Report to the Virginia Department of Social Services

Workforce and Other Factors Impeding Implementation and Sustainment of FFPSA Evidence-Based Programs: A Study of Obstacles and Opportunities

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Section 1

Needs Assessment Gaps Analysis, Year in Review

The Center for Evidence-Based Partnerships in Virginia (hereafter, CEP-Va) set out to help address questions posed by our Virginia Department of Social Services (VDSS) partners regarding the needs of families they serve and where in Virginia specific services could be implemented to better strengthen families. VDSS's plan to help enhance the state's behavioral health service array is made possible by the Family First Prevention Services Act, passed in 2018 to permit new allocations of Title IV-E spending towards evidence-based service programming. In 2021, CEP-Va developed the Needs Assessment Gaps Analysis (NAGA) approach to assess and monitor mental health needs and service gaps within and across VDSS's five regions.

The first report that featured NAGA was submitted to VDSS partners in October 2021. In it, a series of recommendations were presented in menu format. The recommendations that VDSS selected from that first report comprised of the activities conducted throughout 2022 and reviewed herein.

Approach: A Continuous Assessment of Needs

The NAGA approach is one tool used by CEP-Va to guide VDSS and the state in their effort to implement an optimal array of evidence-based services for families in Virginia's Family First Prevention Plan (FFPP). Needs assessments, in essence, aim to assess the needs of a community that remain unremedied by the services and systems currently in place, and are typically conducted at one point or predestined points in time through use of survey and/or community partner interviews. Typically, the end goal is to introduce a new service that if implemented would fill a gap in the service landscape and theoretically ameliorate perceived needs shared by a community.

NAGA differs from the typical needs assessment approach in that it is designed as an ongoing process of data collection, serving both:

a. to fulfill specific VDSS requests (e.g., expand services)
b. to detect (and initiate investigation of) contextual barriers known to undermine such large-scale efforts

To accomplish these aims, CEP-Va constructed a developmental sequence of investigatory phases, where each phase provides data to inform the next. As such, the study sequence is not predetermined and fixed. This is because communities are dynamic and multifaceted, and the outward expressions of communities' needs change, as does collective interpretation. Therefore, CEP-Va approaches assessment at the state level in an adaptive manner, shifting to real-time data to assess geographical and conceptual variations in addition to multilevel change over time.

Developmental Sequence

NAGA is referred to as an approach to study design and recommendation generation for Center partners. Each phase of NAGA contains a series of studies, projects, or products that share the

common aim of supporting long term implementation success of evidence-based programs (EBP) in Virginia. NAGA phases and the studies they include represent a combination of partner requests, such as in the case of public-facing events and outreach, or Center generated lines of inquiry driven by evidence. All studies, regardless of phase, produce findings to assist state leaders in sustaining EBPs years after their initial adoption.

NAGA 1.0. The first phase of NAGA included six individual projects, each designed to identify baseline behavioral health *needs* of families that prevent child safety in the home. Needs include specific mental health concerns, or descriptions of behaviors that are observed to be disruptive to family wellbeing, such as excessive drug use or exposure to violence. Quantitative and qualitative data for analyses were collected from up to approximately 478 participants over eight months in 2021. Detailed findings led to the identification of several service gaps across VDSS regions, as well as crucial considerations for successful implementation of EBPs in Virginia.

Evidence-based practice = a clinical approach that includes therapeutic strategies that have been tested in past research studies and used with patients according to clinician's judgement

Evidence-based programs = manualized treatment packages that have been shown to work in research trials when delivered close to exactly the way they were developed

Evidence-based services = a broad umbrella term for which programs exist underneath, referring the all the service components (ex., evidence-based programs, case coordination) that together contribute to a family receiving high-quality treatment

A set of recommendations were formulated, consisting of potential areas for further investigation or evidence-informed actions to prepare the state for EBP training rollout. Our funding partners at VDSS chose which of the steps to pursue for the following year to support training efforts. Each recommendation was written to convey a goal of subsequent projects or initiatives to be developed and executed by CEP-Va. Out of the ten NAGA 1.0 recommendations proposed, our VDSS partners selected:

1. Work to supplement Community Service Board (CSB) service arrays with Family First funding (i.e., Support System Transformation Excellence and Performance [STEP-VA] efforts)
2. Implement well-supported EBP from Clearinghouse to provide service options for school age children (i.e., Implement EBP for school-aged children)
3. Strengthen Local Department of Social Services (LDSS) engagement with families through frontline personnel training in Motivational interviewing (MI) (i.e., Train LDSS personnel in MI)

Projects vs. Studies. Each NAGA 1.0 recommendation spurred the design and execution of three separate projects that remain ongoing as of February 2023. Descriptions of these projects and updates on their progress are included in this report. See Table 1a for visual explanation of how a selected NAGA 1.0 recommendation initiated a project. Unexpected findings that emerge during the course of a project can initiate a study. In other words, a *NAGA-indicated Study* forms when CEP-Va researchers detect a barrier that has been demonstrated historically and

empirically to derail similar efforts. Initial findings of study produce their own set of recommendations, separate from the ones that follow a project.

Table 1a. NAGA System 2021-2022

NAGA 1.0 Recommendation	NAGA 2.0 Projects	NAGA-Indicated Studies
Support STEP-VA efforts	Project 1: CSB Investment Initiative	PCIT-Va Pilot Study
Implement EBP for school-aged children	Project 2: Title IV-E Prevention Services Training Awards	Regulation Study, Phase I
Train LDSS personnel in MI	Project 3: MI Training Project	None indicated

Status as an official project requires input from our state partners. Studies are triggered by CEP-Va but whether CEP-Va continues down a line of inquiry indicated by a study is determined by state leaders' selection decisions. The NAGA system was designed in this way because Center partners play an integral role in CEP-Va's work related to Family First. See Table 1b for how the NAGA model will progress into 2023 after recommendations from this report are reviewed and subsequently selected.

Table 1b. NAGA System 2022-2023

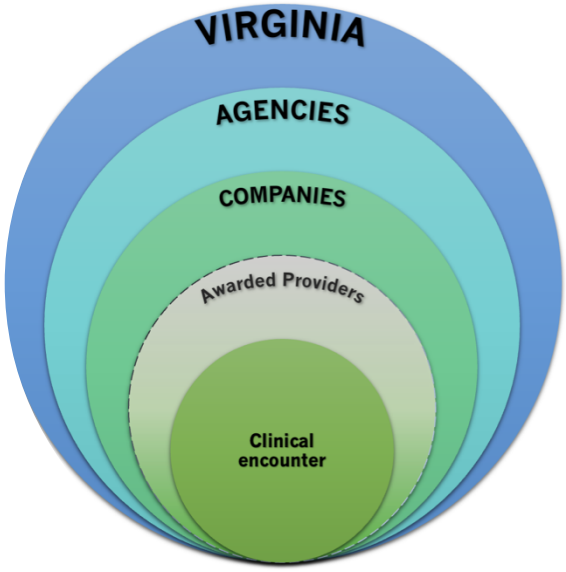
NAGA 2.0 Projects	NAGA-Indicated Studies	NAGA 2.0 Recommendation	NAGA 3.0 Project Examples
Project 1: CSB Investment Initiative	PCIT-Va Study	*Recommendation(s) selected by funders*	PCIT-Va Pilot Project…
Project 2: Title IV-E Prevention Services Training Awards	Regulation Study	*Recommendation(s) selected by funders*	Title IV-E Prevention Services Training Awards; Regulation Project…
Project 3: MI Training Project	None indicated	N/a	N/a

Conceptual Model

It is understood to be CEP-Va's responsibility to draw funders' attention to factors that have the potential to disrupt VDSS' vision for Family First. Certain factors will require investigation outside of VDSS's immediate domain of child welfare and include other domains in which families are represented. This is due to the nature of Family First, as the Act was designed to depend on the calibration of all child-serving, -facing, and -placing entities within one state context. **Attention to all contributing drivers of implementation success and failure is imperative to expect the type of outcomes any *one* agency attempts to reach alone.** Figure 1 illustrates this important aspect of interdependency that underlines NAGA's design to prevent misapplication of Family First funds.

Systems interdependency and the value of context was built into the NAGA model. Interrelated relationships exist amongst state and local governmental agencies, service provider companies, and the families they serve. This means that state *agencies*, such as VDSS, are impacted by Virginia law. Agencies contribute to the legal parameters in which provider companies are responsible for working within to serve families. *Awarded Providers*, public or private companies in receipt of Family First funding to deliver an EBP, live and are shaped within the context of fellow providers to hire and support practitioners to treat families. The clinical encounter represents the junction where an identified family and practitioner meet. What happens in a clinical encounter at any given time can be viewed as an end product of all of the circles depicted in Figure 1 and their impact compounded over time.

Figure 1. NAGA Conceptual Model



PROJECT 1: CSB INVESTMENT INITIATIVE

Rationale

CSBs represent the state's primary access point for behavioral health services for many Virginians, including those with Medicaid and those without insurance coverage. In 2017, new legislation increased the number of services that CSBs are mandated to provide. Then in 2019, state law mandated same day access to screening services. Most CSBs contract with private providers to deliver services required by state law.

VDSS chose to prioritize CSBs and their community partnerships with private providers in the allocation of Title IV-E funds as part of a cross-agency approach to expanding services. Many CSBs cover several localities within their service area (e.g., Horizon), and some CSBs are only responsible for servicing one locality (e.g., Norfolk). Because of the large geographical areas of some, CSBs in rural communities are responsible for two times the number of individuals than CSBs in urban areas.[1]

For the purposes of Title IV-E funding, CSBs provide a natural grouping variable for tracking potential service gaps. Successful adoption and implementation of any service is influenced by the way in which information is transmitted to and by local key players. How agency-specific funding is coordinated at the local level depends upon general awareness of what services are available in an area. CSBs (and their contracted providers) are tasked with offering a service to all of the localities within their coverage area, versus only to a partial selection of localities like many smaller private companies, and they were designed to represent the single point of entry to services for local communities.

Method

CEP-Va sought to prioritize outreach to CSBs according to need, and where to begin required selection of some measure to guide Center efforts and outreach. *Benchmarking* is the practice of using a reference point by which data can be compared over time. Any relevant variable can be used as a reference point, or *benchmark*, as the goal is not to prove cause and effect like in a research study but to guide outreach efforts when capacity and information are limited. CSBs, and connected providers within a CSB's catchment area, were ranked according to the benchmark measure and those at the top were prioritized in Center outreach efforts in 2022.

In the NAGA 1.0 Report (2021), ***foster care entry rate*** was used as a distal outcome variable due to its potential sensitivity to the roles that multiple agencies play in ensuring families receive timely care to prevent out-of-home placement. In alignment with the Family First prevention frame, multiple events that involve multiple individuals are believed to occur before a family meets the threshold for maltreatment. Thus, every child-serving partner, public and private, can participate in preventing such events from happening. See Figure 2a-b for the original and then an updated heat map of this rate across the state.

[1] 2022 CSB Behavioral Health Services Commission Draft, JLARC

Figure 2a. Foster care entry rate 2009-2019

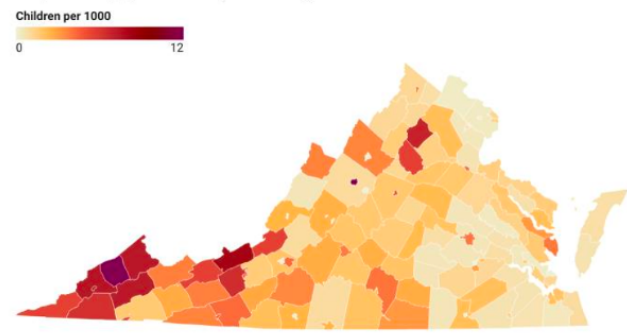
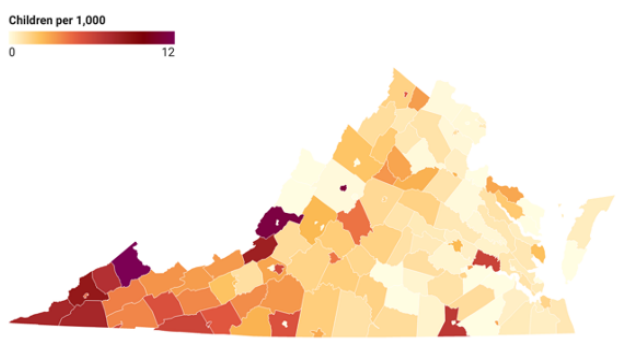


Figure 2b. Foster care entry rate 2021-2022



The CSBs prioritized in 2022 are presented in Table 2 along with change metrics. As depicted in Figure 2a-b, the green and red colored cells represent change from a 10-year average (2009-2019) of CSB-area foster care entry rates to the most recent year. For example, Dickenson CSB exhibited a 10-year average entry rate of 11.95 (not included in Table 2), which dropped to 7.04 last year. This improvement means around 16 fewer children entered care last year than the typical amount (approximately 35 children, see NAGA 1.0 Report) living in the Dickenson CSB catchment area. CSBs listed in Table 2 were selected using the state average as the threshold cutoff. These 13 CSBs combined account for **47%** of the total number of foster care entries in the state for that ten-year period.

