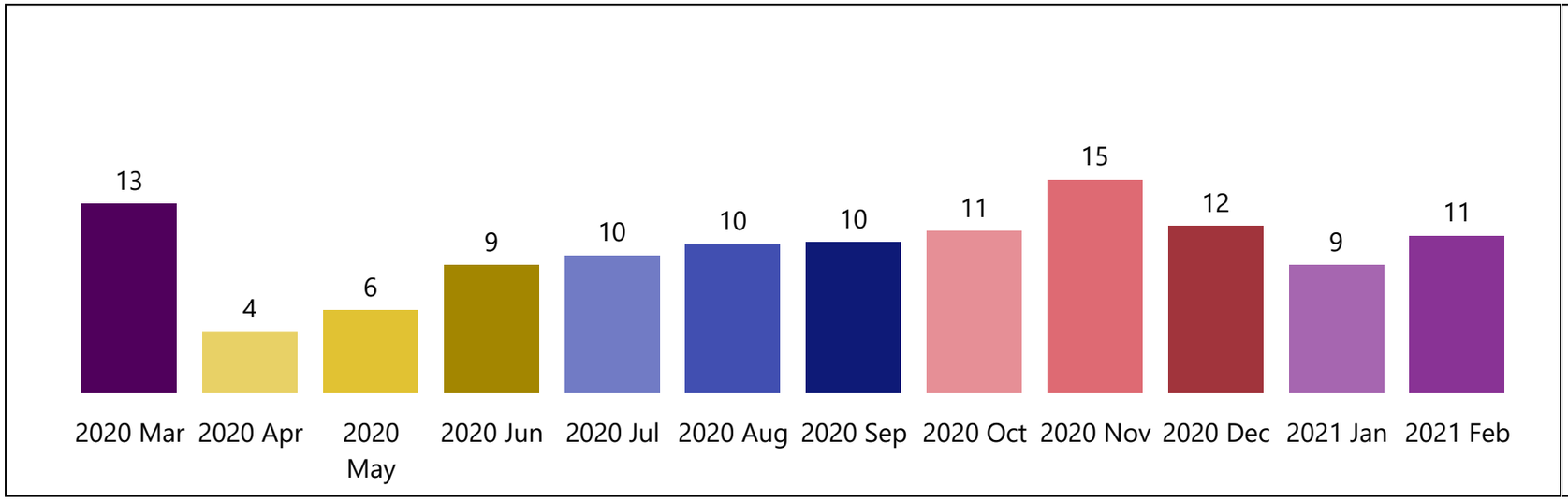


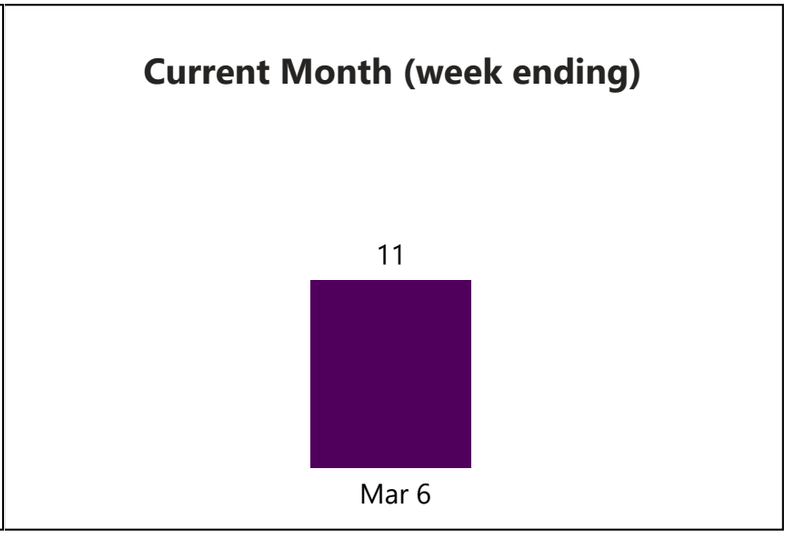
8 - 6

Current Month (week ending)

