# *FAIRFAX-FALLS CHURCH COMMUNITY SERVICES BOARD*

**Ken Garnes, Chair**

**Fairfax County Government Center**
**12000 Government Center Parkway, Conference Rooms 2 & 3**
**Fairfax, Virginia 22035**

Wednesday, July 24, 2013
*7:30 p.m.*

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| **1.** | ***Meeting Called to Order*** | Ken Garnes | 7:30 p.m. |
| **2.** | ***Matters of the Public*** | | |
| **3.** | ***Recognitions*** | | |
| **4.** | ***Amendments to the Meeting Agenda*** | Ken Garnes | |
| **5.** | ***Approval of Board Minutes: May 1, 2013 Work Session, May 22, 2013 CSB Meeting and June 26, 2013 CSB Meeting*** | Ken Garnes | |
| **6.** | ***Matters of the Board*** | | |
| **7.** | ***Executive Directors Report*** | George Braunstein | |
| | A. Funding-Budget Updates | | |
| | B. Other | | |
| **8.** | ***Committee Reports*** | | |
| | A. Fiscal Oversight Committee | Suzette Kern | |
| | B. Substance Use Disorders/Mental Health Workgroup | Susan Beeman | |
| | C. Other Reports | | |
| **9.** | ***Action Items*** | | |
| | A. Associate Committee Members | Susan Beeman | |
| | B. Legislative Recommendations | Laura Yager-Belinda Buescher | |
| | C. FY2013 Carryover | | |
| | D. Ad Hoc Policy Review Committee | Ken Garnes | |
| **10.** | ***Information Items*** | | |
| | A. Strategic Planning Workgroup | Lisa Potter | |
| | B. Draft Transformation Report to the Board of Supervisors | Ken Garnes | |
| | C. Priority Guidelines Access to CSB Services | George Braunstein | |
| **11.** | ***Closed Session:*** Discussion of personnel matters pursuant to Virginia Code §2.2-3711-A-1 | | |
| **12.** | ***Certification of Closed Meeting*** | | |
| **13.** | ***Adjournment*** | | |

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# Fairfax-Falls Church Community Services Board
## Work Session
May 1, 2013

The Board met at the Fairfax County Government Center, 12000 Government Center Parkway, Conference Room 8 in Fairfax, VA.

The following CSB members were present: Mark Sites, Chair; Gary Ambrose, Jessica Burmester, Ken Garnes, Mark Gross, Suzette Kern, and Jane Woods

The following CSB members were absent: Pam Barrett, Mary Ann Beall, Susan Beeman, Juan Pablo Segura, Lori Stillman

The following CSB staff was present: Alan Wooten, Evan Jones and Dave Mangano

Meeting Called to Order:

Mark Sites called the meeting to order at 7:10 p.m.

Lt. Colonel Sites referencing the draft outline of the transformation report previously distributed, requested Board members provide editions and/or further points to include. Following are highlights of the discussion:

- A suggestion was offered to reference in the report the frequent fiscal updates provided through the Fiscal Oversight Committee which have assisted in monitoring impacts on the budget.
- In noting the CSB third quarter report being developed, concern was expressed that there may exist structural imbalances in the services being provided. If there is not sufficient funding to cover the current level of services, it was suggested this should be highlighted in the report.
- While noting the FY2013 yearend forecast is in the black, concern was expressed in a drop in revenues collected between the second and third quarters. It was indicated the level of expenditures has been closely controlled, in part attributable to the vacancies being maintained.
- The question was posed as to whether the drop in revenues may be due to a change that took place during the quarter, inaccurate data provided, or possibly a different methodology used in the second vs. third quarters with the change in staff during this time. In addition, it was suggested there may be a structural issue in how the financial data is generated.
- It was noted if the data is inaccurate, steps be determined to implement a system that will produce accurate information.
- Talking points on some of the factors impacting the change in revenues during this period were provided that indicated: 1) projected figures based on previous year in which there were more staff providing billable services, 2) a five-month FY2012 hiring freeze impact on positions able to generate revenues, and 3) revenue producing services have been operating 10-30% below budgeted capacity due to cost management methods imposed. It

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was also noted FY2013 yearend expenditures are currently projected to have a $2.5 million surplus.

- Fringe benefits were mentioned and the County conversion of exempt positions to becoming benefit eligible resulting from the Affordable Healthcare Act.
- The question was posed if exempt positions which are not included in the vacancy factor should be. It was indicated from the county perspective, exempt positions are usually considered expendable. A request was made to provide a listing of the CSB exempt vacancy factor FY12 vs. FY13.
- During further discussion of the revenues, it was noted a Medicaid and non-Medicaid revenue maximization study is ongoing by Mary Thornton Associates with completion expected in June. It was requested the RFP along with the final proposal/contract be distributed to the Board members.
- Noting a need to include a statement in the third quarter report to the Board of Supervisors (BOS) explaining the drop in revenues while assuring there is an understanding of what occurred, it was suggested the report to the BOS be delayed until further information is obtained and discussion occurs at the May 22nd Board meeting.
- A request was made that a matrix or spreadsheet be provided that identifies the revenue changes from the second to third quarters as well as assign dollar amounts to each area noted in the talking points.
- It was suggested the draft third quarter report be forwarded to the full Board for review when appropriate and that fiscal updates received by the Fiscal Oversight Committee be forwarded to all Board members.
- On the draft transformation report to the BOS, Lt. Colonel Sites indicated he would begin drafting the narrative and noted the June timeline remains firm for submitting the report to the BOS. However, it was indicated it may be July before an oral presentation can be provided, if requested.

The work session was adjourned at 9:15 p.m.

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Date Approved Staff to the Board

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# Fairfax-Falls Church Community Services Board

May 22, 2013

The Board met in regular session at the Fairfax County Government Center, 12000 Government Center Parkway, Conference Rooms 2 and 3, in Fairfax, VA.

The following CSB members were present: Mark Sites, Chair; Gary Ambrose, Susan Beeman, Jessica Burmester, Ken Garnes, Mark Gross, Suzette Kern, Juan Pablo Segura, Lori Stillman and Jane Woods

The following CSB members were absent: Pam Barrett, Dallas "Rob" Sweezy

The following CSB staff was present: George Braunstein, Gary Axelson, Bill Belcher, Allen Berenson, Belinda Buescher, Jeannie Cummins Eisenhour, Jean Hartman, Evan Jones, Jamie MacDonald, Dave Mangano, Lisa Potter, Alan Wooten and Laura Yager

1. Meeting Called to Order

   Mark Sites called the meeting to order at 7:35 p.m.

2. Matters of the Public

   Lt. Colonel Sites introduced and welcomed Jeffrey Wisoff, who has been nominated as the CSB Providence District representative and will be confirmed at the June 18th Board of Supervisors (BOS) session.

   An award from the National Council for Community Behavioral Health Care for an outstanding Mental Health First Aid training program was presented to CSB staff involved in the program including Jamie MacDonald, Pouneh Zeraat and Julia Burgos. In accepting the nationally recognized award, it was noted that youth mental health training will be offered in the near future along with training offered in Spanish.

3. Amendments to the Meeting Agenda

   Jessica Burmester requested Item #9 ID Employment-Day Services be removed from the agenda and deferred to the June meeting. During discussion, concern was expressed that the BOS Human Services Committee is expecting a work plan to be presented in June. In addition, as planning for the FY2015 budget will commence during the summer of 2013, it was indicated a work plan is necessary to determine funding levels and insure budget neutrality. It was noted a presentation will be made to the BOS Human Services Committee scheduled for June 25th and the Intellectual Developmental Disability (IDD) Workgroup will meet in June to further focus on the plan. A motion was offered to remove Item #9 from the agenda, which was seconded and carried.

4. Approval of the Minutes

   A motion was offered by Suzette Kern for approval of the April 17, 2013 Board work session as well as April 24, 2013 meeting minutes of the Fairfax-Falls Church Community Services Board. The motion was seconded and carried.

5. Matters of the Board

- Gary Ambrose reported he recently had the pleasure of visiting Wildflour Bakery, indicating it is a model for Intellectual Disability (ID) employment.
- As there seemed to be an interest in holding an annual Board dinner prior to the meeting on June 26th, Lt. Colonel Sites requested a reservation at Ozzie's restaurant be obtained, if possible.
- A reminder was provided that CSB officer elections will be held at the June meeting and any nominations be provided to committee members Jessica Burmester, Ken Garnes and Mark Gross.

6. Executive Directors Report

*A. Medicaid Funding:*

George Braunstein provided an overview on Potential Budget and Policy Actions Impacting Service Funding in FY2014 and noted, while some of the actions are not yet finalized, they are being proposed and can be implemented without advance notice. During the presentation, it was indicated the following items should be considered in the budget process.

- In charting the FY14 budget, funding directly provided was outlined as well as that received through other funding streams including Housing, Mental Health supports, Block Grants, HIDTA Grant and ID Medicaid Waiver. It was noted funding is received not only by the CSB but by vendors, especially as 80% of ID services are supported through private providers.
- Housing: A consequence of federal sequestration is the proposal to eliminate new housing vouchers as well as a reduction in the amount currently being received by some individuals. In addition, individuals that were scheduled to receive new vouchers and transition out of shelters/residential treatment programs are no longer able to do so. With a reduction in funding levels of current vouchers, some will face homelessness as they will be unable to afford what is projected to be an additional $200-300 per month for rent. It is anticipated 200 people will be affected in some manner by this housing action.
- Mental Health Supports Medicaid: Noting the CSB currently bills about $900,000 for mental health supports under Medicaid, there is a potential loss of $150,000-$400,000 due to a proposed change in the Medicaid rate structure. This hourly billing change could severely impact programs such as Stevenson Place that teach life skills to individuals to allow for their becoming self-sufficient. If unable to make up for this loss of funding, it may not be viable to continue some services.

  Negotiations are underway with the Department of Medical Services (DMAS) as well as the Department of Behavioral Health and Developmental Services (DBHDS) to alter this direction which is being mandated through the federal funding streams. In the upcoming legislative session, this issue will be identified as a priority by the CSBs who will work closely with local governments, keeping them informed and involved in developing strategies as well as advocacy.
- Federal Block Grants: Noting these funds are allocated by the federal government through the state, it is estimated of the $3.2 million, there will be a $277,000

reduction. It was pointed out Prevention has already been hit hard locally and will be further impacted by this reduction.

- High Intensity Drug Trafficking Areas (HIDTA): An $11,000 reduction is anticipated out of an allocation of $100,000. The Crossroads program will be hardest hit proportionally by this action. Similar efforts to those previously mentioned to address mental health supports and identify alternative funding are underway to focus on Block Grants as well as HIDTA funding.
- It was pointed out that there is no room to maneuver in the current budget, and while separately each reduction may not appear large, cumulatively, the impact is substantial.
- ID Medicaid: With the closing of the training centers, a $900,000 shortfall is currently estimated based on 63 individuals requesting to live in the Fairfax area. In addition, analysis is ongoing with receipt of 79 waiver slots, but initially a $1 million shortfall is projected.
- Additional Impacts: Some other areas noted that could affect funding include 1) delayed Medicaid expansion in Virginia, 2) federally facilitated insurance marketplace (health exchange), 3) implementation of Health Reform law resulting in increased audits of credentialed staff that may require paybacks up to an entire year of services, 4) other Medicaid rate restructuring that could possibly target case management, 5) hospitals could decrease capacity to serve the uninsured, and 6) a Medicare-Medicaid Demonstration Project would require expanded efforts to integrate primary care.

B. *LogistiCare:*

- Evan Jones provided background on the complaints received on transportation services provided by LogistiCare through a DMAS contract. While noting DMAS Director of Program Operations Tom Edicola took over in October 2012 and has made a concerted effort to address the complaints, issues continue and have increased over last year. The complaint process was streamlined with more immediate phone responses, but this has not changed the number of complaints overall.
- It was indicated the Fairfax Health Department is negotiating for LogistiCare to contract with FASTRAN to transport 12 elderly individuals and would involve county subsidies.
- With this year being a state election cycle, a recommendation was put forward for CSB Board members to meet with legislators to press this issue and the need for accountability.
- It was also noted that Chairman Sharon Bulova has requested a letter be drafted to Governor Bob McDonnell outlining the concerns with LogistiCare services. The intent is to present the letter to the BOS to obtain full Board support and send in early June.
- CSB Regional Executives have made this a priority item to bring to legislators for budget amendment action.

- CSB Board members were encouraged to attend the next LogistiCare Advisory Committee meeting on June 13th, the details of which will be distributed as soon as available.

C. *Other*:

Mr. Braunstein reported a proposed change to a county zoning ordinance will allow for studio (efficiency) apartments to be developed which would provide more affordable housing. The zoning change would accommodate higher population density as well as development in industrial areas vs. only residential. Mr. Braunstein noted he would forward the proposal to the Board members for review and should the CSB Board support this proposal, a letter could be submitted during the comment period which is open until June 15th. Jessica Burmester offered a motion to send a letter in support which was seconded and passed with two abstentions, Jane Woods and Suzette Kern who wished for time to review the proposal. Mr. Braunstein indicated he would send talking points, and if no objection to supporting the zoning ordinance following review, a draft letter can be prepared.

7. Committee Reports

A. *Fiscal Oversight Committee:*

Suzette Kern welcomed Gary Ambrose as a new member and indicated some recent activities of the committee involved submission of the Third Quarter Report to the BOS as well as review of the revenue variance between the second and third quarters. It was noted following a request, fiscal information will be provided to the full Board on a regular basis as well as the minutes from the Fiscal Committee meetings. It has been recommended a work session be held in the summer to provide an overview of the basic budget process as well as discuss FY2015 budget preparations which should be especially helpful to the new Board members.

To provide a further briefing on the revenue variance between second and third quarters, Bill Belcher provided some of the factors which include: 1) a change in the methodology in reporting, 2) use of previous years historical information, 3) an inability to align fiscal and human resource systems in FOCUS with the transformed CSB structure, and also with Credible, the electronic health record, 4) holding staff vacancies at a level to manage expenditures, which in turn reduced some billing capabilities, and 5) a more conservative approach used in the third quarter forecasting. It was indicated with the alignment of FOCUS and Credible, which is currently ongoing, there will be a marked improvement in forecasting and reporting by allowing for cross-walking with the clinical and administrative business processes, enhancing the position management process, analyzing policy changes to ensure revenues are maximized and collaboration with Department of Management and Budget for updating projections.

It was pointed out the projected $2 million reduced level of revenue in the third quarter may be further revised to $1 million by the end of the year. In response to whether such fluctuations are common, it was indicated revenue fluctuations have historically occurred at the CSB due to the multiple factors affecting revenues including changes in Medicaid rates and billing structure. During the discussion, it was noted that although

there has been a variance in the revenues, it is expected the CSB will come in under budget in FY14.

B. *Internal Committee:*

Following distribution of the CSB Bylaws and Internal Committee goals, Mark Gross provided background on the current committee structure and offered a proposal to:

- Eliminate the Internal and External Committees along with the SUDs/MH and IDD Workgroups.
- Maintain the Fiscal Oversight Committee and form three committees similar to those previously established: 1) SUDs/MH, 2) IDD and 3) Government Relations Committees.
- Ad hoc committees would be established as needed.

In order to restructure the committees, the Bylaws must be amended which requires a 30-day review period prior to action for approval. Noting the review period begins with this notice, a motion was offered to place this recommendation as an action item on the June agenda which was seconded and passed.

C. *Intellectual Developmental and Disability (IDD) Workgroup:*

Referencing the discussion earlier in the meeting, it was indicated there was no further information to report at this time.

D. *Substance Use Disorders/Mental Health (SUDs/MH) Workgroup:*

Lt. Colonel Sites reported a presentation was provided at the May meeting on the integration of health care services.

8. FY2014 Performance Contract

Mr. Braunstein noted the Performance Contract involves reporting of data that encompasses services, financial information as well as quality improvements. As a biennial contract process has been implemented, the request for approval is for the FY14 portion of the contract. Lori Stillman presented a motion to approve, which was seconded and carried.

9. Lt. Colonel Sites noted due to the late hour, the closed session be deferred to the June meeting. A motion was presented to defer the closed session, seconded and passed.

Actions Taken –

- Approval of the April 17, 2013 CSB Board Work Session minutes and April 24, 2013 regular Board meeting minutes.
- FY2014 Performance Contract was approved.

There being no further business to come before the Board, a motion to adjourn was offered, seconded and carried. The meeting was adjourned at 10:05 p.m.

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Date Staff to Board

# Fairfax-Falls Church Community Services Board

June 26, 2013

The Board met in regular session at the Fairfax County Government Center, 12000 Government Center Parkway, Conference Rooms 2 and 3, in Fairfax, VA.

The following CSB members were present: Mark Sites, Chair; Gary Ambrose, Pam Barrett, Jessica Burmester, Ken Garnes, Kate Hanley, Paul Luisada, Lori Stillman, Rob Sweezy, Jeff Wisoff and Jane Woods

The following CSB members were absent: Susan Beeman, Mark Gross, Suzette Kern and Juan Pablo Segura

The following CSB staff was present: George Braunstein, Gary Axelson, Bill Belcher, Belinda Buescher, Evan Jones, Dave Mangano, Lisa Potter, Jim Stratoudakis, Alan Wooten and Laura Yager and Lisa Witt

1. Meeting Called to Order

   Mark Sites called the meeting to order at 7:30 p.m.

2. Recognitions

   Lt. Colonel Sites was recognized for his many years of service to the CSB Board and his leadership acclaimed of the full Board as well as several committees and workgroups throughout his tenure.

   George Braunstein introduced Synathia Morgan, recipient of the second annual 2013 CSB Spirit of Excellence Award, and shared her exemplary service at New Generations, a residential treatment program for women and children.

   As several CSB Board members were joining for the first time, welcome was extended and introductions provided.

3. Point of Order

   Noting not all Board members have had an opportunity to submit some of the documentation to the Clerk's Office of the Board of Supervisors (BOS), Lt. Colonel Sites indicated voting will be deferred this evening, with the exception of the election of CSB officers which will proceed barring any nominations being contested.

4. Amendments to the Meeting Agenda

   With the deferral of voting on Action Item 10B-CSB Committee Restructure, Jane Woods proposed to move this to Information Item 9B on the agenda which will afford further time for review.

5. Approval of the Minutes

Following a request for proposed amendments to the minutes and receiving none, Lt. Colonel Sites noted approval of the May 1, 2013 Board work session as well as May 22, 2013 meeting minutes of the Fairfax-Falls Church Community Services Board will be deferred until the July meeting.

6. Matters of the Board

- Lori Stillman reported the LogistiCare Advisory Board recently met and efforts continue to improve the system and address transportation service concerns.
- Ms. Woods reported the Medicaid Reform Committee established by the Virginia Legislature intends to expand eligibility moving forward as of July 2014.
- Lt. Colonel Sites reported the draft Transformation Report to the Board of Supervisors will be distributed shortly to CSB Board members for review and comment, with a goal of finalizing by the end of July.

7. Executive Directors Report

Noting an update on the budget status will be provided by the Fiscal Oversight Committee, Mr. Braunstein highlighted the following areas:

- Information cards developed by staff describing Project LINK, a program to assist pregnant or post-partum women with substance use disorders, were distributed and it was noted are so effective, the template is being widely used throughout the state. Sandy Sale, Project LINK Coordinator, discovered some inmates in a women's correctional facility have had a hand in printing the cards through the correctional print shop and expressed appreciation for being a part of the process.
- The Virginia Association of Community Services Boards (VACSB) has developed priority items for budget amendments in the upcoming state legislative session, copies of which will be distributed to the Board members as soon as available. Some of the key funding items identified include:
  - Additional funding for Infant and Toddler programs.
  - With a focus on prevention efforts for violent behavior in youth, $500,000 for each planning region to provide program grants. Some of the programs include comprehensive program crisis/intervention services for youth, psychiatry and follow up treatment.
  - For adult mental health as well as co-occurring, funding to create drop-off centers in each part of the state, similar to an emergency room, for assessments vs. hospitalizing unnecessarily. Approximately $1.4 million per CSB is the estimated needed.
  - Funding for substance use/medical detox and recovery-oriented peer services to be provided throughout state as well as to further develop in the local region.
  - Related to the Department of Justice (DOJ) settlement and closing of the Training Centers, additional funding to 1) transition out of Training Centers, 2) case management services while in the Centers, 3) for family support of those not receiving a Waiver, 4) those needing additional nursing to address medical issues, and 5) $2.3 million for housing as well as bridge funding for ID Waiver rates.

In light of previous discussions to enlist support of a Joint Legislative Audit and Review Commission (JLARC) on LogistiCare transportation services, it was noted guidance will be needed as to whether the CSB Board wishes to move this effort forward. Background was provided on a letter from Chairman Sharon Bulova on behalf of the BOS to Virginia Governor McDonnell expressing concern with services provided by LogistiCare. In addition, Ms. Woods requested an update on the number of complaints being filed as well as if all received are being recorded.

It was clarified that legislative proposals identified for support are approved by the CSB Board as well as coordinated through the Fairfax County legislative review process.

8. Committee Reports

*A. Fiscal Oversight Committee:*

- On behalf of Fiscal Oversight Committee Chair Suzette Kern, Ken Garnes reported on the July 19th meeting, the minutes of which were distributed.
- It was indicated the projected expenditures are expected to come in approximately $2 million under budget while revenues are anticipated to be about $1.4 million less than projected. It was noted the Committee continues to closely monitor revenue fluctuations.
- To address the review of CSB fees, a time-limited ad hoc committee is recommended, comprised of three CSB Board members that will work with staff to develop proposed fees for submission to the CSB Board for approval. The process will also entail a 30-day public comment period, followed by a hearing prior to being presented to the CSB Board for action. Lori Stillman, Rob Sweezy and Jeff Wisoff volunteered to serve on the Ad Hoc Fee Committee.
- In addition, to provide an overview of the CSB budget-funding process, a work session will be offered in the near term for CSB Board members wishing to participate.

*B. Intellectual Developmental and Disability (IDD) Workgroup:*

Jessica Burmester reported on the June meeting in which the ID Employment recommendations were discussed as well as the presentation on June 25th to the BOS Human Services Committee. The presentation provided an outline of efforts and recommendations being developed to contain costs including:

- Renegotiation of a three-year contract that expires in June 2015 to revise rates.
- For those unemployed, possible 1) furlough days, 2) implementation of a cap at 90% of current levels, and 3) reduction in the level of program enhancements.
- Implement strategy for self-directed services where the individual determines their own plan.

In discussing ID Waivers, it was noted with a community waiting list of almost 600, 79 slots will be made available on July 1, 2013.

*C. Substance Use Disorders/Mental Health (SUDs/MH) Workgroup*

Lt. Colonel Sites noted at the June meeting Alan Wooten provided an update on the DOJ Training Center closures which allowed for a good discussion with the Associate members.

D. *Legislative Package:*
Due to the proposed restructuring of the Board committees/workgroups and the upcoming August deadline for providing legislative recommendations, Lt. Colonel Sites recommended and there was a consensus that the Executive Committee be tasked with preparing a legislative package to be presented to the full Board for approval.

9. Information Item

A. *Associate Committee Members*
The proposed CSB Associate Committee members for the upcoming year were presented for review, with final approval to take place at the July meeting.

B. *CSB Committee Restructure*
As the vote is being deferred until the July meeting, Board members will be afforded a further opportunity to review the proposed amendments to the CSB Bylaws to eliminate the workgroups and establish three additional standing committees.

10. Action Items

A. *Election of Officers*
On behalf of the Nominating Committee, Ms. Burmester presented the slate of FY2014 CSB officer nominees consisting of Ken Garnes for Chair, Jane Woods for Vice Chair, and as Secretary, Gary Ambrose. The floor was opened for additional nominations for each office, and hearing none, the following occurred:

- Following a motion by Kate Hanley for a vote by acclamation for Ken Garnes as Chair, which was seconded, Mr. Garnes was unanimously elected Chair.
- Following a motion by Ms. Hanley for a vote by acclamation for Jane Woods as Vice Chair, which was seconded, Ms. Woods was unanimously elected Vice Chair.
- Following a motion by Ms. Woods for a vote by acclamation for Gary Ambrose as Secretary, Mr. Ambrose was unanimously elected Secretary.

Lt. Colonel Sites called for a five minute recess prior to the Board entering a closed session.

11. Closed Session

Following a motion which was seconded and passed, a closed meeting was convened for a discussion of personnel matters pursuant to Virginia Code §2.2-3711-A-1.

12. Certificate of Closed Meeting

Following a motion, which was seconded and passed, it was certified that, to the best of the Board's knowledge, only public business matters lawfully exempted from open meeting requirements prescribed by the Virginia Freedom of Information Act and only such public business matters identified in the motion to convene a closed meeting, were heard, discussed or considered by the Community Services Board during the closed meeting.

There being no further business to come before the Board, a motion to adjourn was offered, seconded and carried. The meeting was adjourned at 9:55 p.m.

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| Date | Staff to Board |

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# ***ITEMS TO BE REVIEWED BY CSB***

## *Early Intervention Services for Infants and Toddlers with Disabilities/Part C*

**Support sustainable funding and infrastructure for Part C Early Intervention, which is an entitlement program that provides services for Virginia's infants and toddlers. In order to address immediate concerns, support increasing funding for Early Intervention services by $8.5 million statewide in FY 2013, and support a continued increase in funding of approximately that magnitude in FY 2014 and beyond, if necessary based on continued enrollment growth.** *(Regional position.)*

The Commonwealth of Virginia has long contracted with the Fairfax-Falls Church Community Services Board (CSB) to provide Early Intervention therapeutic services for infants and toddlers with developmental delays in areas such as speech, eating, learning and movement. The CSB, which is the Local Lead Agency for Fairfax County as part of the state's compliance with the federal Individuals with Disabilities Education Act (IDEA) Part C grant, provides services through the Infant Toddler Connection (ITC) program. ITC is funded through a combination of federal, state, local and insurance sources.

As the benefits of early intervention have become more widely known throughout the nation, enrollment in this program has grown from about eight percent per year to 38 percent in the last two years. The Fairfax-Falls Church CSB has gone from serving 789 children on average each month in FY 2010 to serving 1155 children on average per month by FY 2012. This type of explosive growth vastly exceeds committed state funding, not just in Fairfax County but throughout Virginia. In the last two years, some of this funding shortfall has been filled by one-time federal funds and some stopgap funding from the Commonwealth, but the Fairfax County ITC program is still facing at least a $1 million shortfall for FY 2013. Additionally, this shortfall assumes only a minimal increase in children to be served, contrary to recent trends, which could increase the size of the funding gap.

Current state funding levels are simply not sufficient to keep pace with enrollment growth. Fairfax County already provides $2.8 million in local funds to this vital program, which comprises one-third of the ITC budget. If additional state funding is not committed, the shortfall could require the placement of newly eligible families on a waiting list beginning in February 2013. The Fairfax-Falls Church CSB would also likely assess the feasibility of continuing as the local lead agency for this program if adequate state funding is not provided.

## *Funding -- Northern Virginia Training Center (NVTC)*

**Support additional state funding for community placements for individuals leaving the Northern Virginia Training Center, and increased Medicaid waiver rates to support those placements, to ensure the Commonwealth fulfills its responsibility to implement the federal settlement agreement.** *(Regional position.)*

As a result of a settlement agreement negotiated with the U. S. Department of Justice, the Commonwealth will be closing four of the state's training centers, which provide residential

treatment for individuals with intellectual and developmental disabilities, including the Northern Virginia Training Center. Consequently, the 150 individuals currently receiving services at NVTC will need to be transitioned to the community by June 30, 2015, in order to receive community based services.

Unfortunately, existing community based service capacity is not sufficient to serve these individuals at present; therefore, additional capacity must be created. It is estimated that in FY 2013, approximately $7.7 million in start-up funding is needed in Northern Virginia to expand community based residential placements and day support services, including the creation of 14 new community Intermediate Care Facilities (ICF) and 20 Intellectual Disabilities waiver homes.

In addition to creating this expanded capacity, it is estimated that state funding of approximately $10.1 million per year, above the current ID Medicaid Waiver rates, and beginning in FY 2013, will be needed to operate these services. Fairfax County has long supported increasing Medicaid waiver rates for all recipients, which allow Medicaid reimbursement for services provided in the home and community for people with intellectual and developmental disabilities, among others. However, meeting the unique conditions of those transitioning from NVTC requires both increasing and restructuring some existing waiver rates, and should be an essential component of any state solution. Waiver rates are currently well below the cost of providing necessary services, and do not provide sufficient flexibility to meet the needs of the NVTC population. Support changes to waivers that would:

- Increase waiver rates to compensate for higher congregate rates for group homes serving four or fewer;
- Establish higher rates to address the needs of individuals with high, complex and intense needs for support, including employment and day services;
- Increase reimbursement rates to enable the hiring of professional nurses;
- Enhance or reconfigure waiver services to fully reimburse nursing and behavioral supports;
- Adjust billing units of service to streamline and assist providers in achieving adequate quality, and;
- Include appropriate levels of funding to create community residential arrangement and infrastructure.

Successfully implementing the Department of Justice settlement is the Commonwealth's responsibility and obligation, and sufficient state funding for the NVTC population is an essential component of that effort. *(New position)*

## *Medicaid Eligibility and Access to Care*

**Support increasing Medicaid eligibility in Virginia to 133 percent of the federal poverty level, as envisioned by the federal health care reform law, ensuring critical health coverage for some of the most vulnerable Virginians.**

Virginia's Medicaid program provides access to health care services for people in particular categories (low income children and parents, pregnant women, older adults, and persons with disabilities). Costs are shared between the federal government and the states, and states are permitted to set their own income and asset eligibility criteria within federal guidelines. Virginia's current eligibility requirements are so strict that although it is the 11th largest state in terms of population and 7th in per capita personal income, Virginia ranked 43rd in Medicaid enrollment as a proportion of the state's population and 47th in per capita Medicaid spending.

The national recession has placed additional pressures on Medicaid, resulting in more Americans being eligible for this essential program, and the Commonwealth now faces a critical decision, as it decides whether or not to pursue the Medicaid expansion included in the federal health care reform law, along with the sizable federal funding provided for those newly eligible enrollees. It is estimated that the expansion would provide coverage to as many as 430,000 Virginians, including 25,000-30,000 individuals in Fairfax County. Newly eligible individuals would include low income adults (individuals earning less than $15,302 per year or families earning less than $31,155 per year), low income children who lose Medicaid when they turn 19, and adults with disabilities not eligible for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI).

It is clear at this time that the cost to the Commonwealth will be minimal in the first few years, while the savings in indigent and uncompensated care could be significant. Additionally, increasing less expensive preventative care and reducing more expensive emergency care could improve the overall health of residents of the Commonwealth, while slowing the growth in insurance premiums and reducing the "hidden tax" currently borne by all Virginians. As a result, Fairfax County supports increasing Medicaid eligibility in Virginia to 133 percent of the federal poverty level, as envisioned in the federal health care reform law, ensuring critical health coverage for some of the most vulnerable Virginians.

**Oppose actions that shift Medicaid costs to localities, such as through Medicaid service funding reductions, changes to eligibility that shrink access, or other rule changes that erode the social safety net.**

Irrespective of Virginia's decision on the Medicaid expansion, or of any other federal funding cuts or reductions in federal requirements which may be considered in the next Congress, it is essential that the Commonwealth avoid taking actions that effectively shift costs to localities. Due to the increasingly critical shortage of private providers, poor reimbursement rates, and other factors that play a role in an overall increase in Medicaid program costs, ensuring success with any cost containment strategies will require close cooperation between the Commonwealth and local governments, as localities are frequently the service providers for the Medicaid population. Fairfax County supports cost containment measures that utilize innovation, increase efficiency and targeted service delivery, and use of technology to reduce Medicaid fraud, in order to ensure the best allocation of resources without reducing services or access to care.

## *Medicaid Waivers*

**Support funding and expansion for Virginia's Medicaid waivers that provide critical home and community based services for qualified individuals.**

Medicaid funds both physical and mental health services for people in particular categories (low income children and parents, pregnant women, older adults, persons with disabilities). It is financed by the federal and state governments and administered by the states. Federal funding is provided based on a state's per capita income – the federal match rate for Virginia is 50 percent. Because each dollar Virginia puts into the Medicaid program draws down a federal dollar, what Medicaid will pay for is a significant factor in guiding the direction of state human services spending. However, states set their own income and asset eligibility criteria within federal guidelines; Virginia's requirements are so strict though it is ranked 7th in per capita personal income, it is 47th in Medicaid spending for persons with intellectual and developmental disabilities.

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For the most part, each state also has the discretion and flexibility to design its own Medicaid service program and can choose from a menu of optional services and waiver services in the state plan. Virginia offers fewer optional Medicaid services than many other states (in addition to federally mandated services), though Medicaid recipients in Virginia may also receive coverage through home and community-based "waiver" programs, which allow states to "waive" the requirement that an individual must live in an institution to receive Medicaid funding. Waivers result in less expensive, more beneficial care. Waiver services are especially important for low-income families, older adults, people with disabilities and seriously ill individuals in Virginia, where Medicaid eligibility is highly restrictive. The average cost of institutionalizing a person at a state training center is approximately $216,000 per year. By contrast, the cost of providing services for a person in the community through the use of a waiver is approximately $138,000 on average.[1] Virginia can serve nearly three people in the community for each person in a training center.

The number and type of waivers is set by the General Assembly, and the extensive waiting lists for some demonstrate the significant barriers that exist in the Commonwealth (current Virginia waivers include AIDS, Alzheimer's, Day Support for Persons with Intellectual Disabilities, Elderly or Disabled with Consumer-Direction, Intellectual Disabilities, Technology Assisted and Individual and Family Developmental Disabilities Support).

Fairfax County supports the following adjustments in Medicaid waivers:

- **Support automatic rate increases.** While nursing homes receive annual cost of living adjustments, this rate adjustment is not available to providers of Medicaid waiver services. Virginia ranks 47th among the states in the provision of home and community based services. To reduce reliance on institutions such as nursing homes and state training centers, increase the source of less costly community-based services, and ensure the availability and quality of Medicaid providers for personal care and other Medicaid

[1] Updated cost figures from Virginia Department of Behavioral Health and Developmental Services.

community based services, a fundamental rebalancing of reimbursements within Virginia's Medicaid program is necessary. At a minimum, this includes restoring reductions to Virginia's Medicaid waiver services from the 2010-2012 biennial budget; rates should equal at least 90% of cost.

- **Create new consolidated waiver.** Merge the Intellectual Disability (MR/ID) Waiver with the Individual and Family Developmental Disabilities (DD) Waiver and expand services to individuals with autism spectrum disorders. Extend waiver funding for residential services to all recipients of the new consolidated waiver. Assign services under the new consolidated waiver on the basis of urgency of need, rather than length of time on waiting list. As waivers are being revised and new approaches to eligibility are being established, the new eligibility rules should not be structured in a way that would cause individuals who would be eligible today, such as people who are blind, to be deemed ineligible in the future. *(New position)*
- **Support a new waiver for individuals with brain injuries.** Waiver services are also critically needed for individuals with brain injuries who would not be eligible for the new consolidated ID/DD waiver.
- **Support increased waiver funding.** For example, funding is needed to serve the more than 7,200[2] people statewide who are eligible but waiting for ID or DD waiver services. In Fairfax County (as of July 2012), over 1,180 people with intellectual disabilities are on the wait list for services; of those, more than 730 are considered to have "urgent" needs, one crisis away from requiring emergency services and potential institutionalization. More than 800 of those needing ID services qualify for waivers. Increased funding would allow individuals to receive services in the community rather than in a nursing facility or institution, would assist in the requirements and spirit of the DOJ settlement with the Commonwealth, and bring Virginia into compliance with the Olmstead Decision.
- **Support funding for an expansion of services.** Additional medical and behavioral services are needed under Virginia's existing Medicaid waivers, for individuals whose needs extend beyond the standard benefits available. Waiver enhancements such as increased medical and behavioral support components, higher rates for these and other waiver services, and higher Northern Virginia differentials are needed to enhance success in community-based services for individuals transitioning out of training centers under the DOJ settlement with the Commonwealth as well as for people currently on waiting lists.
- **Support Expansion of Home and Community Based Services.** New federal initiatives such as the Community First Choice option allow for states to streamline and improve their Medicaid plans to expand home and community based services at a higher federal reimbursement rate. At a time when Virginia is planning to move residents from state training centers into the community, the Commonwealth should apply for Community First Choice and other opportunities to serve older adults and people with disabilities in their homes and communities.
- **Support consumer empowerment**. Services to help consumers enhance life skills, achieve greater independence, and offer the option of consumer directions and choice should be a priority.