Table 2. NAGA 1.0 Top Priority CSB List

CSB/Behavioral Health Authority (BHA)	2021-2022 Entry Rate	2021-2022 Child Count	Change from NAGA 1.0*	Change in Child Count from 1.0*
Dickenson	7.04	19	-4.91	-16
PD 1	7.05	125	+0.25	+12
Cumberland	6.52	90	+0.39	+8
Valley	5.67	56	+0.13	+14
New River Valley	2.50	57	-2.50	-52
Mount Rogers	4.90	106	+0.76	+21
Richmond	2.44	96	-1.52	-64
Highlands	4.86	57	+1.09	+19
Harrisonburg-Rock.	2.11	38	-1.53	-29
Rapp-Rapidan	1.54	48	-2.04	-41
Blue Ridge	4.51	198	+1.32	+53
Piedmont	3.79	95	+1.06	+25
Horizon	2.14	124	-0.46	-21

**NAGA 1.0 Benchmark = average annual rate of foster care entry from 2009-2019, to avoid atypical reporting during COVID-19.*

Foster care entry: the rate in which children referred to Child Protective Services (CPS) enter the foster care system.

To prevent localities with higher child population density from rising to the top of the list due to volume alone, foster care entry is examined as a rate, i.e., the number of children per 1,000 children in each locality's child population.

Note: Foster care entry rate is not a measure expected to change easily or quickly, nor should it ever be a measure used to diagnose the current actions or intentions of a locality.

Project Impact & Findings

As of February 2023, Family First funding was accepted by **5** of the 13 Top Priority CSBs listed in Table 2: New River Valley, Richmond BHA, Blue Ridge, Piedmont, and Horizon. Two FFT teams and two PCIT programs were supported through Title IV-E, and the fifth CSB commenced Family Check-Up (FCU) training in early 2023.

The impact of this past year's Title IV-E investments into CSBs directly may be better understood in terms of how many families could theoretically gain access to a proven-to-be-effective service. For instance, one full FFT team would enable high-quality and effective care for approximately 20 to 30 families per year.[2] Two new PCIT clinicians typically maintain caseloads of 6 families during the first year in training,[3] and then increase based on referral needs of a given site. FCU clinicians serve 2 families during training when under the most extensive level of supervision and then a minimum of 5 once fully trained. Based on training timelines, FCU clinicians can see at least 15-20 families per year with the capacity to serve many more since treatment length is capped at 15 sessions.[4]

In 2022, Brief Strategic Family Therapy (BSFT) was implemented for the first time in Virginia by a private provider whose coverage area included 6 out of 13 Top Priority CSBs. Two additional providers were awarded with BSFT training: one with overlapping coverage with the first site to increase regional awareness of the EBP, and the second in a further eastern region of the state to begin to evaluate qualitatively whether differences in implementation were present between regions with distinct entry rates.

The CSB Reinvestment Initiative was CEP-Va's first formalized attempt to combine the interests of two child-facing agencies. Outreach via VDSS and CEP-Va led to a series of meetings with CSB leaders and program managers. Undeniably, CSBs have recently undergone several challenges and significant changes as part of the STEP-VA initiative and Medicaid expansion. Many of the CSBs that reported to not have the staff eligible for training, and that much of their capacity had been shifted to crisis response. Regardless, Family First funding to supplement CSB service arrays represented a clear step toward cross-agency collaboration in enhancing access to behavioral health services. Also, CSBs remain an important entry point into behavioral health services for Virginias who are uninsured.

Recommendation 1. Continue to prioritize CSBs.

CEP-Va recommends VDSS continue to prioritize CSBs and providers within the service coverage areas of those in the updated Top Priority CSB List with Title IV-E training funds (see Table 3)**.**

[2] Shared by FFT representative at the 2022 Open House series hosted by CEP-Va and VDSS

[3] Rosas, Y.G., Sigal, M., Park, A. et al. (2022). Predicting a rapid transition to telehealth-delivered parent–child interaction therapy amid COVID-19: A mixed methods study. *Global Implementation Research & Applications,* 2, 293–304. https://doi.org/10.1007/s43477-022-00057-0

[4] Shared by FCU purveyor at the 2022 Open House series hosted by CEP-Va and VDSS

Table 3. Updated Top Priority CSB List

CSB/BHA	2021-2022 Entry Rate
Alleghany Highlands	11.44
PD 1	7.05
Dickenson	7.04
Cumberland	6.52
Valley	5.67
Mount Rogers	4.90
Highlands	4.86
Blue Ridge	4.51
Piedmont	3.79
District 19	2.74
New River Valley	2.50
Rockbridge Area	2.49

Foster care entry rate between 2021-2022 was found to average **2.46** in the state. CSBs found to exceed this updated threshold are listed in Table 3, which together provide service coverage for **43%** of the total number of foster care entries between 2021-2022.

NAGA-Indicated Study

Through CEP-Va's attempts to locate practitioners within CSB coverage areas, an issue related to one of the Family First EBPs, Parent-Child Interaction Therapy (PCIT) emerged. Specifically, a company unaffiliated and unsanctioned by PCIT's credentialing body, PCIT International, is accepting payment for training and certification in PCIT. As a result, some clinicians in the state have been trained (and supposedly certified) by the organization. Many of the clinicians have then advertised and delivered what they have called PCIT, despite the training they received not following the standards of PCIT International.

The company in question does not train according to PCIT International standards or eligibility specifications and appears to omit this important information to those who pay (and dedicate a substantial amount of their time over several months/years) to be trained. For instance, out of a group of 88 clinicians who reported to be certified in PCIT, approximately a quarter were not listed on PCIT International's directory of certified clinicians. It's possible this subgroup of clinicians did not complete full training or were trained by a purveyor unsanctioned by PCIT International. Regardless, the lack of clarity is felt at the local level by referral brokers searching for a Title IV-E service to connect families but unsure whether an unlisted PCIT clinician has been trained adequately. The issue of practicing a model or treatment approach without adequate training is not a new topic, nor one isolated to Virginia. However, it is the specific EBP at hand that requires a clear response regarding who and who is not deemed certified to reimburse Title IV-E and Medicaid for their services.

PCIT is an intensive treatment designed for children with severe disruptive behavior problems and is particularly effective for children who have experienced serious and complex trauma. Implemented in naturalistic play settings, PCIT involves a one-way mirror and use of a hidden ear device worn by the parent while guided through a series of behavior management techniques. PCIT is highly structured; each client session has a predetermined agenda, recommended script, and complex command sequences the clinician is required to follow and coach the parent to perform in real time. The intervention works through strengthening the caregiver-child bond and significantly improving caregiver mental health.[5] Program length depends on child progress, meaning PCIT does not end until the family recovers and can prove their new parenting skills to the clinician. When applied as intended and tested, PCIT has been shown to surpass similar interventions that target symptoms of disruptive behavior disorders (e.g., oppositional defiant disorder) and ADHD in young children.

Increasing access to high-quality interventions like PCIT is an important goal; however, such interventions have been rated high-quality in part because of the rigorous training procedures that create a high threshold for competency to be certified in the EBP. The Family First Prevention Services Act requires a certain level of evidence determined through an independent, systematic review process for a program to be labeled *well-supported* and, in turn, eligible for enhanced federal funding. Studies that measure an intervention's effect are only included in the Title IV-E Prevention Services Clearinghouse if the intervention has been standardized and tested multiple times. Standardized programs include specific instructions for how it should be delivered, and by whom. Only when the same program has been tested more than once, and under certain conditions, can researchers begin to believe the program could be effective and whether it is worth further investment.

Program specifics are determined by the program developer or sanctioned purveyor and include factors related to training intensity, duration, and frequency of didactics and supervision. The developer stipulates training and practice requirements to ensure demonstrated outcomes. Therefore, only individuals judged to have received the type of training and educational background required by program developers should be permitted to deliver the treatment, regardless of whether they are licensed to provide services independently. For most EBPs, certification is the only way developers can ensure competency standards have been met and the treatment is being delivered as it was intended. Without such assurance, the robust outcomes proven in research cannot be reasonably expected.

[5] Warren, J. M., Halpin, S. A., Hanstock, T. L., Hood, C., & Hunt, S. A. (2022). Outcomes of parent-child interaction therapy (PCIT) for families presenting with child maltreatment: A systematic review. *Child Abuse & Neglect*, *134*, 105942.

Recommendation 2. PCIT Training and Certification Standard for Virginia.

PCIT International was founded by the developer of PCIT and is the only organization that offers therapist and trainer certification procedures approved by the developer of the intervention. The training offered by PCIT International mirrors that used in the research studies that serve as the evidence base for the approach and are the reason for its inclusion in the Clearinghouse. Additionally, PCIT International is the sole purveyor listed in the Title IV-E Clearinghouse to provide PCIT training.

For these reasons, state agencies with a stake in PCIT in Virginia are recommended to require all individuals that bill for PCIT services or provide PCIT training meet standards set PCIT International and be enrolled in the EBP Practitioner Registry, the authoritative database of EBP-trained practitioners in Virginia. Licensed or license-eligible practitioners who have been trained by any organization or company unaffiliated with the certifying body are encouraged to be referred to CEP-Va. If the recommendations here are approved, CEP-Va will work with PCIT International to develop a remediation pathway to attain PCIT certification via Title IV-E training funds.

Recommendation 3. Improved Reimbursement Rate for PCIT.

To sustain PCIT and enhance access to this intensive service, **CEP-Va urges an increase in reimbursement for practitioners with verifiable training through PCIT International and who are listed in the EBP Practitioner Registry**. This recommendation spans all funding streams and child-facing agencies oriented toward prevention of out of home placement (e.g., Office of Children's Services [OCS], VDSS). Medicaid reimbursement for all licensed clinicians is particularly encouraged to be increased, given the impact such a service has demonstrated for prevention of later juvenile justice involvement. See Table 4 for a rates comparison across funding streams.

Recommendation 4. Site Certification Model for PCIT.

Given the high rate of practitioner departure from provider site post-training, **CEP-Va recommends that future investment of Title IV-E training funds be allocated toward building competency of provider sites, versus solely investing in individual practitioners**, to create an environment that facilitates PCIT training and effective delivery of the program. VDSS (and other state agencies) is encouraged to permit CEP-Va to examine whether certifying at the site level aids in retention of PCIT International trained clinicians.

Table 4. EBP Reimbursement Schedules by Funder

EBP	DMAS / Medicaid (Obtained 8/22)				OCS / CSA (Obtained 9/22)			VDSS / Title IV-E (Obtained 11/22)		
	Rate	Note	Unit	Code	Rate	Note	Unit	Title IV-E Rate	Note	Unit
FFT	$38.37	33% BA QMHP*	15 min	H0036	$73.60	NoVa	Daily	$73.60	NoVa	Daily
	$41.94	33% MA QMHP*	15 min	H0036						
	$45.82	33% BA QMHP**	15 min	H0036	$64.00	All other areas	Daily	$64.00	All other areas	Daily
	$49.69	33% MA QMHP**	15 min	H0036						
MST	$51.78	33% BA QMHP*	15 min	H2033	$116.00	NoVa	Daily	$116.00	NoVa	Daily
	$56.21	33% MA QMHP*	15 min	H2033						
	$57.38	33% BA QMHP**	15 min	H2033	$101.25	All other areas	Daily	$101.25	All other areas	Daily
	$61.91	33% MA QMHP**	15 min	H2033						
PCIT	$101.93	MD***	50 min	90847	$124.00	-	60 min	$124.00	-	60 min
	$91.74	Psychologist ***	50 min	90847	$149.00	For nationally certified practitioners	60 min			
	$68.80	LCSW, LPC, LMHP***	50 min	90847						
BSFT	$101.93	MD***	50 min	90847	No rate			$300.00	-	Daily
	$91.74	Psychologist ***	50 min	90847						
	$68.80	LCSW, LPC, LMHP***	50 min	90847						

Note. Information obtained through Zoom and email exchanges with agency leaders.

*These rates are set for established teams enrolled with Medicaid MCO or FFS contractor 18+ months

**These enhanced rates are set for new teams in months 0-18 of being enrolled with Medicaid MCO or FFS contractors

***Rates are DMAS recommended service categories, not modality-specific

PROJECT 2: TITLE IV-E PREVENTION SERVICES TRAINING AWARDS

Rationale

A key VDSS strategy to meet the mission of the Family First Prevention Services Act (FFPSA) has been to build workforce capacity through targeted EBP training. VDSS has tasked CEP-Va with the bulk of the work selecting EBPs for implementation, recruiting and vetting appropriate provider companies for training, organizing training events, and ensuring ongoing quality monitoring of each implementation. In brief, CEP-Va: (a) recruited recipients of EBP training; (b) verified EBP purveyor and trainer credentials; and (c) designed, implemented, and adjusted a phased training model for VDSS-funded EBP rollouts. See *Terms Glossary* in Appendix 4 for definition of training terms.

Standard Center Training Model

The CSB Investment Initiative and initial rollout of BSFT illuminated a series of challenges and barriers embedded within the preexisting service landscape. Namely, the issue of a missing comprehensive provider or service directory. Through a different contract agreement, CEP-Va is building an EBP registry to fill in that knowledge gap of where high-quality services are available. The CSB Investment Initiative (Project 1) was impacted by several of the issues captured in NAGA 1.0, but most problematic was the inability of Center staff to delineate whether services advertised through CSBs were accessible since private companies are not bound to cover an entire CSB catchment area. Inconsistencies obfuscated any attempt to map service arrays that did not expire before distribution.