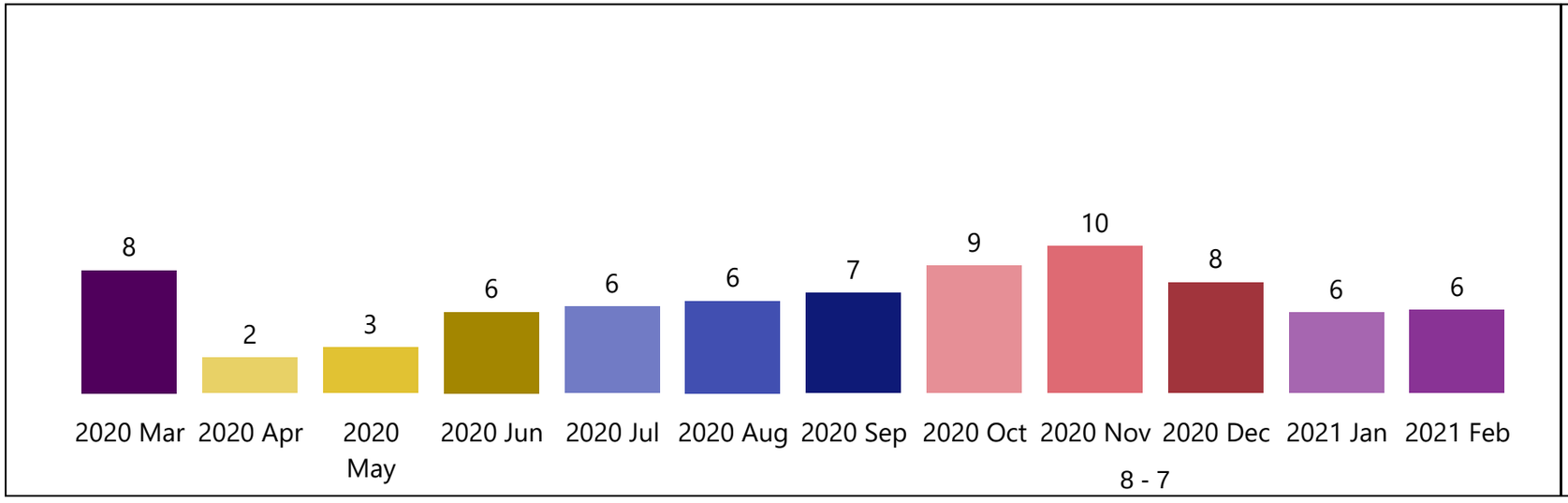


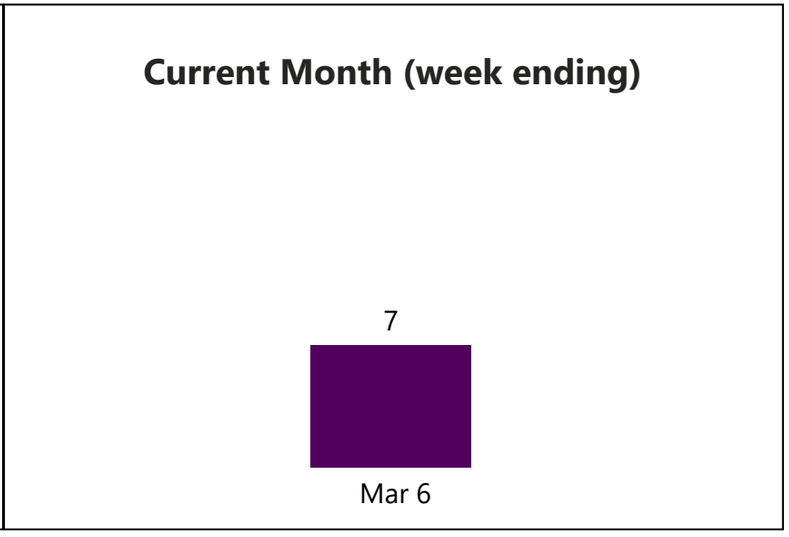
EAR - Average Clients Screened per Day



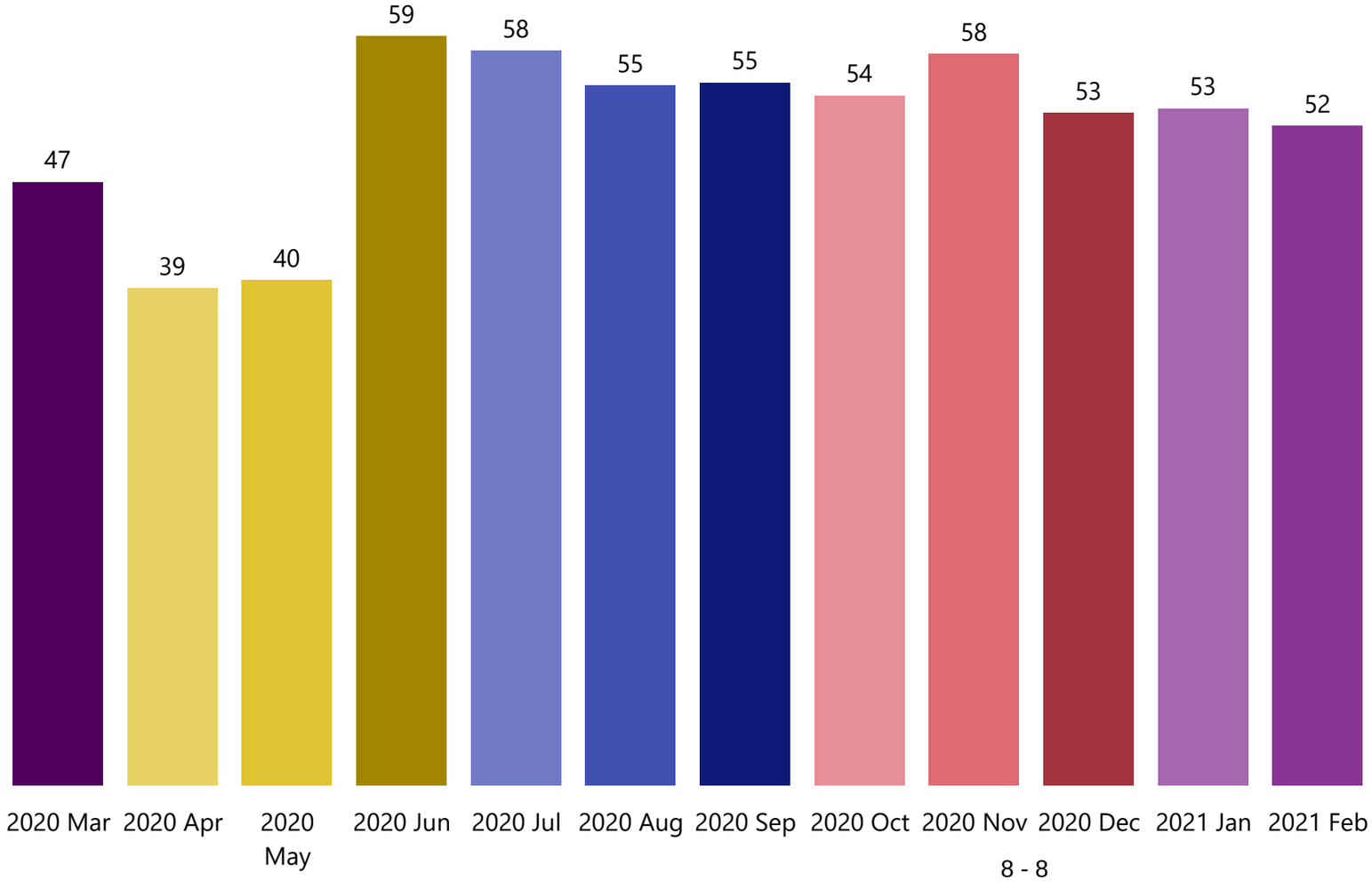


EAR - Average Clients Assessed per Day



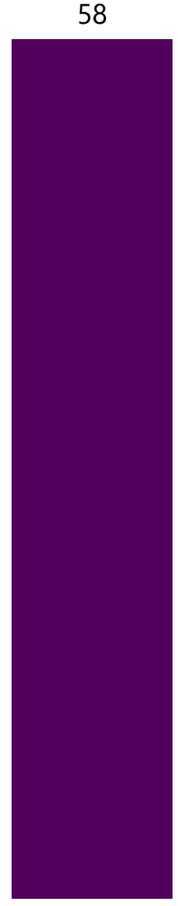


Emergency - Average Clients Served per Day



8 - 8

Current Month (week ending)



Fairfax-Falls Church Community Services Board
Fund 40040 Statement
FEBRUARY FY 2021