[2] Updated cost figures from Virginia Department of Behavioral Health and Developmental Services.

- **Support Dual Eligible Proposal**. Fairfax County and the Community Services Board support Virginia's effort to receive a federal waiver to manage the care of individuals eligible for both Medicaid and Medicare with a plan that includes adequate funding for long term services for the populations served by the Community Services Board. The involvement of the CSB in the planning and implementation would greatly enhance the ability of the new plan to meet special service needs. *(New position)*

Community Based Services

**Support increased capacity for crisis response and intensive community services for children and youth.**

The General Assembly and the Governor are to be commended for supporting funding in FY 2013 for more community-based crisis response for youth and their families. To respond effectively to the need, this service model must be fully funded, as outlined in the VACSB/Voices for Virginia's Children budget amendment. Additional capacity in the Child and Family service system is necessary to address the needs of children and their families requiring intensive community services, to help maintain children safely in their own homes and reduce the need for foster care or residential treatment as the first alternative. One of the programs of concern is the Healthy Families program, which is a nationally recognized home visiting program that has produced tangible positive outcomes in the Commonwealth. Significant funding reductions in recent years have resulted in the elimination of programs in some jurisdictions and threaten the viability of remaining Healthy Families sites. The program provides home-based education and support to first-time parents who have social histories that put them at risk starting during pregnancy until the child reaches age three.

Psychiatric Services for Older Adults

**Support coordinated strategies to meet the growing need for psychiatric services for older adults, promoting recovery and community inclusion.**

The need for psychiatric services for older adults is growing, but the capacity to meet the growing need is limited. Services must be cost-efficient, accessible, and outcome driven. Strategies are needed to coordinate and combine the best of traditional approaches with emerging best practices to promote recovery and community inclusion, including:

- recognition of the need to work holistically with the older adult population;
- revision of policies that perpetuate service silos;
- easier navigation of the support system for older adults and their families;
- better education for health professionals and the community about disorders that can affect older adults and how best to help them; and
- affordable and accessible housing and transportation resources to help the growing population of older adults with psychiatric service needs to allow them to continue to live safely in the community.

## *Mental Health*

Mental Health

**Support the continuation of efforts for mental health reform at the state level and support additional state funding, as part of the promised down payment of such funding to improve the responsiveness of the mental health system.**

It is critical that the state provide adequate resources to ensure that the hundreds of Fairfax County residents with serious mental illness and disabling substance dependence receive intensive community treatment following an initial hospitalization or incarceration.

Substance Use Disorder

**Support increased capacity to address and prevent substance use disorder through robust community based prevention programs.**

Studies show that substance use disorder is among the most costly health problems in the United States. Effective community based prevention programs can reduce rates of substance use disorder and can delay the age of first use. Additionally, prevention programs can contribute to cost savings by reducing the need for treatment – a win-win for all involved.

Emergency Responsiveness

**Support sufficient state funding for those county residents who need acute care service within local hospitals or within our local crisis stabilization programs.**

Drastically reduced state resources for psychiatric hospital beds have caused a shortage of available psychiatric beds during mental health emergencies. This can result in the release of people from custody who meet criteria for detention and are a danger to themselves or others, putting an increased burden on police and emergency staff. The funding the Commonwealth provides for emergency responsiveness does not reflect increased costs over time. As a result, the costs of treating this critical population are increasingly shifted to localities.

Northern Virginia Mental Health Institute Beds

**Support $1.4 million in FY 2014 for additional psychiatric beds at the Northern Virginia Mental Health Institute (NVMHI). Also support sufficient state funding for acute care service within local hospitals or local crisis stabilization programs.** *(Regional position.)*

State funding for 19 psychiatric beds at NVMHI was eliminated in the spring of 2010, which reduced the number of beds at the state facility from 129 to 110. Thirteen of the nineteen beds were restored using one-time state funding and local and regional funds; however, that funding will run out June 30, 2013. In FY 2014, $1.4 million in state funding is needed to restore these essential beds.

While overall state funding for psychiatric beds statewide has been drastically reduced in recent years, and the costs of treating this critical population are increasingly being shifted to localities, the need for state-funded, safety net beds in Northern Virginia is particularly critical, as the region currently has fewer state and private hospital beds per capita than any other region in the

state. While other areas of the state are requesting additional funds to purchase beds in private hospitals to address bed shortages (LIPOS, or Local Inpatient Purchase of Services), the quantity of private psychiatric hospital beds in Northern Virginia continues to decline.

As a result, the number of beds is not sufficient to address the need, creating a shortage of psychiatric beds during mental health emergencies, which sometimes leads to Northern Virginians being hospitalized in areas far outside the region, removing them from their community connections and placing an increased burden on police and emergency staff. Even more alarming, some individuals are prematurely released from custody, even though they meet the criteria for detention and are a danger to themselves or others. Acknowledging this growing concern, the 2012 General Assembly included budget language requiring a report on a long-term plan to ensure adequate capacity is available to serve individuals who require an inpatient bed for the treatment of acute mental illness in Northern Virginia; the study is expected to be published imminently, and may contain findings useful to pursuing additional state funding for NVMHI beds. *(New position)*

# ***ITEMS TO BE REVIEWED BY CSB –***
# ***Updates by CSB staff as of 7-19-13***

## *Early Intervention Services for Infants and Toddlers with Disabilities/Part C*

*[This section will be updated before Wednesday's meeting. Text below is from last year's white paper.]*

**Support sustainable funding and infrastructure for Part C Early Intervention, which is an entitlement program that provides services for Virginia's infants and toddlers. In order to address immediate concerns, support increasing funding for Early Intervention services by $8.5 million statewide in FY 2013, and support a continued increase in funding of approximately that magnitude in FY 2014 and beyond, if necessary based on continued enrollment growth.** *(Regional position.)*

The Commonwealth of Virginia has long contracted with the Fairfax-Falls Church Community Services Board (CSB) to provide Early Intervention therapeutic services for infants and toddlers with developmental delays in areas such as speech, eating, learning and movement. The CSB, which is the Local Lead Agency for Fairfax County as part of the state's compliance with the federal Individuals with Disabilities Education Act (IDEA) Part C grant, provides services through the Infant Toddler Connection (ITC) program. ITC is funded through a combination of federal, state, local and insurance sources.

As the benefits of early intervention have become more widely known throughout the nation, enrollment in this program has grown from about eight percent per year to 38 percent in the last two years. The Fairfax-Falls Church CSB has gone from serving 789 children on average each month in FY 2010 to serving 1155 children on average per month by FY 2012. This type of explosive growth vastly exceeds committed state funding, not just in Fairfax County but throughout Virginia. In the last two years, some of this funding shortfall has been filled by one-time federal funds and some stopgap funding from the Commonwealth, but the Fairfax County ITC program is still facing at least a $1 million shortfall for FY 2013. Additionally, this shortfall assumes only a minimal increase in children to be served, contrary to recent trends, which could increase the size of the funding gap.

Current state funding levels are simply not sufficient to keep pace with enrollment growth. Fairfax County already provides $2.8 million in local funds to this vital program, which comprises one-third of the ITC budget. If additional state funding is not committed, the shortfall could require the placement of newly eligible families on a waiting list beginning in February 2013. The Fairfax-Falls Church CSB would also likely assess the feasibility of continuing as the local lead agency for this program if adequate state funding is not provided.

## *Funding -- Northern Virginia Training Center (NVTC)*

*[Updated by CSB staff 7-19-13]*

***Support additional state funding for community placements for individuals leaving state training centers including the Northern Virginia Training Center (NVTC), and increased Medicaid waiver rates to support those placements, to ensure the Commonwealth fulfills its responsibility to implement the federal settlement agreement. (Regional position.)***

As a result of a settlement agreement negotiated with the U.S. Department of Justice, the Commonwealth will be closing four of the state's five training centers, which provide residential treatment for individuals with intellectual and developmental disabilities. As of July 1, 2013, 108 individuals from Fairfax County reside at state training centers. Of this number, 82 reside at NVTC which is scheduled to close by June 30, 2015.

CSBs are responsible for transitioning all persons at training centers into community-based residential and day support services operated by private non-profit or for-profit providers. Unfortunately, existing community based service capacity is not sufficient to serve these individuals at present; therefore, additional capacity must be created. Under the state's current implementation plan, development and start-up funding is not identified to assist the provider community to expand service and site capacity to meet demand within the specified timeline for closure.

In addition to creating this expanded capacity, the current Medicaid ID waiver rates of reimbursement will need to increase to ensure sufficient, quality services, comparable to the services currently provided at training centers. Fairfax County has long supported increasing Medicaid waiver rates for all recipients, which allow Medicaid reimbursement for services provided in the home and community for people with intellectual and developmental disabilities, among others. However, meeting the unique conditions of those transitioning from NVTC requires both increasing and restructuring some existing waiver rates, and should be an essential component of any state solution. Waiver rates are currently well below the cost of providing necessary services, and do not provide sufficient flexibility to meet the needs of the NVTC population.

Support changes to waivers that would:

- Increase waiver rates to compensate for higher congregate rates for group homes serving four or fewer;
- Establish higher rates to address the needs of individuals with high, complex and intense needs for support, including employment and day services;
- Increase reimbursement rates to enable the hiring of professional nurses;
- Enhance or reconfigure waiver services to fully reimburse nursing and behavioral supports;
- Adjust billing units of service to streamline and assist providers in achieving adequate quality, and;
- Include appropriate levels of funding to create community residential arrangement and infrastructure.

Successfully implementing the Department of Justice settlement is the Commonwealth's responsibility and obligation, and sufficient state funding for the NVTC population is an essential component of that effort.

## *Medicaid Eligibility and Access to Care* *[Updated by CSB staff 7-19-13]*

**Support increasing Medicaid eligibility in Virginia to 133 percent of the federal poverty level, as envisioned by the federal health care reform law, ensuring critical health coverage for some of the most vulnerable Virginians.**

Virginia's Medicaid program provides access to health care services for people in particular categories (low income children and parents, pregnant women, older adults, and persons with disabilities). Costs are shared between the federal government and the states, and states are permitted to set their own income and asset eligibility criteria within federal guidelines. Virginia's current eligibility requirements are so strict that although it is the 11th largest state in terms of population and 7th in per capita personal income, Virginia ranked 43rd in Medicaid enrollment as a proportion of the state's population and 47th in per capita Medicaid spending.

The national recession has placed additional pressures on Medicaid, resulting in more Americans being eligible for this essential program, and the Commonwealth now faces a critical decision, as it decides whether or not to pursue the Medicaid expansion included in the federal health care reform law, along with the sizable federal funding provided for those newly eligible enrollees. It is estimated that the expansion would provide coverage to as many as 430,000 Virginians, including 25,000-30,000 individuals in Fairfax County. Newly eligible individuals would include low income adults (individuals earning less than $15,302 per year or families earning less than $31,155 per year), low income children who lose Medicaid when they turn 19, and adults with disabilities not eligible for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI).

It is clear at this time that the cost to the Commonwealth will be minimal in the first few years, while the savings in indigent and uncompensated care could be significant. Additionally, increasing less expensive preventative care and reducing more expensive emergency care could improve the overall health of residents of the Commonwealth, while slowing the growth in insurance premiums and reducing the "hidden tax" currently borne by all Virginians. As a result, Fairfax County supports increasing Medicaid eligibility in Virginia to 133 percent of the federal poverty level, as envisioned in the federal health care reform law, ensuring critical health coverage for some of the most vulnerable Virginians.

**Oppose actions that shift Medicaid costs to localities, such as through Medicaid service funding reductions, changes to eligibility that shrink access, or other rule changes that erode the social safety net.**

Irrespective of Virginia's decision on the Medicaid expansion, or of any other federal funding cuts or reductions in federal requirements which may be considered in the next Congress, it is essential that the Commonwealth avoid taking actions that effectively shift costs to localities. Due to the increasingly critical shortage of private providers, poor reimbursement rates, and

other factors that play a role in an overall increase in Medicaid program costs, ensuring success with any cost containment strategies will require close cooperation between the Commonwealth and local governments, as localities are frequently the service providers for the Medicaid population. Fairfax County supports cost containment measures that utilize innovation, increase efficiency and targeted service delivery, and use of technology to reduce Medicaid fraud, in order to ensure the best allocation of resources without reducing services or access to care.

## *Medicaid Waivers* *[Updated by CSB staff 7-19-13]*

***Support funding and expansion for Virginia's Medicaid waivers that provide critical home and community based services for qualified individuals.***

Medicaid funds both physical and mental health services for people in particular categories (low income children and parents, pregnant women, older adults, persons with disabilities). It is financed by the federal and state governments and administered by the states. Federal funding is provided based on a state's per capita income – the federal match rate for Virginia is 50 percent. Because each dollar Virginia puts into the Medicaid program draws down a federal dollar, what Medicaid will pay for is a significant factor in guiding the direction of state human services spending. However, states set their own income and asset eligibility criteria within federal guidelines; Virginia's requirements are so strict though it is ranked 7th in per capita personal income, it is 47th in Medicaid spending for persons with intellectual and developmental disabilities.

For the most part, each state also has the discretion and flexibility to design its own Medicaid service program and can choose from a menu of optional services and waiver services in the state plan. Virginia offers fewer optional Medicaid services than many other states (in addition to federally mandated services), though Medicaid recipients in Virginia may also receive coverage through home and community-based "waiver" programs, which allow states to "waive" the requirement that an individual must live in an institution to receive Medicaid funding. Waivers result in less expensive, more beneficial care. Waiver services are especially important for low-income families, older adults, people with disabilities and seriously ill individuals in Virginia, where Medicaid eligibility is highly restrictive. The average cost of institutionalizing a person at a state training center is approximately $225,000 per year. By contrast, the cost of providing services for a person in the community through the use of a waiver is approximately $106,000 on average. Virginia can serve nearly three people in the community for each person in a training center.

The number and type of waivers is set by the General Assembly, and the extensive waiting lists for some demonstrate the significant barriers that exist in the Commonwealth (current Virginia waivers include AIDS, Alzheimer's, Day Support for Persons with Intellectual Disabilities, Elderly or Disabled with Consumer-Direction, Intellectual Disabilities, Technology Assisted and Individual and Family Developmental Disabilities Support).

Fairfax County supports the following adjustments in Medicaid waivers:

- **Support automatic rate increases.** While nursing homes receive annual cost of living adjustments, this rate adjustment is not available to providers of Medicaid waiver services. Virginia ranks 47th among the states in the provision of home and community based services. To reduce reliance on institutions such as nursing homes and state training centers, increase the source of less costly community-based services, and ensure the availability and quality of Medicaid providers for personal care and other Medicaid community based services, a fundamental rebalancing of reimbursements within Virginia's Medicaid program is necessary.

- **Create new consolidated waiver.** Merge the Intellectual Disability (MR/ID) Waiver with the Individual and Family Developmental Disabilities (DD) Waiver and expand services to individuals with autism spectrum disorders. Extend waiver funding for residential services to all recipients of the new consolidated waiver. Assign services under the new consolidated waiver on the basis of urgency of need, rather than length of time on waiting list. As waivers are being revised and new approaches to eligibility are being established, the new eligibility rules should not be structured in a way that would cause individuals who would be eligible today, such as people who are blind, to be deemed ineligible in the future.

- **Support a new waiver for individuals with brain injuries.** Waiver services are also critically needed for individuals with brain injuries who would not be eligible for the new consolidated ID/DD waiver.

- **Support increased waiver funding.** For example, funding is needed to serve thousands of people statewide who are eligible but waiting for ID or DD waiver services. In Fairfax County (as of July 2013), 993 people with intellectual disabilities are on the wait list for waiver services; of those, more 576 are considered to have "urgent" needs, one crisis away from requiring emergency services and potential institutionalization. Increased funding would allow individuals to receive services in the community rather than in a nursing facility or institution, would assist in the requirements and spirit of the DOJ settlement with the Commonwealth, and bring Virginia into compliance with the Olmstead Decision.

- **Support funding for an expansion of services.** Additional medical and behavioral services are needed under Virginia's existing Medicaid waivers, for individuals whose needs extend beyond the standard benefits available. Waiver enhancements such as increased medical and behavioral support components, higher rates for these and other waiver services, and higher Northern Virginia differentials are needed to enhance success in community-based services for individuals transitioning out of training centers under the DOJ settlement with the Commonwealth as well as for people currently on waiting lists.

- **Support expansion of Home and Community Based Services.** New federal initiatives such as the Community First Choice option allow for states to streamline and improve their Medicaid plans to expand home and community based services at a higher federal reimbursement rate. At a time when Virginia is planning to move residents from state training centers into the community, the Commonwealth should apply for Community First Choice and

other opportunities to serve older adults and people with disabilities in their homes and communities.

• **Support consumer empowerment**. Services to help consumers enhance life skills, achieve greater independence, and offer the option of consumer directions and choice should be a priority.

*Note from CSB staff: Took out last year's section re Dual Eligible waivers, as this has been implemented and our CSB is part of the pilot. 7-19-13*

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*Note from CSB staff: The following two sections ["Community Based Services" and "Psychiatric Services for Older Adults" should be moved into the "Mental Health" section below. DFS will also be reviewing these sections. No changes made in the content. 7-19-13*

Community Based Services

**Support increased capacity for crisis response and intensive community services for children and youth.**

The General Assembly and the Governor are to be commended for supporting funding in FY 2013 for more community-based crisis response for youth and their families. To respond effectively to the need, this service model must be fully funded, as outlined in the VACSB/Voices for Virginia's Children budget amendment. Additional capacity in the Child and Family service system is necessary to address the needs of children and their families requiring intensive community services, to help maintain children safely in their own homes and reduce the need for foster care or residential treatment as the first alternative. One of the programs of concern is the Healthy Families program, which is a nationally recognized home visiting program that has produced tangible positive outcomes in the Commonwealth. Significant funding reductions in recent years have resulted in the elimination of programs in some jurisdictions and threaten the viability of remaining Healthy Families sites. The program provides home-based education and support to first-time parents who have social histories that put them at risk starting during pregnancy until the child reaches age three.

Psychiatric Services for Older Adults *[No change 7-19-13.]*

**Support coordinated strategies to meet the growing need for psychiatric services for older adults, promoting recovery and community inclusion.**

The need for psychiatric services for older adults is growing, but the capacity to meet the growing need is limited. Services must be cost-efficient, accessible, and outcome driven. Strategies are needed to coordinate and combine the best of traditional approaches with emerging best practices to promote recovery and community inclusion, including:

- recognition of the need to work holistically with the older adult population;
- revision of policies that perpetuate service silos;
- easier navigation of the support system for older adults and their families;
- better education for health professionals and the community about disorders that can affect older adults and how best to help them; and

- affordable and accessible housing and transportation resources to help the growing population of older adults with psychiatric service needs to allow them to continue to live safely in the community.

## ***Mental Health*** *[No change in first two sections 7-19-13.]*

Mental Health

**Support the continuation of efforts for mental health reform at the state level and support additional state funding, as part of the promised down payment of such funding to improve the responsiveness of the mental health system.**

It is critical that the state provide adequate resources to ensure that the hundreds of Fairfax County residents with serious mental illness and disabling substance dependence receive intensive community treatment following an initial hospitalization or incarceration.

Substance Use Disorder

**Support increased capacity to address and prevent substance use disorder through robust community based prevention programs.**

Studies show that substance use disorder is among the most costly health problems in the United States. Effective community based prevention programs can reduce rates of substance use disorder and can delay the age of first use. Additionally, prevention programs can contribute to cost savings by reducing the need for treatment – a win-win for all involved.

Prevent and Reduce Risk Factors for Youth Violence

**Support funding for programming to prevent and reduce risk factors that lead to youth violence, alcohol/drug use, mental health problems and other risky behaviors; and increase protective factors including mental wellness and healthy coping strategies.**
***New position (VACSB supports) 7-19-13***

The Virginia 2011 Youth Survey results indicate that in a statistically reliable sample of 9th, 10th, 11th, and 12th graders from across the Commonwealth: 20.3% report being bullied on school property; 7% have been threatened or injured with a weapon on school property; 5.5% have missed one or more of the past 30 days of school because they felt unsafe at school or going to or from school; 25.5% report feeling sad or hopeless daily for two more weeks such that they could not perform their typical daily activities; and 16.9% of students reported seriously considered attempting suicide.

Research has defined a set of risk factors that are known to predict increased likelihood of drug use, delinquency, school dropout, mental health problems, and violent behavior among youth and protective factors that exert a positive influence or buffer against the negative influence of risk. Funding is needed to implement evidence based violence prevention and mental health promotion programming based upon regional risk factors.

Emergency Mental Health Services *[Replaces last year's "Emergency Response" and "NVMHI" sections. 7-19-13]*

**Support sufficient state funding for those county residents who need acute care service within local hospitals or within our local crisis stabilization programs.**

Reduced state resources for psychiatric hospital beds have caused a shortage of available psychiatric beds during mental health emergencies. This can result in the release of people from custody who meet criteria for detention and are a danger to themselves or others, putting an increased burden on police and emergency staff. The funding the Commonwealth provides for emergency responsiveness does not reflect increased costs over time. As a result, the costs of treating this critical population are increasingly shifted to localities.

Last year, the General Assembly mandated a study of the bed capacity of the Northern Virginia Mental Health Institute and provided funding to restore some but not all of the bed capacity that had been cut in 2010. The region's acute care capacity is still not sufficient to address the need.

**Support state funding to create Crisis Response Treatment Programs, similar to emergency rooms, for assessment of individuals experiencing behavioral health crises. Such centers provide intervention and treatment services to assess and stabilize individuals in crisis, prevent unnecessary hospitalizations, and substantially reduce time and involvement of public safety officers in any psychiatric crisis.** ***[New position (VACSB supports) 7-19-13.]***

Crisis Response Treatment Programs can provide a combination of mobile and specialized office-based emergency triage, including specialized forensic triage, assessment, short-term treatment, and referral services on a 24 hr/day, 365 days/yr basis to individuals in acute psychiatric distress regardless of their conditions, diagnoses, or disabilities. The goal is to stabilize these individuals and help them engage in ongoing treatment to help them more effectively respond to stress-inducing events. The services are provided by specially trained crisis response and treatment teams composed of psychiatrists, nurses, licensed clinicians, intensive case managers, and peer support specialists cross-trained in behavioral, developmental and medical needs.

# HUMAN SERVICES – SAMPLE & FORM FOR NEW POSITION STATEMENTS

**(Please complete this form for each new position statement.)**

**GENERAL SUBJECT AREA -- TITLE OF PROPOSAL: Investigate and resolve continuing problems with Medicaid-funded transportation services**

**PROPOSAL:**

Support independent analytical study (such as by the Joint Legislative Audit and Review Commission) of continuing problems experienced by Virginians who have intellectual disability or mental illness and who depend on Medicaid-funded transportation provided by the transportation broker, Logisticare. Following the study, support a public review to identify sustainable solutions to ensure that these vulnerable individuals receive safe, reliable transportation. Support quarterly meetings (Logisticare, state and regional officials) to ensure that solutions are being implemented.

**SOURCE:** Fairfax County Board of Supervisors and Fairfax-Falls Church Community Services Board

**BACKGROUND:**

A breakdown in Medicaid-funded transportation services is having serious and detrimental consequences for some of our community's most vulnerable residents. Many individuals who have intellectual disability or a mental illness must rely on Medicaid-funded transportation services managed through a broker, Logisticare. This company has a multi-year and continuing history of poor performance. State and local officials met with Logisticare officials last year and outlined a plan for improving service and responsiveness to complaints. However, the poor performance has continued. *(See next page for more detail.)*

**ANY RELEVANT STATISTICS/DATA:**

In 2012, the Fairfax-Falls Church CSB received over 600 complaints concerning Medicaid contracted transportation providers. This rate of complaints continued through February 2013. In March 2013 a new procedure was implemented so that complaints are now received directly by Logisticare, rather than through the CSB. Although the CSB no longer has a complete log of every complaint, problematic issues continue to be brought to the attention of CSB staff. From July 2012 through June 2013,#the most prevalent issue continued to be the late or early arrival of the provider; over 400 such complaints came to the attention of the CSB during that time period. In 33 instances, the transportation provider failed to show up at all. Another frequent complaint had to do with the individual having to spend far too much time in the vehicle before arriving at their therapeutic service or home (58 complaints).

**RECOMMENDATION:**

(*Do not fill out-- This will be indicated by the Legislative Director and County Executive)*

# HUMAN SERVICES – SAMPLE & FORM FOR NEW POSITION STATEMENTS

**(Supplemental background information to be used by staff)**

#

**GENERAL SUBJECT AREA -- TITLE OF PROPOSAL: Investigate and resolve continuing problems with Medicaid-funded transportation services**

**ADDITIONAL BACKGROUND INFORMATION:**

County supervisors and CSB staff continue to receive complaints about the poor service provided by Logisticare. CSB staff time spent advocating for people experiencing problems with Medicaid-funded transportation services (50 percent of a full-time equivalent employee), continues at the same level as in 2012. Problems include very late pick-ups in the mornings, even after the company has called to confirm an earlier pick-up time; late arrivals at their therapeutic service sites (sometimes as late as mid-morning) because of the number of people the vendor is picking up all over the county; and, most distressing, very late arrivals home, sometimes over two hours late. There have even been instances where an individual was taken to the wrong address. Even after the complaints have been taken, recorded and acknowledged by Logisticare, there have been instances when the same problems occurred the very next day.

CSB staff meets at least weekly with Logisticare representatives to address new, ongoing, and sometimes long-standing complaints. Many of the CSB's service providers lose revenue as late arrivals preclude completion of their normal scheduled day and billing is reduced accordingly. These service providers are also experiencing "complaint fatigue," and in some cases have simply "given up" reporting complaints because they have no confidence that the complaint will result in improved service.

This lack of service and poor response to complaints must not continue. Despite the best intentions of the Medicaid office oversight staff, and even after the imposition of contractual fines, Logisticare continues to provide poor day-to-day customer service. We are convinced that a public, sustained spotlight is needed to reveal and remedy the current unacceptable situation.

**POSSIBLE SUPPORT OR OPPOSITION BY ORGANIZATIONS:**

Possible support: The Arc of Northern Virginia, National Alliance for Mental Illness (NAMI) Northern Virginia

**STAFF CONTACT PERSON(S):** George Braunstein, CSB Executive Director

#

| COMMUNITY SERVICES BOARD | Item: 9A | Type: Action | Date: 7/24/13 |
|---|---|---|---|

Associate Committee Members

Recommended Motion:

I move that the Board accept the following Associate Members as FY2014 members of the Substance Use Disorders/Mental Health (SUDs/MH) Workgroup, or should a CSB standing committee be established, the SUDs/MH Committee:

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

Background:

As part of the annual appointment of Associate Members as outlined in the CSB Bylaws, the nominations of FY2014 Associate Members of the Substance Use Disorders/Mental Health Workgroup were provided at the June 2013 CSB Board meeting for consideration along with notice that a motion for approval would be presented at the July meeting.

FAIRFAX-
FALLS CHURCH
COMMUNITY SERVICES BOARD

**TO:** Susan W. Datta
Chief Financial Officer

**FROM:** George Braunstein
Executive Director

**DATE:** July 3, 2013

**SUBJECT:** FY 2013 Carryover Review

Enclosed please find the FY 2013 Carryover Review submission for Fund 400-C40040, Fairfax-Falls Church Community Services Board (CSB). Please note that this submission is contingent upon CSB Board approval at its July 24, 2013 meeting.

**FY 2013 Fiscal Position**

The FY 2013 ending balance for Fund 400-C40040, CSB totals $6,380,026, over the *FY 2013 Revised Budget Plan* of $1.0M (Attachment A). The FY2013 ending balance includes the $1.0M Infant and Toddler Connection Reserve and $5,380,026, the net total of lower than anticipated non-County revenues and lower than anticipated expenditures. Details follow:

- Non-County revenues total $37,999,111, a decrease of $1,496,340 or 3.8 percent from the FY 2013 Revised Budget Plan of $39,495,451. Of this total, $1,206,653 represents accrued revenues anticipated to be received within 45 days of fiscal year end.
- Actual expenditures total $138,628,193, a decrease of $6,876,366 or 4.7 percent from the FY 2013 Revised Budget Plan of $145,504,559.
- Encumbrances total $3,456,914 which CSB requests be carried forward in FY 2014 for payment of building maintenance and repair projects in progress, undelivered orders, and other outstanding obligations (Attachment B).

**Unencumbered Carryover**

CSB respectfully requests $1,476,000 in unencumbered carryover to support one-time requirements, including $800,000 to be transferred to Fund 10040, Information Technology for Credible data conversion, enhancements, and business intelligence; $400,000 to offset reductions in the federal Housing Choice Voucher (HCV) program impacting existing CSB consumers at risk of homelessness; and $270,000 to offset reductions in federal funding for substance abuse, mental health, and prevention services due to the sequester. Details follow:

- Credible - Data Conversion, Enhancements, and Business Intelligence $800,000
  Funding of $800,000 is requested to be transferred to Fund 10040, Information Technology to support a multi-year project to convert historical consumer and financial data; align critical County systems, business processes, and Credible; and implement improved reporting functionality and business intelligence. To serve the community in a

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703-324-7000, TTY 703-802-3015, Fax 703-324-7092
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cost-effective manner and respond to the evolving challenges of health care reform, CSB requires improved access to real-time data, user-friendly standard management reports, and improved analytic functionality. If approved, funding will support the following project objectives:

- Convert 10 years of behavioral health and financial data in accordance with state and federal laws for data retention;
- Align critical business processes (e.g., scheduling, intake, billing) with Credible and align Credible with other County systems (e.g., FOCUS) to increase administrative efficiencies and improve management and financial reporting;
- Implement enhancements related to the County's late fee, penalty and interest ordinance;
- Improve data quality to meet programmatic and financial reporting and audit requirements (e.g., State Performance Contract);
- Implement Business Intelligence (BI) to improve programmatic, financial, and management reporting (e.g., caseload and staff service hour metrics, performance metrics required for federal, state and County compliance, and cost/revenue trends.

- CSB Housing Assistance – Offset Federal Funding Reductions $400,000
  Funding of $400,000 is requested to offset reductions in the federal Housing Choice Voucher (HCV) program, formerly known as the Section 8 Program, impacting existing CSB consumers at risk of homelessness. As a result of the sequester, the County suspended new leasing in the HCV program effective April 1, 2013. CSB consumers who would have been served coming out of homelessness or off the County's waiting lists as well as those whose bridging affordability eligibility is lapsing will not receive assistance as vouchers normally made available through program attrition will not be able to be reissued. It is anticipated that funding will support housing assistance for approximately 38 CSB consumers.

- Mental Health, Substance Abuse and Prevention Services – Offset Federal Reductions $276,000
  Funding of $270,000 is requested to offset reductions in federal funding for substance abuse, mental health, and prevention services due to the sequester as follows:

| Description | Amount |
|---|---|
| Reduction of $143,000 and 1/1.5 FTE Substance Abuse Counselor II position will eliminate outpatient and case management services for approximately 210 adults with substance use disorder and increase waiting lists for consumers who could be served through a less intensive/expensive level of care, such as residential, detoxification or emergency services. Individuals with co-occurring mental health issues would likely experience an exacerbation of co-occurring symptoms and may require hospitalization. While waiting and not receiving treatment, it is likely that individuals would have increased criminal behavior and involvement with other agencies such as the Department Of Family Services. | $143,000 |
| Reduction of $110,000 and 1/1.0 FTE MH/ID/ADS Senior Clinician position will eliminate case management services for approximately 45 adults with serious mental illness. Without case management services, these individuals will be at higher risk to decompensate and may require more | $110,000 |

| | |
|---|---|
| intensive/expensive services, such as emergency services, crisis care and hospitalization. In addition, reductions in case management staff will affect the adult services continuum as transfers from other programs could not be accepted. It should be noted that this reduction is associated with a decrease of approximately $58,770 in Medicaid reimbursement (assuming 33 percent of consumers on a standard 45 consumer caseload are eligible for Medicaid case management services reimbursed at $326.50/month). | |
| Reduction of $27,000 will eliminate a planned project to provide wellness and suicide prevention through an evidence-based online training program targeted to school personnel, educators in institutions of higher learning, military families, and people who are LGBTQ. The brief web-based training has been demonstrated as effective, includes solid outcome measures and data collection capabilities, and may be managed through less-intensive staff resources than traditional programming. | $27,000 |

**Capital Fund 300-C30010**

CSB respectfully requests existing balances the following Fund 300-C30010 projects be carried forward into FY 2014: HS-000005 Woodburn Mental Health Center and HS-000008 Central Virginia Training Center Group Homes.

If you have any questions, please contact CSB's senior financial manager, Valecia Witt, at 324-5834.

cc: CSB Board
CSB Executive Staff
Gail Ledford, DAHS Director
Ron McDevitt, DAHS FM Business Manager
Afsaneh Tibbs, DIT Policy/Planning Administration Director

# FUND STATEMENT

## Fund 40040, Fairfax-Falls Church Community Services Board

| | FY 2013 Estimate [2] | FY 2013 Actual | Increase (Decrease) (Col. 2-1) | FY 2014 Adopted Budget Plan | FY 2014 Revised Budget Plan | Increase (Decrease) (Col. 5-4) |
|---|---|---|---|---|---|---|
| **Beginning Balance[1]** | **($2,601,407)** | **($2,601,407)** | **$0** | **$1,000,000** | **$6,380,026** | **$5,380,026** |
| Revenue: | | | | | | |
| Local Jurisdictions: | | | | | | |
| Fairfax City | $1,336,100 | $1,336,100 | $0 | $1,336,100 | $1,336,100 | $0 |
| Falls Church City | 605,595 | 605,595 | 0 | 605,595 | 605,595 | 0 |
| Subtotal - Local | $1,941,695 | $1,941,695 | $0 | $1,941,695 | $1,941,695 | $0 |
| State: | | | | | | |
| State DBHDS | $12,712,098 | $12,712,937 | $839 | $12,713,033 | $12,713,033 | $0 |
| Subtotal - State | $12,712,098 | $12,712,937 | $839 | $12,713,033 | $12,713,033 | $0 |
| Federal: | | | | | | |
| Block Grant | $4,352,406 | $4,418,878 | $66,472 | $4,203,857 | $4,203,857 | $0 |
| Direct/Other Federal | 154,982 | 155,081 | 99 | 154,982 | 154,982 | 0 |
| Federal ARRA | 0 | 0 | 0 | 0 | 0 | 0 |
| Subtotal - Federal | $4,507,388 | $4,573,959 | $66,571 | $4,358,839 | $4,358,839 | $0 |
| Fees: | | | | | | |
| Medicaid Waiver | $2,756,068 | $2,484,208 | ($271,860) | $2,756,068 | $2,756,068 | $0 |
| Medicaid Option | 10,664,606 | 10,044,268 | (620,338) | 10,026,774 | 10,026,774 | 0 |
| Program/Client Fees | 5,253,587 | 4,770,470 | (483,117) | 6,279,123 | 6,279,123 | 0 |
| CSA Pooled Funds | 1,660,009 | 1,457,374 | (202,635) | 1,660,009 | 1,660,009 | 0 |
| Subtotal - Fees | $20,334,270 | $18,756,320 | ($1,577,950) | $20,721,974 | $20,721,974 | $0 |
| Other: | | | | | | |
| Miscellaneous | $0 | $14,200 | $14,200 | $0 | $0 | $0 |
| Subtotal - Other | $0 | $14,200 | $14,200 | $0 | $0 | $0 |
| Total Revenue | $39,495,451 | $37,999,111 | ($1,496,340) | $39,735,541 | $39,735,541 | $0 |
| Transfers In: | | | | | | |
| General Fund (10001) | $109,610,515 | $109,610,515 | $0 | $109,233,258 | $109,233,258 | $0 |
| Total Transfers In | $109,610,515 | $109,610,515 | $0 | $109,233,258 | $109,233,258 | $0 |
| **Total Available** | **$146,504,559** | **$145,008,219** | **($1,496,340)** | **$149,968,799** | **$155,348,825** | **$5,380,026** |
| Expenditures: | | | | | | |
| CSB Administration | $6,643,946 | $5,756,861 | ($887,085) | $6,002,307 | $6,809,143 | $806,836 |
| Cross-Cutting | 19,615,846 | 21,740,826 | 2,124,980 | 19,204,764 | $19,730,540 | 525,776 |
| Front Door | 13,809,641 | 14,177,321 | 367,680 | 13,863,598 | $14,044,284 | 180,686 |
| Treatment Services | 41,297,482 | 36,548,702 | (4,748,780) | 44,019,127 | $44,570,369 | 551,242 |
| Community Living | 64,137,644 | 60,404,483 | (3,733,161) | 65,879,003 | $67,271,378 | 1,392,375 |
| Total Expenditures | $145,504,559 | $138,628,193 | ($6,876,366) | $148,968,799 | $152,425,714 | $3,456,915 |
| **Total Disbursements** | **$145,504,559** | **$138,628,193** | **($6,876,366)** | **$148,968,799** | **$152,425,714** | **$3,456,915** |
| **Ending Balance** | **$1,000,000** | **$6,380,026** | **$5,380,026** | **$1,000,000** | **$2,923,111** | **$1,923,111** |
| Infant and Toddler Connection Reserve | $1,000,000 | $1,000,000 | $0 | $1,000,000 | $1,000,000 | $0 |
| **Unreserved Balance** | **$0** | **$5,380,026** | **$5,380,026** | **$0** | **$1,923,111** | **$1,923,111** |

[1] The FY 2013 Beginning Balance of ($2,601,407) is primarily the result of an unanticipated significant increase in service demand and lower than anticipated revenue in FY2012.
[2] The *FY 2013 Estimate* reflects all adjustments.