In response, CEP-Va developed a standard multiphasic implementation model for all EBP training coordinated by CEP-Va staff beginning in 2023. To protect Family First expenditures, the model was designed for providers interested in capacity building and committing to training internal EBP experts to become a self-sustaining training hub. Components of the Standard Center Training Model are consistent with recommended best practices and certifies at the site level versus individual practitioner level. Attention to the entire site, not just the practitioners, is crucial to sustain a service past the first year of implementation. The CEP-Va site certification process, i.e., the Standard Center Training Model, involves:

a. An initial Request for Applications and subsequent formal review process that includes state partner input
b. At least one informal meeting between CEP-Va staff and the provider to further assess EBP fit and site readiness (these are termed *EBP Funding Meetings*)
c. Development of a *Training Plan and Payment Agreement*, a living document that outlines the responsibilities of the provider agency, trainer, state agencies, and CEP-Va
d. A *Training Plan Finalization Meeting* where all parties listed above will discuss the Training Plan, make changes to adapt the plan to implementation site, and set a tentative date for training to begin
e. A kick-off organizational workshop that precedes practitioner training that centers referral brokers and their understanding of an appropriate referral and the enhanced reimbursement rate

f. A series of meetings to assess and document the first year of initial implementation that will indicate site viability and determine additional funding
g. Onboard of all trained practitioners into Virginia's EBP Practitioner Registry and collection of any required fidelity monitoring data.

Training Phases and Implementation Support

Phase I: Fit Assessment. To accomplish provider recruitment, a Request for Applications (RFA) process for Title IV-E Prevention Services Training Awards was developed. The process was initially designed to gauge provider interest in specific EBPs and pilot CEP-Va's fit assessment approach. Mid-way through 2022, the RFA portal transitioned to an ongoing submission portal for allocating training funds through individual awards to providers based on a set of criteria. Funding was also allocated through supplemental awards designated to strengthening a preexisting EBP team, if the EBP was included in Virginia's FFPP (see Table 5).

Table 5. EBPs eligible for a Title IV-Prevention Services Training Award

EBP	Description
MST	Multisystemic Therapy (MST) is an intervention for children 12-17. MST is intended for youth with conduct issues, truancy, law involvement, and poor parent mental health. Length of treatment averages 3-5 months.
FFT	Functional Family Therapy (FFT) is an intervention for children 11-18. FFT is intended for youth with substance use, disruptive behavior and conduct issues, depression, and family conflict. Length of treatment averages 4-8 months.
PCIT	Parent-Child Interaction Therapy (PCIT) is an intervention for children 2-7. PCIT is intended for youth experiencing defiance, aggression, extreme mood swings, ineffective social skills, and safety concerns. Length of treatment averages 6 months but depends on family progress.
BSFT	Brief Strategic Family Therapy (BSFT) is an intervention for children 6-17 and their family. BSFT is intended for families with dysfunctional family patterns and poor parent mental health. Length of treatment averages 3-5 months.
FCU	Family Check-Up (FCU) is an intervention for children 2-17. Family Check-Up is intended for any presenting problems where there is a lack of motivation for treatment and/or disengaged family members. Length of treatment averages 1-4 months.
HB	Homebuilders (HB) is an intervention for children 0-18. Homebuilders is intended for youth and families in crisis and/or unstable living conditions. Length of treatment averages 4-6 weeks.

An information session in February 2022 and a series of program-specific open house series in the following March were held to inform providers about the RFA process to apply for a Title IV-E Prevention Services Training Award. Awards were first granted to providers who were willing to be the initial Brief Strategic Family Therapy (BSFT) implementation sites for the state.

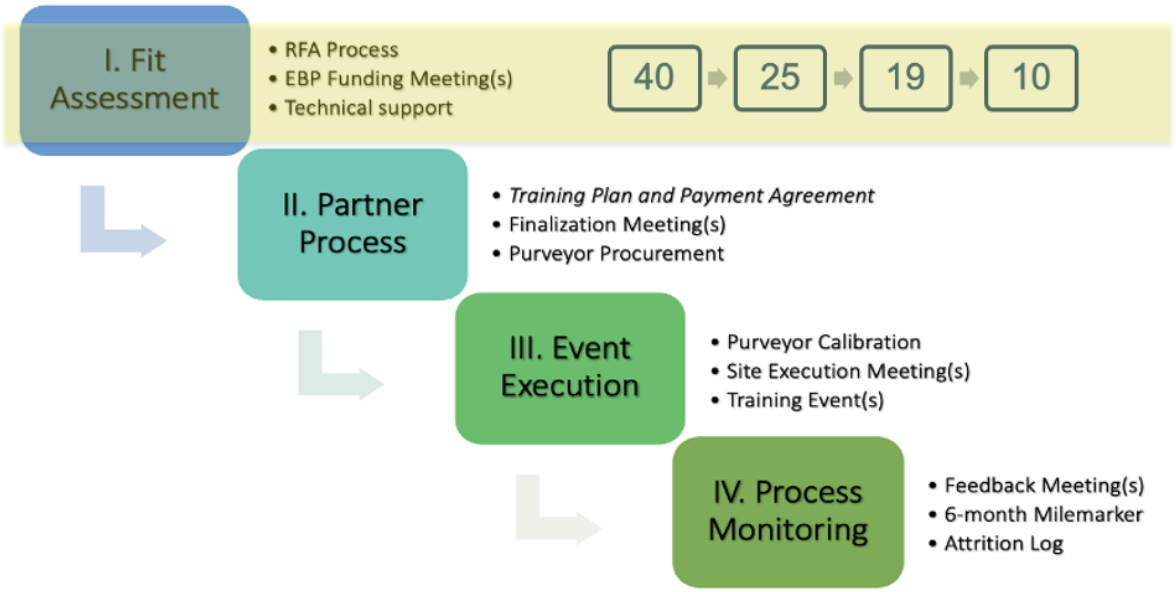
CEP-Va recommended BSFT as the first EBP in Virginia's plan to implement statewide to fill an age-based gap in the EBP array for the state–i.e., school-age children (6-18). BSFT has also been found to decrease caregiver substance abuse, which was found through NAGA 1.0 to be a substantial driver to foster care entry. The intervention has been found to be effective when delivered in multiple settings, most especially schools and in homes.

To access training funds, providers were required to demonstrate key factors associated with EBP readiness and implementation success, such as community need and capacity for the

organization to support the new practice. Providers were also required to furnish a letter of support from their local DSS and/or Children's Services Act (CSA) Coordinator. A review panel of Center and VDSS staff reviewed all applications monthly. Once notified, successful applicants were required to attend at least one *EBP Funding Meeting* with Center staff to confirm components of their application and assess fit of their selected EBP. Rapid turnover of staff eligible for training greatly protracted this phase.

As of December 2022, approximately 40 submissions were collected through the online RFA portal. Of these, 25 submissions were complete, or had all components that were requested to complete a submission packet. Nineteen providers accepted the opportunity to move forward into the next phase to verify practitioner eligibility and discuss funding and fidelity reporting requirements. Ten providers were able to secure the staff for full model implementation and training. Figure 3 depicts the provider procurement process, highlighted, within context of all Training Phases of the Center Standard Training Model.

Figure 3. CEP-Va Standard Training Model



Phase II: Partnering Process. Once an EBP is selected, CEP-Va drafts a site- and EBP-specific Training Plan, a document designed to provide technical information as well as serve as a tangible representation of the planned, research-supported implementation strategy. Awards allotted to new implementation sites differ substantially from smaller supplemental pre-existing team awards, requiring a complex sequence of planning events and on-site implementation support; therefore, multiphasic training plans are only written for full implementation sites.

The CSB Investment Initiative (Project 1) helped Center researchers begin to understand the difficulty likely experienced by local referral brokers in search of providers. Regardless of whether a provider works closely with a given CSB, they are unlikely to be bound to the service coverage

area of the CSB. CSBs are mandated to cover specific groupings of localities but the private providers with whom they contract are not. In an effort to enhance consistency and, in turn, community awareness of a service, Training Plans included formal requests to private providers to expand their coverage area to an entire CSB catchment area. A provider's decision to do so increased their likelihood of receiving additional funding from VDSS post Y1.

Each Training Plan is designed to be a *working* compendium of information expected to evolve as implementation progresses. At minimum, all plans include training format, structure, and estimated timeline to reach competence in an EBP, reimbursement rate and training cost coverage, and important expectations of the provider to maintain certification. Most importantly, plans include individual roles and responsibilities of all parties (VDSS, Center, Provider, EBP Purveyor) before, during, and after initiation of training. The entire training process is discussed during the *Training Plan Finalization Meeting.* Once the Training Plan individualization is complete, approvals from all parties are collected and planning for training execution begins.

Over the course of 2022, a total of 10 training plans for 10 providers were drafted and individualized for full site training of a Family First EBP: BSFT (5), FCU (3), and PCIT (2). Total number of practitioners to be trained across all sites and EBPs was estimated to be 82. The number of plans that were able to be finalized, agreed upon and issued for execution was 8 by December 2022, with 51 practitioners available for training. As of January 2023, 3 providers paused plans for training indefinitely due to staff turnover and concerns around reimbursement.

Phase III: Event Execution. Training requirements, or what training specifically entails, differ across EBP models. EBP training typically includes two components: a workshop series and a consultation period that looks like intensive supervision + progress monitoring with outcome data. Initial training is followed by the EBP's purveyor version of a train-the-trainer site development phase, so that provider sites established through Family First transition into self-sustaining training sites. EBP purveyors remain connected to the sites they've trained indefinitely.

The first full site training event occurred in September 2022 for BSFT, followed by the second BSFT training that occurred in November 2022. As of December 2022, 14 practitioners initiated training. The third BSFT site began training in February 2023. Two full site trainings in FCU are scheduled to begin in March 2023. The first implementation site for FCU will be Horizon CSB which intends to train 25 clinicians and supervisors to work towards becoming a self-sustaining EBP training hub.

Phase IV: Process Monitoring. Implementing EBPs is complex given the many changing dynamics in provider companies. Evidence suggests that sustainment of EBPs is improved with prolonged engagement. Accordingly, CEP-Va remains engaged with providers with trained staff in several ways, through regularly scheduled check-ins and calibration meetings with trainers. A formal meeting six months after training begins is held with the provider, Center, VDSS, and EBP purveyor to review progress and discuss contingent allocation of additional funding post Y1.

As of early 2023, BSFT training began at three sites, across the Piedmont Eastern VDSS regions. All sites combined, 21 clinicians initiated workshop training beginning in September of 2022. As of February 2023, a total of 11 clinicians remain on track to complete training, equating to an **attrition rate of almost 50%.** The following explanations were provided by provider and BSFT consultants as reasons for practitioner-employee departures:

- Competing job offer
- Outpatient therapy without having to adhere to an EBP protocol was more lucrative and less time-intensive
- EBP training requirements reduced time for reportable clinical hours needed for licensure
- BSFT supervision hours could not be counted toward supervision hours required for licensure
- BSFT supervision requirements were too intensive (i.e., trainees felt uncomfortable with heavy session monitoring from BSFT consultants

Concerns for Sustainment

First, additional findings of pilot BSFT sites involved systems barriers that prevented provider sites from receiving appropriate referrals in a timely manner. The BSFT training model requires each practitioner-trainee carry a full caseload of families to learn and deliver BSFT with fidelity. All training sites experienced immense interest from referral brokers at initiation of implementation; however, referrals lagged substantially due to local-level contracting issues that appeared to differ across sites. Feedback reports from site leaders included the following commonalities:

- Arduous contracting procedures that differed across localities and FAPTs
- Insufficient and unreliable Medicaid reimbursements from MCOs
- Lack of local DSS referrals of eligible families so that providers can access an enhanced Title IV-E reimbursement rate
- Lack of understanding for how local CSA dollars could be saved by accessing the new Title IV-E funding stream for sum-sufficient services (i.e., “mandated” eligibility category)

Recommendation 5. Service Coordination Study.

CEP-Va recommends continued disbursement of EBP training funds through the phases described herein and in accordance with the Standard Center Training Model, with one caveat. **Further investment into EBP training should occur only within the context of an in-depth study into service coordination and referral processes at the local level.**

CEP-Va proposes a study on the service coordination teams in charge of making referrals at the local level, i.e., a *Service Coordination Study*. The unique intricacies related to how a family arrives at an EBP provider vary by funding stream as well as locality. A deeper analysis into the coordinating structures that involve all child-facing agencies in the state is strongly recommended, as these systems impact a family’s path and ability to take advantage of an effective service. Results from this type of contextual roots analysis would permit CEP-Va and its funders to begin to organize localities and regions by the characteristics of their respective coordination procedures and develop guidance to improve assimilation of Title IV-E funding. If approved, CEP-Va would engage in the study in 2023, with results presented in early 2024.