		FY 2021 Approved Budget	FY 2021 YTD Budget	FY 2021 Actuals Thru February 2021	Variance from YTD Budget	FY 2021 Projection
	Beginning Balance (Est)	**25,550,695**				**25,550,695**
F	Fairfax City	2,218,100	1,663,575	1,663,575	-	2,218,100
F	Falls Church City	1,005,368	754,026	754,026	-	1,005,368
F	State DBHDS[1]	7,527,316	5,018,211	5,508,965	490,754	7,527,316
F	Federal Pass Thru SAPT Block Grant	4,053,659	2,702,439	2,880,644	178,205	4,053,659
V	Direct Federal Food Stamps	154,982	103,321	32,693	(70,629)	154,982
V	Program/Client Fees	3,994,251	2,662,834	2,818,928	156,094	5,708,359
V	CSA	858,673	572,449	406,523	(165,926)	696,514
V	Medicaid Option	12,518,068	8,345,379	5,388,644	(2,956,735)	9,535,121
V	Medicaid Waiver	2,962,684	1,975,123	4,925,651	2,950,529	7,365,834
V	Miscellaneous	14,100	9,400	88,226	78,826	352,905
	Non-County Revenue	35,307,201	23,806,756	24,467,875	661,119	38,618,158
	General Fund Transfer	147,554,569	147,554,569	147,554,569	-	147,554,569
	Total Available	**208,412,465**	**171,361,325**	**172,022,444**	**661,119**	**211,723,422**
	Compensation[2]	84,104,115	58,225,926	52,687,438	5,538,487	87,484,093
	Fringe Benefits[3]	37,187,394	25,745,119	22,328,457	3,416,662	36,447,724
	Operating[4]	69,145,965	46,097,310	32,176,699	13,920,611	58,909,681
	Recovered Cost (WPFO)	(1,738,980)	(1,159,320)	(554,204)	(605,116)	(1,738,980)
	Capital	76,469	50,979	60,627	(9,647)	76,469
	Transfer Out	1,500,000	1,500,000	1,500,000	-	1,500,000
	Total Disbursements	**190,274,963**	**130,460,014**	**108,199,017**	**22,260,997**	**182,678,987**
	Ending Balance	**18,137,502**				**29,044,434**
	DD MW Redesign Reserve[5]	2,500,000		2,500,000		2,500,000
	Medicaid Replacement Reserve[6]	2,800,000		2,800,000		2,800,000
	Opioid Epidemic MAT Reserve[7]	300,000		300,000		300,000
	Diversion First Reserve[8]	3,329,234		3,329,234		3,329,234
	COVID Revenue Impact Reserve[9]	2,000,000		2,000,000		2,000,000
	Electronic Health Record Reserve[10]	3,000,000		3,000,000		3,000,000
	Unreserved Balance	**4,208,268**				**15,115,200**

Key

F Fixed Annual Allocations

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

Comments

1 FY21 Budget for State Funds Due to Medicaid Expansion, DBHDS reduced our revenue by ~$4.4M.

2-4 FY21 Expenditures budget has not been adjusted for FY20 budget realignment exercise, therefore compensation and benefits budgets are understated and operating budget is overstated. Operating Budget now includes FY20 Carryover Request of $5.8M for encumbrances, of which $250K is allocated from Diversion First Reserve to cover costs associated with medical clearances.

5 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.

6 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.