Attachment B
Justification for Encumbered Carryover

| Cmmt Item | CI Description | Balance | Justification |
|---|---|---|---|
| 510000 | Office Equip&Furnitr | 222,339 | Furnishings, primarily in residential programs, delayed due to prior funding constraints |
| 510020 | Office Supplies | 4,404 | Office supplies awaiting delivery |
| 510030 | Computer Equipment | 461,822 | $0.3M for Electronic Health Record user license, hosting, and e-prescriber services and $ 0.15M to replace obsolete/broken computers |
| 510040 | Computer Acces&Supl | 5,384 | Office supplies awaiting delivery |
| 510060 | Printing Acces&Supl | 1,103 | Office supplies awaiting delivery |
| 510200 | Bldg Maint & Repair | 949 | Office supplies awaiting delivery |
| 510400 | Educational Supplies | 263 | Office supplies awaiting delivery |
| 510420 | Media Supplies | 38 | Office supplies awaiting delivery |
| 510640 | Food Srv Equip/Supl | 10,980 | Residential consumables awaiting delivery |
| 510650 | Hshl Aplnc/Supl/Repl | 9,765 | Residential consumables awaiting delivery |
| 510660 | Med&Lab Eqp and Supl | 28,955 | Medical Supplies awaitng delivery |
| 510670 | Park/Rctn Area Equip | 23 | Office supplies awaiting delivery |
| 512990 | Other Operating Supl | 300 | Office supplies awaiting delivery |
| 513040 | Fuel Oil County | 5,599 | Utilities not invoiced |
| 514020 | Uniform/Wear Apparel | 138 | Office supplies awaiting delivery |
| 520010 | Bldg Maint & Repair | 216,719 | Building repair and maintenance projects in residential programs delayed due to prior funding constraints |
| 520110 | Other Maint & Repair | 3,787 | Janitorial and cleaning supplies awaiting delivery |
| 521030 | Translation Services | 28,300 | Translation services not invoiced |
| 521040 | Employment Services | 713,416 | IDS contracted day support and employment services not invoiced |
| 521050 | Edu/Training Service | 22,793 | Curriculum and training materials awaiting delivery |
| 521080 | Other Pro Cntrct Svc | 95,562 | Contracted peer run and nursing services not invoiced |
| 521090 | Comm & Media Service | 2,076 | Cable and TV supplies awaiting delivery |
| 521100 | Transportation Svcs | 18,386 | Taxi services not invoiced |
| 521110 | Public Works Service | 18,587 | Contracted consulting services not invoiced |
| 521140 | Safety&Emergency Svc | 2,933 | Security equipment awaiting delivery |
| 521150 | Health Related Srvs | 728,516 | $0.4M for pharmacy/pharmaceutical services and $0.3M for contracted servcices for infant and toddlers |
| 521170 | Sbsd Care Svc-FFX&FC | 19,855 | Assistive technology equipment awaiting delivery |
| 521190 | Family Services | 517,868 | $0.4M for IDS contracted group home services and $0.1M for medication access services |
| 521240 | Meals | 20,537 | Residential consumables awaiting delivery |
| 521250 | Misc Services | 59,900 | Contracted temporary personnel services and telecommunication services not invoiced |
| 523090 | Rent of Real Estate | 19,320 | Buidling maintenace and repair projects for residential properties |
| 530000 | Electricity County | 61,367 | Utilities not invoiced |
| 530010 | Natural Gas County | 12,558 | Utilities not invoiced |
| 530020 | Propane | 3,392 | Utilities not invoiced |
| 530030 | Sewer County | 1,995 | Utilities not invoiced |
| 530040 | Water County | 30,570 | Utilities not invoiced |
| 544990 | Other Operating Exp | 106,444 | Contracted IDS residential services not invoiced |
| **Grand Total** | | **3,456,944** | |

Report Group: Budget vs Actual by Commitment Item Fairfax
Commitment Item: FFX2 Fairfax

Date: 07/03/2013
Time: 15:59:47
From: 1 to 12
Year: 2013

Fund :400-C40040 FFX-Falls Church Comm Svcs Board
Fund Center:* *
Funded Prog:* *
Grant :* *

| Description | C/F Budget | Original Budget | Budget Change | Current Budget | Pre Encumbrance | Encumbrance | Actuals | Available Budget |
|---|---|---|---|---|---|---|---|---|
| * 4000 - Property Taxes | | | | | | | | |
| * 4300 - Intergovernmental | | -17,117,340 | -102,146 | -17,219,486 | | | -17,286,896 | 67,410 |
| * 4400 - Charges for Services | | -23,083,242 | 2,748,972 | -20,334,270 | | | -18,756,321 | -1,577,949 |
| * 4500 - Fines & Forfeitures | | | | | | | -14,100 | 14,100 |
| * 4700 - Recovered Cost | | -1,941,695 | | -1,941,695 | | | -1,941,695 | |
| * 4800 - Gifts Donations & Contr | | -56,124 | 56,124 | | | | -100 | 100 |
| * 4920 - Transfer In | | -100,421,627 | -9,188,888 | -109,610,515 | | | -109,610,515 | |
| ** Fairfax County Government Reve | | -142,620,028 | -6,485,938 | -149,105,966 | | | -147,609,626 | -1,496,339 |
| * 5000 - Compensation | | 72,070,704 | -4,000,522 | 68,070,182 | | | 66,294,614 | 1,775,568 |
| * 5010 - Benefits | | 20,525,949 | 3,594,037 | 24,119,986 | | | 23,203,650 | 916,336 |
| * 5020 - Non Pay Employee Benefi | | 1,403 | | 1,403 | | | -1,043 | 2,446 |
| * 5100 - Operating Expenses | 154,888 | 50,727,794 | 3,754,280 | 54,636,962 | | 3,456,914 | 50,591,057 | 588,992 |
| * 5400 - WPFO | | -1,123,974 | -200,000 | -1,323,974 | | | -1,468,098 | 144,124 |
| * 5900 - Contingency | | 418,152 | -418,152 | | | | | |
| * 5600 - Capital Outlay | | | | | | | 7,938 | -7,938 |
| * 5920 - Discount Loss | | | | | | | 75 | -75 |
| ** Fairfax County Government Expe | 154,888 | 142,620,028 | 2,729,643 | 145,504,559 | | 3,456,914 | 138,628,194 | 3,419,451 |
| *** Fairfax Government | 154,888 | | -3,756,295 | -3,601,407 | | 3,456,914 | -8,981,432 | 1,923,112 |
| * 5600 - Capital Outlay | | | | | | | 7,938 | -7,938 |
| * 5920 - Discount Loss | | | | | | | 75 | -75 |
| ** Fairfax Public Schools Expense | | | | | | | 8,013 | -8,013 |
| *** Fairfax County Public Schools | | | | | | | 8,013 | -8,013 |
| **** BALANCE | 154,888 | | -3,756,295 | -3,601,407 | | 3,456,914 | -8,973,419 | 1,915,099 |

FAIRFAX-
FALLS CHURCH
COMMUNITY SERVICES BOARD

**TO:** Susan W. Datta
Chief Financial Officer

**FROM:** George Braunstein
Executive Director

**DATE:** July 10, 2013

**SUBJECT:** FY 2013 Carryover Review

Enclosed please find the FY 2013 Carryover Review submission for Fund 500-C50000, Federal-State Grant Fund for the Fairfax-Falls Church Community Services Board (CSB). This submission includes continuing grants with unexpended balances, adjustments to existing awards, and grants to be closed (Attachment A). Please note that this submission is contingent upon CSB Board approval at July 24, 2013 meeting.

**Continuing Grants**

As part of the FY 2013 Carryover Review, CSB requests that grant end dates be extended for the following continuing grants with unexpended balances.

| Grant Number | Grant Title | Grant End Date |
|---|---|---|
| 1750002-2012 | HIDTA | 09/30/2014 |
| 1750003-2012 | Regional Acute Care | 09/30/2014 |
| 1750004-2012 | Regional Discharge Assistance | 09/30/2014 |
| 1750005-2012 | Regional Crisis Stabilization | 09/30/2014 |
| 1750006-2012 | Regional Recovery Services | 09/30/2014 |
| 1720002-2013 | HIDTA | 09/30/2014 |
| 1750003-2013 | Regional Acute Care | 09/30/2014 |
| 1750004-2013 | Regional Discharge Assistance | 09/30/2014 |
| 1750005-2013 | Regional Crisis Stabilization | 09/30/2014 |
| 1750006-2013 | Regional Recovery Services | 09/30/2014 |
| 1750013-2013 | Homeless Assistance Program* | 12/31/2013 |
| 1750016-2013 | MH Initiative State* | 12/31/2013 |
| 1750018-2013 | Forensic Discharge Planner* | 09/30/2014 |
| 1750019-2013 | MH Law Reform* | 09/30/2014 |
| 1750020-2013 | MH Child & Adolescent Services* | 09/30/2014 |
| 1750025-2013 | START | 09/30/2014 |

** Reflects grant end date not previously requested.*

Please see Attachment B for an overview of grants requiring extended end dates and those to be closed.

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703-324-7000, TTY 703-802-3015, Fax 703-324-7092
www.fairfaxcounty.gov/csb

**Adjustments to Existing Grant Awards**

As part of the FY2013 Carryover Review, CSB requests adjustments to the following existing grant awards:

| Grant Number | Grant Title | Revised Budget |
|---|---|---|
| 1750005-2012 | Regional Crisis Stabilization | $2,116,122 |
| 1750001-2013 | IDEA Part C | $3,529,910 |
| 1750002-2013 | HIDTA | $398,725 |
| 1750003-2013 | Regional Acute Care | $2,439,294 |
| 1750005-2013 | Regional Crisis Stabilization | $1,170,684 |
| 1750012-2013 | Jail & Offender Services | $185,867 |
| 1750001-2014 | IDEA Part C | $3,823,723 |
| 1750016-2014 | MH Initiative – State | $515,529 |
| 1750025-2014 | START | $2,000,000 |

Please see Attachment C for adjustment loading sheets, description of adjustment, and narrative.

**Grant Closeouts**

As part of the FY2013 Carryover Review, the following grants may be closed:

| Grant # | FAMIS Grant# | Title | Date of Closure |
|---|---|---|---|
| 1750002-2009 | 75049g / 09001;09003; 09004;09005 | HIDTA | 06/30/2013 |
| 1750002-2010 | 75049g / 10001;10003 | HIDTA | 06/30/2013 |
| 1750002-2011 | 75049g / 11001;11003 | HIDTA | 06/30/2013 |
| 1750008-2011 | 75093g / 11001 | Reg Child MH Services | 06/30/2013 |
| 1750009-2011 | 75094g / 11001 | Promotion of Wellness | 06/30/2013 |
| 1750010-2012 | 75045g / 12001 | Probation & Parole | 06/30/2013 |
| 1750011-2012 | 75055g / 12001 | Supportive Housing, HUD | 06/30/2013 |
| 1750012-2012 | 75058g / 12001 | Jail & Offender Services | 06/30/2013 |
| 1750013-2012 | 75028g / 12001 | Homeless Assistance Program | 06/30/2013 |
| 1750014-2012 | 75071g / 12001 | VASAVOR | 06/30/2013 |
| 1750015-2012 | 75085g / 12001;12002 | Jail Diversion Services | 06/30/2013 |
| 1750019-2012 | 75089g / 12001;12002 | MH Law Reform | 06/30/2013 |
| 1750020-2012 | 75090g / 12001;12002 | MH Child & Adolescent Services | 06/30/2013 |
| 1750021-2012 | 75091g / 12001 | MH Cooperative Employment Program | 06/30/2013 |
| 1750022-2012 | 75081g / 12001 | VFHY Al's Pals | 06/30/2013 |
| 1750025-2012 | N/A | START | 06/30/2013 |
| 1750014-2013 | N/A | VASAVOR | 03/31/2013 |

All required documentation to close these grants has been submitted to both the Department of Finance and the Department of Management and Budget.

If you have any questions, please contact CSB's senior financial manager, Valecia Witt, at 324-5834.

cc: CSB Board
CSB Executive Staff
Gail Ledford, DAHS Director
Ron McDevitt, DAHS FM Business Manager

**Fairfax-Falls Church CSB**
**FY2013 Carryover Review**

**Attachment A**

| Grant | Title | Grant Total | PTD Revenue | PTD Expenditures | Ready to Close? | Supp Award | Adjustment | Revised Grant | Notes: |
|---|---|---|---|---|---|---|---|---|---|
| **Continuing:** | | | | | | | | | |
| 1750002-2012 | HIDTA | $450,000.00 | $450,000.00 | $443,452.03 | | | | | |
| 1750003-2012 | Regional Acute Care | $3,815,907.00 | $3,738,424 | $2,035,179.44 | | | | | |
| 1750004-2012 | Reg Discharge Assistance | $2,186,827.00 | $1,479,722 | $638,262.13 | | | | | |
| 1750005-2012 | Reg Crisis Stabilization | $1,864,821.00 | $2,012,084.00 | $1,434,863.85 | | | | | |
| 1750006-2012 | Reg Recovery Services | $1,298,035.00 | $1,234,427 | $742,564.61 | | | | | |
| 1750002-2013 | HIDTA | $400,000.00 | $115,707.91 | $115,707.91 | | | | | |
| 1750003-2013 | Regional Acute Care | $2,349,705.00 | $2,439,294 | $2,032,980.91 | | | | | |
| 1750004-2013 | Reg Discharge Assistance | $1,749,374.00 | $1,750,641 | $459,779.43 | | | | | |
| 1750005-2013 | Reg Crisis Stabilization | $833,667.00 | $1,170,683.77 | $685,313.98 | | | | | |
| 1750006-2013 | Reg Recovery Services | $543,192.00 | $543,192 | $501,132.03 | | | | | |
| 1750013-2013 | Homeless Assistance Program | $155,698.00 | $155,697 | $133,449.53 | | | | | |
| 1750016-2013 | MH Initiative State | $515,529.00 | $515,529 | $497,438.96 | | | | | |
| 1750018-2013 | MH Transformation | $70,000.00 | $70,008 | $55,076.35 | | | | | |
| 1750019-2013 | MH Law Reform | $530,387.00 | $530,387 | $170,405.00 | | | | | |
| 1750020-2013 | MH Child & Adolescent Srvc | $75,000.00 | $75,000 | $20,398.00 | | | | | |
| 1750025-2013 | START | $1,536,097.00 | $1,536,741 | $812,360.17 | | | | | |
| **Adjustments:** | | | | | | | | | |
| 1750005-2012 | Reg Crisis Stabilization | $1,993,671.00 | $2,012,084.00 | $1,434,863.85 | | | $122,451 | $2,116,122 | Remove CSB Rev Budget -$128,850; Add NVMH revenue return $251,301; net $122,451 |
| 1750001-2013 | IDEA Part C | $3,653,418.00 | $3,529,910.00 | $3,529,910.00 | | | ($123,508) | $3,529,910 | adj diff of TQ request $610,000 less State OT funds $486,492 equals -$123,508 |
| 1750003-2013 | Regional Acute Care | $2,349,705.00 | $2,439,294 | $2,032,980.91 | | | $89,589 | $2,439,294 | $89,588.97 NVMI refund; need to add to Revenue/Expenditure budget |
| 1750005-2013 | Reg Crisis Stabilization | $833,667.00 | $1,170,683.77 | $685,313.98 | | | $337,017 | $1,170,684 | Funds recap from Prince William & Alexandria |
| 1750012-2013 | Jail & Offender Services | $185,857.00 | $185,867 | $185,867.00 | | | $10 | $185,867 | $10 add'l revenue rec'd; request to increase Revenue/Expenditure by $10 |
| 1750001-2014 | IDEA Part C | $3,043,418.00 | $0.00 | $0.00 | | $780,305 | | $3,823,723 | PY14 - rec'd add'l State Part C funding |
| 1750016-2014 | MH Initiative - State | $322,592.00 | $0.00 | $0.00 | | $192,937 | | $515,529 | continue to align the MHI grant according to decisions in FY2013 |
| 1750025-2014 | START | $1,536,097.00 | $0.00 | $0.00 | | $463,903 | | $2,000,000 | PY2014 - rec'd add'l DBHDS regional funding |
| **Closeout:** | | | | | | | | | |
| 1750002-2009 | HIDTA | $646,878.00 | $645,878.00 | $646,878.00 | Y | | | $646,878 | |
| 1750002-2010 | HIDTA | $400,000.00 | $400,000.00 | $400,000.00 | Y | | | $400,000 | |
| 1750002-2011 | HIDTA | $425,000.00 | $425,000.00 | $425,000.00 | Y | | | $425,000 | |
| 1750008-2011 | Reg Child MH Services | $112,547.00 | $112,547.00 | $112,547.00 | Y | | | $112,547 | |
| 1750009-2011 | Promotion of Wellness | $94,990.00 | $94,990.00 | $94,990.00 | Y | | | $94,990 | |
| 1750010-2012 | Probation & Parole | $64,867.00 | $64,866.29 | $64,866.29 | Y | | | $64,867 | |
| 1750011-2012 | Supportive Housing, HUD | $260,109.00 | $260,108.52 | $260,108.52 | Y | | | $260,109 | |
| 1750012-2012 | Jail & Offender Services | $185,866.00 | $185,866.00 | $185,866.00 | Y | | | $185,866 | |
| 1750013-2012 | Homeless Assistance Program | $172,158.00 | $172,158.00 | $172,158.00 | Y | | | $172,158 | |
| 1750014-2012 | VASAVOR | $134,417.00 | $128,314.63 | $128,314.63 | Y | | | $134,417 | |
| 1750015-2012 | Jail Diversion Services | $321,050.00 | $321,050.00 | $321,050.00 | Y | | | $321,050 | |
| 1750019-2012 | MH Law Reform | $530,387.00 | $530,386.99 | $530,386.99 | Y | | | $530,387 | |
| 1750020-2012 | MH Child & Adolescent Srvcs | $75,000.00 | $75,000.00 | $75,000.00 | Y | | | $75,000 | |
| 1750021-2012 | MH Cooperative Employment Prc | $65,000.00 | $0.00 | $0.00 | Y | | | $65,000 | |
| 1750022-2012 | VFHY Al's Pals | $72,350.00 | $70,431.00 | $70,431.00 | Y | | | $72,350 | |
| 1750025-2012 | START | $985,000.00 | $985,000.00 | $985,000.00 | Y | | | $985,000 | |
| 1750014-2013 | VASAVOR | $134,417.00 | $71,614.98 | $71,614.98 | Y | | | $134,417 | |

| Grant | Grant Title | End Date | Status | Extend End Date or Close Grant | Grant Date Extenstion | Request Guidance on how to close? |
|---|---|---|---|---|---|---|
| 1750008-2011 | REG CHILD COM BH SVC | 6/30/2013 | Active | Close Grant | | |
| 1750009-2011 | PROMOTION OF WELLNES | 2/28/2013 | Active | Close Grant | | |
| | | | | | | |
| 1750002-2012 | HIDTA | 6/30/2013 | Active | Extend End Date | 9/30/2014 | |
| 1750003-2012 | REGIONAL ACUTE CARE | 6/30/2013 | Active | Extend End Date | 9/30/2014 | |
| 1750004-2012 | REG DISCHARGE ASSIST | 6/30/2013 | Active | Extend End Date | 9/30/2014 | |
| 1750005-2012 | REG CRISIS STABILIZA | 6/30/2013 | Active | Extend End Date | 9/30/2014 | |
| 1750006-2012 | REG RECOVERY SVCS | 6/30/2013 | Active | Extend End Date | 9/30/2014 | |
| 1750010-2012 | PROBATION & PAROLE | 6/30/2013 | Active | Close Grant | | |
| 1750011-2012 | Supportive Housing HUD | 6/30/2012 | Active | Close Grant | | |
| 1750012-2012 | JAIL & OFFENDER SVCS | 2/28/2013 | Active | Close Grant | | |
| 1750013-2012 | HOMELESS ASSIST PGM | 2/28/2013 | Active | Close Grant | | |
| 1750014-2012 | VASAVOR | 2/28/2013 | Active | Close Grant | | |
| 1750015-2012 | JAIL DIVERSION SVCS | 6/30/2013 | Active | Close Grant | | |
| 1750019-2012 | MH LAW REFORM | 3/31/2013 | Active | Close Grant | | |
| 1750020-2012 | MH CHILD & ADOL SVCS | 6/30/2013 | Active | Close Grant | | |
| 1750022-2012 | VFHY - AL'S PALS | 4/30/2013 | Active | Close Grant | | |
| 1750025-2012 | REG ID CRISIS STAB | 6/30/2013 | Active | Close Grant | | |
| | | | | | | |
| 1750002-2013 | HIDTA | 9/30/2013 | Active | Extend End Date | 9/30/2014 | |
| 1750003-2013 | REGIONAL ACUTE CARE | 6/30/2013 | Active | Extend End Date | 9/30/2014 | |
| 1750004-2013 | REG DISCHARGE ASSIST | 6/30/2013 | Active | Extend End Date | 9/30/2014 | |
| 1750005-2013 | REG CRISIS STABILIZA | 6/30/2013 | Active | Extend End Date | 9/30/2014 | |
| 1750006-2013 | REG RECOVERY SVCS | 6/30/2013 | Active | Extend End Date | 9/30/2014 | |
| 1750013-2013 | Homeless Assistance Program | | | Extend End Date | 12/31/2013 | rec'd grant incentive $$ that need to be spent by 8/31/2013; allow for posting thru 12/31/2013 |
| 1750016-2013 | MH Initiative - State | 6/30/2013 | Active | Extend End Date | 12/31/2013 | grant balance can be expended through 10/31/2013; please allow for posting thru 12/31/2013 |
| 1750018-2013 | Forensic Discharge Planner | 6/30/2013 | Active | Extend End Date | 9/30/2014 | |
| 1750019-2013 | MH Law Reform | 6/30/2013 | Active | Extend End Date | 9/30/2014 | |
| 1750020-2013 | MH Child & Adolescent Srvc | 6/30/2013 | Active | Extend End Date | 9/30/2014 | |
| 1750025-2013 | REG ID CRISIS STAB | 6/30/2013 | Active | Extend End Date | 9/30/2014 | |

Reflects grant end date not previously requested

**Please advise as to what is needed to close these out? Is it only the GMD that needs to be closed out or do you need a closing form?**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1750002-2009 | HIDTA | 9/30/2012 | Active | Close Grant | | requested to send closeout form for FAMIS grant; sent 6/25/13 |
| 1750002-2010 | HIDTA | 9/30/2012 | Active | Close Grant | | Submitted previously for closure; resubmitted 6/25 |
| 1750002-2011 | HIDTA | 4/30/2013 | Active | Close Grant | | Submitted previously for closure; resubmitted 6/25 |
| 1750010-2013 | PROBATION & PAROLE | 6/30/2013 | Active | Close Grant | | The grant budget was not set up for 2013; no funding was rec'd for this grant; looks like only the GMD was setup; let me know what is needed to close it out. DMB closed out the GMD. |
| 1750021-2012 | MH EMPLOYMENT PGM | 9/30/2012 | Active | Close Grant | | This grant was requested to be ***closed during FY12 CO***; we never rec'd funding for this grant in FY12; requested to send closeout form; sent 6/25/13 |
| 1750021-2013 | MH EMPLOYMENT PGM | 6/30/2013 | Active | Close Grant | | This grant was not set up for 2013; no funding was rec'd for this grant; looks like only the GMD was setup; let me know what is needed to close it out. DMB closed out the GMD |

**Agency:** Fairfax-Falls Church Community Service Board
**Agency Number:** 75
**Grant Name:** Reg Crisis Stabilization
**Grant Number:** 1750005-2012
$1,993,671 + $122,451 $2,116,122
**Sponsor** 4000000044 VA Dept of Behavioral Health & Development Services

**Type of Transaction:** Add'l Funding $122,451

| | | EXPENDITURE | | | | | REVENUE/TRANSFERS | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Grant #** | **Sponsored Program** | **Sponsored Class** | **GL/ Cmmt** | **Current FY Budget** | **Change** | **Revised FY Budget** | **Sponsored Class** | **GL/ Cmmt** | **Current FY Budget** | **Change** | **Revised FY Budget** |
| 1750005-2012 | Program Admin | G_Comp_Salaries | 500000 | $289,424 | | $289,424 | G_Rev_CSB | 442020 | $128,850 | -$128,850 | $0 |
| | | G_Benefits | 501000 | $907,906 | | $907,906 | G_Rev_State | 430035 | $1,864,821 | $251,301 | $2,116,122 |
| | | G_IS-Contracts | 520010 | $30,600 | | $30,600 | | | | | |
| | | G_Other_Purch_Svc | 521150 | $765,741 | $122,451 | $888,192 | | | | | |
| | | G_General_Operating | 544990 | | | $0 | | | | | |
| | | G_Travel | 544508 | | | $0 | | | | | |
| | | G_Training | | | | $0 | | | | | |
| **Total 1750005-2012 Program Admin** | | | | **$1,993,671** | **$122,451** | **$2,116,122** | | | **$1,993,671** | **$122,451** | **$2,116,122** |

## Note:

| | | |
|---|---|---|
| $ | 1,864,821.00 | Original Budget prior to shifting $1m to Prince William |
| $ | (31,980.00) | Reg funds transferred to Norther VA Mental Health |
| $ | 283,281.00 | NVMH returns unspent funds |
| **$** | **2,116,122.00** | Revised Budget |

**$251,301 FY13 CO request to increase Revenue / Expenditure**
**-$128,850 Request to Return $128,850 to Fund 500-c50000**

**Regional Crisis Stabilization (1750005)**

The Commonwealth of Virginia Department of Behavioral Health and Developmental Services allocation to Health Planning Region II to provide crisis stabilization services for both individuals in crisis who need a crisis stabilization program or individuals with intellectual disabilities and mental illness who are at risk of hospitalization

***Approved by Tom Young 7/3/2013***

**Agency:** Fairfax-Falls Church Community Service Board
**Agency Number:** 75
**Grant Name:** IDEA Part C
**Grant Number:** 1750001-2013
**Grant Total:** $3,653,418 - ($123,508) $3,529,910
**Sponsor** 4000000044 VA Dept of Behavioral Health & Development Services

**Type of Transaction:** Return ($123,508)

| | | EXPENDITURE | | | | | REVENUE/TRANSFERS | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Grant # | Sponsored Program | Sponsored Class | GL/Cmmt | Current FY Budget | Change | Revised FY Budget | Sponsored Class | GL/Cmmt | Current FY Budget | Change | Revised FY Budget |
| 1750001-2013 | Program Admin | G_Benefits | 501000 | $405,397 | -$99,000 | $306,397 | G_Rev_Federal | | $0 | $0 | $0 |
| | | G_Comp_Salaries | 500000 | $821,529 | -$24,508 | $797,021 | G_Rev_Pass-Thru | 432570 | $1,536,900 | $0 | $1,536,900 |
| | | G_Other_Purch_Svc | 521180 | $2,401,492 | $0 | $2,401,492 | G_Rev_State | 430035 | $2,116,518 | -$123,508 | $1,993,010 |
| | | G_Travel | 544508 | $25,000 | $0 | $25,000 | | | $0 | $0 | $0 |
| | | | | $0 | $0 | $0 | | | $0 | $0 | $0 |
| **Total 1750001-2013 Program Admin** | | | | **$3,653,418** | **-$123,508** | **$3,529,910** | | | **$3,653,418** | **-$123,508** | **$3,529,910** |

**Note:**

Requested a Revenue/Expenditure increase of $610,000 during FY2013 TQ, however only rec'd $486,492 from the State for a Return to Fund 500-C50000 of $123,508

| | |
|---|---|
| $3,043,418 | Original Award |
| 610,000 | TQ Request |
| 486,492 | State OT award |
| -123,508 | Difference between TQ supplement request & the State's OT award |
| 3,529,910 | |

**IDEA Part C (1750001)**

The Commonwealth of Virginia, Dept of Behavioral Health & Developmental Services (DBHDS) provides funding for the early intervention of infants and toddlers ages birth to 3 years who need strategies to assist them in acquiring basic developmental skills such as sitting, crawling, walking and talking. The Infant and Toddler Connection (ITC) is a statewide program that provides federally-mandated early intervention services as outlined in Part C of the Individuals with Disabilities Education Act (IDEA). ITC provides services including: physical, occupational and speech therapy; developmental services; medical, health and nursing services; hearing and vision services; assistive technology (e.g., hearing aids, adapted toys and mobility aids); family training and counseling; service coordination; and transportation. A level of maintenance or InKind match is required, however there is no exact percentage, the County just needs to prove that there are County dollars supporting this effort and this is accomplished through Fund 400-C40040.

| | | | | |
|---|---|---|---|---|
| **Agency:** | Fairfax-Falls Church Community Service Board | | | |
| **Agency Number:** | 75 | | | |
| **Grant Name:** | HIDTA | | | |
| **Grant Number:** | 1750002-2013 | | | |
| **Grant Total:** | $400,000 | + | ($1,275) | $398,725 |
| **Sponsor** | 4000000019 | University of Maryland | | |

**Type of Transaction:** Return ($1,275)

| | | EXPENDITURE | | | | | REVENUE/TRANSFERS | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Grant #** | **Sponsored Program** | **Sponsored Class** | **GL/Cmmt** | **Current FY Budget** | **Change** | **Revised FY Budget** | **Sponsored Class** | **GL/Cmmt** | **Current FY Budget** | **Change** | **Revised FY Budget** |
| 1750002-2013 | Program Admin | G_Other_Purch_Svc | 521180 | $400,000 | -$1,275 | $398,725 | G_Rev_Pass-Thru | 432570 | $400,000 | -$1,275 | $398,725 |
| | | | | $0 | $0 | $0 | | | | | |
| **Total 1750002-2013 Residential** | | | | **$400,000** | **-$1,275** | **$398,725** | | | **$400,000** | **-$1,275** | **$398,725** |

**Note:**

PY2013 award amount is $410,000 less Sequestration -$11,275; Revised Award $398,725

| | |
|---|---|
| $400,000 | |
| $10,000 | Grant setup as $400,000, however the Award was for $410,000 |
| -$11,275 | less Sequestration |
| $398,725 | |

**High Intensity Drug Trafficking Area, HIDTA (1750002)**

The U.S. Office of National Drug Control Policy provides funding through a sub-award with the University of Maryland - Washington/Baltimore HIDTA for residential and day treatment medical detoxification services. The programs seeks to reduce the incidence and prevalence of alcohol and drug abuse by providing prevention, treatment, and rehabilitation.

**Agency:** Fairfax-Falls Church Community Service Board
**Agency Number:** 75
**Grant Name:** Reg Acute Care
**Grant Number:** 1750003-2013
$2,349,705 + $89,589 $2,439,294
**Sponsor** 4000000044 VA Dept of Behavioral Health & Development Services

**Type of Transaction:** Add'l Funding $89,589

| | | EXPENDITURE | | | | | REVENUE/TRANSFERS | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Grant # | Sponsored Program | Sponsored Class | GL/ Cmmt | Current FY Budget | Change | Revised FY Budget | Sponsored Class | GL/ Cmmt | Current FY Budget | Change | Revised FY Budget |
| 1750003-2013 | LIPOS | G_Benefits | 501000 | | | $0 | G_Rev_State | 430035 | $2,070,336 | $89,589 | $1,536,097 |
| | | G_Comp_Salaries | 500000 | | | | | | | | |
| | | G_Other_Purch_Svc | 521150 | $2,070,336 | $89,589 | $2,159,925 | | | | | |
| **Total 1750003-2013 LIPOS** | | | | **$2,070,336** | **$89,589** | **$2,159,925** | | | **$2,070,336** | **$89,589** | **$2,159,925** |
| **Total 1750003-2013 NOVA Reg Project Office** | | | | $255,619 | | $255,619 | | | $255,619 | | $255,619 |
| **Total 1750003-2013 Deaf Services** | | | | $23,750 | | $23,750 | | | $23,750 | | $23,750 |
| | | | | **$2,349,705** | **$89,589** | **$2,439,294** | | | **$2,349,705** | **$89,589** | **$2,439,294** |

## Note:

| | | |
|---|---|---|
| $ | 2,349,705.00 | Original Budget prior to shifting $1m to Prince William |
| $ | 89,588.97 | NVMH returns unused funds |
| | $2,439,294 | |

**$89,589 FY13 CO Request to increase Revenue / Expenditure**

## Regional Acute Care 1750003

The Commonwealth of Virginia Department of Behavioral Health and Developmental Services allocation to Health Planning Region II for local inpatient purchase of service for consumers with risk issues who need inpatient treatment but cannot be admitted to the state psychiatric hospital due to capacity or complex clinical issues.

***Approved by Tom Young 7/3/2013***

**Agency:** Fairfax-Falls Church Community Service Board
**Agency Number:** 75
**Grant Name:** Reg Crisis Stabilization
**Grant Number:** 1750005-2013
$833,667 + $337,017 $1,170,684
**Sponsor** 4000000044 VA Dept of Behavioral Health & Development Services

**Type of Transaction:** Add'l Funding $337,017

| | | EXPENDITURE | | | | | REVENUE/TRANSFERS | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Grant # | Sponsored Program | Sponsored Class | GL/ Cmmt | Current FY Budget | Change | Revised FY Budget | Sponsored Class | GL/ Cmmt | Current FY Budget | Change | Revised FY Budget |
| 1750005-2013 | Program Admin | G_Comp_Salaries | 500000 | | $41,245 | $41,245 | G_Rev_State | 430035 | $833,667 | $337,017 | $1,536,097 |
| | | G_Benefits | 501000 | | $14,346 | $14,346 | | | | | |
| | | G_Other_Purch_Svc | 521150 | $833,667 | $281,426 | $1,115,093 | | | | | |
| | | G_General_Operatin | 544990 | | | $0 | | | | | |
| | | G_Travel | 544508 | | | $0 | | | | | |
| | | G_Training | | | | $0 | | | | | |
| **Total 1750005-2013 Program Admin** | | | | **$833,667** | **$337,017** | **$1,170,684** | | | **$833,667** | **$337,017** | **$1,536,097** |

## Note:

| | | |
|---|---|---|
| $ | 1,842,321.00 | Original Budget prior to shifting $1m to Prince William |
| $ | (1,008,654.00) | FY12 CO adj - funding redirected by DBHDS to Prince William to open a Crisis Care facility |
| $ | 833,667.00 | |
| | | |
| $ | 410,005.02 | Prince William returned unspent funds |
| $ | (154,171.00) | Reg funds transferred to City of Alexandra |
| $ | 81,182.75 | Alexandria returns unspent funds |
| **$** | **1,170,683.77** | Revised Budget |

**$337,017 FY13 CO Request to increase Revenue / Expenditure**

**Regional Crisis Stabilization (1750005)**

The Commonwealth of Virginia Department of Behavioral Health and Developmental Services allocation to Health Planning Region II to provide crisis stabilization services for both individuals in crisis who need a crisis stabilization program or individuals with intellectual disabilities and mental illness who are at risk of hospitalization

***Approved by Tom Young 7/3/2013***

**Agency:** Fairfax-Falls Church Community Service Board
**Agency Number:** 75
**Grant Name:** Jail & Offender Services
**Grant Number:** 1750012-2013
**Grant Total:** $185,857 + $10 $185,867
**Sponsor** 4000000044 VA Dept of Behavioral Health & Development Services

**Type of Transaction:** Add'l State funding $10

| | | EXPENDITURE | | | | | REVENUE/TRANSFERS | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Grant # | Sponsored Program | Sponsored Class | GL/Cmmt | Current FY Budget | Change | Revised FY Budget | Sponsored Class | GL/Cmmt | Current FY Budget | Change | Revised FY Budget |
| 1750012-2013 | Program Admin | G_Benefits | 501000 | $62,865 | | $62,865 | G_Rev_State | 430035 | $26,055 | $9 | $26,064 |
| | | G_Comp_Salaries | 500000 | $122,992 | $10 | $123,002 | G_Rev_Pass-Thru | 432740 | $159,802 | $1 | $159,803 |
| | | | | $0 | $0 | $0 | | | $0 | $0 | $0 |
| **Total 1750012-2013 Program Admin** | | | | **$185,857** | **$10** | **$185,867** | | | **$185,857** | **$10** | **$185,867** |

**Note:**
We received an additional $10 in revenue and we are requesting to increase the Revenue/Expenditure budget to balance it with the YTD actuals

**Jail & Offender Services (1750012)**
Jail and Offender Services Initiative - Federal pass-through and State funding used to provide treatment services in the Adult Detention Center.