Second, NAGA 2.0 initiation of Title IV-E funding for Family First EBP rollout was significantly impacted by staff turnover, or lack of capacity due to losing and then being unable to hire licensed staff. Importantly, a pattern emerged for those practitioners who did not complete training and provider companies that decided not to move forward after applying and subsequently being offered training funds. Licensed clinicians, who have already received training in many of the principles and concepts embedded in EBPs, were torn between donating their time to the EBP and delivering outpatient services that earned them greater pay without having to change their practice. Even with the enhanced reimbursement rate and free training, many providers were unable to find a way to make the time investment worth the loss in billable outpatient hours.

Recommendation 6. Continued Regulation Study.

The Center's initial efforts to support the state's training goals necessitated an immediate closer look into trainee attrition and workforce supply. This was a driver for the focus of the Regulation Study, as initiated through the NAGA model of immediate response to an implementation barrier. The first phase of the Regulation Study began to explore the actual structures in place that influence the state's ability to leverage an entirely new funding stream to establish child welfare's stake in behavioral health service expansion.

The preliminary findings of this report as they relate to the regulatory context of the state are presented in Section 2. **The Center requests approval from VDSS to continue the Regulation Study past its initial phase by selecting areas for further examination as they are presented and described within the study's narration of findings.**

SEE SECTION 2 for NAGA-Indicated Regulation Study.

PROJECT 3: MOTIVATIONAL INTERVIEWING TRAINING

Rationale

As part of NAGA 1.0 Report (2021), Motivational Interviewing (MI) was recommended to strengthen LDSS engagement with families through frontline personnel training. The MI approach targets several behavioral change domains, focusing on guiding individuals through ambivalence to change and increasing motivation for change. Addressing caregiver substance use has been a noted concern for many caregivers involved in child welfare, especially in Western and Piedmont regions of Virginia. MI has positive effects on its own but also demonstrates evidence for promoting engagement with other EBPs in a service array. MI may also have positive effects for those in receipt of training; studies have begun to show that use of MI spirit and strategies increases satisfaction, empathy, and resiliency, and decreases disengagement and burnout (Endrejat & Kauffeld, 2020; Pollak et al., 2016, 2020). Outcomes such as these could be helpful at reducing workforce turnover, a major driver to the challenges Virginia faces in addressing behavioral health problems.

Project Activity

CEP-Va coordinated a process to select a company appropriate for large scale training of the VDSS workforce in MI. A Request for Applications announcement for an MI trainer was sent to all MINT (Motivational Interviewing Network Trainers) trainers and members. The application required that companies: (a) describe their training approach, (b) present a plan for sustainability, (c) use a fidelity measurement model, and (d) have experience with the child welfare system. The submission window was open from September 19th, 2022 to October 14th, 2022. Twenty-three applications from MINT trainers and members from various states across the US and Canada were received. Two workgroups were formed including VDSS and Center staff to review and score applications. Interviews were hosted by Center staff with each of the final four applicants with VDSS representatives present. The final selection was made in a meeting of VDSS leaders and Center staff in December 2022.

Next Steps

CEP-Va is working closely with VDSS and Sage to build out: (a) a phased training plan for all in-home workers, (b) a fidelity monitoring program to be implemented during the training phase and post training, and (c) intentional data collection before, during, and after training to gauge the effects of the training with the workforce. Furthermore, CEP-Va will work with VDSS to consider expansion of the MI training for other members of the VDSS workforce.

Section 2

REGULATION STUDY: Initial Phase

In October 2022 at the VACSB Public Policy conference, an executive-level behavioral health stakeholder shared their insight when they stated, “Regulations are a problem. They are inconsistent and confusing to most.” Much of the audience made up of Virginia behavioral health providers, CSBs, researchers, and additional state stakeholders nodded in agreement. Similarly, Center staff were experiencing challenges related to regulations in real time during the initial rollout of Family First EBP service expansion. Although several barriers have impeded the early stages of Family First implementation, regulations represented one of the most vexing.

The goals of the Regulation Study were to,

a. to examine existing regulations fueling the structure of Virginia’s workforce design
b. to illuminate barriers to effective EBP implementation and service delivery

This investigation into Virginia’s behavioral health workforce regulations was geared towards providing perspective for purveyors and state regulatory entities. CEP-Va was interested in understanding the state’s available workforce and their capacity to improve accessibility of services within the current regulatory environment. The recommendations that are proposed from this initial phase of study are based on preliminary data collected and presented herein. Feedback from our state partners will dictate the scope of further investigation in 2023 (see Recommendation 6).

Method

1. National and state-specific needs assessments and workforce reports were collected and contextualized with the reports in CEP-Va’s needs assessment library (see *Workforce Trends*)
2. Guidance disseminated by all regulatory bodies were reviewed, as well as other state equivalents (see *Regulatory Guidance*)
3. A series of interviews (n = 34) were conducted with individuals from the following groups,
    a. State employees,
    b. Providers with experience in EBP implementation,
    c. Local government employees,
    d. Individual practitioners with experience in EBP training and delivery

Procedure. State agency needs assessments and workforce reports from 2013-2022 were reviewed to detect recurring themes shared by more than one agency. Regulations related to licensing and scope of practice were examined and then cross-walked with other stakeholder state agencies that impact workforce and Medicaid reimbursement. Interviewees were recruited through snowball referral, and interviews ranged from approximately 20-90 minutes each. Given the sensitivity of content discussed, all interview notes were recorded without identifying

information (demographic information was not collected) and processed by the two doctoral-level research scientists at CEP-Va.

Importantly, a number of state regulatory and guidance changes happened to occur during the time interviews were conducted and, as such, vastly contrasting opinions of how these changes applied dominated and obfuscated interview content. Inconsistencies in interpretation of state regulations were so varied both across and within groups of interviewees that determination of a set of clear themes (such as those visualized in NAGA 1.0) was unattainable. Thus, information gleaned during interviews was used to provide historical context for which archival records were reviewed and were integrated into the preliminary hypotheses presented in the *Interpretation of Initial Findings* section. Direct quotes from these conversations have been included within findings without identifying information.

Workforce Trends. The State Needs Assessment Information Library (SNAIL) was developed as a way for CEP-Va to synthesize various reports released by the child-serving agencies in the state. As an internal project, SNAIL is a knowledge bank used to build an understanding of context into Center activities. SNAIL is updated on an ongoing basis by Center doctoral students and include the following:

- 2022 CSB Behavioral Health Services Commission Draft, JLARC
- 2022 Assessment of the Capacity of Virginia's Licensed Behavioral Health Workforce, Virginia Health Care Foundation
- 2022 Service Gap Survey (2021 Follow-up), OCS
- 2021 Service Gap Survey, OCS
- 2021 Report on HB 728/SB 734 Children's Residential Workgroup, DBHDS
- 2020 Virginia Behavioral Health System Needs Assessment Final Report, DBHDS
- 2020 Review of the Children's Services Act and Private Special Education Day School Costs, JLARC
- 2019 Listening Tour Report, Virginia HEALS project / Linking Systems of Care
- 2018 Virginia Behavioral Health Redesign Stakeholder Report, DMAS/DBHDS
- 2018 Virginia Statewide Substance Abuse and Behavioral Health Needs Assessment, OMNI Institute/DBHDS
- 2016 Juvenile and Criminal Justice Outcomes of Youth Completing Services through the Children's Services Act, OCS
- 2015 Child and Youth Crime Victims Stakeholder Survey, Virginia HEALS
- 2013-2022 Virginia's Licensed Clinical Social Worker Workforce Reports, DHP
- 2013-2022 Virginia's Licensed Clinical Psychologists Workforce Reports, DHP
- 2013-2022 Virginia's Licensed Professional Counselors Workforce Reports, DHP

Regulatory Guidance. A number of public regulatory documents issued by several state-level bodies were reviewed for the purposes of the Regulation Study. Agencies most involved in behavioral health service provision and payment for youth and families were included in this initial phase of CEP-Va's review, and comprise of:

a. DHP
b. DBHDS
c. DMAS

These entities absolutely shape the service landscape for families most likely to experience public systems involvement and present for essential services at CSBs. State laws for health professions contain scopes of practice, establish requirements for licensure, and grant authority to boards that then have the power to write regulations for how to implement those laws. Health regulatory boards also determine the administrative procedures for implementing regulations and laws, such as license applications and renewal cycles.

Department of Health Professions. DHP, is an Executive Branch agency located in the Health and Human Resources Secretariat. DHP licenses and regulates over 500,000 healthcare practitioners across 62 professions in the state of Virginia. Their mission is to, "ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to health care practitioners and the public."[6] DHP is responsible for 13 regulatory boards, including the Board of Counseling, the Board of Psychology, and the Board of Social Work.

The Board of Counseling houses existing laws and regulations for six licenses (Licensed Marriage and Family Therapists [LMFT], Licensed Professional Counselors [LPC], Licensed Substance Abuse Treatment Practitioners [LSATP], Resident in Counseling, Resident in Marriage and Family Therapist, and Resident in Substance Use Treatment), three certifications (Rehabilitation Providers [CRP], Substance Abuse Counselors [CSAC], and Substance Abuse Counseling Assistants), and two registrations (Qualified Mental Health Professional [QMHP], Registered Peer Recovery Specialist [RPRS]). The Board of Psychology oversees five licenses (Applied Psychologist, Clinical Psychologist, School Psychologist, School Psychologist-Limited, and Sex Offender Treatment Provider) and the Board of Social Work oversees three licenses (Clinical Social Worker, Baccalaureate Social Worker, and Master's Social Worker) and two registrations (Associate Social Worker and Registered Social Worker).

Department of Behavioral Health and Developmental Services. DBHDS, is the governing body for behavioral health and developmental services in the Commonwealth of Virginia. At the state level, DBHDS oversees and funds the 40 CSBs designated to serve as the single point of entry for publicly-funded behavioral health services. In 2017, legislation associated with STEP-VA enacted a new requirement for CSBs to provide nine new services when before only emergency services were mandated by law. Then in 2019, a new state law required CSBs to provide same-day access to screening services.

A key relevant function of DBHDS for this study is the agency's role in licensing providers for each numerous service type (see here and here). DBHDS licenses companies/organizations such as CSBs and private providers, and not individuals, who provide an array of services in the behavioral health space. Regulations clearly state that they do not include in their definition of provider *any individual practitioner who holds a license issued by DHP*. DBHDS license types include outpatient, intensive-in home, residential treatment, case management, day treatment, inpatient

[6] Virginia Department of Health Professions - Licensing Health Professionals. (n.d.). Retrieved February 24, 2023, from http://dhp.virginia.gov/index.html

psychiatric, substance abuse outpatient, mental health community support, and more than a dozen more.

Department of Medical Assistance Services. DMAS regulates reimbursement of services covered by Medicaid and Virginia's Title XXI program for child health (FAMIS). A critical role played by DMAS is in its definitions of service types and their billing rates, a process largely governed by federal law and regulations through Centers for Medicare and Medicaid Services (CMS). DMAS is not the only payer of behavioral health services in Virginia, but they did account for more than $1.3B of expenditures in FY2022. Nationally, Medicaid accounts for almost 25% of adult behavioral health and substance use treatment expenditures and more than half of child mental health services. As a result, DMAS is a key economic driver of behavioral health services in the state.

DMAS categorizes services to be on a continuum of care based on acuity. Levels of care represent steps along the continuum from prevention to inpatient care, and then services are embedded within each level of care. The basic process established by DMAS for billing for behavioral health services is as follows:

1. Appropriate licenses must be in place (from DHP and from DBHDS)
2. Provider must be an enrolled Medicaid provider
3. For most (if not all) behavioral health services, a service authorization is required from the Managed Care Organization (MCO)

Prior authorization for a service is a requirement to obtain approval from a MCO for certain service categories such as intensive in-home, and the *consumer* may not receive care until the request is approved. DMAS has contracted six MCOs to provide access to care for Medicaid patients across Virginia. Each of the state's 40 CSBs must individually deal with multiple sets of paperwork, when before they only had to claim through DMAS. See JLARC (2022) Chapter 5: Medicaid Funding for CSB Behavioral Health Services.[7] DMAS is also involved with FAPT and modifications to the Virginia Code in recent years has implicated CSA to adhere to Medicaid adverse benefit determinations made by the state's contracted MCOs.

Preliminary Findings

Common challenges shared by past needs assessments that include mention of workforce ***and*** shared by more than one agency include:

- Lack of funding to offer competitive pay
- Increased practitioner credentialing requirements and burdensome licensure process, lack of regulation alignment across agencies
- Lack of consistent, sufficient, and affordable resources, training, and education for behavioral health professionals throughout the Commonwealth
- Aging workforce and high percentage of professionals set to retire soon with insufficient number of replacements
- Need for more care navigator or peer/family support roles to help families access services

[7] *CSB Behavioral Health Services Commission Draft*

- Increase in burdensome, redundant, and inconsistent documentation needs for clinicians, prescribers, and support staff, most especially for CSBs

National data provide additional context for understanding state and local concerns. According to the most recent (2021) large-scale surveillance report on mental health care access, Virginia ranks **39th** among US states for mental health worker availability.[8] This ranking is based on the number of psychiatrists, psychologists, Licensed Clinical Social Workers (LCSW), LPCs, MFTs and advanced nurse practitioners physically present in the state during 2021. The term *availability*, versus accessibility, is important here, given that we do not know whether these practitioners were actively seeing patients and, if so, accepting insurance during that time. In Virginia, the individual patient to practitioner ratio is 480:1, compared to the national average of 350:1. For 2020 and 2021, Virginia ranked **48th** out of all US states for overall accessibility to care for youth, indicating that youth in Virginia exhibited a higher rate of mental illness during that time paired with greater difficulty accessing care for their symptoms.