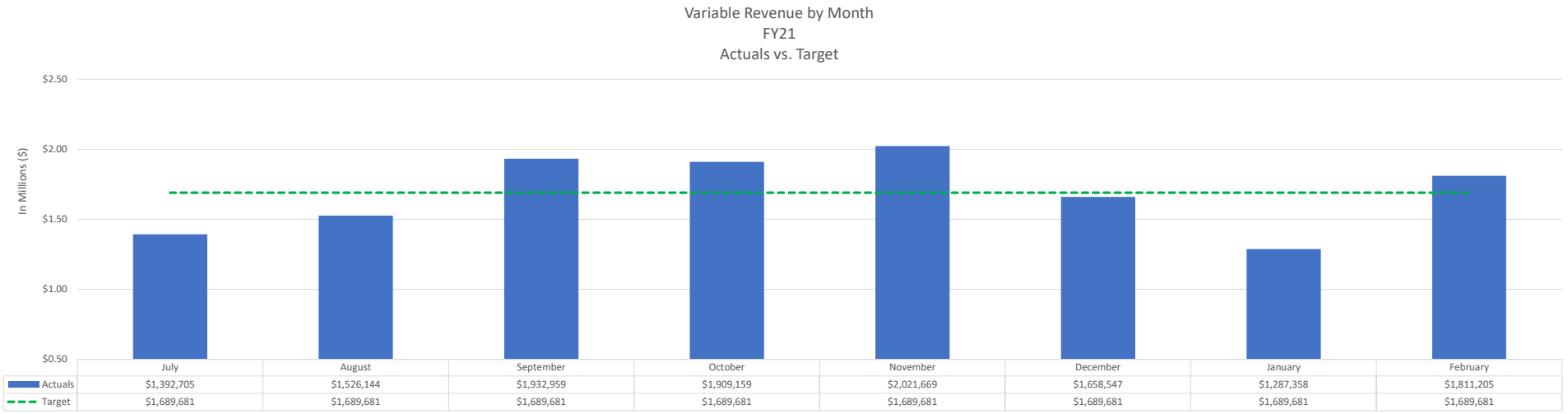
7 The Opioid Use Epidemic Reserve provides flexibility, consistent with the Board of Supervisors' FY 2018-FY 2019 Budget Guidance, as the County continues to work with national, state, and regional partners on strategies to combat the opioid epidemic.

8 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.

9 As a result of COVID-19, the CSB is forecasting a negative impact to variable revenue in FY21. Since COVID-19 began, the CSB has seen a decline in services provided to our clients, resulting in less billable revenue (since April 2020, there's been a 40% decrease in billable revenue). We anticipate this being an ongoing issue until there is a vaccine or other factor that would allow the CSB to operate at full capacity.

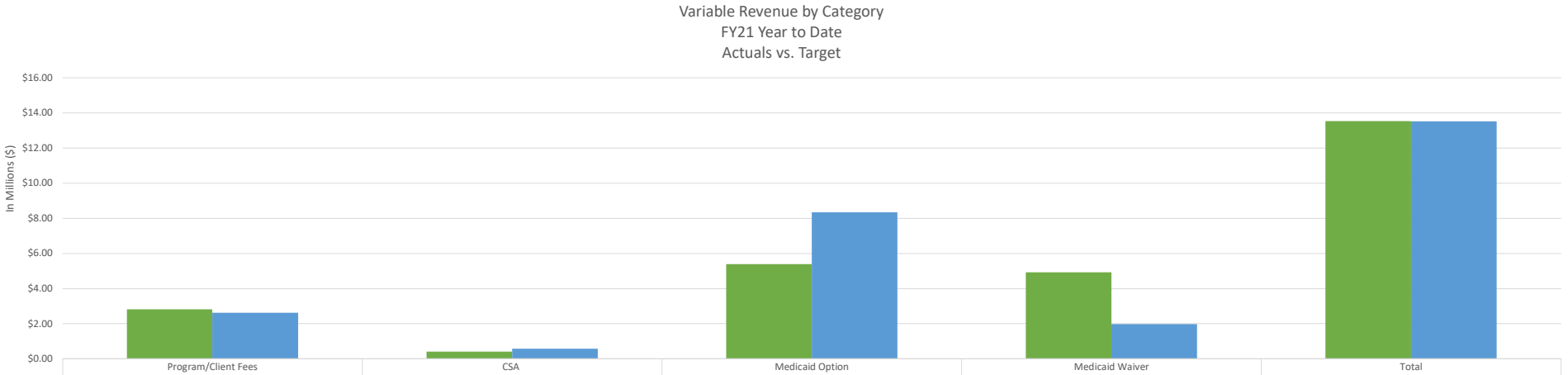
10 Establish a reserve of $3,000,000 for the implementation of a new electronic health record. The current electronic health record contract with the incumbent Credible will end on August 24, 2021. Even though we have 5-year renewal option year to exercise, the CSB elected to move forward with procuring a new EHR that can support the current and future agency behavioral health requirements. This primary procurement vehicle was the HCSIS procurement released in August 14, 2018 looking for a single EHR vendor to support Health Department and CSB requirements and to promote moving to an integrated healthcare platform. The final HCSIS down-select resulted in two possible vendors and no single vendor solution. The needs of our CSB dictates a progressive and more stable EHR platform capable of aligning itself with the future of our CSB. EHR platforms routinely become obsolete base on growing innovations in technology. We have been with our current incumbent vendor since March 2011.