**Agency:** Fairfax-Falls Church Community Service Board
**Agency Number:** 75
**Grant Name:** IDEA Part C
**Grant Number:** 1750001-2014
**Grant Total:** $3,043,418 + $780,305 $3,823,723
**Sponsor** 4000000044 VA Dept of Behavioral Health & Development Services

**Type of Transaction:** Add'l State funding $780,305

| | | EXPENDITURE | | | | | REVENUE/TRANSFERS | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Grant # | Sponsored Program | Sponsored Class | GL/Cmmt | Current FY Budget | Change | Revised FY Budget | Sponsored Class | GL/Cmmt | Current FY Budget | Change | Revised FY Budget |
| 1750001-2014 | Program Admin | G_Benefits | 501000 | $637,792 | | $637,792 | G_Rev_Federal | | $0 | $0 | $0 |
| | | G_Comp_Salaries | 500000 | $1,593,407 | | $1,593,407 | G_Rev_Pass-Thru | 432570 | $1,536,900 | -$188,376 | $1,348,524 |
| | | G_Other_Purch_Svc | 521150 | $792,219 | $780,305 | $1,572,524 | G_Rev_State | 430035 | $1,506,518 | $968,681 | $2,475,199 |
| | | G_Travel | 544508 | $20,000 | $0 | $20,000 | | | $0 | $0 | $0 |
| | | | | $0 | $0 | $0 | | | $0 | $0 | $0 |
| **Total 1750001-2014 Program Admin** | | | | **$3,043,418** | **$780,305** | **$3,823,723** | | | **$3,043,418** | **$780,305** | **$3,823,723** |

**Note:**
The approved PY2014 Anticipated Budget for IDEA Part C is $3,043,418, however an additional amount was rec'd from the State for a PY2014 Revised Budget $3,823,723

**IDEA Part C (1750001)**
The Commonwealth of Virginia, Dept of Behavioral Health & Developmental Services (DBHDS) provides funding for the early intervention of infants and toddlers ages birth to 3 years who need strategies to assist them in acquiring basic developmental skills such as sitting, crawling, walking and talking. The Infant and Toddler Connection (ITC) is a statewide program that provides federally-mandated early intervention services as outlined in Part C of the Individuals with Disabilities Education Act (IDEA). ITC provides services including: physical, occupational and speech therapy; developmental services; medical, health and nursing services; hearing and vision services; assistive technology (e.g., hearing aids, adapted toys and mobility aids); family training and counseling; service coordination; and transportation. A level of maintenance or InKind match is required, however there is no exact percentage, the County just needs to prove that there are County dollars supporting this effort and this is accomplished through Fund 400-C40040.

**Agency:** Fairfax-Falls Church Community Service Board
**Agency Number:** 75
**Grant Name:** MH Initiative-State, MH Child & Adolescent Services
**Grant Number:** 1750016-2014
**Grant Total:** $322,592 + $192,937 $515,529
**Sponsor**

**Type of Transaction:** $192,937

| | | EXPENDITURE | | | | | REVENUE/TRANSFERS | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Grant # | Sponsored Program | Sponsored Class | GL/Cmmt | Current FY Budget | Change | Revised FY Budget | Sponsored Class | GL/Cmmt | Current FY Budget | Change | Revised FY Budget |
| 1750016-2014 | Program Admin | G_Comp_Salaries | 500000 | $243,257 | | $243,257 | G_Rev_State | 430035 | $322,592 | $192,937 | $515,529 |
| | | G_Benefits | 501000 | $76,335 | | $76,335 | | | | | |
| | | G_Other_Purch_Svc | 521190 | $0 | $192,937 | $192,937 | | | | | |
| | | G_Travel | 544508 | $3,000 | | $3,000 | | | | | |
| | | G_General_Operating | 544990 | $0 | | $0 | | | | | |
| | | | | $0 | | $0 | | | | | |
| **Total 1750016-2014 Supportive Housing** | | | | **$322,592** | **$192,937** | **$515,529** | | | **$322,592** | **$192,937** | **$515,529** |

**Note:**
Align grant budget to reflect the entire DBHDS funding

**MH Initiative - State, SED Initiative (non Mandated CSA HM) (1750016)**

Mental Health Initiative, SED Initiative (non Mandated CSA HHM) - The Commonwealth of Virginia Department of Behavioral Health and Developmental Services allocates funds for mental health services to seriously emotionally disturbed children. Case management services are provided to children eligible under the State Plan who reside in a community setting, in gaining access to needed medical, social, educational and other services.

**Agency:** Fairfax-Falls Church Community Service Board
**Agency Number:** 75
**Grant Name:** START
**Grant Number:** 1750025-2014
$1,536,097 + $463,903 $2,000,000
**Sponsor** 4000000044 VA Dept of Behavioral Health & Development Services

**Type of Transaction:** Addl DBHDS funding $463,903

| | | EXPENDITURE | | | | | | REVENUE/TRANSFERS | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Grant # | Sponsored Program | Sponsored Class | GL/ Cmmt | Current FY Budget | Temp Alloc | CO Budget Setup | Revised FY Budget | Sponsored Class | GL/ Cmmt | Current FY Budget | CO Budget Setup | Revised FY Budget |
| 1750025-2014 | Program Admin | G_Comp_Salaries | 500000 | $0 | | $45,000 | $45,000 | G_Rev_State | 430035 | $0 | $2,000,000 | $2,000,000 |
| | | G_Benefits | 501000 | $0 | | $15,000 | $15,000 | | | | | |
| | | G_Other_Purch_Svc | 521150 | $0 | $425,000 | $1,938,000 | $1,938,000 | | | | | |
| | | G_General_Operating | 544990 | $0 | | | $0 | | | | | |
| | | G_Travel | 544508 | $0 | | $1,000 | $1,000 | | | | | |
| | | G_Training | | $0 | | $1,000 | $1,000 | | | | | |
| **Total 1750025-2014 Program Admin** | | | | **$0** | **$425,000** | **$2,000,000** | **$2,000,000** | | | **$0** | **$2,000,000** | **$2,000,000** |

## Note:

Received additional funding in the amount of $463,903 from DBHDS, Regional funds
Requesting a Temporary Allocation of $425,000 with the entire $2m setup at CO

**Regional ID Crisis Stabilization START (1750025)**

START (Systematic, Therapeutic, Assessment, Respite and Treatment) is a linkage model to promote a system of care in the provision of community services, natural supports and mental health issues. Service provided help divert individuals from unnecessary institutionalization and keep them in their communities and homes, and include: mobile crisis teams, alternative crisis community placements, and short-term crisis stabilization beds in small settings.

***Approved by Tom Young 7/3/2013***

| COMMUNITY SERVICES BOARD | Item: 10A | Type: Information | Date: 7/24/13 |
|---|---|---|---|

## Strategic Planning Process: Fairfax Falls-Church Community Services Board

BACKGROUND:
The CSB staff will begin a process to update our strategic plan. The process will define and articulate the organization's direction, set goals and objectives for moving forward in a dynamic environment, identify strategic activities and establish a clear system of performance measurement. The resulting strategic plan will assist in setting service priorities and will serve as a tool to help determine allocation of resources.

The strategic planning process will include input and feedback from consumers, partner agencies and organizations, community members, the CSB board and staff. Phases of strategic planning will include development, implementation and ongoing evaluation.

A Strategic Planning Development Workgroup will be convened August 2013, and CSB staff is requesting workgroup participation from 1-2 CSB Board members.

The Strategic Planning Development Workgroup will:

- Establish plan for environmental scan
- Develop SWOT analysis
- Review and potentially revise mission, vision and values
- Establish goals and objectives, strategic activities, and a system of performance measurement

The Workgroup will meet 1-2 times per month and it is anticipated that the Development Workgroup will continue through December 2013. While the Development Workgroup will guide initial activities, a variety of stakeholders will be invited to participate in the strategic planning process. CSB staff will keep the board informed of strategic planning activities and will seek input on components to include the CSB mission, vision and values. Once a draft is completed, the plan will be presented to the CSB Senior Management Team endorsement and CSB Board approval.

STAFF:
Lisa Potter

# Fairfax-Falls Church Community Services Board

## Report to the Fairfax County Board of Supervisors

**July 2013**

### Introduction

This report provides an update on the implementation of recommendations of the Josiah H. Beeman Commission and the Fairfax-Falls Church Community Services Board's (CSB) organizational transformation. The report also presents an update on the CSB's implementation of the County Executive's Fairfax-Falls Church Community Services Board Restoring Fiscal Stability work plan. Finally, the report summarizes information the CSB Board has gathered and analyzed over the past year from service recipients and their families, community partners, CSB staff and others regarding CSB service priorities, current service gaps and critical needs in our community that remain unmet.

Our intent with this report is to update you on our progress as well as our challenges as our two boards continue to work together to guide and equip the CSB for the challenges that lie ahead.

### Implementation of Josiah H. Beeman Commission Recommendations and Subsequent CSB System Transformation

After over a year of investigation and study, the Josiah H. Beeman Commission published a report *http://www.fairfaxcounty.gov/opa/beemancommission/finalreport.htm* identifying key areas in the CSB system that required change, particularly in mental health services. The subsequent implementation plan, based on the report recommendations, acknowledged that a full transformation of the mental health service system would require involvement of the entire CSB system, including intellectual disability and substance use disorder services. The implementation plan -- approved by the CSB Board, the Fairfax County Board of Supervisors, and city leaders of the cities of Fairfax and Falls Church -- identified the need for a full transformation of CSB services and leadership so that organizational silos, defined by disability, would no longer restrict anyone's access to services.

The Beeman Commission recommendations provide a benchmark for what a truly outstanding CSB can and should be. The Fairfax-Falls Church CSB has made considerable progress in implementing these recommendations, even during the economic challenges of recent years.

Attached to this report is a chart *http://www.fairfaxcounty.gov/csb/about/beeman/transformation-completion-report.pdf* that identifies every recommendation listed in the original Beeman Commission report and the status of its implementation as of November 2012, based on actions taken over the last three years *(Attachment A)*. Of the 54 recommendations, 51 have been addressed sufficiently to provide for a foundation for continued implementation. Only three of the recommendations (3.2, 6.3, and 7.3) were determined to be unfeasible to pursue further at this time.

The restructuring of the CSB organization is enabling the agency to provide services tailored to individual needs. People who are most disabled and in need of CSB services often experience more than one challenge, such as a co-occurring mental illness and substance use disorder. The new organizational structure better enables the CSB to focus staff and material resources to provide integrated treatment to address individual needs of those we serve. It also provides greater opportunities for sharing of staff expertise, information and resources throughout the organization.

Many CSB service recipients, regardless of their disability, require similar basic community supports to be able to live successfully in the community. These include access to primary health care; opportunities for employment and day support activities; and safe, affordable housing. System-wide initiatives have been launched to enhance these supports. The success of these efforts will depend on strong community partnership and commitment.

## Implementation of County Executive's Work Plan

On July 3, 2012, County Executive Ed Long presented to the Board of Supervisors a work plan to address short-term and long-term requirements for the CSB's ongoing service planning and financial management *http://www.fairfaxcounty.gov/csb/about/2012-07-03-county-executive-workplan.pdf*.

Most areas of the work plan have been, or are being, completed. Highlights include the following:

- The CSB ended the 2013 Fiscal Year with a positive budget balance.
- After reviewing recommendations from an outside consultant, the CSB Board proposed a plan to enable the CSB and the county to continue to provide employment and day support services for individuals with intellectual disability including those graduating each year from the county's special education programs.
- The CSB's Infant and Toddler Connection program implemented all of the work plan recommendations, including a family coaching model which empowers families and also limits service authorizations, resulting in cost avoidance of $428,000 in FY2012 and $345,000 in FY2013. The average monthly cost of ITC services per family has been reduced from $417 in 2011 to $332 in FY2013.
- All service and leasing contracts are being reviewed to address any payment larger than market rates and aligning incentives to ensure accountabilities.
- Implementing this work plan generated $1.5 million in savings, efficiencies, and some new revenues that the CSB was able to apply to the FY2014 proposed reduction.

Attached to this report is a copy of the work plan and an update on its implementation *(Attachment B).*

## Staff Presentations

The CSB staff has been working in project groups to find available savings, efficiencies and further improvements throughout the service delivery system. These efforts continue as part of the CSB's overall operations. The staff is also analyzing key growth recommendations and determining how much it will cost to grow these service areas. Staff is also identifying important gaps – continuing needs in the

community that neither the CSB nor other service providers in the community are fully addressing.

The CSB Board heard staff presentations from all of the CSB's core service areas, including services for:

- individuals with intellectual disability;
- adults with mental illness:
- adults with substance use disorders and co-occurring substance use and mental illness;
- youth and their families;
- infants and toddlers with developmental delays;
- wellness and health promotion for all 1.1 million residents.

Each presentation described the population served, how they enter and exit the CSB service system, service partners, gaps in the current system (who is not getting served), what works well, recommendations for change, and current national and local trends.

Concise summaries of all six presentations are attached to this report. (*Attachment C).*

Two of the CSB presentations (youth/family and wellness/health promotion) are being included in a countywide study (includes community organizations) of behavioral health needs for youth. Recommendations will be made in the fall for changes needed to better meet the behavioral health needs of youth across the system and in the community.

The CSB service area presentations indicate that throughout the CSB system the need for CSB services exceeds our current resources. This situation compels us to prioritize directly operated and contracted services for those individuals whose mental illness, substance use disorder and/or intellectual disability is most disabling. We look forward to working with the BOS and community leaders to develop additional resources and strategies to meet the needs of those who the CSB cannot serve.

## Public Hearings and Online Survey

In March 2013 the CSB Board held public hearings and conducted an online survey to find out from county (and city) residents what CSB services they considered to be of greatest importance. In all, 25 people testified at the hearings, and 324 responded to the online survey.

At the hearings, people spoke movingly about the life-changing, sometimes life-saving, impact of CSB services, and implored the CSB Board to do all it could to continue providing them. People also spoke about gaps in the system.

Attached are copies of the written testimony presented at the hearings. *(Attachment D)*

The online survey asked respondents to rank by order of importance the following seven categories of CSB services:

- Prevention and education about substance use, mental illness.
- Early intervention to stop less serious conditions from becoming more acute.
- Short-term counseling to individuals and families experiencing behavioral health challenges.

- Crisis intervention to address situations where lives are at risk.
- Long-term treatment for people with serious mental illness and/or substance use disorders.
- Long-term case management for people with intellectual disability and mental illness.
- Helping people access housing, medical care and employment / daytime activities to be able to live safely in the community.

Survey respondents included people receiving CSB services, family members, county staff, other service providers, concerned community members and many others. Most survey respondents ranked "crisis intervention" as the most important service category and "short-term counseling" as the least important.

Survey results showed the categories ranked in the following order, with the most important listed at the top:

- Crisis intervention to address situations where lives are at risk.
- Long-term treatment for people with serious mental illness and/or substance use disorders.
- Helping people access housing, medical care and employment / daytime activities to be able to live safely in the community.
- Long-term case management for people with intellectual disability and mental illness.
- Early intervention to stop less serious conditions from becoming more acute.
- Prevention and education about substance use, mental illness.
- Short-term counseling to individuals and families experiencing behavioral health challenges.

The CSB Board engaged a private consultant to conduct a statistical analysis of the survey results. The analysis confirmed that the difference between the highest and lowest rankings was statistically significant. Moderately ranked items were not significantly different from each other.

All of the survey results, including individual comments, can be viewed online at *https://www.surveymonkey.com/sr.aspx?sm=VHiiQWbZY9bNxMnjjIF6KR07sCplmwV6wbLBGzV8Y2I_3d* The survey analysis is attached. *(Attachment E)*

The survey points to the need for a full continuum of services with the greatest priority focused on adequate access for people who are in crisis and/or whose conditions are most disabling. Community partnerships and nontraditional approaches need to be explored to address the service needs of those in our community who the CSB cannot serve.

### Current and Future Challenges

Although the bulk of the CSB's budget comes from local funds, the agency also relies on federal and state revenues, as well as third party payments (Medicaid, insurance, and fees). Current economic projections indicate limited growth in our region and the potential for a significant, negative impact as the federal budget contracts. While the state may provide increased funding for one priority service area in the CSB system, such as emergency services or Medicaid waivers, it is often at the expense of another service area, such as community supports.

Meanwhile, the need for CSB services in all areas continues to grow. Many people seeking services for mental illness, substance use disorders and intellectual disability have to wait or go elsewhere. It is clear that additional community supports need to be expanded or developed through partnerships to meet these needs. By keeping a high number of staff positions vacant, the CSB has been able to maintain a positive budget balance, but this has been achieved at a significant price. Throughout the system, which has been stretched thin after years of trying meet increasing demands with limited resources, CSB employees are making difficult choices about who they can and cannot serve. We are seeing increasing evidence of the detrimental effect this stressful situation is having on our staff (increased staff turnover, health / safety concerns) as they strive to provide quality services with decreasing resources. Staff has asked for and deserves clear guidance and support in making these decisions.

Recognizing our responsibility as the governing body of this organization, the CSB Board is currently working to clarify CSB service priorities to be applied consistently throughout the agency to ensure that those who most urgently need -- and who would be most harmed without -- CSB services can receive them. We will also be considering strategies and options for managing the growing demand for services for those who are most disabled by their conditions and also meeting the needs of those whose conditions are less severe, but who have no alternative options for treatment. We ask for your support and guidance as we tackle this challenge.

**Conclusion**

We deeply appreciate the consistent, strong support the Fairfax County Board of Supervisors has provided to ensure that the CSB stays on course to achieve goals set by the Beeman Commission.

We hope you will conclude, after reading the information we have presented, that we are staying the course, moving steadily in the direction of integrated services for those in our community who need us the most. You will also recognize, as you read the presentations from the CSB service areas, that we are facing the reality of finite resources. We will need your counsel and guidance as we make difficult decisions in the months ahead.

It is important that we continue to work together – our two Boards and our community as a whole – to build a stronger community safety net of services that includes housing, employment opportunities, and access to primary health care for our community's most vulnerable residents. Backed by this kind of concrete community support, the CSB can help thousands of Fairfax County residents overcome challenges of mental illness, substance use disorder, and intellectual and developmental disabilities to live successfully in our community.

Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# County of Fairfax, Virginia

**MEMORANDUM**

**DATE:** JUL - 3 2012

**TO:** Board of Supervisors

**FROM:** Edward L. Long Jr.
County Executive

**SUBJECT:** Fairfax-Falls Church Community Services Board (CSB) Restoring Fiscal Stability Work Plan Outline

As indicated in the May 31, 2012, Memorandum to the Board of Supervisors regarding the Fairfax-Falls Church Community Services Board's (CSB) fiscal update, staff has been investigating the key financial issues that are contributing factors to the CSB's budgeted shortfall. A Work Plan has also been developed to address both the short- and long-term requirements for ongoing service planning and financial management.

The CSB is a large department that provides a diverse array of services with a complex funding and revenue structure comprised of federal, state, and local funding, and with Medicaid, private insurance, and consumer fees as revenues. As staff continue to investigate possible service and budget containment strategies, the complexity of the issues are further amplified because they must be considered from a human services system-wide perspective. Many of the human service agencies support the CSB's consumers and are likewise affected by the availability of CSB services. Further, the human services agencies rely on the CSB for much needed services to their own priority populations. The recommended enhancements set forth in the Josiah H. Beeman Commission report and the CSB's subsequent transformation designed to implement the Beeman recommendations are factors that further complicate the issues, drive system changes, and affect both services and financing. Thus, a range of short-term and long-term strategies and actions will be necessary to assist the county and the CSB in identifying and implementing fiscal controls and service policy and practice improvements.

Under the leadership of Deputy County Executive Patricia Harrison and Chief Financial Officer Susan Datta, staff from the CSB, the Department of Management and Budget (DMB), and the Department of Administration for Human Services (DAHS) have developed a Work Plan that outlines the approach for investigating, analyzing and addressing the CSB's fiscal and accountability issues and identifies the activities necessary to address the program and policy changes needed to restore fiscal stability

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and contain service delivery within approved budget parameters. The Work Plan focuses on concerns related to financial management oversight; budget planning, including revenue collections (Medicaid, private insurance, and consumer fees); outsourcing opportunities; provider rate negotiation processes; cost effective service delivery models; communication; and long term trend analysis and strategic planning.

The Work Plan identifies the critical issues and includes activities necessary to examine feasible options and make recommendations for sound directions and key decisions. Additionally, the lead person or department is identified and target due dates are noted. Some items on the Work Plan involve internal process changes that will not require either CSB Board or BOS approval. The BOS will be kept apprised of progress throughout implementation of the Work Plan.

Attachment: Restoring CSB's Fiscal Stability - Work Plan

cc: Patricia Harrison, Deputy County Executive
Susan Datta, Chief Financial Officer
George E. Braunstein, Executive Director, Fairfax-Falls Church Community Services Board
M. Gail Ledford, Director, Department of Administration for Human Services

**Restoring Fiscal Stability for the Fairfax-Falls Church Community Services Board**

**Work Plan**

## Introduction

A primary contributing factor to the Fairfax-Falls Church Community Services Board (CSB) budget deficit is an increased service need and service utilization that has outpaced budget authority and revenue projections and actuals; this imbalance must be addressed. A prudent fiscal stability plan must also analyze and adapt the financial and budget oversight structure for the CSB to ensure that every dollar that comes in and every dollar that goes out is properly managed. To better facilitate the day-to-day and routine monitoring of CSB's financial portfolio, several immediate changes were identified and have been implemented to ensure that the fiscal and contract teams are able to prepare timely financial statements that provide an accurate picture of CSB's financial situation. Long-term solutions to ensure ongoing effective fiscal management practices are being developed, as outlined below.

Furthermore, as we institute an enhanced and revised monitoring and management plan of CSB's finances, CSB leadership and program staff, with CSB Board and other stakeholder consultation, will identify options for redesign of service delivery models: to include program structure, consumer eligibility, co-pay and fee requirements, and consideration of additional cost containment strategies, such as capitated service levels. This work plan also includes strategies to maintain proactive and transparent communication with stakeholders and the community and to establish long-term operational planning mechanisms to recognize and appropriately plan for future needs and trends.

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## 1. FINANCIAL LEADERSHIP, CONTROLS, AND ACCOUNTABILITY

The CSB's funding structure is a complex system supported by federal, state, and local funds, as well as by consumer fees; revenues from Medicaid and Medicare; and third party insurance. This composition is further complicated by the numerous rules and regulations associated with the funding sources that require extensive financial expertise and oversight to ensure effective monitoring, management, and accountability. This Work Plan includes a number of enhancements to the financial management and program oversight processes formerly in place for the CSB. Staff has already begun to implement many of the strategies noted in the Work Plan.

| Action | Activities | Timing & Status | Lead |
|---|---|---|---|
| 1.1. **Establish a County/CSB Fiscal Oversight Committee (FOC), to include County CFO, Deputy County Executive, CSB Director, DAHS Director, DMB Deputy Director, and DPSM and DHR representatives, as necessary.**<br><br>Determine immediate, short-term, and longer-terms strategies for effective oversight, analysis, communication, and reporting of CSB and HS System fiscal issues. | Establish a multi-disciplinary CSB fiscal oversight team.<br>• Monitor expenditures and revenues bi-weekly making adjustments as necessary and recommending further service or cost containment strategies.<br>• Assess and analyze situations, and make recommendations in the areas of:<br>o Budget (Forecasting and monitoring of Personnel and Operating);<br>o Accounting, Audit, and Financial Reporting (Internal and External); and<br>o Agency programmatic/structural matters to include an assessment of federal and state legislation, policies, and regulations in respect of the fiscal operations of the agency. | Established and working | Harrison, Datta, Full FOC |
| | Provide monthly status updates to the County Executive. | Established and working | Harrison, Datta, Braunstein |
| | Create a Human Services (HS) System-wide Quarterly Reporting Process for HS Leadership review; identify system-wide issues and address immediate fiscal concerns, if revealed. | Established and working | Ledford, DAHS Financial Team |

| Action | Activities | Timing & Status | Lead |
|---|---|---|---|
| **1.2. Restructure the DAHS financial team serving the CSB.**<br><br>Re-assess the tasks and responsibilities associated with all financial management, revenue development and billing functions, procurement, and contracting functions to ensure that appropriate and timely communication, staffing patterns and levels, reporting, and checks and balances exist. | Reorganize financial team to include reassignment of some staff.<br>• Analyze and revise assignment of tasks and functions to delineate clearly the roles and responsibilities for budget and financial management and program management staff. | Immediate – in progress | Harrison, Ledford, Braunstein |
| | Create a short-term "Fiscal Management Team" jointly led by a DAHS and DMB fiscal analysts.<br>• De-construct, analyze, and provide recommendations to the CSB Director, Chief Financial Officer, Deputy County Executive, and FOC on strategies to contain costs.<br>• Identify key financial practices that are contributing to inability to analyze trends, receive payments, forecast expenditures, issues with service authorization, etc.; provide recommendations to mitigate identified challenges. | Immediate – in progress | Harrison, Datta, Ledford, Braunstein |
| | Restructure the DAHS budget and financial team to best align with the CSB's new structure resulting from the transformation. | Target Date: October 2012 | Ledford, Braunstein |
| **1.3. Improve the budget development process.**<br><br>Ensure the CSB budget clearly ties revenues to expenditures, is aligned with the agency structure, and accurately takes into account service and funding trends. | Identify funding and service trends that have budgetary impact for the CSB and work with the FOC and DMB on how best to present data and make budget requests in the future. | Target Date: October 2012 | Hannam, Dunbar, Braunstein, CSB Senior Management |
| | Align the activities of the budget and financial team for the annual budget process (e.g., contract rate analysis and requests, lease analysis, performance measures) with those used in other human service agencies. | Immediate – in progress | DAHS Financial Team |

| Action | Activities | Timing & Status | Lead |
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| **1.4. Assess and strengthen CSB Board governance capacity.**<br><br>Ensure the CSB Board's fiduciary responsibility and communication practices meet the needs of the CSB, the CSB Board, the BOS, and other stakeholders. | Identify strategies to assess the strengths of the CSB Board and take steps to strengthen their capacity to work together and to fulfill fiduciary responsibilities. | Immediate – in progress | Braunstein, CSB Senior Management, CSB Board |
| | Identify lead CSB staff support and coordinate with the DAHS Financial Team for the staff support to ensure the necessary information for the newly formed CSB Board Fiscal Oversight Committee. | Immediate – in progress | Braunstein, CSB Senior Management, CSB Board |
| **1.5. Identify best practices for contracting and billing for Infant-Toddler Connection (ITC).**<br><br>Ensure contracting and billing practices are adopted that ensure the best opportunity for the county to manage service utilizations, revenue return and billing collections, while ensuring sufficient access to service. | Investigate and make recommendations regarding the cost/benefit of the current CSB contracting and billing strategies for ITC. | Target Date: December 2012 | Auditor to the Board of Supervisors |
| | Investigate the cost/benefit of the existing CSB policy related to the county assuming all risk of paying contractors prior to payment received from third party payers. (Current practice is to pay providers first and seek reimbursement from family and third party payers after services have been rendered.) | Following release of the Auditor's Report in November 2012 | Auditor to the Board of Supervisors |
| | Make a recommendation regarding the effectiveness of the current practice of the outsourced billing model for services; suggest alternative methods or areas to improve efficiencies. | Following release of the Auditor's Report in November 2012 | Auditor to the Board of Supervisors |
| | Determine if the county status as a lead agency for Part C continues to be financially feasible. | Following release of the Auditor's Report in November 2012 | Braunstein, CSB Senior Management, CSB Board |
| | Analyze Auditor's findings and recommendations; develop and implement policy and practice changes as needed. | Following release of the Auditor's Report in November 2012 | Braunstein, CSB Senior Management, CSB Board |

| Action | Activities | Timing & Status | Lead |
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| **1.6. Analyze existing co-pay and fee-for-service policies and practices to identify potential enhancements.**<br><br>Maximize revenue potential through co-pay and fee-for-service opportunities. | Determine if CSB is maximizing family/individual co-pays. Compare CSB co-pay policies to other jurisdictions. | Target Date: November 2012 | Auditor to the Board of Supervisors |
| | Using the Auditor's findings, make recommendations to improve the overall effectiveness of the county's collection policy and practices. | Following release of the Auditor's Report in November 2012 | CSB Senior Management, CSB Board |
| **1.7. Implement position control strategies to limit personnel costs.**<br><br>Provide preservation of mission-essential positions. Review management structure and key administrative functions within the Central Services Unit for potential reduction or consolidation of functions.<br><br>Achieve targeted savings by effectively managing hiring, including holding positions vacant to achieve necessary savings and/or eliminating filled positions in order to ensure the retention of direct service delivery and residential and critical clinical positions.<br><br>Take significant steps to reduce overtime, including a full review of overtime practices. Overtime will only be authorized for essential coverage.<br><br>Reinforce restrictive policies concerning travel, attendance at conferences, seminars and retreats, and mandate consideration of video or telephone conferencing prior to authorizing any staff travel. | Develop a plan to hold positions vacant throughout Fiscal Year 2013 and beyond, as necessary. Position vacancy numbers will be finalized after carryover once FY2013 funding is determined. | Immediate – in progress | Braunstein, CSB Senior Management, DAHS-HR Team |
| | Identify positions that can be considered as potential savings to structurally rebalance personnel services expenditures. | Immediate – in progress. Due November 2012. | Braunstein, CSB Senior Management, DHR |
| | Implement a rapid deployment model to deploy staff to provide essential services and coverage. | Immediate – in progress | Braunstein, CSB Senior Management |
| | Establish a position requisition policy for review of all hiring requests to ensure only essential positions are authorized for hire. Include in the policy up-to-date fiscal targets for use in the decision making process. | Immediate – in progress | Braunstein, DAHS-HR Team |
| | Develop a tool to monitor position and compensation data, as well as to produce regular projections of compensation spending. | Target Date: July 2012 | Hannam (DAHS Senior Financial Manager) |
| | CSB Executive Director will review and authorize all overtime, non-local travel, and training requests. | Established - in progress | Braunstein |
| | At bi-weekly FOC meetings, CSB Executive Director will present a vacancy status report, projected overtime requirements, and all position hire requests. | Established - in progress | Braunstein |

## 2. SERVICE UTILIZATION AND COST CONTAINMENT

As service demand increases and revenues and resources constrict, it is imperative that the CSB explore options for more effective and efficient ways to balance service delivery with the availability of resources. The CSB Work Plan includes approaches that will be explored to accomplish this difficult, yet necessary task.

| Action | Activities | Timing & Status | Lead |
|---|---|---|---|
| 2.1. **Investigate alternative service models for Employment and Day Support Services for those currently receiving services, including former ID graduates.**<br><br>Investigate alternative business and service models, to be incorporated into future years' budgets, to ensure long term sustainability of and the maintenance of effective access to Employment and Day Support Services for individuals with intellectual disabilities. The program is currently committed to serve 1255 people with a budget of $13.3 million, which is $1.2 million less than what is needed in FY 2013 and beyond. Without service utilization containment strategies, the annual cost of service will grow based on contract increases, new graduates, those currently waiting for services (70 individuals as of July 1, 2012) and new residents seeking services. | CSB and DAHS staff, with support of an outside consultant, will explore and propose alternative service models and payment/financing strategies and options that can be structured to meet increasing demands within budget parameters.<br>• With input from the CSB Board and County staff, the FOC will develop an RFP/scope of work for consultant services. | Consultant report due to CSB Board January 2013<br><br>Final report due to BOS March 2013 | Braunstein, CSB Senior Management, CSB Board, Consultant |
| | Develop a provider/county work group to identify potential immediate and long-term cost containment measures.<br>• Investigate other models currently in use nationally.<br>• Examine opportunities for business partnerships for low- or no-cost placements. | Target Date: December 2012 | Braunstein, CSB Service Directors, Consultant |
| | Engage providers, family advocates, and the CSB Board to recommend a service model that contains program enhancement for individuals needing more services than their Medicaid payments will cover and allows the flexibility to meet projected growth in the consumer population seeking services.<br>• Include recommendations for implementation. | Target Date: November 2012 | Braunstein, CSB Senior Management, CSB Board, Consultant |

| Action | Activities | Timing & Status | Lead |
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| **2.2. Investigate alternative service models for Infant Toddler Connection (ITC).**<br><br>Investigate cost-effective business and service models for the Infant and Toddler Connection that ensure long term sustainability of and the maintenance of effective access to services. The program currently has a projected $1 million shortfall, despite increasing their revenues by an additional $1 million over their budget target, due in part to a 38% increase in referrals over the past two years. | Provide timely information to the Board's auditor and assist in the review of the ITC service authorization and business practices. Identify the specific local cost and state cost for implementation of the program and project cost for FY 2013 - 2015. | Target Date: November 2012 | Braunstein, CSB Senior Management, Auditor |
| | Investigate other ITC service models, to include the Parent Coaching Model, current used across the country and within Virginia. Analyze national best practice models for delivering similar services within limited resource environments. | Target Date: November 2012 | Braunstein, CSB Senior Management, CSB Board |
| | Recommend service model options that contains services/authorizes services within projected revenues/budget authority. | Target Date: November 2012 | Braunstein, CSB Senior Management, CSB Board |
| | Investigate options under the state's fee policy to examine potential benefits of assessing fees based on an ability-to-pay assessment or insurance coverage.<br>• Consider the need to propose changes to the state fee policy and the feasibility and impact of such changes. | Target Date: November 2012 | Braunstein, CSB Senior Management, CSB Board |

| Action | Activities | Timing & Status | Lead |
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| **2.3. Reconfigure residential support services across disability areas to reduce personnel and operating costs.**<br><br>Analyze efficiencies and options of either outsourcing and/or merging similar intermediate and longer term support services provided to individuals with Substance Use Disorders (SUD), Serious Mental Illness (SMI) and/or Intellectual Disability (ID). | Determine interest, capacity, and costs among private providers of support services.<br>• Identify potential third party revenue streams for each option.<br>• Identify opportunities to outsource services.<br>• Identify opportunities to reduce the costs of leases through cost-sharing or other strategies. | Target Date: November 2012 | Braunstein, CSB Senior Management, DAHS Financial and Contracts Teams |
| | Analyze the staffing levels and expertise required to support individuals from different disability areas with similar needs. | Target Date: November 2012 | Braunstein, CSB Senior Management |
| | Analyze leased property inventory and investigate efficiencies via possible relocations or repurposing to decrease number and cost of County leases in the residential continuum. | Target Date: November 2012 | DAHS Physical Resources Team, Braunstein, CSB Senior Management |
| | Assess impact of proposed changes and of any outsourcing on the overall continuum of residential services and the community safety net provided by the CSB. | Target Date: November 2012 | CSB Board, Braunstein, CSB Senior Management |
| **2.4. Reconfigure jail based services to reduce personnel costs.**<br><br>Investigate the efficiencies and cost savings of narrowing the scope of services currently provided by the CSB and explore non-CSB funding and outsourcing options. | Research and recommend a new service model.<br>• Analyze the staffing, fiscal, and resource reduction or reallocation implications of re-focusing forensic services.<br>• Analyze the benefits and impact of restructuring staffing coverage.<br>• Analyze the potential cost savings of outsourcing services. | Target Date: November 2012 | Braunstein, CSB Senior Management |
| | Communicate with stakeholders regarding the CSB's change in focus and explore cost sharing possibilities with the Sheriff's Office and Juvenile Court. | Target Date: November 2012 | Braunstein, CSB Senior Management |

| Action | Activities | Timing & Status | Lead |
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| **2.5. Examine demand and utilization of adolescent day treatment services to identify potential cost and service efficiencies.**<br><br>Determine savings opportunities through service reduction, consolidation, and/or outsourcing. | Research best practices to determine to what degree consolidation and integration of youth mental health and alcohol and drug services would result in cost savings of at least 5%.<br>• Utilize resources to implement evidenced based co-occurring treatment. | Target Date: November 2012 | Braunstein, CSB Senior Management |
| | Recommend opportunities for outsourcing.<br>• Explore community capacity for outsourcing.<br>• Identify the extent to which outsourcing would result in cost savings.<br>• Identify third party funding mechanisms for outsourced services. | Target Date: November 2012 | Braunstein, CSB Senior Management |
| | Determine needed improvements to maximize reimbursements. | Target Date: November 2012 | Braunstein, CSB Senior Management |
| **2.6. Examine demand and utilization of Intensive Community Treatment (ICT) teams.**<br><br>ICT teams work with people who have serious mental illness and/or co-occurring substance use disorders, many of whom are homeless; other service models, though, may prove more efficient and effective. | Explore service model adaptations for cost and service efficiencies. | Target Date: November 2012 | Braunstein, CSB Senior Management |
| | Evaluate the ongoing clinical and financial efficacy of the current services to determine program viability. | Target Date: November 2012 | Braunstein, CSB Senior Management |
| **2.7. Develop prescribing protocol and review process to achieve cost savings on medications that are paid for by the CSB.**<br><br>Ensure medications are procured at the best possible price. | Review current CSB formulary for potential cost savings. Conduct quarterly report to review cost/savings. | Target Date: October 2012 | Braunstein, CSB Senior Management, DAHS Financial Team |

| Action | Activities | Timing & Status | Lead |
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| 2.8. **Explore alternative business models and use of technology (e.g., telepsychiatry) to assure sustainability of providing crisis intervention.**<br><br>Such initiatives are becoming established as best practices for their effectiveness and efficiency. | Explore successful mental health emergency service models nationwide for potential cost savings and best practices.<br>• Initiate two pilots programs to expand telepsychiatry. | Target Date: October 2012 | Braunstein, CSB Senior Management |
| 2.9. **Access commitment and efficacy of training (i.e., Crisis Intervention Training, Mental Health First Aid) to other county agencies and organizations.**<br><br>Determine cost/benefit of training provision. | Document costs incurred to provide training and explore sources of cost reimbursement.<br>• Assess level of demand and participant willingness to pay. | Target Date: October 2012 | Braunstein, CSB Senior Management |
| 2.10. **Evaluate level of CSB staff support needed to sustain Fairfax REACH .**<br><br>Determine return on investment of agency support for REACH. | Examine alternative ways to support the work of the REACH board and mission. | Target Date: October 2012 | Braunstein/CSB Senior Management |
| 2.11. **Explore alternative service models for prevention, wellness, and health promotion services considering opportunities for internal realignment, countywide consolidation, and outsourcing.**<br><br>Ensure prevention and wellness promotion services remain available and viable. | Review options and ideas that may result in cost-savings, service/staff reductions, or an overall redesign with consideration to meeting legal mandates, community needs, and long-term savings. | Target Date: October 2012 | Braunstein, CSB Senior Management, Harrison, Ellis, Bruce |
| | Explore the feasibility of peer-run volunteer "warm line" for people with behavioral health concerns. | Target Date: October 2012 | Braunstein, CSB Senior Management |

| Action | Activities | Timing & Status | Lead |
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| 2.12. **Review all currently contracted services to identify potential cost savings.**<br><br>Examine utilization rates, costs, and revenue possibilities to ensure maximum cost benefits and potential savings. | Identify the utilization rate of each service to determine the level of need compared to the cost of service provision. | Target Date: October 2012 | Braunstein, CSB Senior Management, DAHS Contracts Team |
| | Compare contract rates with best practices and with rates for comparable services in other jurisdictions to determine if the CSB is paying a fair price. | Target Date: October 2012 | Braunstein, CSB Senior Management, DAHS Contracts Team |
| | Identify all potential third party funding sources that could be utilized for each service.<br>• Propose strategies to use alternative funding sources to offset costs of contracted services. | Target Date: October 2012 | Braunstein, CSB Senior Management, DAHS Contracts Team |