The Healthcare Workforce Data Center (HWDC) is part of DHP, to collect and analyze data on the supply and demand of the health professions workforce. The HWDC reports provide profession-by-profession information collected via survey of the licensed workforce and are published each year. Interestingly, HWDC workforce reports indicate a steady *increase* in the number of licensed behavioral health professionals in Virginia. Within the past decade, the number of licensed clinical psychologists (LCP) has increased by 25%, LPCs by 66%, and LCSWs by 39%. However, it is important to note an increase in volume of professionals does not indicate an increase in workforce capacity. Growth must be examined within the context of population growth, and national data tell us that the patient to practitioner ratio in Virginia indicates less capacity than the national average.[7]

HWDC profession workforce reports also show that there are notable regional and workplace type differences in the licensed workforce. Consistent among LCPs, LPCs, and LCSWs, there has been negligible growth of the workforce outside of urban areas of the state. That is, growth in the licensed workforce has been only observed in the most urban and populated regions. Further, the large majority of licensed professionals in the state across all three professions work in group or solo private practice settings instead of CSBs, outpatient mental health facilities, or governmental agencies. Departure to the private sector has been a growing trend, as documented by DHP data. **As of 2022, approximately 60% of Virginia's licensed workforce reported to provide services out-of-pocket (i.e., cash or self-pay), 45% accept private insurance, and fewer than 30% accept Medicaid.**

[8] Reinert, M, Fritze, D., & Nguyen, T. (October, 2022). *The State of Mental Health in America.* 2023 Mental Health America, Alexandria, VA.

Study Pivot Point
The behavioral health practitioner workforce in the state of Virginia includes both licensed (or *license-eligible*) and unlicensed (*license-ineligible*) professionals. The data tell us that the licensed workforce is experiencing an unprecedented explosion of opportunity and latitude in their roles. Some of this has to do with emergency orders due to COVID, but the exit from positions that require a clinician to treat families in their homes had been occurring long before 2020. **The licensed workforce has been for several years transitioning away from serving the Medicaid population as the demand for behavioral health as well as the number of families willing to pay out of pocket has increased.** This trend is not one that can be corrected nor reset without significant structural changes to how we train, compensate, and maintain these workers in positions outside of the comfort of their homes and the freedom that not having to claim for reimbursement allows. If this level of transformation cannot happen expeditiously, then alternative options should be explored.

Because of these findings, regulation review was narrowed to those individuals most likely to serve the population of Virginians unable to access private practice or pay out-of-pocket for care: QMHPs.

State Regulatory Environment and QMHPs
For the first phase of the Regulation Study, we focused on the roles and perceptions of three state agencies: DHP, DBHDS, and DMAS, with an emphasis on their involvement in overseeing the QMHP workforce. QMHPs in Virginia are required to abide by sets of regulations authored by DBHDS, DHP, and DMAS to render services, maintain their QMHP designation, and reimburse for services. QMHPs do not represent the only workforce providing services reimbursed through Medicaid; however, their title and registration status originated with DMAS.

The following sections detail each agency's regulatory role with regard to QMHPs. Subsequently, the section titled Interpretation of Initial Findings dives deeper into how these different sets of rules combine to impact the overall mental health workforce.

DHP. DHP's Board of Counseling provides regulatory oversight for Licensed Mental Health Professionals (LMHP) and QMHPs. The oversight of the QMHP workforce transferred from DMAS to DHP and the Board of Counseling in 2019 with the stated goals of quality control and public safety. Current regulations provide guidance for the practice, certification, or registration of practitioners whose services fall under the definition of *counseling*.

The Board defines counseling as,

…the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health.

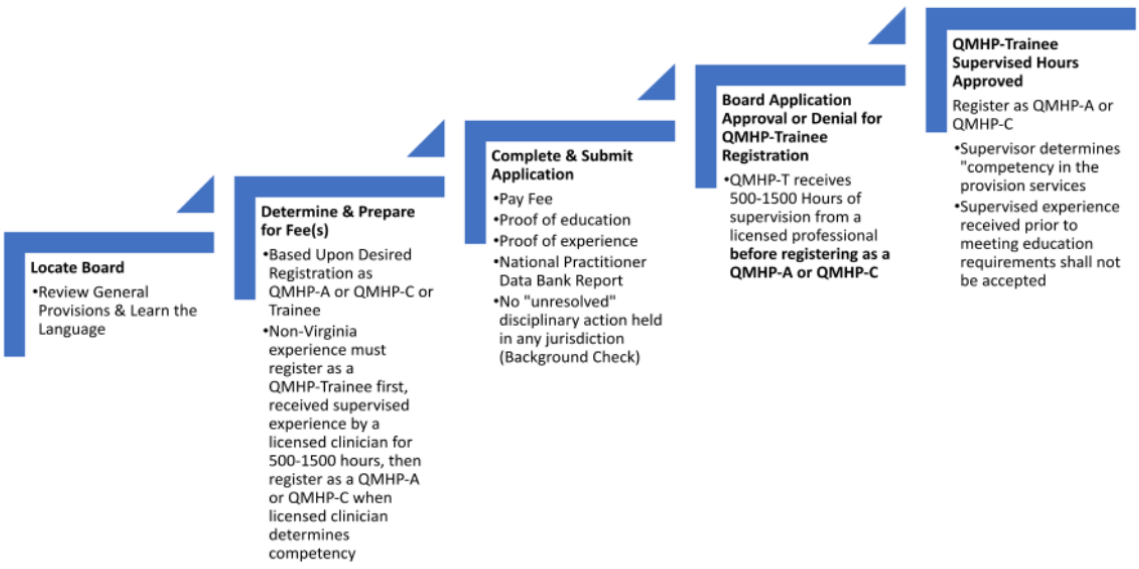
DHP via the Board restricts counseling practice to licensed or licensed-eligible practitioners. The Board defines a QMHP's scope of practice to consist solely of ***collaborative mental health services*** [emphasis added], further described to mean,

…those rehabilitative supportive services that are provided by a qualified mental health professional, as set forth in a service plan under the direction of and in collaboration with either a mental health professional licensed in Virginia or a person under supervision that has been approved by the Board of Counseling, Board of Psychology, or Board of Social Work as a prerequisite for licensure. 18 Va. Admin. Code § 115-80-50

Both masters-level and bachelors-level professionals register as QMHPs. MA-level QMHPs must have a graduate degree in psychology, social work, counseling, marriage and family therapy, special education, or an adjacent human services field. BA-level QMHPs are allowed to have a greater range of degree disciplines if accompanied by 15 hours in a human service field. Licensed RNs and OTs qualify for QMHP registration. Full registration status requires a number of supervision hours that ranges from 1,500 to 3,000 depending on degree and must occur within a 5 year period. Applicants with a master-degree in psychology, social work, and aligned fields can waive the supervision requirement with proof of "500 hours of experience with persons with mental illness." Supervision "shall consist of face-to-face training in the services of a QMHP until the supervisor determines competency in the provision of such services, after which supervision may be indirect in which the supervisor is either onsite or immediately available for consultation."

QMHPs register as either a QMHP-C, for *child*, or a QMHP-A, for *adult*. Before reaching full QMHP registration status, applicants must collect supervision hours as a registered QMHP-Trainee. These applicants are referred to as QMHP-Trainees (QMHP-T) by DHP, but as QMHP-Eligible (QMHP-E) by DBHDS and DMAS. Supervision hours, regardless of whether multiple family members are present or the family system as a whole is being treated, can only be counted toward one registration designation or patient category: Adult or Child. If a person is required to have both A and C designations for their work, they must complete the registration process for each in full. Despite the two designations, QMHPs who are both QMHP-A and QMHP-C are only required to satisfy the continuing education requirements for one per year, which is 8 CEs.

Figure 4. QMHP Registration Path (18 Va. Admin. Code § 115-80-10)



DBHDS. QMHPs are relegated to specific locations, as regulations state QMHPs "shall provide such services as an employee or independent contractor of the [DBHDS] or the Department of Corrections, or as a provider licensed by [DBHDS]." DBHDS provides the oversight for mental health services while DHP issues the designation of QMHP to persons who complete the application process and are approved to register with the Board of Counseling as a QMHP-A, QMHP-C, or QMHP-T.

Beginning in 2019, DBHDS regulations caution providers of the potential for citations if a provider fails to verify employees' QMHP designation through DHP's registry. According to 18 Va. Admin. Code § 115-80, a QMHP's purpose is to provide ***collaborative mental health services*** for adults and children. DBHDS is involved because DHP allocates QMHPs to service categories that their employer is licensed by DBDHS to provide. A person with the QMHP designation is not permitted to render service autonomously or practice independently (i.e., without supervision), regardless employer DBHDS licensure status.

Out of the service categories licensed through DBHDS, QMHPs are allowed to render services within specific delineated service categories according to their -A/C classification. QMHP-As are allocated to Mental Health Skill Building, Partial Hospitalization or Day Treatment, Crisis Stabilization, and Psychosocial Rehabilitation. QMHP-Cs are allocated to provide Intensive In-Home and Therapeutic Day Treatment.

DBHDS also embeds supervision requirements into licensed service categories for QMHPs, LMHPs, and Supervisees/Residents, in addition to those set by DHP. QMHP-T/Es are allowed to provide any of the aforementioned services under supervision while working towards registration as a QMHP-A or QMHP-C, and QMHP-As are included in the group of permitted supervisors for

QMHP-Ts. According to DBHDS guidance titled *Licensing Intensive In-home Services*: “A QMHP who is not a LMHP or Supervisee/Resident can provide administrative supervision only. They cannot provide clinical supervision.” Additional information that delineates these two types of supervision could not be found within the timeline of this initial study phase, but it may not matter given the great latitude supervisors are granted by DHP/BoC to discontinue regular supervision once they determine QMHP-supervisee competency.

It may also be important to note that QMHPs can supervise QPPMHs, or Qualified Paraprofessional(s) in Mental Health. QPPMH is a practitioner category monitored by DBHDS only, as they are not included within DHP’s list of health professionals for oversight. QPPMHs must have an associate’s degree in a mental health related field and “a minimum of 90 hours classroom training and 12 weeks of experience under the direct supervision of a QMHP-A providing services to individuals with mental illness.” (12VAC35-105-20) DBHDS also monitors Peer Recovery Specialists (PRSs), who *are* included in DHP’s purview and requirement for registration. In contrast to QMHPs, PRSs are not required to have any type of formal education degree but must undergo 60 hours of direct instruction provided by a PRS authorized by DBHDS to train. PRSs and QMHPs share a similar scope of practice to provide collaborative services to assist individuals with mental illness.

DMAS. Beginning in 2019, DMAS began to require QMHPs to be registered with the Board of Counseling to be reimbursed for services. DMAS sets the policies and parameters on the circumstances in which services can be billed for, making the agency’s role a critical one in understanding the workforce landscape because these policies guide how behavioral health companies design their business models and practices. Specifically, state-set reimbursement should include consideration for

- Overall system goals and strategies to promote cost-effective care
- Intended delivery and desired outcomes of the service
- Ensuring payment rates are sufficient to enlist enough providers and are not excessive to incentivize over- or under-utilization of other services

If services are rendered by a QMHP but are required to be conducted by a licensed professional, then the service will not be reimbursed; however, QMHPs can claim and be reimbursed for services they are allowed to deliver. As previously mentioned, DBHDS sets which services, or service categories, QMHPs can deliver, ex. Intensive In-home. DMAS has its own set of specifications for how activities within a DBHDS service category can be administered, and by whom, in addition to DBHDS. For the Intensive In-Home service, counseling is named as an essential component of the service; however, *counseling* can only be conducted by a licensed or licensed-eligible individual according to DHP and to be reimbursed through Medicaid according to DMAS.

Interpretation of Initial Findings

One resulting and critical challenge of the complexity of regulations for behavioral health service delivery is that without excellent cross-agency communication, there is room for considerable confusion for all involved participants in the system. Our review of regulations related to QMHPs

is a prime example; confusion about who is permitted to provide and bill for specific services is a pain point in the system. Because there are multiple ways services can be labeled across agencies, some of which are open to interpretation, the need for cross-agency coordination and revision is high. However, state agencies are often not able to be as nimble as would be ideal, resulting in challenges for behavioral health providers and their clients. In the following sections, we highlight areas in need of additional clarity; these have been organized by preliminary hypotheses as section headers for each.

Finding 1: QMHPs are a poorly understood workforce.

Although introduced in DHP in 2017 as a formal role, Qualified Mental Health Professionals (QMHPs) have been a plentiful and critical part of Virginia's behavioral health workforce. Registration has provided some data on QMHPs in the state, but data about this group of practitioners remains scarce.

In this section, a few findings related to QMHPs are reviewed.