February FY21 YTD Revenue Analysis



	July	August	September	October	November	December	January	February
Actuals	$1,392,705	$1,526,144	$1,932,959	$1,909,159	$2,021,669	$1,658,547	$1,287,358	$1,811,205
Target	$1,689,681	$1,689,681	$1,689,681	$1,689,681	$1,689,681	$1,689,681	$1,689,681	$1,689,681

**Target is reflective of expected Medicaid expansion revenue ($4.4M for FY21)*



	Program/Client Fees	CSA	Medicaid Option	Medicaid Waiver	Total
Actuals	$2,818,928	$406,523	$5,388,644	$4,925,651	$13,539,746
Target	$2,624,501	$572,449	$8,345,379	$1,975,123	$13,517,451

Fiscal Oversight Committee
CSB HR Update – March 12, 2021

Mgr.

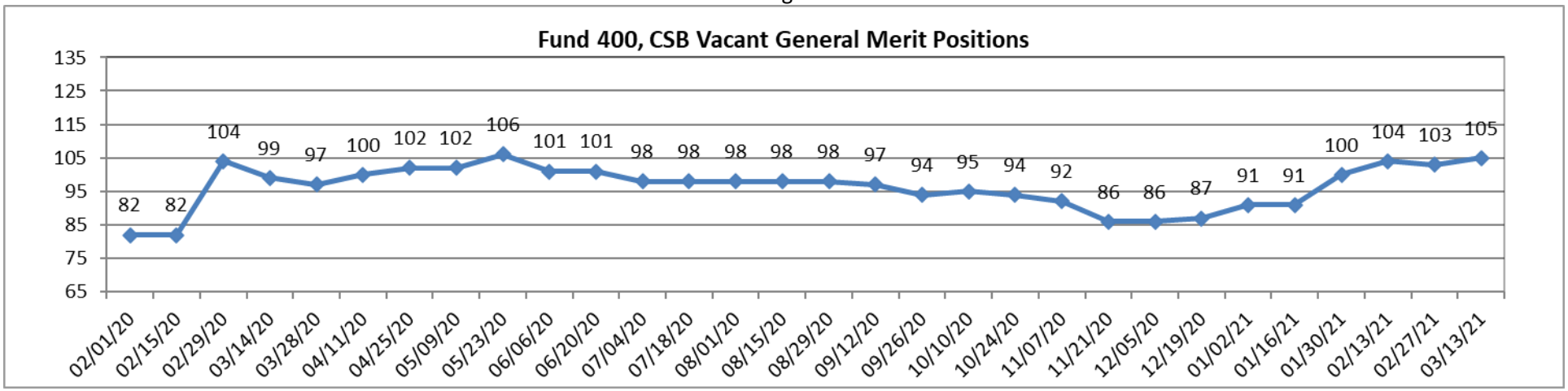


Figure 1: Increase in February 2020 reflects 24 non-merit conversions

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

Service area / program	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	February		March	
Emergency Svcs/MCU	6	5	6	5	3	3	3	3	2	2	3	4.5	3.5 CIS	3.5	2.5 CIS
													1 Peer Support Spec		1 Peer Support Spec
Behavioral Health – Outpatient Svcs	13	13	13	15	16	14	13	11	7	7	6	10	4 BHS II	11	5 BHS II
													5 BH Sr. Clin		5 BH Sr. Clin
													1 LPN		1 LPN
Youth & Family – Outpatient Svcs	5	6	6	6	6	4	3	4	4	4	7	8	6 BH Sr. Clin	9	6 BH Sr. Clin
													1 BHS II		2 BHS II
													1 BH Mgr.		1 BH Mgr.
Support Coordination	19	16	18	15	11	11	10	8	8	8	8	8	8 DDS II	10	9 DDS II
															1 DDS III
ADC/ Jail Diversion	8	8	5	4	6	7	9	9	8	7	9	7	5 BHS II	7	5 BHS II
													1 BH Sr. Clin		1 BH Sr. Clin
													1 BH Mgr.		1 BH Mgr.