## 3. COMMUNICATION

To help facilitate an understanding of the multidimensional CSB service delivery and funding structure among its many stakeholders, the CSB will put into effect clear and consistent communications providing data and information in a timely manner, and opportunities for input on proposed service policy and practice changes. This approach will assist decision makers, consumers, county staff, and other stakeholders as the CSB works to achieve its goals and objectives. The communication strategies noted in the CSB Work Plan are designed to keep pace with the circumstances affecting the CSB's progress in addressing the FY 2013 challenges.

| Action | Activities | Timing & Status | Lead |
|---|---|---|---|
| **3.1. Ensure timely and transparent communication with the public, the Board of Supervisors, and other stakeholders.**<br><br>Gather outside information, solicit perspectives, and adapt approaches for various audiences.<br><br>Provide regular, clearly written and understood, updates regarding policy and service changes and ensure opportunities for input and feedback on proposed service changes. | Provide regular updates on the status of budget management planning to the CSB Board Executive Committee and the CSB Board Fiscal Oversight Committee.<br>• Provide the full CSB Board a monthly update. | Immediate – in progress | Braunstein, CSB Senior Management, FOC |
| | Develop regular opportunities to gather input from stakeholders and general public and provide information about CSB services.<br>• Use facilitated methods (e.g., Nominal Group Process) with key groups of stakeholders (e.g., advocates, providers, parents) through community meetings, focus groups, and other avenues to gather input on service priorities and containment strategies. | Immediate – in progress | Braunstein, CSB Senior Management, CSB Board External Committee |
| | Provide status updates at the Board of Supervisors Human Services Committee and to individual BOS members as requested.<br>• Utilize this Work Plan as a guide for updates to the BOS and the CSB Board. | July, September, November 2012; January 2013 | Harrison, Braunstein, CSB Senior Management, FOC |
| | Develop and implement a process by which all press communication is managed by the PIO and the CSB Executive Director. | Immediate – in progress | Braunstein, CSB Senior Management |

| Action | Activities | Timing & Status | Lead |
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| **3.2. Ensure timely and transparent communication with CSB staff.**<br><br>Provide CSB staff accurate information about the budget, and its impact on services and their jobs through the use of timely emails, memos and site based dialogues. Additionally, provide opportunities for CSB service directors to provide service model recommendations, suggested policy changes, and practice changes that address the critical issues of cost containment and service utilizations. | Provide written updates to staff no less than once every two weeks.<br>• Within one business day, share with staff any items presented in a public forum, along with appropriate context. | Immediate – in progress | Braunstein, CSB Senior Management, CSB Board |
| | Utilizing the service directors' established team, use this Work Plan as a guide for making work assignments, reviewing data and service options and presenting recommendations.<br>• Identify a lead service director to coordinate and monitor the work plan task assigned to the service directors.<br>• Meet with service directors weekly to discuss progress, issues, share decisions, and action items.<br>• Monitor the implementation of the work plan and present recommendation to CSB leadership, the DCE and the FOC regarding policy changes and service utilization. | Immediate – in progress | Braunstein, CSB Senior Management |
| | Develop and implement an ongoing process by which staff can – anonymously, if preferred – provide feedback and recommendations for service redesign or cost savings.<br>• Address recommendations in updates to staff. | Immediate – in progress | Braunstein, CSB Senior Management |

## 4. LONG-TERM SERVICE TREND ANALYSIS AND STRATEGIC PLANNING

Although the CSB Work Plan is intended to address the identified FY 2013 budget shortfall for the agency, the strategies will also address factors that will affect the CSB operations in the longer-term. The CSB will strengthen its strategic efforts in planning for the future and in utilizing data to determine the effects of demographic trends on service delivery and funding. The strategies identified in the CSB Work Plan describe both the short-term and longer-terms approaches that will be pursued.

| Action | Activities | Timing & Status | Lead |
|---|---|---|---|
| **4.1. Complete the CSB organizational transformation.**<br><br>Complete the CSB transformation based on the Beeman Commission recommendations and subsequent Implementation Plan to ensure a cost effective service provision system that effectively addresses the needs of quality services and adequate access. | Develop and present a revised transformation plan that balances cost management strategies, revenue enhancement plans, and service delivery models.<br>• Ensure the plan enables completion of the process within by the end of FY2014.<br>• Upon BOS approval, implement with shared oversight of the DCE, DMB, DAHS, CSB Board and CSB staff | Target Date: October 2012 | Braunstein, CSB Senior Management, CSB Board |
| | Implement an ongoing evaluation of the transformation and reorganization. (Consider use of an independent evaluator.)<br>• Include process, efficiency, and outcome evaluation elements.<br>• Ensure adequate feedback from clients, families, and providers is included. | Target Date: October 2012 | Braunstein, CSB Senior Management, CSB Board |
| **4.2. Prioritize CSB services to people with the greatest need and who are unable to access services elsewhere.**<br><br>Prioritize services based on need, criticality, and effectivenss. | Research service prioritization best practices and develop protocols for CSB.<br>• Identify the current capacity of service providers and explore the need to build capacity to address unmet needs and develop coordinated linkages. | Target Date: January 2013 | Braunstein, CSB Senior Management, CSB Board |

| Action | Activities | Timing & Status | Lead |
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| 4.3. **Implement a new, ongoing, strategic planning process.**<br><br>Develop and implement an annual process to review and revise a long-term strategic plan for the CSB. | Develop and implement a process for creating and continually updating a CSB strategic plan that incorporates anticipated service and funding needs into evolving service delivery models. | Target Date: January 2013 | Braunstein, CSB Senior Management, CSB Board, DAHS |
| 4.3.1. **Complete regular demographic trend analyses.**<br><br>Develop and implement an annual demographic trend assessment and analysis process to assist in predicting service and funding needs. | Forecast service needs based on the following demographic information:<br>• Overall population growth and trends;<br>• CSB and partner service delivery trends;<br>• Diagnoses and other service related trends (e.g., autism spectrum disorder diagnoses); and<br>• Other relevant data. | Target Date: January 2013 | Braunstein, CSB Senior Management, DAHS |
| | Develop and implement a process by which demographic data is updated annually and used to inform strategic and other service planning efforts. | Target Date: January 2013 | Braunstein, CSB Senior Management, DAHS |
| 4.3.2. **Complete regular economic, legislative, and budgetary trend analyses.**<br><br>Develop and implement an annual economic, legislative, and budgetary assessment and analysis process to assist in predicting service and funding needs. | Forecast new and changed revenue streams and service mandates from federal, state, and local governments. | Target Date: January 2013 | Braunstein, CSB Senior Management, DAHS |
| | Identify larger economic trends (e.g., increasing poverty) and their potential impacts on services and revenue streams. | Target Date: January 2013 | Braunstein, CSB Senior Management, DAHS |
| | Develop and implement a process by which economic, legislative, and budgetary data is updated annually and used to inform strategic and other service planning efforts. | Target Date: January 2013 | Braunstein, CSB Senior Management, DAHS |

| Action | Activities | Timing & Status | Lead |
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| 4.3.3. **Complete regular service delivery trend analyses.**<br><br>Develop and implement an annual service delivery trend analysis process to assist in predicting service and funding needs. | Identify emerging evidence-based and best practices in relevant fields and their potential impact on local services and outcomes. | Target Date: January 2013 | Braunstein, CSB Senior Management, DAHS |
| | Evaluate CSB and provider practices to identify opportunities for replication of successful services. | Target Date: January 2013 | Braunstein, CSB Senior Management, DAHS |
| | Conduct a comprehensive environmental scan, to include the involvement of community stakeholders, to identify various perspectives on service models, community needs, and the current and anticipated funding environment. | Target Date: January 2013 | Braunstein, CSB Senior Management, DAHS |
| | Develop and implement a process by service delivery trend data is updated annually and used to inform strategic and other service planning efforts. | Target Date: January 2013 | Braunstein, CSB Senior Management, DAHS |

| Issues | Actions | Timeframe & Status | Lead | Results |
|---|---|---|---|---|
| **Financial Leadership, Controls & Accountability** | | | | |
| The CSB's funding structure is a complex system supported by federal, state, and local funds, and consumer fees; revenues from Medicaid and Medicare; and third party insurance.<br><br>This structure is complicated by the numerous rules and regulations associated with the funding sources that require extensive financial expertise and oversight to ensure effective monitoring, management, and accountability.<br><br>To most effectively address the complexities of the department, a number of enhancements to the financial management and program oversight processes formerly in place for the CSB need to be occur. | 1. Establish a County/CSB Fiscal Oversight Committee (FOC), to include County CFO, Deputy County Executive, CSB Director, DAHS Director, DMB Deputy Director, and DPSM and DHR representatives, as necessary.<br>2. Restructure the DAHS financial team serving the CSB.<br>3. Improve the budget development process.<br>4. Assess and strengthen CSB Board governance capacity.<br>5. Identify best practices for<br>6. Analyze existing co-pay and fee-for-service policies and practices to identify potential enhancements.<br>7. Identify best practices for contracting and billing for Infant-Toddler Connection (ITC).<br>8. Implement position control strategies to limit personnel costs. | Began in February 2012; fully implemented and ongoing.<br><br>FOC meeting every two weeks for reviews, updates, and action as necessary. | CSB/DAHS Leadership | • Developed additional budget management tools to ensure timely and comprehensive review of all CSB expenditures and revenues.<br>• Revised and implemented a Managed Vacancy Planning process and management and analysis tools to effectively examine staffing patterns, staffing needs, and to address health and safety requirements.<br>• Oversight and management of revenues from billable services and third party payor sources are coordinated through one team ensuring consistent practices and application of procedures.<br>• Monthly reports to CSB Board occurring regularly and full DAHS and CSB support for all Fiscal Committee meetings.<br>• Continued lead agency role for ITC based on analysis approved by BOS Auditor. Recommended policy and practice changes made that will save more than $800,000 over the next two years. |

| Issues | Actions | Timeframe & Status | Lead | Results |
|---|---|---|---|---|
| **Service Utilization and Cost Containment** | | | | |
| Service demands have increased as revenues and resources have constricted. The CSB needed to explore a variety of options for more effective and efficient ways to balance service delivery with the availability of resources. | 1. Investigate alternative service models for Employment and Day Support Services for those currently receiving services, including former ID graduates.<br>2. Investigate alternative service models for Infant Toddler Connection (ITC).<br>3. Reconfigure residential support services across disability areas to reduce personnel and operating costs.<br>4. Reconfigure jail based services to reduce personnel costs.<br>5. Examine demand and utilization of adolescent day treatment services to identify potential cost and service efficiencies.<br>6. Examine demand and utilization of Intensive Community Treatment (ICT) teams.<br>7. Develop prescribing protocol and review process to achieve cost savings on medications that are paid for by the CSB.<br>8. Explore alternative business models and use of technology (e.g., telepsychiatry) to assure sustainability of providing crisis intervention. | 1. Consultant Report to CSB Board April 2013 and CSB initial recommendations to BOS June 2013 | CSB & DAHS | • New models for ID Day Employment under review by CSB staff in consultation with community providers. Short term budget neutral plan will be part of FY15 CSB budget submission and long term model will be presented during FY14 for BOS review.<br>• New ITC service models implemented during FY13 with savings realized for both FY13 and FY14.<br>• In residential support services a potential savings of $75,000-$200,000 in lease and contract changes identified with continued ongoing reviews of services that support residential such as facility maintenance and lawn care.<br>• Further review of contracted residential services identified through restructuring internally as well as with contractors $400,000 in savings.<br>• $200,000 potential savings identified in jail based services and program restructuring continues for further efficiencies by FY15.<br>• Adolescent day treatment review led to over $200,000 in savings with Leland House contract being realized by CSA and overall child/adolescent services currently being reviewed for priority service areas.<br>• ICT review resulted in assignments to ensure efficient use of staff and eliminated continuing revenue deficits.<br>• Prescribing protocol review identified significant cost savings already established and additional potential savings of $85,000.<br>• A tele-psychiatry services pilot was completed January 2013 with limited utilization. Ongoing review to improve access to these services and billing.<br>• Administrative functions review identified $580,000 in potential personnel savings.<br>• Alternative prevention/wellness service model redesign completed February 2013 with a gradual implementation planned. |

| Issues | Actions | Timeframe & Status | Lead | Results |
|---|---|---|---|---|
| **Communication** | | | | |
| To improve the an understanding of the multidimensional CSB service delivery and funding structure among its many stakeholders, the CSB needs to enhance its communication plan by ensuring more consistent communications and providing data and information in a timely manner, as well as increasing opportunities for input on proposed service policy and practice changes.<br><br>New communication strategies need to be implemented and designed to keep pace with the circumstances affecting the CSB's progress in addressing challenges. | 1. Ensure timely and transparent communication with the public, the Board of Supervisors, and other stakeholders.<br>2. Ensure timely and transparent communication with CSB staff. | Ongoing | CSB | Communications have been established through frequent status reports and presentations to the BOS, consistent communications including forums and multiple written communications with staff as well as other stakeholders. |

| Issues | Actions | Timeframe & Status | Lead | Results |
|---|---|---|---|---|
| **Long Term Service Trend Analysis and Strategic Planning** | | | | |
| In addition to needing to address an identified FY 2013 budget shortfall for the agency, additional strategies are needed to address factors that will affect the CSB operations in the longer-term. | 1. Complete the CSB organizational transformation.<br>2. Prioritize CSB services to people with the greatest need and who are unable to access services elsewhere.<br>3. Implement a new, ongoing, strategic planning process.<br>4. Complete regular demographic trend analyses.<br>5. Complete regular economic, legislative, and budgetary trend analyses.<br>6. Complete regular service delivery trend analyses. | Ongoing | CSB | Transformation plan submitted to CSB Board for final recommendations to BOS. Prioritization definitions completed and awaiting updating of FOCUS and Credible for reliable data on capacity. |

# Individuals with Intellectual Disability (ID)

**Quick definition/description of the population / eligibility / priorities:**

- Individuals, age 2 through adulthood, with a diagnosis of intellectual disability before age 18.
- Individuals at risk of serious harm, homelessness or institutionalization are top priority for support coordination (case management) services.
- Individuals and their families who require support coordination and access to community supports to maintain optimal functioning and family stability.
- Individuals transitioning from school-based to community-based day or employment services
- Individuals requesting Medicaid ID Waiver eligibility determination, placement on waiting list, and Medicaid State Plan Option Targeted Case Management (TCM).
- Individuals served in directly operated CSB Community Residential Services, 24 hour group homes and residential supported living arrangements.

**What is the experience of someone coming into the service system?**

The goal is to provide a welcoming, respectful service experience, helping connect people with a level of care based on their needs and that will prove beneficial to them.

**Describe services/levels of intensity within the service continuum**

- Eligibility determination for CSB and Medicaid TCM and ID Waiver. "ID Waiver" refers to Medicaid payment for certain services to individuals rendered in the community (one month or less).
- Information and referral to community supports and resources as needed, requested and appropriate.
- Intensive, active or monitoring levels of support coordination as needed to assist with benefits, housing and residential supports, respite services, vocational/employment supports, transportation, and some therapeutic consultation and assessment services (on-going for as long as needed).
- Discharge planning, residential and day services placements for individuals in state residential training centers, child foster care placements and school contract placements (as long as needed).
- Transition planning and access to adult day support/employment services for students aging out of school (average one year).

**What partners exist related to each service?**

- State agencies: Department of Behavioral Health and Developmental Services (DBHDS), Department of Medical Assistance Services (DMAS), Department of Aging and Rehabilitative Services (DARS).
- Local agencies: Family Services (DFS), FCPS, Housing and Community Development (DHCD), other CSBs.
- Multiple residential and day support/employment private providers (locally contracted and DMAS Waiver providers).
- Advocacy and membership organizations such as The Arc of Northern Virginia and the Virginia Association of Community Rehabilitation Programs (vaACCSES), the Virginia Association of Community Services Boards (VACSB).
- Faith-based organizations such as McLean Bible Church (Jill's House) and Christian Relief Services.
- Private housing providers such as Capstone Properties, Wesley Housing, RPJ Housing.

**How do people leave services and what happens?**

- Services continue for as long as needed although the services and service intensity may vary based on re-determination of need and choice
- Individuals in directly operated residential age in place with (minimal turnover)
- Some individuals are transferred to other CSBs when they move out of Fairfax County

**What are the gaps in the present system/who is least likely to get service (now and in future based on current climate and direction)?**

- Long wait lists for those eligible for Medicaid ID Waiver funding and services.
- No identified state funding for non-Medicaid Waiver eligible.
- Decreased local funding to meet demand for those who are either non-Medicaid eligible or on ID Waiver wait lists.
- Lack of culturally competent clinical and community services to serve individuals with challenging needs.
- Lack of psychiatric expertise familiar with individuals with ID/DD and mental illness.
- High risk individuals requiring extensive intensive support coordination.
- Increased numbers of persons aging out of child foster care and contract school placements who cannot return home and have no identified funding; this population takes priority on the ID Waiver wait list over people living at home with aging parents/caregivers.
- Lack of sufficient provider capacity, particularly residential, to meet demand in Northern Virginia, resulting in necessity to move people to other jurisdictions to access residential placements.
- The DOJ Settlement Agreement with Virginia will demand greater local resources and service capacity to comply with the transition of 114 Fairfax residents in state training centers set to close between 2014 and 2020.

**Trends and Outcomes**

**What works well / what are key outcomes?**

- Person-centered individualized plans of care
  - 90% of people with intellectual disability meet their Person-Centered Plan objectives
- Availability of choice in provider services.
- Self-directed (local funding) or consumer-directed (Medicaid funding) service options.
- In-home supports, to include nursing, under Medicaid Waiver for medically fragile individuals.
- Individuals who have supports necessary to live in the community, have day activities or employment, and a network of friends.
- 90% of individuals with intellectual disability are satisfied with targeted support coordination and residential services

**What are recommendations for changes?**

- Support opportunities to increase choice and grow capacity through partnerships with families, advocacy and faith-based organizations, other County agencies, and private provider partners
- Examine opportunities to maintain or expand services while achieving cost efficiencies if possible.

**What are the current trends in the field locally and nationally?**

- Person-centered services.
- Smaller residential settings than traditional group home models, such as sponsored living arrangements, 1 to 2 person apartments, with more flexible supports.
- Employment First options vs. group or facility based day support settings.
- Consumer-directed, flexible funding streams.

# Adult Mental Health Services

**Quick definition/description of the population / eligibility / priorities:**
**In general, individuals who presently meet the criteria for receiving services have many of the following characteristics:**

- Diagnosis of a major psychiatric illness that is impeding an individual's life in many ways;
- History of multiple Psychiatric Hospitalizations
- One or more primary healthcare issues and/or co-occurring substance use issues
- Lack or limited natural community supports.

Initial screening services are available for adults with a mental health issue or co-occurring mental health and substance abuse issue who live in Fairfax County or the cities of Fairfax or Falls Church.

Individuals who are deemed to not have a serious mental illness are referred to private providers in the community. Individuals who appear to have a serious mental illness or co-occurring serious mental illness and substance use issue are scheduled for an assessment. The assessment will determine if the individual will access additional services within the CSB or if they will be referred to a private provider in the community. In addition, individuals who are screened for services are triaged for priority needs based upon some of the following factors:

- Individuals in crisis are immediately transitioned to emergency services
- Individuals leaving the state hospital or targeted hospital beds in the community are prioritized for an assessment. This is completed within 7 days of request and usually much quicker.
- Other individuals with a serious mental illness are assessed at the closest service site to their residence. The wait for an initial assessment varies between 3 and 13 days. The wait for a full assessment takes between 11 days and 6 weeks depending on the location.

### What is the experience of someone coming into the service system?

The goal is to provide a welcoming, respectful service experience, helping connect people with a level of care based on their needs and that will prove beneficial to them.

### Describe services/levels of intensity within the service continuum/range of time in each service area.

Adults with serious mental illness primarily connect or re-engage with the CSB a variety of ways:

- **Centralized entry services**- Individuals receive a triage phone screening and are either referred to a private provider or offered an appointment for an assessment. If needed, staff works with Emergency Services if there are safety concerns. The individual has an assessment which is approximately two hours in length. Additional information is gathered and a service recommendation is provided to the individual.
- **Emergency Services**- Individuals receive an assessment to determine their level of immediate risk. A determination is made on if they require hospitalization, diversion to crisis care, crisis intervention counseling, or short term medication services.
- **Contacting their previous case manager**-Individuals are screened to determine present needs. The individual can begin receiving services if they meet the present CSB admission criteria, are in need of CSB services, were seen by the case manager within the past year, and the case manager has capacity on their caseload.
- **Other-** Individuals may also access services through homeless outreach services, peer-run drop-in centers, and transfers from programs that serve individuals with primary substance abuse issues or intellectual disabilities.

Once eligibility is determined, an individual may access a number of different services programs within the CSB's network of care. These services are provided based upon the individual's need and the availability of the program. Core components of the mental health service continuum are:

- Case Management Services (occurs at multiple different intensities)
- Intensive Community Treatment (occurs in the community at different locations)
- Psychiatry (occurs at multiple different locations throughout mental health programs)

- Residential Services (occurs in multiple locations with multiple different levels of care)
- Day Treatment Services (two primary levels of care: Community Readiness and Adult Partial Hospitalization)
- Employment Services (occurs in multiple locations at varying level of intensity)
- Peer Run Services (occurs in multiple locations throughout the county)
- Jail based services include mental health screenings and psychiatric medication services

Emergency services are always available as needed for these individuals.

### What partners exist related to each service area (are they contractor or collaborator)?

Each program within the area has multiple agencies with which they partner. There is a blend of public and private partnerships that coordinate with directly operated and contract programs. Many of these partnerships are listed below:

- Dept. of Housing and Community Development
- PRS, Inc.
- Virginia Dept. of Rehabilitative Services
- Pathway Homes
- The Reston Drop-in Center
- The Laurie Mitchell Empowerment and Career Center
- Women's Center
- Jewish Social Services
- Catholic Charities
- Virginia Tech Counseling
- The Brain Foundation
- State and local psychiatric Hospitals
- Community Residences
- Fairfax County Health Department
- Office to Prevent and End Homelessness
- Inova Health System
- Good Hope Housing
- Good Shepherd
- Volunteers of America
- Reston Interfaith
- Christian Relief Services
- George Mason Counseling
- Northern Virginia Family Services
- Dept. of Administration for Human Services
- Dept. of Family Services
- Office of the Sheriff
- Fairfax County Police

### How do people leave services and what happens?

When people leave services, it is often for the following reasons:

- Individuals who have improved sufficiently to be served in the community and have located a private provider of psychiatric services.
    - NOTE: In the past individuals with mental illness have been able to transition out of CSB mental health services to receive services in the community. Because of limited community psychiatric services and the present psychiatric impairment level of individuals served in the CSB, this no longer happens in significant numbers.
- Individuals require skilled nursing homes and move to an out of area nursing home.
- Individuals self-discharge and leave the area
- Individuals leave employment services when they no longer need employment supports.

### What are the gaps in the present system/who is least likely to get service (now and in future based on current climate and direction)?

**Most Significant Gaps:**

- Case management caseloads are averaging 60-80% beyond recommended ranges
- Affordable housing stock for individuals served by the CSB
- Bed capacity in moderate to high supervised residential programs
- Community capacity to provide alternatives for low cost psychiatric services and low cost medications
- Immediate availability for psychiatric beds for individuals at highest risk
- Employment services

**Least likely to get CSB services:**

- Individuals who don't have a serious mental illness
- Individuals that have other community supports
- Individuals with or without a serious mental illness that require intensive case management or residential services are most likely to be underserved

| Trends and Outcomes |
| --- |
| **What works well / what are key outcomes?**<br>• Ability to serve individuals with co-occurring mental health and substance use disorders has improved.<br>• A stronger emphasis on employment is helping to get more individuals jobs.<br>• Individuals do better when engaged in case management, psychiatric, and recovery services.<br>• Increase in peer-run services that have infused recovery-oriented services throughout the mental health system.<br>• Residential services that provide varying levels of care and housing types.<br>• Psychiatry and primary healthcare services that provides best practice services.<br>• Intensive case management and community services helps individuals engage in services.<br>• Person-centered care that is tailored to each individual.<br>• Sampling of outcomes by people served through ARS:<br>  ○ 90% are able to better deal with crises<br>  ○ 91% are getting along better with family members<br>  ○ 88% are doing better in social settings<br>  ○ 96% believe they can grow, change, and recover |
| **What are recommendations for changes?**<br>• Fully staffing programs or making the decision to significantly scale back services in some areas.<br>• Manage caseload size and expand the capacity to provide more case management in the community.<br>• Decrease amount of spending on housing while cultivating affordable housing opportunities.<br>• Increase peer services that emphasize a use of natural community supports.<br>• Increase amount of psychiatric time and capacity for community to serve varying psychiatric needs.<br>• Develop an urgent care service model that can quickly serve individuals that qualify for services.<br>• Develop an efficient case management and psychiatric model that can more efficiently serve individuals that have reached a moderate to high level of mastery of their mental health/recovery. |
| **What are the current trends in the field locally and nationally?**<br>• Programs that have the capability to serve individuals with co-occurring mental health and substance use disorders.<br>• Encouraging employment as quickly as possible.<br>• Recovery-oriented services that place a high value on partnering with peer-run services.<br>• Integration of behavioral healthcare and primary healthcare.<br>• Services are not site-based, but provided in the community. |

# Adults with Substance Use Disorders and/or Co-occurring Substance Use and Mental illness

**Quick definition/description of the population / eligibility / priorities:**
Adults with substance abuse/co-occurring disorders can access a system of care that is based on:

- National Standards set forth by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the American Society of Addition Medicine (ASAM).
- SAMHSA Treatment Improvement Protocol (TIP) 32 identifies outpatient, day treatment, inpatient, residential treatment, detoxification, continuing care, group homes and booster sessions as core components of the continuum of care.
- SAMHSA Treatment Improvement Protocol 44 (TIP 44) summarizes an expert consensus panel finding that treatment matching is most effective when there is a continuum of services—ranging from low to high intensity.

**Individuals served**:

- Adults with substance abuse/dependence and co-occurring disorders. Family members also receive services
- 67% criminal justice referral (based on individuals assessed from October 1 through December 31, 2012)
- 2,030 individuals assessed in 2012

**Priority Populations:**

- Pregnant women using intravenous drugs
- Pregnant women
- Individuals using intravenous drugs
- Individuals with Substance Dependence

**What is the experience of someone coming into the service system?**

The goal is to provide a welcoming, respectful service experience, helping connect people with a level of care based on their needs and that will prove beneficial to them.

**Describe services/levels of intensity within the service continuum**

- Individuals contact the **Entry and Referral Office** and receive a telephone screening
  - Welcoming approach
  - Triage for emergency needs
  - Provide information about immediate service availability and refer to community resources if applicable
  - If applicable, scheduled for a comprehensive assessment. By design: assessment also available at Detox, Jail. No Detox Assessments now due to staff vacancies.
- Individuals attend assessment with trained clinicians. Wait time is currently 10 days from initial contact; however for much of 2012, the wait time for an assessment was 3 weeks.
  - Comprehensive assessment reviews all life areas.
  - Matching with services based on national standard, ASAM Patient Placement Criteria, paired with individual choice. Least restrictive/least intensive service utilization is priority.
  - CSB treatment referrals closely match national data (TEDS, 2009; 1,804,858 records, 45 states)
    - National data – 42% outpatient, 12 % intensive outpatient, 11% short-term residential, 8% long term residential, 27% other-detox and community referrals
    - CSB data: 53% outpatient, 13% intensive outpatient, 14% short-term residential, 6% long-term residential; 14 % other- community referrals
- Individuals are referred to the services which are matched to their needs. Mixing and matching occurs to meet individual needs. In order of level of intensity, the services are:
  - **Outpatient** – group-based, 1x per week, 3 hours per group; 3 months in duration, primarily didactic.

1,700 people served in FY 12, $1,294/person-data combined with IOP below.
    - Available at Gartlan, Annandale, Fairfax in both English and Spanish
  - **Intensive Outpatient (IOP)** – 3x per week, 3 hours per group; 4 months duration, substance use and mild co-occurring.
    - Offered at Gartlan (English only), Fairfax (English and Spanish available here, as well as specialized Men's program)
  - **Day Treatment** – 5x per week, 4 hours per day for approximately 5 months.
    - Fairfax site provides men's day treatment.
    - Specialized Women's/children day treatment at Recovery Women's Center in Fairfax.
  - **Jail Based Services** – includes assessment, jail based treatment, case management
  - **Short-term Residential** – 90 days, A New Beginning- 160 people/year, $14,059/person; Phoenix Program (contract), New Generations Stabilization.
    - Least restrictive environment for individuals who have multiple failed outpatient attempts and cannot remain abstinent in the community. Problems in multiple life areas due to addiction. Rehabilitation Model. Continuing Care and step-down built in to promote community integration and flow-through.
  - **Longer Term Residential** – 6-9 months in 24 hour programming. Least restrictive environment for individuals with severe impairments in most life areas. 96% with previous treatment at less intensive level of care which did not adequately address severity of functioning. Average # of previous treatment episodes = 2.8. Homelessness, incarceration, unemployment, health issues. Habilitative Model. 80% co-occurring mental illness (moderate level of severity), 85% criminal justice involvement. Continuing Care and step-down built in to promote community integration and flow-through.
    - Crossroads, 176 people in all levels/year, $9,215/person;
    - New Generations (pregnant, women, children), 53 people/year in all levels, $14,780 per person.
    - Cornerstones, 40 people in all levels /year. Specialized programming for individuals with severe mental illness and substance dependence. Mental illness - high levels of acuity and severity. Programming highly individualized; smaller, calmer setting that is less stimulating.
- Services available to all throughout the continuum include
  - Psychiatric assessment and treatment – non-SMI, ineligible for ongoing psychiatric service once leaving substance abuse programming
  - Case management – intensity based on level of need.
  - Peer and community support services – peer specialists, alumni groups, non-profit organizations, 12 Step network
  - Vocational services – provided mostly through the Virginia Department for Aging and Rehabilitative Services. Some CSB staff support. Community network support.
  - Detoxification – Fairfax Detoxification Center. Medical, clinically monitored, Suboxone and medicated assisted treatment.

**What partners exist related to each service area (are they contractor or collaborator)?**

- Probation and Parole: 17% of referrals, Additional 11.5% served with court involvement; percentage increases as level of service intensity increases. Individuals given option for treatment in lieu of incarceration or as condition of probation. Alternative to incarceration.
- Alcohol Safety Action Program (ASAP): Approximately 39% of referrals (Individuals with DUI offenses with higher need than offered at ASAP) come from ASAP.
- Department of Family Services/Foster Care/Child Protective Services: A small but highly complex number of referrals. Parents with children involved with foster care or CPS referred for services to promote recovery/family reunification.
- Phoenix House of the Mid-Atlantic: vendor for residential treatment services, located in Arlington.
- Substance Abuse and Addiction Recovery Alliance (SAARA): provides peer support specialists at various locations through CSB contract.

- Oxford House: evidence-based approach for recovery housing. Not affiliated or funded by CSB.
- Alumni/peer groups: Friends of A New Beginning, HOPE (Helping Other People Engage) program, Friends of Crossroads, Crossroads Alumni.

**How do people leave services and what happens?**

- Due to continuum of service and community recovery partners, the vast majority of individuals exit to self-sustaining community resources.
- Recovery promotes self- sufficiency, employment, stable housing.

**What are the gaps in the present system/who is least likely to get service (now and in future based on current climate and direction)?**

- Overall capacity issues: Based on the Fairfax County population and prevalence data, 72,600 individuals are estimated to be in need of treatment services. Approximately 5,000 individuals were served through the CSB in FY 2011, leaving an unmet need in our community of 67,000 people.
- Over the last decade, OP services has lost 40 staff positions. In addition, since 2007, there has been a reduction of 17 beds serving 60-70 people annually in residential services.
- Extensive waiting list for most disabled in need of residential treatment. Multiple treatment failures at lower levels of intensity. Currently 71 people are waiting for intermediate care, 90 for long term.
- Extensive waits for individuals needing medical detoxification services. Individuals in need of medical detoxification wait 2-3 weeks.
- Psychiatric services: wait time in outpatient is 30 days for initial assessment at Gartlan, 2 weeks and increasing at other sites.
- Services for individuals who do not speak English.
- Peer support, outreach and engagement: capacity is limited by funding. One-time funding for current programming expires 2014.
- Individuals receiving psychiatric services while in CSB substance use/co-occurring services are not able to continue to receive these services once treatment is completed.