1. QMHPs have been estimated to tally approximately 19,000 in the state; however, this number is virtually unknown as it relates to licensed practitioners. This is because many licensed practitioners also hold a QMHP registration, and the extent of that overlap is unclear. CEP-Va maintains a practitioner database for a project outside of the NAGA umbrella. Of a sample of 70 licensed practitioners in the EBP Directory, 44% also held an active or expired QMHP registration. Residents of counseling were most likely to have both registration and licensure statuses.
2. If QMHPs do not represent a distinct group of individuals, then it's possible QMHP registration operates as a step that clinicians under supervision for licensure go through in order to bill for certain services when in training. For instance, MSWs in particular appear to have a clear QMHP path built into their degree. Further, CSBs remain the staple training hubs where practitioner-supervisees gain experience and hours toward licensure, as well as the entry point for uninsured community members—many of whom under emergency provisions newly qualify for Medicaid coverage—for services reimbursable by QMHPs. The evidence is too preliminary to say with confidence, but **QMHPs and LMHPs are unlikely to constitute discrete groupings of *unlicensed*, *license-eligible*, or *license-eligible* individuals.** More likely, they represent developmental phases within an individual's professional trajectory to independent practice.
3. What is known for certain is that QMHPs largely represent the workforce entering families' homes and were described as likely to do so widely outside of the CSB setting. Interview content included certainty that QMHPs make up the primary practitioners employed by private companies who may not be licensed by DBHDS, or are licensed but also provide services outside of the DBHDS service category structure. These providers functioning outside of the DBHDS licensing arena may believe contracted QMHPs fall under the coverage of an individual's DHP license. Interviewees at the local level were more likely than those at the state level to be aware of this reality, as many state-level representatives reported to believe QMHPs are restricted to CSBs and large providers of intensive or residential services covered by Medicaid. It's possible that private companies that employ

QMHPs without a DBHDS license are within their right to do so, as regulations are unclear (see Finding 2.1).

4. The BoC does not track supervisors of QMHPs over time; only at certain points in the registration and renewal process. This level of oversight seems insufficient given that QMHPs are allowed to supervise other professionals, such as QPPMHs and QMHP-Es. For QMHP's own supervision, DHP permits relaxation of oversight once a supervisor determines competency, after which supervision is downgraded to being available for consultation.

Consequences of these findings include:

1. There's potential that the pre-registration step of QMHP-E, the dual registration procedures of QMHP-C and QMHP-A, in combination with the additional set of supervision requirements for licensure creates a slog in the workforce pipeline. Despite the protracted process, supervision practices are not required to differ or adapt to the developmental level of any supervisee, license-eligible or not. Without evidence to support requirements, the path to licensure may include unnecessary steps unknown to state regulatory bodies within an already steep requirement schedule for pre-licensure post-graduate training.
2. DBHDS has a heavy role in setting the supervision parameters of QMHPs (as well as QPPMHs and PRSs). These requirements in conjunction with DHP's define the type and quality of supervision received (hence, learned) and, in turn, delivered to others. DHP regulations delegate the power of determining competency to individual supervisors, to the extent of permitting QMHPs essentially to practice without oversight. DMAS regulations allow unlicensed supervisees to make this determination. Within context of other regulations, DHP may be inadvertently delegating significant authority to the QMHP, as their supervisory protocol includes two underlying assumptions:
    a. QMHPs are able to attain competency, and therefore practice without routine oversight, because LMHPs share a common understanding of competency
    b. QMHPs are able to assess properly when it is time to reach out for consultation. In other words, QMHPs are expected to self-regulate (and ensure public safety from themselves).
3. Because of the supervisory roles permitted by DBHDS, the trust allotted to supervisors by DHP, and the leniency allowed by DMAS toward license-eligible (but not yet licensed) supervisees, it is possible that several individuals are providing behavioral health services across a variety of settings without structured oversight.

Recommendation 7. QMHP Study.

CEP-Va recommends an in-depth study on the QMHP workforce with the aim to improve applicability and impact of BoC regulations. If permitted by governance committee partners, CEP-Va could collaborate with DHP/BoC in such a project. Also, the project could be folded into the work of other initiatives underway dedicated to workforce. Study activities with the objective of characterizing the QMHP workforce include the following,

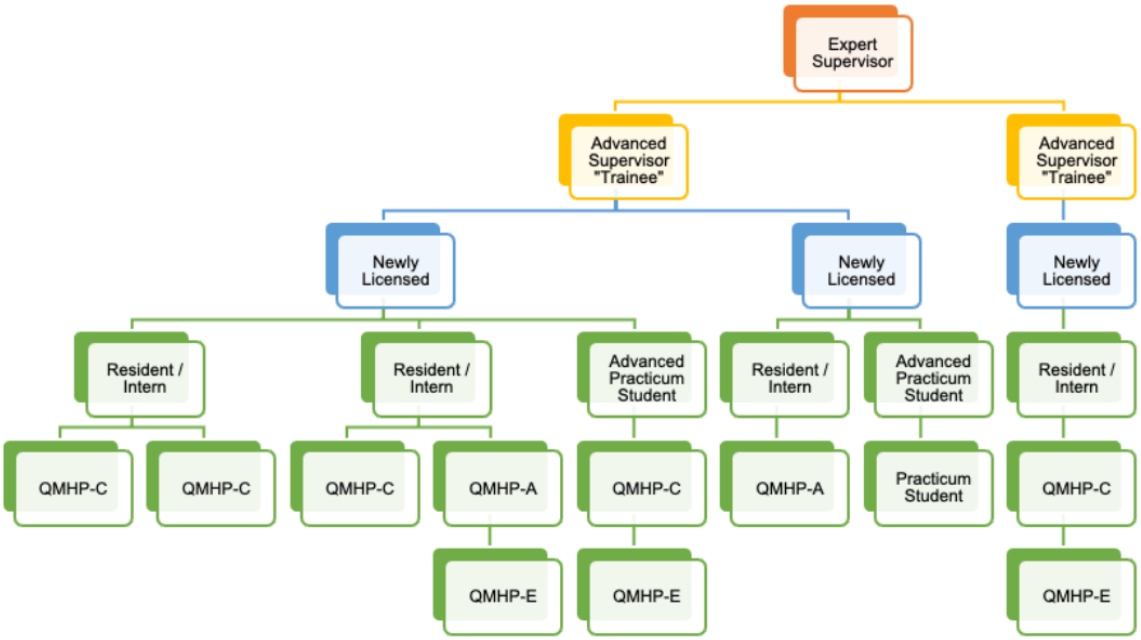
- Conduct a survey with the QMHP workforce that collects demographics, educational and experience background, in addition to any other information to help begin to characterize the overall group
- Perform follow-up interviews to confirm emerging group characteristics
- Collect any additional data necessary to begin to determine whether sets of characteristics are present within the population as a whole
- Determine number of subgroups based on relationships among and between group characteristics
- Reexamine potential for reclassification of QMHP workforce, or clarification of existing delineations, based on emergent subgroups (i.e., is the -A/-C dichotomy warranted?), with the goal of removing unnecessary paperwork and extra steps to full licensure

Recommendation 8. QMHP Supervision Capacity Building.

CEP-Va encourages DHP and DBHDS to work together to enhance supervision capacity, possibly in partnership with CEP-Va. The work is recommended to begin with CSBs or private providers affiliated with CSBs. Supervision expectations must first be determined and then standardized for each level of the workforce regardless of a licensure or discipline's guild. For instance, LCSWs appear to have more stringent requirements than all other professions at a commensurate level, with QMHPs having the least. Potential areas to explore include, but are not limited to the following:

- Develop a multi-tiered supervisory structure, or supervision cascade (e.g., more experienced supervising less experienced practitioners in chains of 3-4, creating multiple layers of supervisory oversight for cases seen by unlicensed practitioners); See Figure 5
- Develop guidance for agencies that support supervision best practices in combination with incentives for "proof of use"
- Develop guidance for Board applicants on their rights to competent supervision, decision-trees for when to request supervision/consultation, and supervisory contracts
- Develop a supervisory directory for individuals to seek out supervisors based on areas of expertise for case consultation
- Develop a path that allows expert consultation (i.e., external supervision) hours to be counted toward licensure/registration requirements to supplement regular supervision
- For DHP/BoC in particular, raise minimum supervision requirements of unlicensed workforce to routine supervisor contact and remove option for "on call" supervision (or stepped path that requires regular proof of competency)

Figure 5. Example Supervision Cascade to Enhance Capacity of Licensed Workforce



Finding 2: Inconsistencies in language across agencies creates confusion related to mental health service delivery.

Language used across agencies is at times inconsistent, resulting in confusion for multiple stakeholder groups (e.g., public, provider companies, state regulators). Examples of confusion are listed in abridged form below. See Appendix 2 for a preliminary content analysis of how common yet important words are used interchangeably, examples include,

1. Use of the term *provider* to refer to a company (e.g., DBHDS) and a person (e.g., DBHDS, DMAS).
2. Use of the phrase Mental Health Professional by DHP to refer to any licensed person despite the existence of the QMHP role, which references an unlicensed person.
3. Lack of clear guidance on the roles permitted to QMHPs given potentially conflicting language about their scope across agencies. Per DBHDS, QMHPs can provide treatment and therapeutic interventions. Per DHP, QMHPs may NOT engage in counseling practice. However, DHP includes treatment interventions in their definition of counseling. DMAS guidance reflects similar incongruence with DHP terms. (See Appendix 2)

Consequences of these inconsistencies include:

1. Possible loophole for provider companies to avoid DBHDS licensure.
2. Confusion among the public, who may view the QMHP title as meaning something different from what the regulations state.

3. DHP's definition of a protected term, *counseling*, includes activities that DBHDS allows QMHPs to do in accordance with their designated service category. **This means DBHDS may relegate QMHPs to service elements that are included in the BoC's definition of counseling, which is outside of a QMHP's scope of practice.** It's possible these potential contradictions exacerbate confusion among provider companies regarding the appropriate role for QMHPs.

Recommendation 9: Ontological Alignment.

DHP and the BoC are encouraged to clarify further their definition of *counseling* in addition to the components used in the definition of that word. Reaching consensus of common terms such as *assessment*, *diagnosis*, *therapy*, *treatment,* and *intervention* is also strongly recommended. All state agencies are strongly encouraged to use the same language and definitions for protected terms, to compile one standard glossary that is hierarchical – also referred to as an *ontology*.[a]

Ontologies are arranged from general to specific terms that create a foundational touch point for understanding what is being requested, expected, and eventually reimbursed. For example, *activity scheduling* is a *practice element*, or skill, used by a practitioner. Its parent term, in accordance with the current evidence, is behavioral activation. Below is an example that could become an excerpt in a complete ontology:

Counseling:
1. *Treatment intervention*
    a. *Behavioral activation*
        i. *Activity scheduling*

Recommendation 10: Regulation Audit.

A comprehensive investigation or audit of all behavioral health profession regulations governed by all three boards to determine inconsistencies and whether each licensed, certified, or registered class of professions meets the criteria set by the Board of Health Professions for guiding regulation decisions readopted in 2019.[b] The following areas are proposed for additional inspection and/or clarification within context of the current workforce crisis and the evidence to date that supports their continuation:

- Bachelor-level professionals who are license-eligible, and other exceptions to the practice status categories of licensure, certification, and registration
- How scopes of practice are defined and whether clear delineations across the professional guilds are warranted (e.g., who can provide supervision)
- Limits related to time and expiration of supervisory hours, or other resource intensive requirements (i.e., exams)

a. Michie, S., West, R., Finnerty, A. N., Norris, E., Wright, A. J., Marques, M. M., ... & Hastings, J. (2020). Representation of behavior change interventions and their evaluation: Development of the Upper Level of the Behaviour Change Intervention Ontology. *Welcome Open Research*, *5*(123), 123.

b. 75-2 *Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions*, revised February 25, 2019 (begin at p. 6)

Study Pivot Point
In addition to state regulatory bodies, interview findings necessitated including EBP purveyors as another main contributor to the state's regulatory environment.

Finding 3: State initiatives and federal programs designed to increase EBPs highlight key regulation-related workforce challenges for Virginia

In the late 2010s and early 2020s, the commonwealth embarked on several initiatives related to widespread implementation of EBPs, including the Behavioral Health Redesign for Access Value & Outcomes (Project BRAVO). Further, the 2018 federal law called the FFPSA has prompted Virginia (and all states) to build out EBPs in the child welfare space. Many of the EBPs to be implemented have been studied for decades and have long-standing training models, models that provide yet another set of guidelines for the qualification of a practitioner to deliver a particular service. In many cases, the empirical literature has demonstrated that when properly supervised, practitioners delivering an EBP need not be licensed to achieve the same results as licensed individuals.[9]

EBP Purveyors. Program developers, trainers, or vetted spokespeople who represent an evidence-based program, its developers, or certifying entity, and have a clear stake in how the program is delivered. Because purveyors typically operate across state and country lines, they build their own set of policies governing who is eligible to be trained and deliver the services contained in their programs. To the extent that these policies are less restrictive than state (and federal) regulations related to licensure or billing, problematic questions emerge for provider companies and state policy makers. As one example, if Program X states that one need not be licensed to be trained in (and thereby deliver) the program but the state regulations require a license, a challenging bind emerges. An expert treatment model developer that has studied the model extensively in controlled studies has determined the level of experience needed to deliver the treatment but the state regulation prevents some forms of that delivery based on unclear evidence.

Some details on EBPs are relevant. First, for this report, the focus is on EBPs–that is programs with a considerable evidence base recognized by one or more clearinghouses of such treatments. It would be obviously problematic to change state policy or regulations based on a company's policy in the absence of strong evidence to do so.