## Trends and Outcomes

**What works well / what are key outcomes?**

**What Works Well:**

- Continuum of services based on National Standards. Use of National criteria for service matching.
- Use of Evidence-Based Practices.
- Treatment services to promote recovery coupled with thorough integration with recovery-based community supports to promote exit into community-based, non-subsidized services.
- Strong collaborative relationship with partners such as Alcohol Safety Action Program and Probation and Parole.

**Key Outcomes:**

- Outpatient Services: Data collected FY 2012
  - Overall 92% completion rate for all outpatient programming.
  - 94% of individuals served satisfied with services received.
  - 78% served demonstrate improvement in work or school functioning after 30 days of treatment.
  - [Future data collection will capture increased functioning in employment or school, reduction in drug and alcohol use, stable housing, primary healthcare provider and reduction in criminal behavior.]
- A New Beginning:
  - 60% treatment completion rate, which is 6% above the national average (TEDS 2009).
  - 90% moved into community based housing, 61% employed at 90 day follow up
- Crossroads:
  - 94% of individuals showed a reduction in drug and alcohol use, 94% had reduction in criminal behavior. No new charges

- 68% of clients funded through High Intensity Drug Trafficking Area (HIDTA) had a reduction in arrests one year prior to treatment compared to one year following treatment.
- 95% of those completing services were employed or in school at follow-up.
- 87.5% moved into community-based housing at discharge. Of those 77% were unsubsidized housing.

- New Generations:
  - 100% births with positive birth outcomes as determined by APGAR scores of 8 or above(last 8 births)
  - 100% children connected to health care by time of discharge, 98% mothers connected with health care by time of discharge, 100% children with required immunizations by time of discharge, and 100% left for community-based housing at discharge. Of those, 82% left for non-subsidized community-based housing and 18% subsidized housing. FY 2013 July-Dec
  - At 3-month follow-up, 100% had no drug or alcohol use and 100% had improved family relationships and social connectedness. FY 2013 July- Dec.

**What are recommendations for changes?**

- Consider transitioning services and resources from the outpatient level of care to intensive outpatient level of care.
  - Work with community providers for provision of outpatient services (outpatient service providers exist in community).
  - Consider provision of ambulatory detox as part of intensive outpatient services. Transition individuals directly into intensive outpatient services and continue assessment.
- Continue to review trends and data related to length of stay at residential programs. Consider reduction in length of stay if data supports positive outcomes.
- Consider increasing the use of medication assisted treatment.
- Research resources and evidence-basis for possible reallocation of resources to enhance recovery peer support.

**What are the current trends in the field locally and nationally?**

- Providing co-occurring capable and enhanced services within substance abuse treatment continuum.
- Using motivational interviewing.
- Using medication-assisted treatment.
- Using recovery peer supports.
- Utilizing evidence based approaches.

# Fairfax-Falls Church Infant & Toddler Connection

**Quick definition/description of the population / eligibility / priorities:**
Infant and Toddler Connection (ITC) serves children birth through 3 who have a developmental delay of 25% in one or more areas of development, or a diagnosed condition with a high probability of future delays. Early intervention services are based on the adult learning model and on the premise that children learn best from their own caregivers in a familiar and safe environment. Parents are coached to find ways to use every day activities as a bridge to skill development.

**What is the experience of someone coming into the service system?**

The goal is to provide a welcoming, respectful service experience, helping connect people with a level of care based on their needs and that will prove beneficial to them.

**Describe services/levels of intensity within the service**

- Service intensity is determined by a team of staff and the family according to family identified outcomes that are based on the family priorities and concerns. This plan, known as the Individualized Family Service Plan (IFSP), can be reviewed at any time but must be formally reviewed every 6 months.
- Children determined not eligible for ITC, are referred to private therapists in the community if desired by the family.
- On average the time in ITC is 18 months.

**What partners exist related to each service area (are they contractor or collaborator)?**

- ITC provides intake, eligibility determination and initial service plan.
- 85% of families are served by contractors for ongoing services.
- Collaborators are Inova Neonatal Intensive Care Unit, FCPS, Early Head Start and Health Department.

**How do people leave services and what happens?**

- At age 2 children eligible for FCPS special education services may be transitioned to the schools; they must transition by age 3. Families decide whether and when to receive FCPS services but at age 3 they are no longer eligible for ITC.
- ITC served 3,090 children in FY 2012; of theses, 1,643 were new intakes.
- 191 children left services prior to age 3 with no developmental delays.
- 410 went to FCPS special education services.

**What are the gaps in the present system/who is least likely to get service (now and in future based on current climate and direction)?**

- ITC services are federally mandated to serve all eligible children.
- State funding has not been adequate to meet the growth in service demands.

**Trends and Outcomes**

**What works well / what are key outcomes?**

- Success is determined by meeting the outcomes on the child's plan.
- The IFSP outcomes are based on functional skill development that will allow the child and family to participate to the fullest in their homes and communities.

- All children are assessed at intake on federally determined Child Outcome Indicators. These indicators compare a child's skills to their same-age peers. These are assessed again at exit from ITC, and in addition it is documented if the child made any gains on the indicator even if he or she has not "caught up" to same age peers. The exit indicators for children going onto the Fairfax County Public School (FCPS) system are used by the schools as a baseline for their program.
  - 44.73% of children (overall state is 38.18%) demonstrated improved functioning comparable to same-aged peers.
  - 31.98% (overall state is 22.39%) of children demonstrated improved functioning to a level nearer to same aged peers but did not reach it.
- Success is also measured by meeting targets for family satisfaction measured by the state survey which indicate families feel confident that they can meet the child's needs.

**What are recommendations for changes?**

- Maximum oversight and training for all providers is needed to implement the primary provider approach. More than 87% of the services provided each month are provided by a contract agency.

**What are the current trends in the field locally and nationally?**

- Interventions with young children and family members must be based on explicit principles, validated practices, best available research, and relevant laws and regulations. See handout on principles for Early Intervention Part C.

# Youth and Family Services

**Quick definition/description of the population / eligibility / priorities:**

- Youth from birth through 18 and emerging adults up to 22 who are not eligible for adult case management services. For every youth seen, a parent receives service as well. Service is provided using a family approach which is time intensive. Families often have challenges such as homelessness, unemployment, substance, mental health, or health issues; problems with other children.
- Youth with or at risk of SED (Serious Emotional Disturbance), intellectual disability, substance abuse and co-occurring combinations of both. In addition, serious impairment in their daily living functions that could make them at risk for residential placements, and lack of resources to get their needs met other than through the CSB.
- Youth have a variety of disorders including trauma-emotional, physical, sexual abuse, schizophrenia, substance use and addiction, autism spectrum, intellectual disability, anxiety, reactive attachment disorder, school phobia, conduct disorder, pregnancy, high risk sexual behavior, runaway, self-harm/harm to others, gang involvement, criminal activity.

**What is the experience of someone coming into the service system?**

The goal is to provide a welcoming, respectful service experience, helping connect people with a level of care based on their needs and that will prove beneficial to them.

**Describe services/levels of intensity within the service continuum**

Every youth coming into the system receives an assessment, which determines which services will be provided. In some cases, such as VICAP (Virginia Independent Clinical Assessment Program), the assessment itself is the only service. But in most cases an array of services can be provided, including:

- Outpatient: assessment, care coordination (case management) and treatment. Length of service: from 10 weeks to ongoing. For the ADS Outpatient Program, 95% complete service and have improvement on being symptom free during service. In Day Treatment programs, 85% of the youth complete their treatment goals.
- Psychiatric, nursing and pharmacy services. Length of service: as needed while in services.
- Co-occurring day treatment. Length of service: from three to nine months.
- Residential services. Length of service: from three to nine months. Sojourn: 80% are able to transition to the community after being in the program. Leland: 83% return to the community at the end of their placement (up to 45 days).
- Juvenile forensics services. Length of service: for a single psychological evaluation up to a six-month court-ordered Beta Program. Comparison outcomes across the state are being calculated by the Juvenile Court. For the time frame of 7/1/11 to 6/30/12, 69% of youth in the Beta program did not return to the court for additional charges.
- Discharge planning, CSA case management, mandatory outpatient treatment monitoring. Length of service: from a single consultation through six to nine months of ongoing case management.
- CSA-funded intensive care coordination. Length of service: up to 15 months. 89% still in the community after 3 months and 81% still in the community after 6 months.

**What partners exist related to each service area?**

- **Collaborators:** families; Fairfax County Public Schools; DFS-Foster Care; DFS-Child Protective Services; DFS-Family Preservation Services; Juvenile Domestic Relations Court; Health Department; private providers (contractors with CSA); Commonwealth Center for Children and Adolescents and up to 150

contracted CSA private providers. Due to legal mandates for children and CSA requirements, involvement in service coordination with other agencies is high, requiring significant staff time.

**How do people leave services and what happens?**

- Youth and families leave the service after completion of time-limited treatment programs and may return if needed. For those youth on medication, they may be referred to the private sector, but most often stay in case management services while receiving medication services.

**What are the gaps in the present system/who is least likely to get service (now and in future based on current climate and direction)?**

**Most Significant Gaps:**

- Service demand exceeds current capacity. This is especially true now because of the substantial vacancy factor.
- This also deters external agencies from making appropriate referrals.
- Outpatient services are unable to provide step-down services from higher intensity levels of care such as day treatment and residential programs.
- There are case management gaps for services to aging out youth/emerging adults in light of more stringent entry criteria for adult services. (20% of outpatient case loads are 18 years or old.)
- Lack of capacity for providing lead CSA case management services.
- Scarcity of psychiatric beds.
- Mobile crisis intervention services (some regional funding from the state coming).
- New initiatives such as VICAP and school services have been taken out of outpatient staff appointment time, increasing the wait for services.
- Meeting the MH needs of parents whose needs don't rise to adult service admission definition.

**Least likely to get services:**

- Youth who do not meet SED (Serious Emotionally Disturbed) or AR (At-Risk) criteria are less likely to receive mental health services.
- Substance use disorder services, however, are typically determined by court orders or school suspensions/ expulsions.
- Families that have private coverage other than Medicaid are referred out.

## Trends and Outcomes

**What works well / what are key outcomes?**

**What works well:**

- Continuum of services
- Ongoing collaboration with other agencies and partners.
- Integration of substance use and mental health services and integration of psychiatric services for co-occurring disorders (Dartmouth initiative).
- Integration of SUD/MH management.
- Reduction of out-of-home placements (ICC)
- Trauma-informed care (Dr. Gil, etc).
- CSB-Fairfax County Public Schools collaboration on onsite treatment services.
- Court-funded services provided at Juvenile Detention Center.
- VCU collaboration on assessment of evidence based services and needs (Dr. Southam-Gerow).

**What are key outcome measures?**

- School performance

- Criminal involvement
- Improved family functioning
- Hospital utilization
- Residential utilization
- Reduction of substance use
- Symptom reduction
- Medication compliance
- Satisfaction surveys

**What are recommendations for changes?**

- Fill staff vacancies.
- Expansion of CSA/mental health case management.
- Expansion of time-limited services for youth with lower acuity disorders.
- Increase youth psychiatry hours.

**What are the current trends in the field locally and nationally?**

- Trauma-informed care.
- Evidence-based/best practices.
- Integrated co-occurring care.
- Strategic, systems and structural family therapy.
- Motivational interviewing.
- Affect regulation/Dialectical Behavioral Therapy for youth.
- Cognitive Behavioral Therapy.
- Psychoeducational groups.
- High fidelity wrap-around services (Intensive Care Coordination).
- Vocational and educational supports.

# CSB Wellness, Health Promotion, and Prevention Services

**Quick definition/description of the population / eligibility / priorities:**

The goal is to strengthen the Fairfax-Falls Church community so individuals, families, schools, faith-based organizations, and workplaces take action to **promote** emotional health and **reduce** the likelihood of mental illness, substance abuse including tobacco, violence, and suicide.

- Focuses on people who do **not** need treatment. Prevents substance use (including tobacco) in youth and substance abuse in adults; promotes wellness and mental health.
- Helps build capacity to adapt, respond to, and control life's challenges and changes.
- Service are provided in the community, often where people naturally gather, not generally at CSB sites.
- Focus is beyond traditional programs and includes strategies included in the Prevention Spectrum above.
- Services are designed for the whole community, making this the largest "caseload" in the CSB (population is 1.2 million!). Eligibility is related to requirements of specific programs or strategies.
- High value on culturally and linguistically competent services and sustainable services

**What is the experience of someone coming into the service system?**

The goal is to provide a welcoming, respectful service experience, helping connect people with a wellness service that will prove beneficial.

Participation in a prevention program is voluntary and the atmosphere during recruitment and outreach is welcoming. Youth generally need parental permission for participation where all expectations for participation are provided. Participants should experience respect and a focus on health promotion regardless of the program, activity, or event.

**Describe services/levels of intensity within the service continuum**

- Services are provided to people with who may have early signs of problem behavior, populations identified as experiencing risk factors, or for those with early signs of problem behavior.
- For people involved in programming, services run from 2 sessions to 42 sessions, depending on the program design. Participants are encouraged to stay involved in programs for their duration.

**Who are the partners for this service area?**

- United Prevention Coalition, Safe Youth Coalition, Virginia Foundation for Healthy Youth, NEXUS, Fairfax County LiveWell, Department of Family Services, Department of Neighborhood and Community Services, Police Department, Area Agency on Aging, Connections for Hope, Reston Interfaith, Our Daily Bread, Alexandria Neighborhood Health Services, Herndon HealthWorks, Prevention Connections, Community Health Care Network, Juvenile Court, Northern Virginia Community College, Access Hope, APA, FCPS, Manilla, Faith Communities in Action, Health Department, Partnership for Youth, Gang Task Force, Office of Public and Private Partnerships, numerous pre-schools, and many more.

**How do people leave services and what happens?**

- People leave services when programs complete and/or are linked with other services.

**What are the gaps in the present system/who is least likely to get service (now and in future based on current climate and direction)?**

- Staff has been cut by 70% in the past 7 years. It is not feasible for the remaining staff to demonstrate a community impact. Staff members are fatigued and have been through ongoing change and transition.
- Dedicated resources have been so reduced that it is difficult to accomplish mission to implement prevention strategies or to demonstrate impact due to decreasing capacity.

- No certified Youth Mental Health First Aid Instructors.
- Limited Spanish-speaking Mental Health First Aid Instructors.

## Trends and Outcomes

**What works well / what are key outcomes?** This group has achieved unprecedented NATIONAL recognition ***seven*** times in past 12 years. (NREPP, NASADAD, SAMHSA/OJJDP, MHFA-NCCBH) + 3 NACos

**What works well:**

- Evidence based programs are proven to be effective when implemented as designed
- Collaborative, cross-disciplinary, and community-driven approaches are most effective
- Data collection and evaluation tools support "getting to outcomes"

**What are key outcome measures?**

- Total # served in FY 2012: **18,190**
- Total # served during FY 2012 in multi-session education/programming: 3,720

***Mental Health First Aid***

- FY 2012 (8 months of implementation): 345 were trained
- 97% of participants received certification
- Increase in helping skills and knowledge plus reported changes in behaviors related to mental health crisis situations; 35% report intervening in situations in the first 60 days of program completion.

***Parents Raising Safe Kids***

- Total # served during FY 2012: 149
- Select outcomes: significantly improved their positive parenting, conflict management skills, and decreased use of harsh discipline

***Al's Pals***

- Total # served during FY 2012: 629 children at 14 centers in 45 classrooms
- Children experienced statistically significant, positive change in levels of Social Cooperation, Social Interaction, and Social Independence.

**What are recommendations for changes?**

- As part of the CSB Board Transformation Planning, determine whether the current model and goals can be achieved within the CSB alone given service priorities and the 70% loss of staffing, or if the cross agency collaboration or consolidation concept should be more fully supported (requiring a paradigm and organizational shift). If this service area is to remain in the CSB, it should be better prioritized. The cuts to this service area have been disproportionate to the rest of the CSB system and other county agencies.
- Support training for 10 Youth MHFA Instructors
- Develop a strategic plan with service priorities to help the Board and the community understand this complex service area.
- RFI for contracts is about to be released. CSB will need to decide if contracting out some services is desirable depending on what service model is adopted.

**What are the current trends in the field locally and nationally?**

- Inclusion of whole health strategies as opposed to focus on single issues. Since risk factors tend to correlate across key community issues, cross-system collaboration, planning, and strategic resource planning are all important. Most funders require this level of collaboration.
- Inclusion of programming as one component of a larger strategic framework that includes community involvement, capacity-building, and policy change.
- Evidence-based programming and practices.
- Focus on population-level services, policy and environmental change.
- Primary and behavioral health integration that includes promotion and wellness as key components

CSB Public Hearing March 7, 2013 – Fairfax County Government Center, Room 9-10, 7:30pm

Board members- Sites, Woods, Gross, Kamber, Garnes

Staff members- Braunstein, Osborne, Wooten, Axelson, Mangano, Potter, Buescher, Naylor, Jones

Public- 7 community members signed in; several more were present; two testified.

Synopsis of Speakers

| Speaker | Affiliation | Synopsis |
|---|---|---|
| Jane Alexander | Parent of resident at NVTC | See written testimony. State set unrealistic timetable for closure of NVTC. Appreciates CSB letter urging delay of closure. |
| Robert Anthony | Parent of resident at NVTC | See written testimony<br>Says there would be no cost impact if closure deadline is extended. Said the NVTC parents group conducted a telephone survey of parents of NVTC residents; 70 responded. Of those 70 responses, 97% were happy with care their family member was receiving from the state-run training center. "There is a population that needs this level of support." |

Public hearing adjourned at 8:45 pm

Jane Anthony - CSB Talk for March 7th

I'm Jane Anthony – mom to Jason Kinzler and Co-President of Parents & Associates of NVTC.

We as parents are very concerned about the proposed closure of NVTC. The legislators have built in some safeguards and reporting mechanisms, but the onus is on you our CSBs. We have a very unrealistic timetable with an unprepared community.

Across Northern Virginia the CSBs have let it be known that the influx of behaviorally challenged and medically fragile residents from NVTC needs more time and a better waiver rate to support their move. The DBHDS has made it clear that they intend to move residents of NVTC who do not select a community residence within three months of closure to another Training Center. The targeted Center for our "children" is CVTC in Lynchburg – 160 miles away. At 68 years of age, I am one of the younger parents. Moving our loved ones miles away is unconscionable. Our parents are not only up in years but many of them have their own health issues that prohibit traveling. **This is far from a "Home like Yours in the Community" and we know you share our view.**

Our children are a medically fragile and behaviorally challenged group of folks that require supports that need to be tailor made to meet their needs. They have lived at NVTC for a lifetime OR in the case of many of our residents have failed group home placements. The cost of building in Northern Virginia is expensive and providers are reluctant to move forward without a new waiver and the promise of ICF/MR level of care.

We need your support to slow the process down and re-look at the No. VA Regional Plan. NVTC is the safety net of the system and given this course of action by the DBHDS we will have not only major disruption but increased risks of morbidity.

Northern Virginia needs to support NVTC residents in Northern Virginia – we rely on you our CSBS to make this happen.

Jane Anthony
Co-President of NVTC Parents & Associates
2055 Wethersfield Court/Reston, VA 20191 – janthonyjane@comcast.net

# NORTHERN VIRGINIA TRAINING CENTER IS NEEDED

Robert Anthony, Ph.D.

Good evening, I am Bob Anthony the stepfather of a resident of NVTC. I have also spent a career working for non-profit organizations funded by the Federal Government to evaluate the effectiveness of various programs. Tonight I wish to explain why ~~the~~ some residents of NVTC could not be safely supported in the community and also set the record straight on several misconceptions.

There are many residents of NVTC who are exceptionally medically fragile and require frequent treatment, supervision, or quick emergency responses from nurses or other medical professions. Group homes or small ICF/IDs cannot afford to provide such intensive support without the economies of scale and flexibility offered by NVTC.

Other residents suffer from dangerous uncontrollable impulsive behaviors and need an environment with a lower level of stimulation as well as attentive support staff and safe spaces to settle down. Yet others chew on or eat inappropriate items that pose choking risks unless their environment is free of such hazards. Without the larger safe living areas and

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grounds of NVTC, these individuals would be confined to a few small rooms most of the time. Scientific research shows that for people with low mobility and few self-care skills have over 70 percent greater mortality in community settings in comparison with Training Center placements. This includes community ICF/IDs.

I have given you a table comparing Training Center and Community coverage of essential services and supports enjoyed by the residents of NVTC. Note that DBHDS does not report the hidden costs covered directly by Medicaid budget. Other services are either not offered or underestimated in the average ID waiver estimates. Academic research shows that the total of all costs in the community is comparable to NVTC rates.

Another misconception is that NVTC closure has already been decided. Judge Gibney explicitly stated in his order approving the Consent Decree that the decision to close Training Centers is for the state legislature. The Finance Subcommittees of the House and Senate are engaged in ongoing consultation with DBHDS.

Please consider in your planning for current residents of NVTC how they are to receive the frequent and responsive attention

from health care professionals. Please consider all of the costs of community placements. Please consider the ongoing role NVTC for those who need it. And remember that 97 percent of surveyed Authorized Representatives of NVTC residents would like their loved one to stay there.

## Costs Not Accounted for in HHR Budget for Many of the Services and Supports Essential to Training Center Residents After Transitioning to the Community

| Service or Support | Training Center Coverage | Community Coverage |
|---|---|---|
| Pharmacy and pharmaceuticals | Medicaid budget | Medicaid budget |
| Hospitalization or treatment by specialist | Medicaid budget | Medicaid budget |
| Early release from hospital and prevention of hospitalization | In HHR budget | Medicaid budget |
| Physician and psychological* on-campus services: Diagnostics, checkups, and treatment | In HHR budget | Medicaid budget |
| Transport for treatment or day program | In HHR budget | Medicaid budget |
| Frequent monitoring, staff supervision, and preventative care by on-campus physicians, psychologist, nurses, and therapists | In HHR budget | Not offered** |
| Dental services and specialized facilities such as, Hydrothermal pool sensory stimulation room, etc. | In HHR budget | Separate Budget*** |
| Nursing services: Active treatment Therapeutic consultations: Occupational, physical, speech, etc. | In HHR budget | Underestimated in HHR budget |
| Assistive technology and environmental modifications | In HHR budget | In HHR budget |
| Residential supports: Room and board | In HHR budget | In HHR budget |
| Day supports or supported employment | In HHR budget | In HHR budget |
| Residential supports: Direct care staff and Staff retention | In HHR budget | Underestimated in HHR budget |
| Reducing error, abuse, or neglect by Team approach, supervision, & multiple staff on duty | In HHR budget | Not in HHR budget |

* Training Centers and the START program in the community are to provide crisis stabilization services. Demand for START will evolve.

** Nurses are dedicated to one or very few residents at some homes as a very expensive solution for those with intense needs.

*** Regional Community Support Centers at Training Centers currently provide such services as a separate program.

For more information, contact Robert Anthony Ph.D., rwanthony71940@comcast.net, (703) 860-8652

## Comments on the Costs Not Accounted for in HHR Budget

**Early release**... Nurses and care units at Training Centers support early release from hospitals as well as avoid some hospitalizations. Training Centers have stabilized residents after failures in the community resulted in long hospital stays, clearly suggesting greater risk of hospitalizations for center residents who move into community placements.

**Physician**... Multiple physicians and psychologists on staff provide many health services on campus.

**Transport**... This benefit is covered by rates at Training Centers but paid for by Medicaid in the community, outside the HHR budget but still a cost to the state.

**Frequent monitoring**... Community providers say it is too costly to have professional staff on site at each of many dispersed locations, and Medicaid does not cover preventative care, increasing the risks for center residents moving to the community.

**Dental services**... Presently the Regional Community Support Centers (RCSC) provide these services through a state program based at Training Centers.

**Nursing services**... Nursing and therapeutic services are more intensely in demand from those who might transition from Training Centers. The real cost of care in the community is masked in the HHR budget because only the average costs for people with intellectual disabilities waivers are collected.

**Assistive technology**... Training Centers have highly specialized staff and shops to modify or build assistive devices, such as reconfigured wheelchairs, that are not available commercially.

**Residential**... Residents pay a portion of room and board from their SSI or SSDI in both the Training Center and the community.

**Day supports**... Most Training Center residents have a day support program or supported employment on or off campus.

**Direct care staff**... The CSBs have written numerous letters explaining that the current wage rates are insufficient to recruit and retain staff especially in Northern Virginia.

**Reducing error**... Note that the CSB estimated need for four staff on day and evening shifts plus two on night shift, a total of ten shifts, already exceeds the $104,000 rate assumed by DBHDS for a four-bed home.

CSB Public Hearing March 13, 2013 – Gartlan Center, 7:00pm

Board members- Gross, Beeman, Sites, Kern, Kamber

Staff members- Wooten, Tomlinson, Axelson, Mangano, Cooper, Nelson, Braunstein, Yager

Public- 8 community members present

Synopsis of Speakers

| Speaker | Affiliation | Synopsis |
|---|---|---|
| Lynne Crammer | Board Chair, SAARA of VA | - Provided handout with data on substance abuse effects, waiting lists for services<br>- Provided data (in handout) about #s served, wait times, etc.<br>- At a time we should increase services for people with substance use disorders, not talking about compromising<br>- At a time when we should strive for early engagement, we are talking about serving only people who are significantly disabled- Not sure what that means for substance abuse<br>- The CSB and County have made promises to constituents to help people who can't receive services otherwise; CSB is supposed to be the safety net<br>- With regard to a full continuum of care and supports for recovery—How can that be done with this transformation plan?<br>- Dilemma to limit services to indigent and uninsured—These are not people who cannot be served in private provider<br>- Recovery takes a full continuum of EBP<br>- Seems like is "placed at bottom of the barrel"<br>- Engagement in services is very important in substance abuse treatment services.<br>- Important to engage adolescents<br>- Prevention is going by the wayside- would like us to do more prevention but cannot forget there are substance abusers in need of treatment |
| Patrice Whelen | Parent of a son at Crossroads | - Child had extensive early childhood issues and learning struggles. As he got older, ran into legal, mental health, and addiction issues. Been at Crossroads 7 months—he has been in many programs of shorter duration.<br>- He has learned a great deal while there and, for first time, setting goals. Starting to transition – but he has needed this long term program to learn.<br>- Urges board to keep program stay open and continue with duration<br>- Thanks to board for opportunity for him to be there and help him become a contributor to society. |

| Speaker | Affiliation | Synopsis |
|---|---|---|
| Edward Lee | | Affirmed what previous speaker had stated and passed |
| Terry Atkinson | Past president of Gartlan Advisory Board—but not speaking for Board | Support the priorities put forward- Release of funds to fill current staff vacancies. Every dollar cut and every position kept vacant means less people served. What appears to be a savings in a CSB translates to a cost to another county agency- Police, courts, jails, OR a resident in need falls through the cracks. CSB, BOS, Co Ex has to consider the domino effect of budget decisions. No more fat left to cut. Thorough decision making requires a broad view across the county |
| Peter Kinzler | Father of son in NVTC | Son requires constant care and that is his priority. Speaks as father and as an attorney. Thanks to CSB for publicly stating that the timeframe to remove residents of NVTC in the timeframe required. Believes it is wrong and cruel for authorized representatives to have to make the decisions to move into a community unready or an institution 150+ miles away. DD act, IDEA, and other ICF-ID program—DOJ settlement agreement does not require the closure of any TC. Fundamental question is that why would we remove the one thing that is working well. Ratio of 4:1 volunteers for every resident. Tremendous support. 80% of authorized reps were surveyed—90% of them would prefer that people stay at the TC. First argument is cost. Where is the DBHDS data that supports their bottom line numbers? No data has been provided-- Urge you to request the data source. Determine whether or not there is a substantial savings. This change will disrupt resident lives. Ideology is the fundamental basis for department's push to move to closure- Dangerous basis for action. Fails to appreciate the wide range of disabilities in the community for people with ID in the community. Community may be great for some but for others, institutions are the least restrictive alternative. It is arrogant to substitute their judgment for that of caregivers. Not making case that group homes cannot serve people adequately—but only if properly staffed. This is a caution. Virginia underfunds care for people with ID. Not actually asking for CSB to correct since that's out of authority. Settlement agreement offers a possible course to leverage quality and better community care- with fixed waiver costs and fixed levels of care. Think there's a community of interest to get necessary care and quality of care for people in community. Northern Virginia Regional Plan is within scope and an opportunity to work together again. Would prefer to have child housed inadequately in community than in another facility 160 miles away. It would make him very unhappy but better than far away from family. |

Public hearing adjourned at 7:40 pm

– LYNNE CRAMMER
3/13

# TALKING POINTS MARCH 13, 2013 FORUM

## AT ISSUE:

- Shortened stays at residential facilities. Should be based on clinical need, not budgetary issues.
- Individuals with SA issues are "significantly disabled" and are defined as a priority population. An appropriate continuum of services to meet their needs is essential.
- Individuals seeking recovery do best when they are together. This happens in offices and facilities and represents essential services for the population.
- We must ensure that appropriate services are available to all to priority populations. These services must be designed to meet the needs of individuals served regardless of where the essential services take place. For individuals with substance use disorders, these services take place in "office based" and Facility Based programming.
- If funding is diverted due to a one size fits all designation of core service, this will negatively impact priority populations, especially the SA priority population. We must focus on services to priority populations rather than priority services
- Maintaining a continuum of service provision is essential to meet the varying needs of the priority SA population.

## Fairfax data as of January 2013:

- Of 11,273 unduplicated individuals admitted to CSB services in 2012, only 16% received services for Substance Abuse
- Waiting lists;
    1. Youth outpatient & day treatment 6-24 weeks depending upon the site
    2. A New Beginning—83 waiting
    3. Crossroads---85 waiting
    4. New Generations—3waiting
    5. Cornerstones—8 waiting
    6. Detox—164 waiting
- All programs are at capacity

## *Impact of Substance Abuse on Local Budgets nationwide:

- Average amount spent on substance abuse and addiction was 10.9% of local budgets.
- Of the 10.9%, an average of 97.6% was spent in local programs such as criminal justice, education, health care which "carry the burden" of substance abuse and addiction
- Of the 10.9%, an average of 2.4% was spent on preventing or treating the problem
- Conservative estimates indicate that in 2005, local governments spent $93.3 billion on the burden of substance abuse and addiction
    1. The lion's share of local burden spending is in justice, education, and health ($71.5 billion)

2. Next largest area of spending is in public safety ($12.8 billion)
3. 3rd largest in child and family assistance programs ($7.6 billion)
4. 4th largest in workforce absenteeism $1.4 billion)

*SHOVELING UP ii: *The Impact of Substance Abuse on Federal, State, and Local Governments,* May 2009. National Court Appointed Advocate Association (CASA). Based on 4 local jurisdictions in Tenn., Oregon, and North Carolina (2 jurisdictions).

Statement to CSB
March 13, 2013
Terry Atkinson
6153 Deer Ridge Trail,
Springfield, VA 22150
(703) 922-5787

I am the past president of the Gartlan Center advisory board. However, I am not representing the advisory board; I am speaking for myself.

I support the proposed priorities put forward by the CSB. In particular, I support releasing funds to the CSB to fill current staff vacancies.

It's important to remember that every staff vacancy and every dollar cut from the budget means less service or no service for someone in need. Also, it's important to consider that when services are removed from one CSB office, another office must take up the slack often at greater cost. More often than not, what appears to be a savings in the CSB translates into a cost in another county agency. So, when PACT and ICTs are not fully staffed, the costs go up for hospital emergency rooms, the police, the courts, the jail, and other agencies. Or worse, a resident in need falls through the cracks in the system. The CSB, the county executive, and the Board of Supervisors must consider the domino effect of their decisions regarding the budget.

As has been pointed out by others, there is no fat left to cut, every dollar cuts into meat and bone. Thorough decision-making demands a broader view across county services.

CSB Public Hearing March 20, 2013 – Fairfax County Government Center, Rooms 2-3

Board members- Sites, Beeman, Garnes, Kern, Segura, Burmester

Staff members- Braunstein, Wooten, Buescher, Yager, Osborne, Berenson, Anderson, Hartman, Mangano

Synopsis of Speakers

| Speaker | Affiliation | Synopsis |
|---|---|---|
| Judith Korf | NVTC parent | Wants to work with CSB and other stakeholders on alternative plan- 2/8 planning meeting re discharge, didn't want her indiv moved – report received was inaccurate, mentions that resident would be moving in April 2013 – typo? Checking into it. Submitted written testimony. |
| Sheila Kuders | Parent of 3 children with special needs | Written testimony included. 7 community members stood in support as she spoke. Funding needed. Bond on ballots during next election cycle? Not acceptable to say, repeatedly, "not enough resources." Focus on homelessness has marginalized others who are not homeless but need services. "Would this county tolerate elderly people with Alzheimer's walking the streets, homeless? So why schizophrenics?" |
| William Taylor | Concerned families / VOICE | Son, in college, ill due to addiction, depression. Didn't know what to do. School based AD counselor recommended he go out of state to residential program. Worked – sober for 5 yrs, has a job. None of the medical providers mentioned the CSB. Didn't know about CSB services. Asked CSB to open lines of communication via medical providers – let people know there's a county agency that can help. |
| Lynda Smith Bugge | Grandmother of 16 yr old in foster care | Intermittent help from social worker, Medicaid is being cut this month. Mother brain injured 10 yrs ago. Looking for housing, wait lists are interminable. Need for housing – we don't know where to look. |
| Linda Leisz | Recipient of ADS services | Today, has a job, homeowner, my life was saved by the CSB. Husband, former heroin addict, also saved by CSB. Do not cut treatment. |
| Joyce Cantrell | Recipient of ADS services | Was homeless, unemployable, frequent arrests. Found her way to detox, then A New Beginning (ANB). Victim of domestic violence for many years, vicious cycle. Was given hope at ANB. Got additional support – "I mattered." Got her children back. Now employed since 2 days after leaving ANB, now a homeowner. |
| Becky Ianni | Son had SUD, depression | Described her guilt, enabling behavior. Son attempted suicide 4 times until entered A New Beginning. July 2010. She and husband and other children attended support programs at ANB – education, support gave her back her life, helped her deal with his alcoholism. Now in recovery. Importance of programs for family members as well as those with SUD. |

| Speaker | Affiliation | Synopsis |
|---|---|---|
| Catherine Mirch | Concerned families | Hard to live with family member with mental illness. Coordinates a monthly mtg at NVMHI for family members of those with borderline personality disorder (drugs often don't work effectively). Last night's meeting – determined we have to do something. The county, the country has failed us in the realm of mental health. Everyone who suffers from a MH disorder is unique. Her son is an addict now. Had issues early in school – emotional disorder. Early intervention needed in schools. Referenced Boys' Town.<br><br>Spoke again later in meeting – asked others who testified to give her their contact info. There's a lot of energy. |
| Lavonne Pherson | Daughter has serious mental illness (SMI)<br>Concerned families of Fairfax County – for housing | Adopted child through foster care. Has SMI. Needs more services. Fairfax County needs more programs for young adults. Urges that we look at Arlington County's programs. Asks that system be transparent and accessible. People with SMI need housing with supports. Urges county to support bonds to provide supportive housing. |
| Art Banks | Parent of son (39) at NVTC | Waited over 10 yrs for space at NVTC – severe needs. Pleased with placement at NVTC. Weekly visits. Staff take residents out to shows, activities. Son is able to show affection. NVTC has excellent medical staff. Mentioned N Virginia Magazine – Dr. Becker was listed as one of the best doctors in the region in two specialties (med director at NVTC). Even if it's a weekend, Dr. Becker sees him when he returns from hospital after medical events. Dental services at NVTC. Wheelchair fitting, careful staff. Concerned about severe weather service interruptions when relying on community caregivers. |
| Diana Hurd | Recipient of CSB services, ADS | Grateful for CSB programs. Women's recovery program. Her children were in foster care. Could only have one child there. Now in same job 4.5 yrs. Single parent. Program taught her that she could do it. Wouldn't be where she is today without county's help. Children have issues – ADHD. They are also in therapy now. Feels secure that if her children need help, it will be available in the community for them. |
| Bill Robinson | Father of Diana Hurd | She had been in various other programs. This program in Fairfax County really did work. Engaged the people there, got their attention, realistic. Serious people in an effective program. This is a program that works. Ratio of benefits to costs very high. Daughter's life was saved – there was nothing he could do about it. This program saved her. Sober for 5 years, has a job, nurses aid training, will be an ADS counselor. She would have lost her children. You have saved three lives with this program. If you have minimal dollars, put it into programs like this. |

| Speaker | Affiliation | Synopsis |
|---|---|---|
| Meghan Tedford | Recipient of AD services | Was homeless, 5 month pregnant, entered 18 month program. Saved her life and life of her child. Taught her how to be a mom, be responsible, work hard, do things the right way. Since graduation, went to a transitional housing program, got license back, pay taxes, enrolled at NOVA to be a vet technician, 4 yrs at same job. Thank you for the program. Especially programs where you can take your children or try to get children back, really needed. |
| Amy Nece | Recipient of AD services | 3 yrs sober – direct result of ADS Fairfax County. Addicted later in life, starting with prescription meds, later heroin, crack, had children. Tried one week at EAP / detox, then back to work. Never worked. Had to lose everything, including custody of 18-month old daughter. Learned to be a mom and be sober, get along with family who was caring for her daughter. Staff was with me every step of the way. Still talks to staff there, weekly. Asks that cuts be distributed evenly across program areas, not disproportionately cut SUD services. Wants to be able to help others. |
| Michelle Bulla | SUD – Vet in U.S. Coast Guard | Recently graduated from 18-month residential program. Was homeless and suicidal. Today fully employed, in transitional housing. Taxpayer, wants to be self-sufficient. Taught me how to be a person again. I needed every bit of that time. Lost her adopted daughter due to her addiction. Can still call the residential program if she needs help. Addiction was a disability – I couldn't save myself, I needed help. |
| Joanna Walker | NAMI | Son, 26, has general anxiety disorder, ADHD. Son was homeless for a year. We were encouraged to keep him homeless, that would put him on top of the housing list. Only 50 people last year were housed in Fairfax County. Women with children come first – but young men with SMI need housing, too, and are defenseless. Can't be home. Combative. Parents pay for his housing. Couldn't get SSI, Medicaid. Wasn't "sick enough". CSB tried to work with him. He was suicidal for a year, he would call his mom weekly, beg her to kill him. She called Emergency Services – because he didn't have a plan, they said they couldn't help him. |
| Nathaniel Ford | SUD services recipient | Sober 23 years, after receiving CSB services. Was suicidal, using substances, alcohol. Couldn't read, no self esteem. Thanks Fairfax County – program got down to the causes of what was really going on. The substance use was just the symptom. CSB got down to the root causes. My life has changed because of you all. I want others to have the same opportunity I had. A lot of people are depending on what you do today. I have a Kindle, I can read, I brought my harmonica. Talked to my granddaughter today. I have a life today. |
| Rich | SUD service recipient | A New Beginning (2001) saved his life. Has a family, able to provide for them today. I try to give back, help others who are at the center now. |

Public hearing adjourned at 7:15 pm

# Comments to the Fairfax-Falls Church Community Services Board
# March 20, 2013

I am Judith Korf, parent and guardian of Adam who resides at NVTC and has severe behavioral issues. Adam was admitted to NVTC in 1998 after waiver home placement failed, seriously endangering him and others. All efforts to move him back to the community in the intervening 14 years were unsuccessful. Waiver funding does not cover the required supports, and providers are keenly aware of the potential liability involved in serving clients like Adam.