Although EBPs vary across many dimensions (e.g., theoretical model, treatment delivery approach), they share in common a rigorous and often phased training approach used to ensure fidelity to the model. Training often involves both didactic and rehearsal components and is often spread across multiple days. Most EBPs also involve ongoing (and costly) supervision and consultation throughout a training period of six to twelve months. In many EBPs, the consultation

[9] *Ex.* Lau, A. S., Lind, T., Motamedi, M., Lui, J. H., Kuckertz, M., Innes-Gomberg, D., ... & Brookman-Frazee, L. (2021). Prospective predictors of sustainment of multiple EBPs in a system-driven implementation context: Examining sustained delivery based on administrative claims. *Implementation Research and Practice*, *2*, 26334895211057884.

period continues indefinitely. For most of the EBPs, there is also ongoing fidelity measurement that is used as immediate and developmental feedback for the practitioners who are being trained. The fidelity measurement feedback system is an ongoing process for many EBPs even after the initial training period. Last, many EBPs require a site or individual license or certification to be considered an official provider of the EBP. Further, these licenses or certifications must be renewed annually, often requiring demonstration that service quality standards are being maintained.

As such, most EBPs possess intensive quality assurance procedures designed to keep each practitioner faithful to the model. As a result, practitioners delivering EBPs are under a level of supervised scrutiny not found in most other practice settings (e.g., intensive in-home services). See Table 6. For this reason, many EBP purveyors have set their minimum training and experience thresholds for practitioners at lower levels than many states have established for providing services like those found in the EBP. In this way, the data used by EBP purveyors to support their policies about experience and training level needed to deliver the program serve as *potential justification for states to consider relaxing their own regulations requiring practitioner licensure to provide certain EBPs*, a point we return to in our recommendations.

Table 6. Most common supervisory components embedded into EBPs

Evidence-based supervisory component(s)	Definition
Live supervision + immediate feedback	Supervisor observes session live and provides immediate feedback to supervisee
Video recording review + in real time feedback	Supervisee records video of the session and supervisor provides feedback to supervisee while they review the recording together
Video recording review + delayed feedback	Supervisee records video of the session and supervisor reviews at a later time and provides feedback
Audio recording review	Supervisee records the audio of a session and supervisor reviews at a later time
Skills practice: Role-play	Supervisor and supervisee engage in a role-play so that supervisee can rehearse specific skills
Skills practice: Modeling	Supervisor shows supervisee how to deliver specific skills by modeling them first
Assessment data review / progress monitoring	Supervisee collects assessment data from clients and supervisor reviews this data over time to track client progress
Case notes review	Supervisee writes notes about the session or case and supervisor reviews these notes

Note. Listed in rank order from most to least intensive.

Virginia Case Study. Evidence-based programs are not new to Virginia. Reportedly, MST has been accessible to CSB-referred families for decades. In 2016, availability of these high-quality services increased when the Department of Juvenile Justice (DJJ) invested in their youth population and set up a coordinated system of certified MST and FFT teams across the state. Primarily QMHPs staffed these teams under a multi-layered supervision structure. EBP expert-consultants trained administrative staff and organization leaders through a parallel program development process (4-6 months to complete). Once providers and their staff made it past initial training, sites became licensed and their teams certified. Ongoing support and monitoring were provided through a highly structured quality assurance process and a booster workshop schedule that all QMHPs were required to attend quarterly. Measurement outcome data reflected good outcomes and these data were fed back to licensed sites through regional consultants and team supervisors.

In 2021, as part of the rollout of Project BRAVO, DMAS issued a new requirement for MST and FFT teams to be reimbursable through Medicaid. The other option for these families was and still is intensive in-home programming, a broad service category without baseline practice sequences, training or documented supervision procedures, treatment principles or basic standards of care. Since both EBPs were delivered through a traditional in-home model and team-based, QMHPs filled these positions prior to DMAS's announcement. Regardless of whether providers had met all of the EBP purveyors' requirements, QMHPs were newly restricted to one position on EBP teams of 3, or 33% of any team makeup. At least two team members were then required to be licensed (i.e., LMHPs). Almost immediately after the 33% rule was announced, many teams disbanded and care was reportedly disrupted for families before treatment completed. One interviewee estimated that "for every QMHP that left, 10 families were left hanging."

EBP team-based models typically require practitioners to be designated to the EBP full-time, and this is the case with MST. Fully salaried practitioners on certified teams were blocked from practicing any other modality than the EBP. Purveyors also require teams to be fully staffed to deliver the model with fidelity; therefore, members of incomplete teams were required to wait for their employers to hire licensed clinicians. Providers reported unprecedented difficulty securing licensed staff, and the licensed practitioners they could secure were barred from providing any other service. Further, providers with understaffed and inactive teams were not exempt from annual licensing and consultant fees required to maintain their EBP site license.

Mid-way into 2022, MST and FFT expert consultations reported more than half of EBPs teams were understaffed. Incomplete teams impacted service utilization rates, despite extensive waitlists. A timeline of reports collected from intermittent provider updates estimated that over the course of one year, at least 8 MST and FFT teams closed in total. Hiring issues required providers to consolidate staff into fewer teams, while providers continued to struggle with the Medicaid billing structure and managed care authorizations. MST cases were reported to require several hours of additional work each week, some of which to be adherent to the EBP model, that go uncompensated. In total, four provider companies were estimated to discontinue their MST or FFT service by early 2023. See Appendix 3 for maps of teams as of February 2023.

Implications. EBP Purveyors are included in the regulatory context because they contribute to the rigidity that providers and practitioners are charged with navigating. Unintended outcome is that they, too, may be **working against EBP sustainment in the state**.

As presented in the key summary of findings above, it is possible that most regulations set by states reflect continued allegiance to the traditional model of psychotherapy, which designates the clinician as the sole responsible power in charge of drawing out change from the identified patient. Evidence-based medicine ushered in a new concept of *team-based care*, through evidence that *multiple individuals each with their own individual skill sets work together to improve outcomes for the identified patient*. In this model, the patient may continue to see only one clinician when they present for care, when in actuality an entire team of professionals and a tiered quality assurance system with data monitoring are present but invisible. Many EBPs require full video recording of an entire session to be reviewed by multiple consultants and experts. Whether by design or not, **evidence-based programs remove and redistribute the power inherent to a clinician's role, and the clinician is reassigned as a conduit.**

The current regulatory context appears to prevent EBPs from being applied with fidelity, or like how they were designed, developed, and tested to be effective. In Virginia, restrictions enforced from multiple state-level entities, in addition to the EBP purveyors themselves, ***have functioned to move practitioners and providers away from the evidence base***. Providers and practitioners are caught in a double-bind situation, where adherence to one set of rules automatically identifies them as practicing outside the scope of another. Proven outcomes of EBPs such as lessened court involvement, improved family functioning, and fewer out-of-home placements in residential treatment facilities and congregate group homes, apply to all of the regulatory bodies' interests.

Other States. A cursory look into EBP delivery by unlicensed practitioners in other states has returned some preliminary leads that could be further studied by CEP-Va in a future study. For instance, Pennsylvania, a commonwealth and a county-administered state similar to Virginia. According to PA's regulations, to provide any form of counseling, social work, or therapy, a person must be licensed. However, if working through an EBP team-based model, unlicensed clinicians are permitted to be on the team and only the team supervisor is required to be licensed. This is an allowance the state has granted to EBP purveyors according to EBP purveyors, but this allowance has not yet been made clear within state regulations or state guidance materials.

In Louisiana, the Department of Health includes an official allowance for bachelor-level clinicians to deliver EBPs specifically. The state's Medicaid program includes flexibility with hiring in light of their workforce shortage and history of staff turnover. Providers are allowed to hire bachelor-level therapists if the applicant is "clearly better qualified than the master's-level applicants" and if the bachelor's degree is in a human services field.[10] All other team-based EBP models covered by Medicaid have received the same regulatory relief in Louisiana, through state-mandated provider

[10] Louisiana Behavioral Health Services Provider Manual (2022). Chapter 2: Medicaid Services, Appendix E-2.

agreements that require the EBP purveyor to conduct all hiring processes, including vetting educational requirements and interviewing candidates.

New Mexico has gone a step further, integrating at least one EBP purveyor and their authority to license EBP sites into their state code, perhaps similar to how DBHDS licenses service categories. Unlicensed bachelor-level practitioners are permitted to be a part of EBP teams and claim for therapeutic interventions, assessments, case management, and crisis stabilization under strict supervision (§ 8.321.2.28). Similar to DMAS in Virginia, New Mexico's Human Services Department Medical Assistance Division only permits one member of a three-person team to be unlicensed bachelor-level. The other two practitioners must be master-level *and* licensed. Supervision (e.g., two hours per week) and other training requirements (such as quarterly workshop training) mandated by the EBP purveyor company are included in the state code.

Medicaid programs across states have leveraged the non-licensed workforce for substance use disorder treatment for many years. A comprehensive review conducted by the National Academy for State Health Policy (2019) found that unlicensed workers allowed to bill for Medicaid were typically categorized as peers, counselors, or other qualified staff. Counselors, the category that most aligns with QMHPs in Virginia, were not required to have more than a bachelor's degree in 31 states, and 28 of these states reimburse these individuals for delivery of counseling services under supervision. Requirements and restrictions varied across states, but the following themes shared by the majority emerged:

- Unlicensed staff are only permitted to deliver services in licensed behavioral health agencies, and most commonly as part of a team.
- A variety of licensed health professionals could provide state-approved supervision of unlicensed, bachelor-level practitioners, such as advanced addiction specialists, nurse practitioners, and others with expertise relevant to where the unlicensed individual delivered services.
- Most states define the frequency and nature of supervision, which was typically ongoing and more intensive for unlicensed practitioners.

In short, many EBP training companies successfully train practitioners to fidelity whose training is akin to Virginia's QMHPs. These EBPs have an extensive and ongoing consultation requirement, meaning that the practitioners are trained and have ongoing contact with experts in the EBP (in addition to their local supervisor). EBP training company guidelines are thus, at times, inconsistent with Virginia regulations, with Virginia regulations being stricter (see Table 7 and corresponding key). Although Virginia has to this point maintained its more stringent guidelines, the conflict between them and EBP training company guidelines poses risk for successful implementation of the EBPs.

Table 7. EBP Purveyor v. State Regulations for Eligibility to Practice

EBP / Service	Diploma / GED	has BA (*QMHP*)	has MA (*QMHP*)	License Eligible	Licensed
Purveyor Rules for Service Provision					
MST		*1 max.*			
FFT					
PCIT					
BSFT					
FCU					
MI					
HB					
Virginia-specific Laws/Regulations for Service Provision					
IIH*					
IIH - MST**		*1 max.*			
OP*					
OP - FFT**		*1 max.*			

***Practitioner requirements are set by DHP within DBHDS service categories of IIH = Intensive In-Home and OP = Outpatient.

****Practitioner requirements are set by both DHP and DMAS within DBHDS service categories adapted to EBP(s).

Table 1 CELL KEY:

Light green = Practitioner status of cell column can ***deliver*** the EBP/service.

Dark green = Practitioner status of cell column can ***supervise delivery*** of the EBP/service.

Red = DMAS's reinforcement of DHP regulations for QMHPs within the context of two team-based EBPs presents a scenario where two sets of regulations appear to contradict each other. DHP restricts counseling and marriage and family therapy to licensed individuals only.

Gray = "Gray area"; DBHDS defines IIH service category as including "individual and family counseling," which are practice elements named to be outside of the QMHP scope of practice. IIH also includes "life, parenting, and communication skills; and case management and coordination with other services," which appear to align with DHP's only designation for QMHPs: collaborative mental health services, without further description. Therefore, only a portion of IIH can be delivered by a QMHP. (12VAC35-105-20)

Recommendation 11*: *QMHP Scope Expansion.

CEP-Va proposes to work with DHP, DBHDS, DMAS, and other agencies to identify a path that permits QMHPs to deliver specific federally-funded EBPs that include a scope of practice not usually permitted for (but not unknown to) QMHPs–that is, counseling practice. CEP-Va would propose specific EBPs to the state, those with high levels of structure, ongoing consultative oversight and fidelity measurement, and with governance committee approval, those EBPs would be considered special cases, and CEP-Va would recommend that all such exceptions would be documented in the state's EBP Registry. The recommendation would improve or strengthen current oversight procedures for QMHPs, in addition to installing structure and therapeutic scripts that transform their work into effective practice.

Finding 4: Regulations have worked to de-incentivize delivery of higher quality services and most especially to the Medicaid population.