Thank you very much for publicly making clear the inability of local CSBs to meet the arbitrary timetable set by the DBHDS for closing NVTC. As you know, the DOJ-Virginia settlement agreement as modified and signed by Judge Gibney in August 2012 does not require the closing of any Training Center. Further, it reaffirms the rights of Training Center residents and their authorized representatives to choose continued Training Center placement. We also thank you for opposing the stated intention of DBHDS to move those residents who are not placed in the community to a distant Training Center, probably CVTC 160 miles away, three months prior to the scheduled closing of NVTC.

The cost estimates associated with the DBHDS plan are unsupported by hard data. As indicated by Dr. Anthony's study already shared with you, there is no demonstrable difference in costs that would justify moving the residents of NVTC into an unprepared and under-resourced community, exposing them to great risk of harm.

At the same time, action is long overdue to meet the needs of those who can and wish to live in the community. Further delay is unconscionable. The Settlement Agreement specifies a required number of slots and imposes quality control measures that will aid you in the effort to secure the improved waiver services and staff compensation that are needed. We hope to work with you, community representatives, and providers to develop alternatives to the DBHDS plan. It is time to revisit the Northern Virginia Regional Plan that was developed jointly in 2010 with all the stakeholders including the CSBs. It is designed to allow for use of the NVTC campus not only for residents, but for those in the community who need all the adjunct services. The use of the grounds can be modified to accommodate others with disabilities, including such organizations as Wounded Warriors. NVTC is the safety net of the system. With sound and careful planning, it can continue to be all of this and much more.

Provided separately: Copies in PDF of Corinne Reilly's article in the *Washington Post*, February 17, 2013.

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The Washington Post

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# Plan to close Va. institutions stokes worry for families of the developmentally disabled

**By Corinne Reilly, Published: February 17**

On his bad days, Adam Bertman would crush light bulbs with his bare hands. He once launched the heavy lid of a toilet tank down the stairs, striking a caregiver.

One of his worst days came in fall 1998, when Bertman, who has autism and brain disease, became upset while out for a supervised walk. He started throwing rocks at cars and was so out of control by the time police officers arrived that they pulled their guns.

That was Bertman's life before he entered the Northern Virginia Training Center in Fairfax, one of the commonwealth's five state-run institutions for the developmentally disabled. It was before he developed relationships with the center's staff members, who have learned to read his body language for signs that he is becoming agitated.

But now, as the state prepares to close four of the five centers and move their residents to community-based group homes, his mother, Judith Korf, worries that Bertman, 41, will end up in the same situation again.

She and other family members are fighting the plans, arguing that their loved ones, many of whom are so disabled they have problems with basic functions, such as swallowing food, need far more care than they will probably get in community settings. Indeed, Bertman is not the only one at the Fairfax center who landed there after community placements failed.

"When I think about what's going to happen when the training centers are gone — I just don't even want to think about it," said Korf, who is 69 and lives in Reston. "For Adam, I think the past has shown that this is the only thing that works."

Virginia is among the last states to begin dismantling its large institutions for the developmentally disabled, a decision that was made as part of a year-old settlement agreement with the Justice Department, which argued in a lawsuit that Virginia was discriminating against training center residents by keeping them institutionalized. All but one of the commonwealth's five training centers, as the state calls them, are to be shuttered by 2020, with the one in Fairfax set to close by July 2015.

The state has touted the plan as the best thing for the approximately 18,000 developmentally disabled Virginians who are receiving or waiting for services: Training center residents get to move into the community to homes that will meet their needs, and with the money that is saved by closing the centers, the state can begin to make a dent

in its waiting list. About 7,400 families are in line for services or group-home placement, and many have been waiting for years.

Jim Stewart, commissioner of the Virginia Department of Behavioral Health and Developmental Services, said the population at the training centers has been decreasing for decades, from nearly 6,000 in the 1970s to about 900 today.

"What's happening now," Stewart said of the plan to get rid of the centers, "was already happening" on its own.

State officials said they are confident that the training centers' residents can be properly cared for in the community, and they note that no one will be forced to accept community placement. For guardians who insist on a training center, the state is keeping open one center in Chesapeake, with 75 beds.

But even among those who think the training centers should be shuttered, there is deep concern that the state is rushing the process to meet unrealistic, arbitrary closure deadlines. The biggest problem, according to many county officials and some Virginia legislators, is that there are not enough group homes to receive the training center residents. Most existing homes are full, and little has been done to set up new ones to add capacity.

The families who are fighting the closures got a small boost last week when two General Assembly subcommittees made recommendations that could slow the process and give legislators more oversight, but the measures have yet to be approved. For now, the state and the centers are proceeding with the closures as planned.

Peter Kinzler, whose 38-year-old son, Jason, has lived at the Northern Virginia Training Center since he was 3, said providing the safest environment possible should take precedent.

"They're putting ideology over what we know is best for our child," he said.

Jason has Angelman syndrome, a rare and complex neuro-genetic disorder. He is extremely medically fragile and functions cognitively at about the level of a 6-month-old. He constantly puts things in his mouth — he once ate 11 inches of a blanket — and because he cannot communicate, close monitoring of his health is often the only way to know when something is wrong.

County officials said more group-home capacity has not been added partly because Fairfax has some of the most expensive real estate in the country, and Medicaid funding is inadequate, so few private group-home operators are interested in expanding.Some believe nothing will change without state incentives or intervention.

"We know for a fact that the community is not ready to absorb these residents," said Del. Eileen Filler-Corn (D), whose district includes the local training center.

Korf fears it will never be ready for her son.

When he was young, she had hoped she could care for Bertman at home until transitioning him into a group home. But over time, he became too strong, too aggressive and too unpredictable.

He has no major physical deficiencies and understands almost everything that is said to him, but his verbal skills and his willingness to use them are limited. He is easily overwhelmed and agitated and prone to destructive outbursts. He constantly tests limits and is the most stable when he knows someone else is firmly in control.

At the Northern Virginia Mental Health Institute in Falls Church, where Bertman spent more than a year, the staff dealt with his behavior by sedating him, Korf said. At two group homes, his caregivers were unable to keep Bertman and those around him safe. He went on rampages, threw the toilet tank lid and crushed the light bulbs.

With all other options exhausted, Bertman finally was granted a spot at the training center 14 years ago, when he was 27. He lives with three other men who have at least two staff members with them at all times. He receives recreational, occupational and speech therapy. When he feels up to it, he swims and does art projects. His favorite thing, which his caregivers indulge, is visiting the airport to watch planes come and go.

He still has bad days, but they are less frequent and eruptive than they once were. Korf credits the structure and stability of his life at the training center, along with the staff, who have come to understand Bertman.

On a recent day, he agreed to show a visitor his room, which is decorated with race cars and mementos from Special Olympics competitions, but after a few minutes he became tense. "He needs some space," a staff member said when he noticed Bertman's face tighten. "Let's just step out and give him a minute."

Korf once agreed that all institutions for the developmentally disabled should be closed. The Northern Virginia Training Center changed her mind. She said she worries that in a group home Bertman will regress and, after a few bad incidents, he will become more isolated from the world than he is now, not less.Or worse, he will end up hurting himself or someone else.

As if to reassure her, the staff that is planning the training center discharges have told Korf that Bertman will probably be among the last to be moved.

But Korf finds no comfort in it.

"I think what they're really saying," she said, "is that they have no clue what they're going to do with him."

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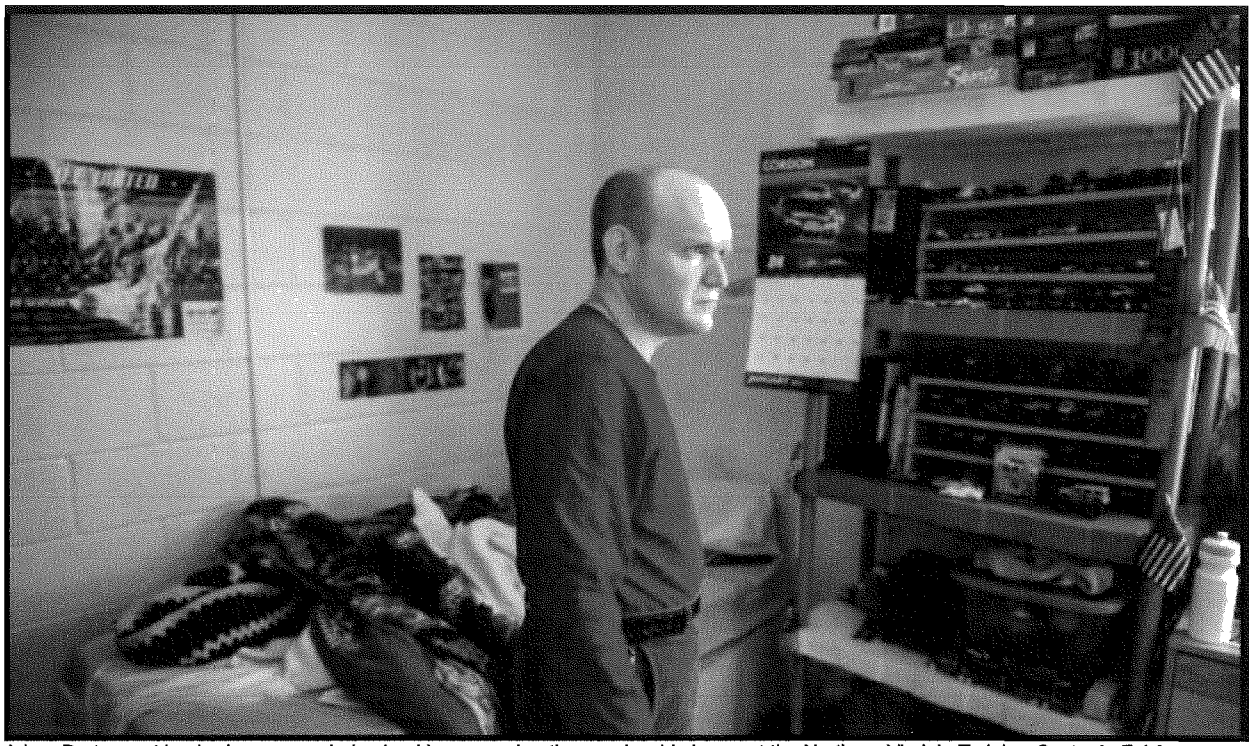
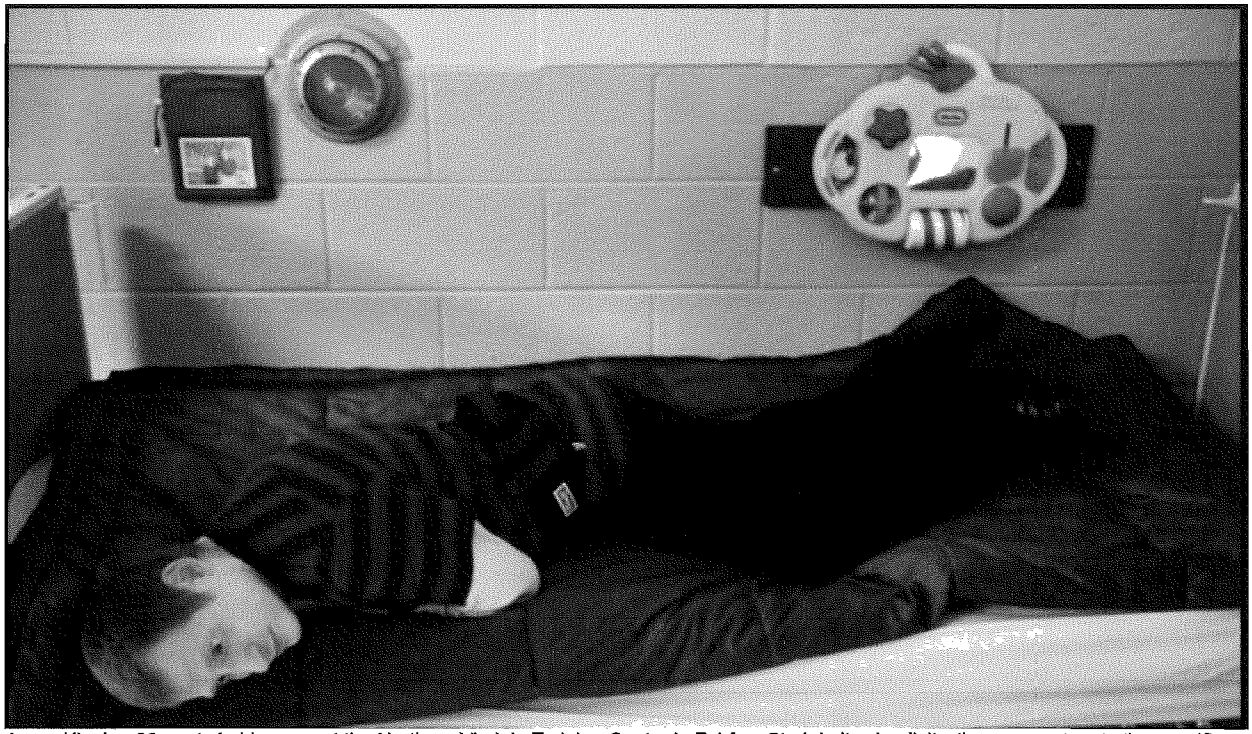


Adam Bertman, 41, who has severe behavioral issues and autism, makes his home at the Northern Virginia Training Center in Fairfax. Virginia plans to close all but one of its institutions for the developmentally disabled. Family members are fighting the plan, arguing that their loved ones, many of whom are so disabled they have problems with basic functions, need far more care than they will probably get in community-based group homes. Nikki Kahn / THE WASHINGTON POST

Judith Korf, 69, of Reston gets a hug from son Adam Bertman, 41, who has behavioral issues and autism. The Fairfax center's staff has learned to read his body language for signs that he is becoming agitated. Nikki Kahn / THE WASHINGTON POST

Adam Bertman, 41, makes his home at the Northern Virginia Training Center in Fairfax. The state plans to close all but one of its institutions that cater to the developmentally disabled by 2020. The Fairfax facility is set to close by July 2015. "For Adam, I think the past has shown that this is the only thing that works," said Judith Korf, Bertman's mother. Nikki Kahn / THE WASHINGTON POST

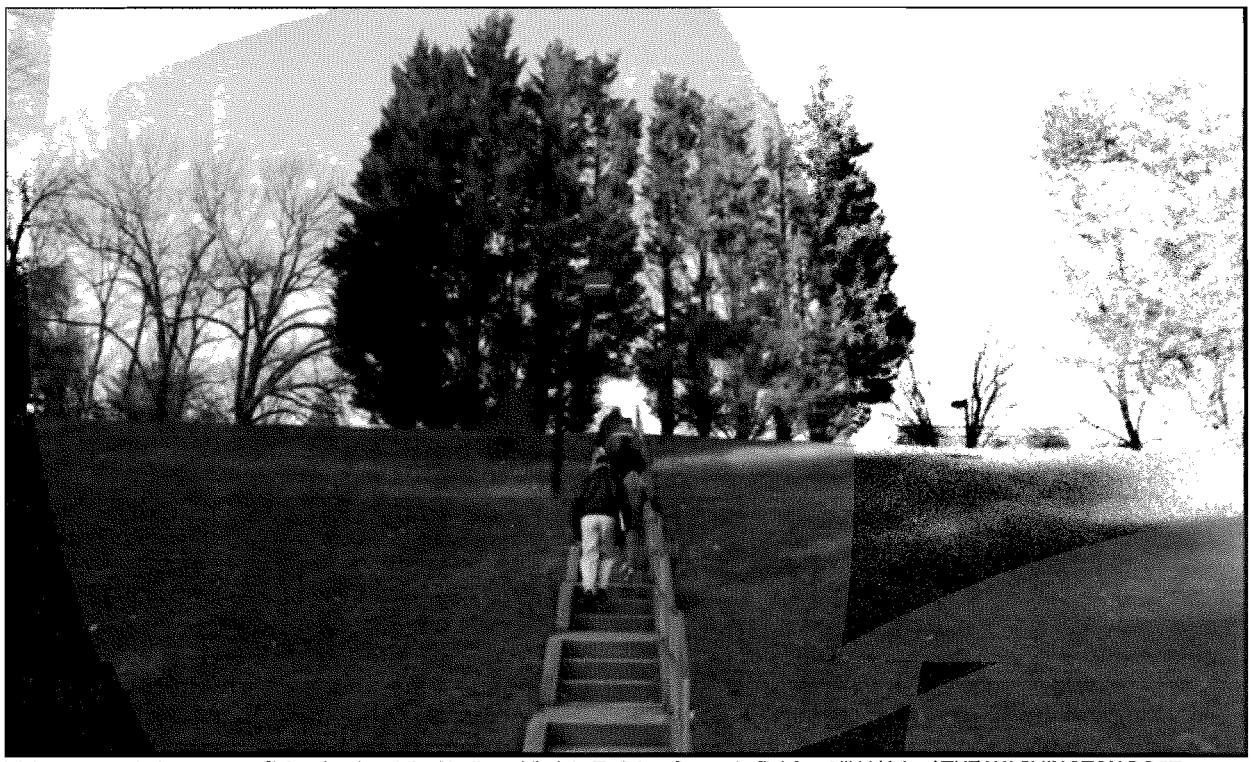
Judith Korf turns on a bubble tube that controls the colors and is based on the concept of Snoezelen, which provides multisensory feedback promoting color recognition and visual perception, during a visit to the Northern Virginia Training Center in Fairfax. "When I think about what's going to happen when the training centers are gone — I just don't even want to think about it," Korf said.
Nikki Kahn / THE WASHINGTON POST



Jason Kinzler, 38, rests in his room at the Northern Virginia Training Center in Fairfax. Stark in its simplicity, the room caters to the specific needs of Kinzler, who has lived at the facility since he was 3. His father, Peter Kinzler, said providing the safest environment possible should take precedent. "They're putting ideology over what we know is best for our child," he said. Nikki Kahn / THE WASHINGTON POST

Jason Kinzler gets support from social worker Lauren Kempin and his parents, Peter Kinzler and Jane B. Anthony, at the Northern Virginia Training Center in Fairfax. Jason has Angelman syndrome, a rare and complex neuro-genetic disorder. He is extremely medically fragile and functions cognitively at about the level of a 6-month-old. Nikki Kahn / THE WASHINGTON POST

Visitors cast their shadows on a pathway at the Northern Virginia Training Center in Fairfax. The center is home to the developmentally disabled, and the state plans to close it. Nikki Kahn / THE WASHINGTON POST



Visitors make their way up a flight of stairs at the Northern Virginia Training Center in Fairfax. Nikki Kahn / THE WASHINGTON POST

Written submission to the Fairfax-Falls Church Community Services Board

March 20, 2013

My name is William Taylor. I've been a resident of Fairfax County since 1972.

Several years ago one of our sons, then 20 and a college student, became quite ill as a result of substance addiction as well as anxiety and depression. Over the course of several months his ability to function spiraled downwards. We tried to get help for him, but weren't really sure what to do. We were able to get him in to see a private psychiatrist up here, but that wasn't enough. On at least two occasions he ended up in the psychiatric wards of local hospitals up here. Finally, an alcohol and drug counselor associated with his school recommended that we consider taking him out of state to a residential treatment program she knew about. We didn't know whether this was the right course, but we didn't seem to have any other options. Over the course of the next year and a half he was in two different residential programs, both out of state, as well as halfway house programs. The good news is that the treatment finally worked. He's been sober for over five years, completed college, and has had a steady job for nearly three years.

What I want to bring to your attention this evening is that through all of this none of the medical providers, or anyone else, mentioned the CSB to us. We had no idea of the many services that you provide. As you know, when a family is faced with a crisis involving mental illness or substance abuse, that's not the kind of thing most of us feel comfortable talking about with friends. It would have helped immensely to have been able to talk to someone with expertise who could have pointed us in the right direction. There's no "consumers guide" to getting this type of help. And the crises that happen must be dealt with right away.

We're thankful that we were able to get our son the help he needed. But we'll never forget how frightened and helpless we felt going through it, even though we had the advantage of being well-educated and able to pay for some level of private care. Afterwards we thought often about what it must be like for others who don't have those advantages. Who knows how many never even know how to ask for help? For that reason, we're committed to doing whatever we can to help others in that situation. We ask that you do whatever you can to open lines of communication to the community, through medical providers and elsewhere, so that families who are facing these problems today at least know there is a county agency that is able to help.

# ADVOCACY OF CONCERNED FAMILIES OF FAIRFAX COUNTY

Community Services Board Public Hearing -- Wednesday, March 20, 2013 -- 6:00 pm -- Fairfax County Government Center

## URGENT NEED FOR SUPPORTIVE MENTAL HEALTH HOUSING

1. Fairfax County has a serious and shocking shortage of affordable housing for all low-income populations, but the situation is hardest on those with serious mental illness who need housing with supports.

2. According to a recent report, there are nearly 1,700 individuals on the Fairfax-Falls Church CSB's housing waiting list, and only 50 new spaces were added to the inventory last year. At this rate, it would take 35 years to clear the waiting list, even if no new individuals were added.

3. Fairfax County's CSB enlists an endless, complicated, undefined, and ridiculously confusing housing waiting list "procedure" that involves multiple lists.

4. We are told by county staff that our seriously mentally ill family members will only qualify for supported housing if we throw them out of our homes, and they are living on the streets.

    a. This policy is inhumane. It produces unnecessary crises and psychiatric emergencies, and creates dangers for our loved ones and society as a whole.

5. We respectfully urge the CSB and Fairfax County's Board of Supervisors to devote more resources and attention to this issue, with consideration given to bonds, SROs (Single Resident Occupancy structures), developer incentive programs, and other means of creating more housing.

6. As a basic, first step toward addressing the housing challenge faced by people with mental illness in Fairfax County, streamlining the housing application process, and fairly prioritizing eligible applicants, we advocate for the CSB's near-term creation of a comprehensive list of currently available housing opportunities and options for individuals with mental illness, with a single registration point for this housing.

## URGENT NEED FOR GREATER ACCESS TO MENTAL HEALTH TREATMENT

1. The tragedy at Newtown reminded us all of the need to make mental health treatment more widely available, especially for young people.

2. In Fairfax County we have some excellent facilities and dedicated staff, but access is very limited, waiting lists are long, and navigating the system is so complicated that even individuals with supportive families can't find their way in.

    a. At the onset of our experience with mental illness, we were unaware of the CSB and its services, and many families and individuals seeking help are still unclear.
    b. When finally finding out about the CSB and requesting services, we have endured lengthy wait times, only to be denied services with no explanation. (The intake evaluation alone can take three months to complete, eligibility criteria are unclear, and there is no explanation when services are denied.)
    c. We encourage the CSB to continue to increase its outreach efforts toward fostering broader public awareness of its existence, of mental health services available, how to access those services, and who is eligible for services. Aggressive partnership with Concerned Families of Fairfax County and similar organizations offers one avenue to do this.

3. Communication between the CSB and family members must be more collaborative. Families provide the vital insight needed to evaluate and refine their loved one's services, and could provide a tremendous resource for the CSB.

4. We respectfully urge the CSB and Fairfax County's Board of Supervisors to provide additional resources to expand mental health treatment and to work with clients and their families to make the system transparent and accessible.

5. We also encourage the CSB to devote additional resources to programs targeted to young adults with serious mental health and/or substance abuse issues.

    a. This is the age group where effective treatment is most likely to produce lifelong benefits -- and denial of treatment is most likely to lead to tragedy.

Comments before the Fairfax/Falls Church Community Services Board regarding the Northern Virginia Training Center
By Arthur L. Banks, Reston, VA
March 20, 2013

**OUR SON**, Jonathan Banks, is 39 years old and has resided at NVTC since 1997. His handicapping conditions are profound, both mentally and physically. Hi mental age has been estimated to be 6 to 9 months. He is non-verbal and non-ambulatory. He requires full care. He must be fed a pureed diet and is on adult diapers. He has Gran Mal seizures several times each month.

**WELL PLEASED** – We are very well pleased with Jon's home at NVTC for many reasons including these listed below.

**OUR VISITS** – We visit Jon every week when we're not out-of-town. He very visibly receives and returns our affections.

**COMMUNITY ENGAGEMENT** – We believe that Jon is appropriately engaged in the community. On workdays he goes to Central Fairfax Services in Springfield. Recreation therapists and many volunteers provide wonderful free-time activities evenings and weekends. Trips include visits to local malls, regional parks, and outdoor and indoor performances. There is church every Sunday at NVTC and Easter Seal Camp each summer.

**HEALTH MAINTENANCE** – Jon is covered by our HMO medical insurance. We are well pleased with our HMO, but have observed that physicians are very uncomfortable when confronted with non-verbal adult patients. NVTC's Medical Director, Andrew Becker, MD and his team are very effective in working with Jon. In a recent Northern Virginia Magazine article on area physicians, Dr. Becker received top ratings in both Internal Medicine and Neurology.

**NVTC's OCU** – Jon has been hospitalized on several occasions during the past 16 years at NVTC for needed surgery or other health urgencies. Upon his return he is placed in the Observational Care Unit with enhanced 24-hour nursing coverage. Dr. Becker immediately visits residents returning to the OCU even on weekends.

**DENTAL CARE** – Prior to Jon's acceptance into NVTC, we were frustrated as we were turned away from community dentists who told us they were not qualified or equipped to provide dental care for Jon. At NVTC he routinely receives dental care by staff dentists.

**THERAPISTS** – After using hand-me-down wheelchairs for years, Jon was authorized a new wheelchair designed specifically for his needs in 2012. I was present when the vendor was

there to do the measurements and take the order. I was amazed at the intimate knowledge of my son's characteristics and detailed recommendations provided by 3 staff therapists with different specialties. They were again present with the vendor at wheelchair delivery to do final foam seatback enhancements and wheelchair adjustments.

**RESIDENT TRANSPORTATION –** Regular group transportation is provided for residents by NVTC vehicles and staff or contracted services between NVTC and resident work places and recreational venues.

**SEVERE WEATHER SERVICE INTERUPTIONS** – It's been said, "a chain is only as strong at its weakest link." Although severe weather events are not common they do periodically occur. Here are some relevant implications:

- Access to residential home sites: Our home was located on a well-traveled residential road. When blizzards came, it was sometimes two or three days before our road was re-opened for travel... except by foot to the nearest plowed street.
- Our Caregivers: When Jon was 18 to 23 we had caregivers (from a reputable firm) come to our home to assist us mornings and afternoons. Due to their own family or transportation issues, these caregivers often canceled on severe-weather days. We had our own professional commitments, but had to cancel these at the last moment in order to stay home with our son.
- Electrical Service for heating and cooking: We have many friends and acquaintances in Northern Virginia who have been out of lights for up to 4 days following a severe storm.

NVTC, by contrast, has a policy that during severe weather conditions, caregivers remain until their replacement arrives. And, NVTC has huge generators around campus to supply needed electricity during power outages. All critical services remain viable on campus throughout the weather emergency.

**IN SUMMARY –** To us it seems logistically and financially implausible if not impossible to provide the existing high level of care and security now enjoyed by NVTC residents and families, in a decentralized system. It seems far more rational to us to keep these severely handicapped individuals together where all their needed services can be provided on location.

Respectfully offered,

-Art Banks
art.banks@verizon.net
703.624.1687

Becky Ianni

9833 Natick Rd, Burke, VA 22105

703-801-6044

My son, who is 29, is an alcoholic.

My life started to change in 2004 when I picked Chris up from where he was living and drove him to a local Mental Health hospital where he was admitted. He came home about a week later with a diagnosis of severe depression and alcoholism. Because he was so sad, I went with the depression as the cause of his physical and mental collapse.

Looking back now I realize I did so much out of guilt and ignorance about the nature of alcoholism. I blamed myself for his drinking in the first place. I played" the what if" game for months. What if I had done more for him as a child, what if I had done more to boost his self esteem, what if I hadn't drank diet soda when I was pregnant with him maybe he wouldn't have dyslexia and he wouldn't have had low self esteem. It went on and on. These feelings of guilt lead me to enabling Chris's alcoholism.

Chris continued to drink and I continued to feel helpless. Then in September of 2009 my world crashed. Chris drove to a local motel and got very drunk and then took a bottle of Advil PM and went into a coma like state for 36 hours when he woke up and wasn't dead he slit his wrists.

Nothing existed in my world but him. I had almost lost my son and I was terrified. I was afraid to miss a single visiting period in case it was the last time I would see him. I began saving his phone messages and texts thinking if he died I would still be able to hear his voice and read his words. I was now living in a new world where there seem to be no rules. He remained in the hospital for a month.
He stayed sober for about 5 months.

Then he began to drink again and from that time until he entered the program at ANB Chris tried to commit suicide 4 more times. I felt as If I was living in hell. It seemed as if my whole existence was to keep Chris safe. I lived day to day worried it might be the last day I would see my son alive. With each attempt I became more and more exhausted and more and more scared.

My husband and I finally told him he had to enter the program recommended by the community service board, ANB or move out. He entered the program in July of 2010.

With Chris safe at ANB I started to deal with my feelings that I had bottled up as I lived day to day in fear since that first suicide attempt in Sept of 2009.

I attended all the educational meetings that were offered at ANB and began to understand the nature of alcoholism. I also attended the support group offered weekly at ANB along with my husband where I was able to share my fears with others who understood. The family counselor offered support to my husband, my other 3 children, who were struggling with their feelings about Chris's drinking, and myself, as we tried to deal with Chris's alcoholism and its effects on us individually and us as a family.

I slowly accepted that there was nothing I could do to stop Chris from drinking or to keep him safe and that all my attempts to do so were just hurting me and my family. This acceptance bought a great deal relief to me as well as sadness. As a Mom I feel that it was my job to keep my kids healthy and safe and to accept that in this case isn't possible was incredibility hard for me. It was and is something that I have to work on constantly.

The only reason I was able to survive Chris's alcoholism was because of the education and support I received from the counselors at ANB. They gave me back my life and helped me to deal with all the emotions that go along with having someone you love being an alcoholic.

I would be lying if I were to tell you that I never worry, feel guilty or all those other emotions we feel for those that we love but I have learned not to let them control my life. Since Chris's graduation there have been times when the fear has come back where I have had to make decisions that have caused me guilt but I have learned better ways to deal with them. I know that I can always go back and attend the support group at ANB or give one of the family counselors a call for support.

Chris has had one relapse since graduated over two and half years ago and I was able to deal with it without falling apart because of the knowledge I gained at ANB.

I hope when you have to make decisions about cutting programs such as ANB that remember my story and realize that these programs help not just those who are addicted become productive member of society but all those who love them as well.

My name is Sheila Kuders and I am the parent of three special needs young adults, diagnosed with Autism Spectrum and Schizoaffective Disorder. Most parents struggle to meet the needs of one special individual, but my husband and I have struggled to meet the clinically significant needs for three children for the past 25 years. We have had to juggle special education IEPS x 3, multiple admissions to psychiatric hospitals, counseling, psychiatric bills uncovered by insurance, special education attorneys, social issues etc. In addition, we have had to deal with young adults in the home who are underemployed and placed in jobs by the Department of Rehabilitative Services that offer unstable work hours. On top of that, there is a lack of accessible appropriate day support programs to make up for these gaps in consistent work activity. Our young adult children, as well as many others throughout this county require support in all areas of life; housing, medical services, escort for travel, supervision, an advisor for financial matters, and most important of all, community integration. Many families in this county have been suffering hardships for many years. All parents get older, develop their own health problems, and cannot commit to meeting their loved ones needs indefinitely. Even with the

best of early interventions, most people who suffer from a perpetual disability will eventually require some level of adult services. Something has to be done to rectify the lack of funding to support these needs. Perhaps a bond could be put on the ballots during the next election cycle? Perhaps if Virginia moves forward with the Medicaid expansion under the Affordable Care Act, some additional funding streams will become available. But the current, repeated answer of "there are limited resources", is just not acceptable.

Many parents of the mentally ill have been told that their loved one has to be homeless in order to qualify for services. The effort to end homelessness is understandable and I fully support it. However, the focus on this endeavor has severely marginalized county residents who are in dire need of mental health services. County residents should not be penalized for taking care of their own children. It makes no sense to tell people to put their loved ones in dangerous situations, such as the streets, or homeless shelters, in order to qualify for help. This fails to pass the sanity test and results in costly and unnecessary crisis and psychiatric emergencies, and creates dangers for the community. Would this county tolerate elderly people afflicted with Alzheimer's Disease wandering the streets and uncared for? No, of course not! So then why is it OK for schizophrenics?

Fairfax County has a serious shocking shortage of supportive housing for the mentally ill. The application process needs to be streamlined and a prioritizing system should be established. The prioritizing system should include severity of the illness, age of the individual, the individuals family situation, the presence of more than one disabled individual in the home, and so forth. Certainly, if an individual is discharged home from a residential treatment facility, they should be automatically referred to CSB MH for follow along services and transition into adult services within a reasonable period of time.

Thank you for letting me speak to you tonight.

View Summary

Download Responses | Browse Responses »

## PAGE: OFFICIAL FAIRFAX COUNTY GOVERNMENT SURVEY

1. Tell us about yourself. (This is optional.) Are you someone who receives (or has received) CSB services, or a family member? CSB employee? Community member?

| | Response Count |
|---|---|
| Show replies | 198 |
| **answered question** | **198** |
| **skipped question** | **126** |

2. Please rank on a scale of 1 (least important) to 7 (most important) each of the following types of service the CSB provides in the community:

| | 1-Least Important | 2 | 3 | 4 | 5 | 6 | 7-Most Important | Rating Average | Rating Count |
|---|---|---|---|---|---|---|---|---|---|
| **Prevention and education about substance use, mental illness.** | 10.2% (33) | 8.3% (27) | 8.3% (27) | 11.7% (38) | 15.4% (50) | 11.7% (38) | **34.3% (111)** | 4.86 | 324 |
| **Early intervention to stop less serious conditions from becoming more acute.** | 0.9% (3) | 6.5% (21) | 9.6% (31) | 10.8% (35) | 15.1% (49) | 21.9% (71) | **35.2% (114)** | 5.39 | 324 |
| **Short-term counseling to individuals and families experiencing behavioral health challenges.** | 5.9% (19) | 5.9% (19) | 10.8% (35) | 15.1% (49) | 21.3% (69) | 15.4% (50) | **25.6% (83)** | 4.89 | 324 |
| **Crisis intervention to address situations where lives are at risk.** | 2.2% (7) | 1.5% (5) | 2.5% (8) | 7.4% (24) | 5.9% (19) | 12.7% (41) | **67.9% (220)** | 6.23 | 324 |
| **Long-term treatment for people with serious mental illness and/or substance use disorders.** | 3.7% (12) | 2.2% (7) | 4.3% (14) | 6.5% (21) | 11.1% (36) | 18.8% (61) | **53.4% (173)** | 5.89 | 324 |
| **Long-term case** | | | | | | | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **management for people with intellectual disability and mental illness.** | 2.8% (9) | 4.6% (15) | 7.1% (23) | 7.7% (25) | 12.3% (40) | 18.2% (59) | **47.2% (153)** | 5.66 | 324 |
| **Helping people access housing, medical care and employment / daytime activities to be able to live safely in the community.** | 4.0% (13) | 5.2% (17) | 4.3% (14) | 8.6% (28) | 7.7% (25) | 19.4% (63) | **50.6% (164)** | 5.72 | 324 |
| | | | | | | | **answered question** | | **324** |
| | | | | | | | **skipped question** | | **0** |

3. Please share any additional information you want us to know regarding your reasons for ranking any of the above as you did and regarding the CSB services you consider to be most important.

| | Response Count |
|---|---|
| Show replies | 192 |
| **answered question** | **192** |
| **skipped question** | **132** |

4. Is there any other information you wish to share with us?

| | Response Count |
|---|---|
| Show replies | 115 |
| **answered question** | **115** |
| **skipped question** | **209** |

| COMMUNITY SERVICES BOARD | Item: 10C | Type: Information | Date: 7/24/13 |
|---|---|---|---|

## Priority Guidelines Access to CSB Services

BACKGROUND:

Defining our priority populations is something the CSB has done repeatedly over the years to ensure consistency with state and federal codes and regulations, our state performance contract and block grant funding. Since this exercise has not formally been completed with our CSB Board since transformation was implemented, it was decided this was prudent to do at this time as a follow up to the staff presentations to the CSB by the service directors last winter/spring. Also, the CSB is constantly challenged by more requests for services than we have resources to provide; therefore, it is necessary to redefine and clarify our priority populations and services to ensure we are expending our staff and fiscal resources according to our mandates, regulations, performance contract, and funding sources.

The CSB Senior Leadership has led the effort to transform the CSB service system to one that is more flexible and responsive to people with multiple complex needs. However, resources are always limited and an increasing number of people are either on a waiting list or referred to the private sector. It is never our intent to deny anyone with a legitimate request to receive services at the CSB, however, the priority for service access is recommended to be individuals who are disabled by their mental illness, substance use and/or developmental disability. The attached document seeks to define those priority populations and to seek the support of the CSB Board to endorse these priorities in policy. This document is also requesting the CSB Board's support to engage Fairfax County leadership in planning for and funding any of those community needs that will not be regularly met by the existing CSB service system. It is recognized that these efforts will always be transparent to all and involve those we serve or intend to serve in the process.

*Additional Attachments*:

In 2008 the CSB solicited consultation and guidance from Michael Gillette, Ph.D., on ethical considerations in prioritizing and allocating services when confronted with scarce resources. Other CSBs did the same, including Alexandria. Dr. Gillette is a professional ethicist who has provided consultation to the ethics committees of our CSB, Alexandria CSB and other localities. Dr. Gillette's guidance was helpful in applying ethical principles in the Board's discussion and consideration of population and service priorities, especially when challenged with budget reduction proposals and requests for services exceeding available resources.

Included for your review and information are two documents from July 2008, the Development of Principles to Guide the Lines of Business Reduction Options Process for the Fairfax-Falls Church CSB and Proposed Principles for Selecting and Prioritizing Reduction Options, as well as two additional documents from the Alexandria CSB from April 2006, Policy Recommendations and Complete Guidelines for Assigning Priority in CSB Services at the Program Level. The Alexandria documents parallel the same consultation, processes and purposes undertaken in July 2008 by the Fairfax-Falls Church CSB, but are included because their content is more complete and comprehensive and may be more helpful to your review and understanding.

STAFF:

George Braunstein
Alan Wooten

# Guidelines for Assigning Priority Access to CSB Services

Six years ago, the Board of the Fairfax-Falls Church Community Services Board (CSB) worked with a health care ethicist to create guidelines that could be used to set priorities for service access when resources are scarce. Attached are those guidelines endorsed by the CSB Board at that time. The CSB Senior Leadership has recently developed a set of recommended definitions of those populations that would be defined as meeting the criteria defined as having the greatest need *(Inclusionary Criteria C)*.

Given the serious implications in establishing any guidelines, especially at a time of relatively scarce resources, the CSB staff is asking the CSB Board to establish a process to review the attached recommendations from Senior Leadership as well as the existing guidelines, responding to the three questions below

1) Will the CSB Board endorse these descriptions of our priority populations as defining those people who meet the criteria for "Need"?
2) Will the CSB Board endorse making this definition of "Need" as the highest priority for accessing services following "Prior Commitment"?
3) Will the CSB Board endorse that addressing the service needs of all those meeting the "Need" definition would be a priority over providing service access to those in other inclusionary categories?

# CSB Priority Population and Service Priorities

The CSB Senior Leadership has led the effort to transform the CSB service system to one that is more flexible and responsive to people with multiple complex needs. However, resources are always limited and an increasing number of people are either on a waiting list or referred to the private sector. It is never our intent to deny anyone with a legitimate request to receive services at the CSB, however, the priority for service access is recommended to be individuals who are disabled by their mental illness, substance use and/or developmental disability. This document seeks to define those priority populations and to seek the support of the CSB board to endorse these priorities in policy. This document is also requesting the CSB board's support to engage Fairfax County leadership in planning for and funding any of those community needs that will not be regularly met by the existing CSB service system. It is recognized that these efforts will always be transparent to all and involve those we serve or intend to serve in the process.

## PRIORITY POPULATIONS

The Fairfax-Falls Church Community Services Board (CSB) Service Leadership has identified the following Priority Service Populations based upon definitions from the Virginia Department of Behavioral Health and Developmental Services, the Federal Substance Abuse Prevention and Treatment Block Grant, and Part C of Individuals with Disabilities Education Act (IDEA).

Screening, wellness, health promotion and prevention, and acute and emergency CSB services are available for individuals who are not in these priority service areas. However, it is recommended that individuals must meet the Priority Service Population criteria below to also be eligible for non-emergency/non-acute CSB services.

Individuals may be in more than one Priority Population and receive services accordingly. Individuals who are only in one priority population receive the CSB services which address the needs of the population area they are in. So, for example, an individual in the substance use priority population *only,* is not also eligible for services designed for the Intellectual Disability population unless that individual is also in the Intellectual Disability population.

It is further recommended that individuals and families, who are able to secure services privately, must first seek those services before being considered for public CSB services; no matter what priority population they are in.

### A. MENTAL ILLNESS POPULATION

A1. Adults with **Serious Mental Illnesses** (SMI) assessed along the three dimensions of diagnosis, functional impairment, and duration.

- Diagnoses: Diagnoses of severe mental illnesses include diagnosis along the schizophrenia spectrum, predominantly thought and psychotic disorders, or persistent major affective disorders AND
- Impairments: Impairments on a recurrent or continuous basis that seriously impair functioning in the community to include one or more of the following:

  - Inability to consistently perform practical daily living tasks required for basic adult functioning in the community;
  - Persistent or recurrent failure to perform daily living tasks except with significant support of assistance by family, friends or relatives;
  - Inability to be consistently employed at a self-sustaining level or inability to consistently carry out homemaker roles; or
  - Inability to maintain a safe living situation.
- Duration: The duration of the serious mental illness is anticipated to be of a long duration and characterized by a chronic nature. It usually has or, if left untreated, is likely to result in repeated or significant psychiatric hospitalizations.

A2. Children and Adolescents birth through age 17 with **Serious Emotional Disturbance** (SED) resulting in a serious mental health problem that can be diagnosed under DSM and /or all of the following:
- Problems in personality development and social functioning which have been exhibited over at least one year's time.
- Problems which are significantly disabling based upon the social functioning of most children their age.
- Problems that have become more disabling over time and service needs that require significant intervention by more than one agency. Children with a co-occurring SA or ID diagnosis are also meet the criteria for SED

A3. Children, birth through age 7, who are **At Risk** of developing a *Serious Emotional Disturbance* by means of one of the following:
- Exhibit behavior that is significantly different from or maturity that is significantly behind most children their age, and which is not the result of developmental disabilities or intellectually disability.
- Have experienced physical or psychological stressors which put them at risk for serious emotional or behavioral problems.

**B. SUBSTANCE USE DISORDER POPULATION**

B1. Adults with a DSM diagnosis of a **Substance Dependence Disorder** (not including sole diagnosis of nicotine dependence) who also present with cognitive, behavioral and physiological symptoms and impairments as a result of substance use in one or more of the following areas:
- Continuation or intensification of substance-related symptoms despite previous substance abuse treatment interventions
- Inability to be consistently employed at a self-sustaining level or consistently carry out homemaker roles
- Inability to fulfill major role obligations at work, school or home
- Involvement with legal system as a result of substance use

- Involvement with the foster care system or child protective services as a result of substance use
- Multiple relapses after periods of abstinence or lack of periods of abstinence
- Inability to maintain family/social relationships due to substance use
- Inability to maintain stable housing (i.e. own housing or contributing toward housing costs in shared housing)
- Continued substance use despite significant consequences in key life areas (i.e., personal, employment, legal, family, etc.)
- Hospital or medical intervention as a result of substance use

B2. Children and adolescents (less than 18 years old) with a DSM diagnosis of substance abuse or dependence, who have used substances in the prior 12 months (or who have been in a controlled environment and used substances within the 12 months prior to entry); who present with cognitive, behavioral or physiological symptoms; and present with impairments as a result of substance use in one or more of the following areas:

- Continuation or intensification of substance-related symptoms despite previous substance abuse treatment interventions
- Inability to fulfill major role obligations at work, school or home
- Involvement with legal system as a result of substance use
- Multiple relapses after periods of abstinence or lack of periods of abstinence
- Inability to maintain family/social relationships due to substance use
- Continued substance use despite significant consequences in key life areas (, i.e., personal, employment, legal, family, etc.)
- Hospital or medical intervention as a result of substance use

B3. Special priority Populations (In order of priority)

1. Pregnant women who are IV drug users
2. Pregnant women
3. IV drug users

**C. INTELLECTUAL DISABILITY AND DEVELOPMENTAL DELAYS POPULATIONS**

C1. Infants and Toddlers: Children birth until the age of three years old who have a confirmed eligibility for Part C of Individuals with Disabilities Education Act (IDEA) and their families are eligible for early intervention services through Infant and Toddler Connection (ITC)

C2. Children and Adults: Children no younger than two years old and adults with a diagnosis of Intellectual Disability (ID) with onset prior to the age of 18 who have significant deficits in at least two areas of adaptive living skills (i.e. communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction functional academic skills, work leisure health and safety)

C3. Diagnosis of **Intellectual Disability (ID)** must be documented by:

- For children ages 2-6 years of age, a developmental evaluation with a diagnosis of developmental delay or intellectual disability **or**
- For individuals age 6 and older, a psychological evaluation completed prior to the age of 18 providing a diagnosis of intellectual disability with a full scale IQ of about 70 or below. In addition, an evaluation confirming the diagnosis of intellectual disability is required to have been completed within the past seven years.

# POLICY RECOMMENDATIONS FOR:
# Guidelines for Assigning Priority in CSB Services at the Program Level

Alexandria Community Services Board

## POLICY

Alexandria CSB is committed to providing services in a fair and consistent manner. Unfortunately, demand for services often outpaces supply of resources and there are times when difficult choices must be made regarding which consumers will receive the services in question. This policy is designed to guide staff in making priority judgments in the provision of service in an ethically defensible, understandable and consistently repeatable way so that all consumers will be treated ethically even in the face of scarcity.

## PROCEDURES

1. Alexandria CSB will make all reasonable efforts on a general level to maximize the availability of resources to its consumers. However, we do recognize that scarcity will exist across the agency and in specific program areas. This policy will only be invoked once reasonable efforts have been made to maximize resources and the efficiency with which they are delivered.
2. Alexandria CSB will place highest priority on the provision of services that are mandated by law, policy or contractual obligation. The process defined below applies only to the prioritization of non-mandated services or to the prioritization of services within a mandated function where scarcity exists.

3. EXCLUSIONARY CRITERIA

   When a shortage exists, it is first necessary to determine the limits of the group of individuals who may be ruled-in for further consideration. There are two general classes of potential recipients who can be ruled-out for services on the basis of broad exclusionary criteria.

   A. Constituency: ACSB shall restrict itself to serving Alexandria residents (as defined by existing law and policy) and those others who have a specific claim on ACSB services based on contractual arrangements entered into by ACSB or the Alexandria City Government.
   B. Inappropriate Requests: ACSB shall refuse to provide services that it is not designed, mandated or funded to supply.

4. INCLUSIONARY CRITERIA

   Once the broad categories of eligible clients have been defined, if an excess of demand still exists, then the following criteria shall be applied to prioritize access. These criteria should be applied in order, so that movement down the list will only take place when all potential recipients who satisfy higher level priorities have been served. These criteria should be applied within each program until either all potential recipients are served or resources are no longer available.

A. Prior Commitment: Currently enrolled consumers who continue actively to satisfy the terms of their appropriate treatment plans and maintain program eligibility should remain enrolled even if new potential consumers present with equal or greater need. This commitment to existing clients does not supersede any other policies regarding discontinuation of services. If clients fail to meet financial or programmatic expectations, they may still be discharged according to existing agency policy.
B. Alternative Resources: Once all consumers who satisfy the previous criterion have been served, if additional resources are available, they shall be allocated to individuals who do not have alternative sources of service. A client who refuses to access private insurance or other funding options **shall not** be considered to lack alternatives, and shall not receive priority under this criterion.
C. Need: Once all consumers who satisfy the previous criterion have been served, if additional resources are available, they shall be allocated to individuals with serious and imminent needs. Need must be understood to include the risk of harm associated with a failure to access services. Staff should consider only need of a serious, emergent type such that failure to meet the needs will, imminently and with high probability, result in A) loss of basic physiological function, B) exposure to life and/or safety risks, C) failure to meet basic developmental needs, or D) imminent degeneration of condition that will lead to one of risks A-C.
D. Efficiency: Once all consumers who satisfy the previous criterion have been served, if additional resources are available, they shall be allocated to individuals who can be served efficiently and whose enrollment in a program may generate opportunities for greater delivery of services to others. Efficiency should be understood to include not only serving the maximum number of individuals, but also a cost-benefit analysis of the services under consideration.
E. Effectiveness: Once all consumers who satisfy the previous criterion have been served, if additional resources are available, they shall be allocated to individuals who show the greatest likelihood of maximally benefiting from receipt of services.
F. Comparative Need: Once all consumers who satisfy the previous criterion have been served, if additional resources are available, they shall be allocated to individuals who have been rank ordered based upon their degree of need in areas such as social functioning, higher cognitive development and employment success. Needs of these types should be distinguished from the more serious and imminent needs addressed above.
G. Random Selection: Once all consumers who satisfy the previous criterion have been served, if additional resources are available, they shall be allocated to individuals on a first-come-first served basis.

# Development of Principles to Guide the Line of Business Reduction Options Process for the Fairfax-Falls Church CSB

July 21, 2008 Edition

*(Including recommendations from CSB Committees and Staff* ***in italics****)*

In accordance with the process adopted by the CSB Board on June 25, 2008, the month of July will be used to develop and eventually approve a set of principles that will guide the development of a prioritized list of reduction options for FY 2010 which must total $16.2 million as directed by Fairfax County. Action by the CSB Board is scheduled for July 30.

In developing these principles, we must keep in mind the following requirements.

- The FY 2008 Lines of Business as published by the County will serve as the initial point of reference. *(see http://www.fairfaxcounty.gov/dmb/lobs/2008/106.pdf)*
- Reductions must relate to a line of business or a portion of a line of business that is currently funded taking into consideration the 4% reduction imposed for FY 2009.
- Reductions must be ongoing.
- Each reduction option will be categorized as one of the following: Mission Critical, Mission Essential, Mission Impaired, or Mission Non-Essential.
- Each reduction option will be classified as: Efficiency or Cost Savings, Reduced Level of Service, or Elimination of Program.
- Relationship to County Vision Elements and the Board of Supervisors Priorities will be shown.

## Conceptual Framework

For several years, the CSB has benefited from the expertise of Michael Gillette, Ph.D. who has served as a consultant to our Ethics Committee and has periodically provided valuable training to our staff. On May 30, 2008, he conducted our Annual Ethics Seminar with the topic "Ethical Prioritization and Allocation of Scarce Resources." *(A copy of the materials used at the seminar is available on the CSB website at www.fairfaxcounty.gov/csb/announcements/publications/csbethicspres.pdf)*. Dr. Gillette's materials are based both on his familiarity with scholarly writing on this topic and on his consultation with CSBs in Virginia.

Here is a very brief summary of some of the related concepts and principles as presented by Dr. Gillette in the seminar referenced above.

The Process of Rationing

1. A fair approach to rationing is one that seeks to maximize benefit to the least advantaged member of the group.
2. Once minimum standards are met for everyone, additional resources should be used to improve the situation of those who are least advantaged.

What Ethical Leaders Do

- Identify default obligations
- Recognize distinct obligations across individuals, disciplines and departments
- Prioritize conflicting obligations
- Support valid processes

Inclusionary Criteria (in numerical order)

1. Most serious needs (e.g. loss of basic physiological functions, exposure to life and safety risks, failure to meet basic developmental needs, or degeneration of condition that will lead to greater risk of previously mentioned condition)
2. Efficiency
3. Effectiveness
4. Comparative need

Other Criteria to be applied on an individual basis:

- Exclusionary
  - Person does not reside in the service area
  - Service requested is inconsistent with the agency's mission or the service is simply not designed to meet a particular need.
- Inclusionary
  - Persons currently enrolled in treatment who satisfy the terms of their treatment plan should remain enrolled even if new potential consumers present with equal or greater need.

## Proposed Principles for Selecting and Prioritizing Reduction Options

(including recommendations from CSB Committees and Staff ***in italics***)

The following principles are proposed for adoption by the CSB Board in developing the Line of Business Reduction Options as required by Fairfax County. (Based in part on Default Assumptions: CSB Obligations on slides A15–20 of Dr. Gillette)

1. Maintain capacity to meet all mandates:
   A. Federal
   B. State Code
   C. DMHMRSAS Performance Contract
      - *Meet State Mandates (FFICC)*
      - *Meet Applicable Federal and State Mandates, State Performance Contract (Pregnant Women; IV Drug Users; Comprehensive Services Act for Children; Collaboration with DFS, Hospitals, Physicians; Prevention Services; Case Management Services; Treatment in Lieu of Incarceration; Services for First Time Drug Offenders) (SA Comm.)*
      - *Ensuring Consumer Health and* Safety *(Emergency Services for people in crisis (Case Management) (ID Comm.)*
      - *Honoring Mandates Commonwealth of Virginia (DMHMRSAS; Eligibility determination for people requesting services - Case Management; Admission and discharge planning for people living in State Facilities (Case Management) (ID Comm.)*
      - *Meet State Mandates (SAPT Block Grant, Synar/Youth Tobacco Use Prevention, State Performance Contract) (Prev.)*
      - *To the greatest extent possible, DMHMRSAS Performance Contract regulations as outlined in the following components of the Contract must be adhered to: Partnership agreement, Joint DMHMRSAS and CSB requirements, DMHMRSAS general requirements of CSBs, Federal general requirements of CSBs, Regional programs (CSU)*
   D. *Assure Compliance with Grant and Contract Requirements (VTSF- Grant and Contract, SAPT) (Prev.)*

2. Maintain ability to maximize *non-County/City resources* and to fulfill all oversight and reporting requirements
   - *Maintain Alternative Resources (FFICC)*
   - *Program Success and Cost Effectiveness (Impact on Revenue Generation) (SA Comm.)*
   - *Availability of Alternate Resources (Insurance, Private Programs, Other Public Programs, Non-profit Organizations) (SA Comm.)*
   - *Protecting Non-County Resources Medicaid (Case Management, Directly Operated and Contracted Residential Services, Contracted Day Services); Vocational Rehabilitation (Directly Operated and contracted Day Services); City of Falls Church; Fairfax City*
   - *Preserve Revenue-Producing Services (LRP Replication Training) (Prev.)*

3. Preserve essential Interagency agreements and services as specified in State Code or County agreements and expectations
   - *Preserve Interagency Agreements and Partnerships (FFICC)*
   - *Impact on Business Partners (Department of Family Services, Department of Probation and Parole, Fairfax County Office of the Sheriff, Alcohol Safety Action Program (ASAP), Courts, Community Agencies and Organizations) (SA Comm.)*
   - *Prioritize Need (Countywide Prevention Goal Areas, CSB Prevention Plan Priorities) (Prev.)*
   - *Preserve Interagency Agreements and Partnerships (FCPS, FCCPS, ACT Program Partners, VTSF Partners) (Prev.)*

4. Distribute resources to the highest priority functions needed to maintain a consumer and family focused comprehensive *array of services*
   - *Preserve the Continuum of Substance Abuse Services (Prevention Services, Outpatient Services, Day treatment Services, Residential Services) (SA Comm.)*
   - *Preserving Service Availability - Preserve an array of effective and efficient services and partnerships (public and private)*
     - *Effectiveness = maximizing individual outcomes*
     - *Efficiency = serving the maximum number of individuals while being attentive to cost-benefit analysis (ID Comm.)*

5. Continue Transformation Initiatives to the maximum extent possible
   - *Preserve those services that embody the elements of the Department's vision. (MH Comm.)*

6. Use the following criteria to address conflicting priorities:
   A. Most serious needs (e.g. loss of basic physiological functions, exposure to life and safety risks, failure to meet basic developmental needs, or degeneration of condition that will lead to greater risk of previously mentioned condition)
      - *Emphasize services for people most in need. (MH Comm.)*
      - *Level of Risk to Client (Life, Health, Safety or Worsening illness) (SA Comm.)*
      - *Ensuring Consumer Health and* Safety (*Residential housing and supports to keep people from being homeless - Directly Operated and Contracted Residential Services) (ID Comm.)*
      - *Ensuring Consumer Health and Safety (Maintain essential services to prevent family instability and risk of abuse and neglect) (ID Comm.)*

   B. Efficiency
      - *When equal or better outcomes can be achieved at a lesser cost by private providers, shift resources. (MH Comm.)*
      - *Look for innovative solutions when that can replace cuts in services. (MH Comm.)*
      - *Maximize Service Efficiency (FFICC)*

   C. Effectiveness

- *Using evidence based practices to make decisions about treatment options including medications. (MH Comm.)*
- *Looking at support groups and other types of groups. (MH Comm.)*
- *Choosing community based services over facility based services when appropriate. Look at providing the same intensity of services in a non-residential setting for programs that we may be planning that are residential. (MH Comm.)*
- *Maximize Service Effectiveness (FFICC)*
- *Prioritize Need (FFICC)*
- *Program Success and Cost Effectiveness (Best Practice Models, Program Outcomes, Program Sustainability, Program Utilization, Duplication of Services) (SA Comm.)*
- *Cost Effectiveness/ Impact of Potential Reductions on Physical Facilities and/or Leases (County Buildings, Long Term Leases) (SA Comm.)*
- *Effectiveness (Evidence-Based Programs and Practices, Program Outcomes, Utilization, Program Sustainability) (Prev.)*

D. Comparative Need
- *Level of Risk to Client (Comparative need) (SA Comm.)*
- *Prioritize Need (Consider populations most benefiting from prevention services) (Prev.)*

E. *Special populations (e.g. co-occurring disorders, deaf, non-English proficient, HIV+, homeless)*
- *Prevent Homelessness (FFICC)*
- *Consider Special Needs (Individuals with additional disabilities, Non-English Speaking) (SA Comm.)*
- *Impact on Persons with Co-occurring Disorders (Programs who rely on ADS Service to ensure provision of comprehensive co-occurring services; Joint Programming; Clients who Receive Services in Multiple Programs) (SA Comm.)*

F. *Difficult to Reinstitute Programming if Funding is Restored (Building and Space Allocation, Configuration and Co-location; Budget Implications; NIMBY) SA Comm.)*

Associated principles proposed for use in <u>implementing</u> reductions if necessary.

1. *Preserve treatment options for people currently in treatment when loss of treatment would cause relapse or negative consequences. (MH Comm.)*
2. *Encourage and support natural supports. (MH Comm.)*
3. *Maximize participation of consumers in all decisions of services they receive. (MH Comm.)*
4. *Preserving Service Availability (Maintain service to existing participants) (ID Comm.)*
5. *Preserving Service Availability (Minimize waiting lists for services) (ID Comm.)*
6. *Property maintenance and renovations/rehab decisions must be evaluated in terms of a positive long-term return on investment and/or the preservation of affordable housing stock for consumers. (CSU)*

7. *Information Management decisions must be evaluated in terms of positive return on investment for the whole CSB. (CSU)*
8. *Worn or broken equipment and furnishings for CSB properties must be replaced in a timely manner. (CSU)*
9. *Telecommunication service plans should be evaluated at least annually to ensure the least amount of cost for the greatest benefits. (CSU)*
10. *'Train-the-trainer' return on investment should always be considered when evaluating the cost of training. (CSU)*
11. *Grantsmanship skill-building should be encouraged*. (CSU)

# COMPLETE DISCUSSION OF:
# Guidelines for Assigning Priority in CSB Services at the Program Level

A Recommendation from the
Alexandria Community Services Board Ethics Committee

## INTRODUCTION

Alexandria CSB was recently asked by the local governing body to develop a method by which priority judgments could be made in allocating resources for community based supports. This discussion presumes that a true shortage of resources exists, and that the need for prioritization is based on the assumption that some individuals will either receive a less than optimal level of service, or they will be refused services entirely until increases in funding are obtained. The ACSB Ethics Committee was asked to analyze this issue and generate recommendations. This document is a recommendation only, from the Ethics Committee, and it is based on an analysis of the ethical issues involved. We recognize that other factors may also contribute to a full discussion of this issue, but the Ethics Committee has restricted its recommendations to the moral aspects of the problem.

We recognize that the allocation of scarce resources can be discussed at two distinct levels: macro-allocation and micro-allocation. Macro-allocation involves a system-wide and society-wide analysis of which programs will be funded and to what degree. In making these types of allocation decisions, society in general as well as the local governing body and the Community Services Board must decide the relative support that will be granted to all possible recipients of public resources. We certainly recognize that ethical issues arise at this level. Ethical decisions are made when the Federal Government chooses funding levels for national security versus transportation infrastructure. Local governing bodies make similar choices when they set funding levels for the educational system versus public safety services. Likewise, the Community Services Board must prioritize its support for mental health, mental retardation, substance abuse treatment and prevention services. Although, in an environment of scarcity, funding any one area of any budget necessarily requires reductions in other areas of that budget, we believe that these ethical concerns fall outside of the scope of this document.

For present purposes, the Ethics Committee has restricted the recommendations in this document to the process of micro-allocation. We are concerned with the process by which specific choices are made in the prioritization of services to specific individuals within the categories that appropriate authorities have already chosen to fund at particular levels. We believe that although conversation of the ethical issues involved in macro-allocation would be useful, our current task is to assist staff members in making difficult choices within the environment that actually exists. That environment includes

limitations on resources that occur because of the value judgments already made at higher and more general levels of authority.

Prior to developing a specific mechanism for the allocation of scarce resources, three assumptions should be made clear. First, we recommend that discussions of this type are only ethically justifiable in the environment of scarcity. If sufficient resources were available to meet the needs of appropriate clients, then no need would exist for limiting access. If resources can be generated by increasing efficiency, then our first obligation is to take necessary steps to improve the way resources are used. We assume in this discussion that all reasonable efforts are being made both to increase existing funding streams or secure new ones, and to maximize the efficiency with which those funds are utilized.

The second assumption that should be made clear is that the CSB exists as an organization that is designed to meet the needs of those individuals within a geographic area who present with mental health, mental retardation or substance abuse needs. We recognize that the CSB exists to provide only certain types of services and that it does not have an obligation to provide whatever services might help individuals if those services lie outside of the mission of the agency. We also believe that the CSB exists to provide a final safety net for appropriate clients. On this basis, the CSB maintains a commitment to providing services to those in greatest need.

Third, we recognize that certain functions are mandated by law, policy or contractual obligation. We believe that it is ethically appropriate for the CSB to satisfy its mandated and contractual obligations first, prior to applying the algorithm described herein. It is possible, however, that scarcity may develop within a mandated program, in which case these guidelines could serve to prioritize services within that program.

By carefully examining the mission, values and goals of service for the CSB, the Ethics Committee recommends that a two step procedure should be utilized in making allocation decisions. The first step is to make broad distinctions to serve as exclusionary criteria based on the goals of the agency. In other words, there will be many people who can be ruled out for services based on general conditions. By engaging in this effort first, we can reduce the pool of individuals whose situations will have to be examined in greater detail to support priority judgments. After exclusionary criteria have been applied, a group of eligible individuals will most likely remain that is larger than the available supply of resources. At that point, we recommend that a series of inclusionary criteria be applied to develop a rank-ordered priority for individuals served. We recommend that the CSB should do everything within its power to move as far down the list of ordered potential recipients as possible. Ultimately, however, the exact point at which resources run out, and therefore the level on the priority list at which the CSB must begin to refuse services, will be contingent on the available resources and may vary from year-to-year.

By producing this two-staged approach, we believe that the CSB can best target the appropriate group of potential recipients, and clearly communicate the rationale for micro-economic choices between specific individuals. This state of affairs has three

advantages. First, it will allow the CSB to make rational and ethically based decisions for its clients thus ensuring a fair and consistent basis for resource allocation. Second, it will enable the CSB to explain to clients the fair and consistent manner in which resource allocation decisions are made. Third, it will enable the CSB to communicate to the local governing body and funding sources just what specific funding level adjustments will do for specific groups of individual consumers.

STEP ONE: EXCLUSIONARY CRITERIA

We recommend that there are two general classes of potential recipients who can be ruled out for services on the basis of broad exclusionary criteria. Those criteria are Constituency and Inappropriate Requests.

C. Constituency: ACSB exists as an agency within a specific geographic and political location that is designed to meet the needs of individuals who reside in that area. While it may be appropriate to enter into cooperative regional efforts with neighboring CSBs and thereby extend constituency claims in specific ways, services should otherwise be restricted to those individuals who are residents of Alexandria. We do not believe that it is appropriate for the CSB to define who is a resident of Alexandria. We recommend only that, consistent with existing legal definitions, ACSB may ethically restrict itself to serving only those individuals who are defined by local, State and Federal law as appropriate constituents of the Alexandria local government.
D. Inappropriate Requests: Some individuals may request services that the CSB is simply not designed, mandated or funded to satisfy. We recommend that the CSB must clearly define what it does, and that it is ethical to refuse to provide services that are inconsistent with its mission. (For example, Alexandria CSB does not provide brain injury services and it may reasonably continue to limit the scope of services to the specific areas within its mission. Reasonable effort should be made to communicate with the public about what ACSB is committed to provide.)

STEP TWO: INCLUSIONARY CRITERIA

Once the broad categories of eligible clients have been defined, there is still likely to be an excess of demand. A series of additional criteria should then be applied to prioritize access. The CSB should attempt to move as far down this list as possible. We recommend that the exact location at which the CSB refuses further service is based solely on resource availability. In other words, once clients qualifying under the first priority are served, additional resources should be used for those who satisfy priority two. If resources remain after satisfying their needs, the CSB should then move on to satisfying consumers who are described by priority three. This process will continue until resources are exhausted. At that point, the CSB will have a clear and communicable understanding of the services that will not be provided if additional resources are not made available.

1) Prior Commitment: Currently enrolled consumers who continue actively to satisfy the terms of their appropriate treatment plans and maintain program eligibility should remain enrolled even if new potential consumers present with equal or greater need. We do not believe that active clients should have their services withdrawn if the services that have been initiated continue to be indicated.
2) Alternative Resources: We recommend that ACSB has a clearly defined role to provide a continuum of care in Mental Health, Mental Retardation and Substance Abuse Services. We exist in many ways as a safety net provider and we believe that one of our

fundamental roles is to assist those individuals who are unable to find alternative services. This does not mean that it would be wrong to replicate services that are offered elsewhere if those services are a reasonable component of CSB work, and it does not mean that our services should be considered free. It implies only that the CSB has a special obligation to help individuals who ***need*** to be helped. Individuals who can access services elsewhere do not actually need our services. Therefore, we recommend that such individuals may ethically be considered as lower priority in the face of scarcity and may be excluded from further consideration. (For example, an 18-year-old student with MR is eligible to receive services through the school system until age 21. His choice to leave school does not, we recommend, create an ethical obligation on the CSB's part to provide services. Other clients who have no other options should be considered first.)

3) Need: We recommend that those individuals with serious and imminent needs should be given priority. Need must be understood to include the risk of harm associated with a failure to access services. When assessing need, all efforts should be made to identify those individuals who will, with high degrees of probability, suffer serious and imminent risk to life or irreversible harm. Clearly, many individuals will present with a variety of needs. At this point in the process, however we consider only those individuals whose need is of a serious, emergent type such that failure to meet their needs will likely result in A) loss of basic physiological function, B) exposure to life and/or safety risks, C) failure to meet basic developmental needs, or D) imminent degeneration of condition that will lead to one of risks A-C. These individuals should be given priority at this step in the allocation process.
4) Efficiency: Once those with serious and imminent needs have been served, assuming that additional resources remain for allocation, the CSB should recognize its duty to attempt to serve as many individuals as possible. Therefore, efficiency now becomes a relevant factor. The CSB should, at this point, rank possible allocation schemes in order to maximize efficiency. Efficiency should be understood to include not only serving the maximum number of individuals, but also a cost-benefit analysis. If revenues can be generated by serving some clients, those new revenues can then be used to extend the scope of service. These types of efficiency calculations are morally acceptable after we have served those already in the system and those with serious and imminent risks.
5) Effectiveness: Once we have maximized efficiency, if resources continue to be available, priority may then be placed on individuals who show the greatest likelihood of maximally benefiting from receipt of services. While the concept of efficiency is applied across a group of individuals, the concept of effectiveness is applied to specific individuals and indicates a desire to maximize the outcome for the targeted individuals.
6) Comparative Need: Once basic needs have been met and efficiency and effectiveness achieved, attention may then shift to a comparative analysis of lesser needs. At this point in the allocation process, individuals should be rank ordered based upon their degree of need in areas such as social functioning, higher cognitive development and employment success. Needs of these types should be distinguished from the more serious and imminent needs addressed above, although we in no way mean to indicate that this level of need is unimportant.
7) Random Selection: Once the above delineated criteria have been applied, it is plausible to argue that any remaining claims on services are of relatively equal urgency and efficiency. Recognition of this fact generates an assumption that all additional claims are of equal value and should be treated equally. It is then ethically permissible to allocate any remaining resources on the basis of random selection. We recommend that a first-come-first served selection model is ethically acceptable at this point.

CONCLUSION

There is no question that the topic of this document is ethically and emotionally difficult. If scarcity did not exist, none of the priority judgments discussed here would be necessary. Nevertheless, scarcity is a reality that is not likely to abate in the foreseeable future. We believe that ACSB and its supporting local officials have an ethical obligation to make allocation decisions in a rational way that can be communicated clearly to the individuals involved. We believe that saying 'no' is ethically justified in the face of scarcity, but that the people who are told 'no' have a right to know why they have been refused support. This document is an attempt to create a fair and understandable system for determining not only when we say 'no' but why, to others, we say 'yes'.

This report is a recommendation only and it is based on an analysis of the ethical issues involved. If further discussion or explanation would be useful, the Ethics Committee is available.

This report was written by Michael A. Gillette, Ph.D. and is based on the consensus opinion of the Alexandria CSB Ethics Committee.