A few key regulatory and procedural impediments threaten implementation of FFPSA EBPs such as FFT, MST, BSFT, and FCU. These challenges include:

1. DBHDS licensable services and CSB intake procedures have an individual versus family focus (i.e., separation of child and adult services). QMHP-As and -Cs are allotted to different services, including those conducted in a child's home in the presence of family members. Every Family First EBP requires participation of family members in addition to the traditionally-identified patient.
2. CMS and DMAS rate structures have not kept pace with scientific evidence[11] and do not have clear ways to account for intensive, system-oriented, and family-engaged treatment approaches. As one example, many EBPs involve extensive contacts with multiple members of a family's system (e.g., teacher, probation officer); many of these contacts are not billable. EBPs also require continuous feedback and communication with other agencies and stakeholders involved in a family's case, such as local DSSs initiating referrals. Rate structures do not take into account these interactions that can be resource-intensive and time consuming but predictive of EBP sustainment.
3. Inability to claim essential components of proven-to-be-effective models was one problem, as mentioned above. In addition, MCO procedures for case coordination and connecting members to providers was experienced by providers as severely lacking. MST and FFT providers were previously assisted by DJJ and regional service coordinators to ensure families were properly informed and connected to care. Without such a bridge, the no show rate experienced by providers billing Medicaid led to an unfavorable cost-benefit analysis. One provider reported to analyze service utilization data from almost one year of claiming Medicaid and determined that their average daily productivity rate was reliably half of the rate predicted by DMAS.

[11] Fraher, E., Spero, J., Thomas, S., Galloway, E., & Wilson, H. (December, 2019). *How data and evidence can (and should!) inform scope of practice.* North Carolina Institute of Medicine Policy Fellows.

Taken together, EBP models contain practice uncompensated by Medicaid, and what can be compensated is insufficient in proportion to the level of effort necessary to attain reimbursement. Interviewees provided the following additional reasons for reducing or discontinuing services to the Medicaid population:

- Six different sets of paperwork in addition to any required EBP paperwork
- High rate of adverse authorization determinations
- MCOs failing to recognize other credentialed sites providing services in a different location than the main licensed provider location
- Lack of responsivity of MCOs when peer reviews have been requested
- Slow authorizations disrupt EBP models with a crisis component, providers must access other funding streams first then transition to Medicaid once the MCO responds

Notable consequences of these findings include:

1. Disincentive for providers to invest in family-based EBPs
2. Some providers that choose to invest in such EBPs are eschewing Medicaid

Recommendation 12: Funding Alignment.

Align rate structures and reimbursement totals across funding streams to reduce confusion and potential of over incentivizing providers to discontinue EBPs for more lucrative services, such as the intensive in-home when billed at a high weekly dosage by QMHPs. Example solutions to try would include increasing Medicaid funding or building easy-to-access braided funding models (e.g., Title-IVE, Medicaid, CSA) approaches.

Recommendation 13: Tiered EBP Rates.

CEP-Va strongly recommends discontinuing the practice of setting reimbursement rates for individual EBPs, such as FFT and MST, and to instead work with CEP-Va and contracted expert consultants to determine a set of tiered rates for EBPs. For example, it may be most sensible to establish the highest rates for the most intensive, family-involved, team-based, consultation intensive, EBP models and the lowest rates for more traditional, individual practitioner driven, office-based models.

In Closing

NAGA yielded a lot of actionable steps for the state and highlighted many of the challenges facing the state as it embarks on the ambitious implementation of a slew of EBPs in the context of FFPSA. The state can take heart that Virginia is not alone in these struggles. All states are experiencing similar challenges in their FFPSA efforts. Fortunately, CEP-Va sees multiple ways that VDSS and other state agencies could take direct actions to improve chances for EBP sustainment in the commonwealth.

A few other final considerations are warranted. First, protections in place have been referred to as regulations throughout this report. This is because protections convey a purpose to protect the public from the unskilled practitioners. What does not easily come to mind is the harm we do to the public when we neglect to serve a vulnerable population. Balancing these two protections is a challenge the state should acknowledge and meet head on. As has been detailed in the Regulation Study, within the context of many EBPs the former risks (i.e., unskilled practitioners causing harm) are mitigated to a great extent. Thus, CEP-Va sees an opportunity to reduce the latter risk–that is, lack of access to services despite the potential for workforce expansion.

Integrated behavioral health and acknowledgement of behavioral health in primary care is leading to new team structures and new roles for LMHPs. Science is telling us that people get better and do so faster through strategies and formats that are not yet acknowledged on a large scale or built into state regulatory structures. Virginia may be unprepared for, and even structured to reject, evidence-based solutions and EBP sustainment. Fortunately, there is ample time to solve this problem and good evidence to bring to bear in that effort.

Because states can define license requirements and regulate behavioral health professional scopes of practice, Virginia has agency to address the challenges. However, unless changes are made, Virginia remains a state for which many EBPs are a bad fit for long-term sustainment. That need not remain the case. The first phase of the Regulation Study highlighted the state's challenges; the findings also foreshadow the state's chance to become a national leader in EBP implementation.

Appendices

Appendix 1: Summary of Recommendations

Recommendation 1. *[Continue to]* ***Prioritize CSBs.***
CSBs remain an important entry point into behavioral health services for Virginias who are uninsured. CEP-Va recommends VDSS continue to prioritize CSBs and providers within the service coverage areas of an updated Top Priority CSB List (presented in Table 3) with Title IV-E funds.

Recommendation 2. PCIT Training and Certification Standard for Virginia.
State agencies with a stake in PCIT in Virginia are recommended to require all individuals that bill for PCIT services or provide PCIT training meet standards set by PCIT International and be enrolled in the EBP Practitioner Registry, the authoritative database of EBP-trained practitioners in Virginia. Licensed or license-eligible practitioners who have been trained by any organization or company unaffiliated with the certifying body are encouraged to be referred to CEP-Va. If the recommendations here are approved, CEP-Va will work with PCIT International to develop a remediation pathway to attain PCIT certification via Title IV-E training funds.

Recommendation 3. Improved Reimbursement Rate for PCIT.
To sustain PCIT and enhance access to this intensive service, CEP-Va urges an increase in reimbursement for practitioners with verifiable training through PCIT International and who are listed in the EBP Practitioner Registry. This recommendation spans all funding streams and child-facing agencies oriented toward prevention of out of home placement (e.g., Office of Children's Services [OCS], VDSS). Medicaid reimbursement for all licensed clinicians is particularly encouraged to be increased, given the impact such a service has demonstrated for prevention of later juvenile justice involvement.

Recommendation 4. Site Certification Model for PCIT.
Given the high rate of practitioner departure from provider sites post-training, CEP-Va recommends that future investment of Title IV-E training funds be allocated toward building competency of provider sites, versus solely investing in individual practitioners, to create an environment that facilitates PCIT training and effective delivery of the program. VDSS (and other state agencies) is encouraged to permit CEP-Va to examine whether certifying at the site level aids in retention of PCIT International trained clinicians (i.e., PCIT-Va Pilot Study).

Recommendation 5. Service Coordination Study.
CEP-Va proposes a study on the service coordination teams in charge of making referrals at the local level, i.e., a Service Coordination Study. The unique intricacies related to how a family arrives at an EBP provider vary by funding stream as well as locality. A deeper analysis into the coordinating structures that involve all child-facing agencies in the state is strongly recommended, as these systems impact a family's path and ability to take advantage of an effective service. Results from this type of contextual roots analysis would permit CEP-Va and its funders to begin to organize localities and regions by the characteristics of their respective coordination

procedures and develop guidance to improve assimilation of Title IV-E funding. If approved, CEP-Va would engage in the study in 2023, with results presented in early 2024.

Recommendation 6. Continued Regulation Study.

The Center's initial efforts to support the state's training goals necessitated an immediate closer look into trainee attrition and workforce supply. This was a driver for the focus of the Regulation Study, as initiated through the NAGA model of immediate response to an implementation barrier. The first phase of the Regulation Study began to explore the actual structures in place that influence the state's ability to leverage an entirely new funding stream to establish child welfare's stake in behavioral health service expansion. The preliminary findings of this report as they relate to the regulatory context of the state are presented herein. The Center requests approval from VDSS to continue the Regulation Study past its initial phase introduced below by selecting areas for further examination as they are presented and described within the study's narration of findings.

Recommendation 7. QMHP Study.

CEP-Va recommends an in-depth study on the QMHP workforce with the aim to improve applicability and impact of BoC regulations. If permitted by governance committee partners, CEP-Va could collaborate with DHP/BoC in such a project. Also, the project could be folded into the work of other initiatives underway dedicated to workforce. Study activities with the objective of characterizing the QMHP workforce include the following,

- Conduct a survey with the QMHP workforce that collects demographics, educational and experience background, in addition to any other information to help begin to characterize the overall group
- Perform follow-up interviews to confirm emerging group characteristics
- Collect any additional data necessary to begin to determine whether sets of characteristics are present within the population as a whole
- Determine number of subgroups based on relationships among and between group characteristics
- Reexamine potential for reclassification of QMHP workforce, or clarification of existing delineations, based on emergent subgroups (i.e., is the -A/-C dichotomy warranted?), with the goal of removing unnecessary paperwork and extra steps to full licensure

Recommendation 8. QMHP Supervision Capacity Building.

CEP-Va encourages DHP and DBHDS to work together to enhance supervision capacity, possibly in partnership with CEP-Va. The work is recommended to begin with CSBs or private providers affiliated with CSBs. Supervision expectations must first be determined and then standardized for each level of the workforce regardless of a licensure or discipline's guild. For instance, LCSWs appear to have more stringent requirements than all other professions at a commensurate level, with QMHPs having the least. Potential areas to explore include, but are not limited to the following:

- Develop a multi-tiered supervisory structure, or supervision cascade (e.g., more experienced supervising less experienced practitioners in chains of 3-4, creating multiple layers of supervisory oversight for cases seen by unlicensed practitioners); See Example below

- Develop guidance for agencies that support supervision best practices in combination with incentives for “proof of use”
- Develop guidance for Board applicants on their rights to competent supervision, decision-trees for when to request supervision/consultation, and supervisory contracts
- Develop a supervisory directory for individuals to seek out supervisors based on areas of expertise for case consultation
- Develop a path that allows expert consultation (i.e., external supervision) hours to be counted toward licensure/registration requirements to supplement regular supervision
- For DHP/BoC in particular, raise minimum supervision requirements of unlicensed workforce to routine supervisor contact and remove option for “on call” supervision (or stepped path that requires regular proof of competency)

Recommendation 9. Ontological Alignment.

DHP and the BoC are encouraged to clarify further their definition of *counseling* in addition to the components used in the definition of that word. Reaching consensus of common terms such as *assessment*, *diagnosis*, *therapy*, *treatment,* and *intervention* is also strongly recommended. All state agencies are strongly encouraged to use the same language and definitions for protected terms, to compile one standard glossary that is hierarchical – also referred to as an *ontology*.

Ontologies are arranged from general to specific terms that create a foundational touch point for understanding what is being requested, expected, and eventually reimbursed. For example, *activity scheduling* is a *practice element*, or skill, used by a practitioner. Its parent term, in accordance with the current evidence, is behavioral activation. Below is an example that could become an excerpt in a complete ontology:

Counseling:

1. *Treatment intervention*
    a. *Behavioral activation*
        i. *Activity scheduling*

Recommendation 10. Regulation Audit.

A comprehensive investigation or audit of all behavioral health profession regulations governed by all three boards to determine inconsistencies and whether each licensed, certified, or registered class of professions meets the criteria set by the Board of Health Professions for guiding regulation decisions readopted in 2019.[1] The following areas are proposed for additional inspection and/or clarification within context of the current workforce crisis and the evidence to date that supports their continuation:

- Bachelor-level professionals who are license-eligible, and other exceptions to the practice status categories of licensure, certification, and registration
- How scopes of practice are defined and whether clear delineations across the professional guilds are warranted (e.g., who can provide supervision)
- Limits related to time and expiration of supervisory hours, or other resource intensive requirements (i.e., exams)

Recommendation 11. QMHP Scope Expansion.
CEP-Va proposes to work with DHP, DBHDS, DMAS, and other agencies to identify a path that permits QMHPs to deliver specific federally-funded EBPs that include a scope of practice not usually permitted for (but not unknown to) QMHPs–that is, counseling practice. CEP-Va would propose specific EBPs to the state, those with high levels of structure, ongoing consultative oversight and fidelity measurement, and with governance committee approval, those EBPs would be considered special cases, and CEP-Va would recommend that all such exceptions would be documented in the state's EBP Registry. The recommendation would improve or strengthen current oversight procedures for QMHPs, in addition to installing structure and therapeutic scripts that transform their work into effective practice.

Recommendation 12. Funding Alignment.
Align rate structures and reimbursement totals across funding streams to reduce confusion and potential of over incentivizing providers to discontinue EBPs for more lucrative services, such as the intensive in-home when billed at a high weekly dosage by QMHPs. Example solutions to try would include increasing Medicaid funding or building easy-to-access braided funding models (e.g., Title-IVE, Medicaid, CSA) approaches.

Recommendation 13. Tiered EBP Rates.
CEP-Va strongly recommends discontinuing the practice of setting reimbursement rates for individual EBPs, such as FFT and MST, and to instead work with CEP-Va and contracted expert consultants to determine a set of tiered rates for EBPs. For example, it may be most sensible to establish the highest rates for the most intensive, family-involved, team-based, consultation intensive, EBP models and the lowest rates for more traditional, individual practitioner driven, office-based models.

Appendix 2: Preliminary Content Analysis (Section 2, Finding 2)

1. Provider as entity vs. Provider as a person

Commonly heard in interviews included variations of "DBHDS licenses places, DHP licenses people." However, contrary to the meaning the mantra conveys, DBHDS uses the term provider to inhabit two meanings: the provider as a *person*, and the provider as an *entity*, such an organization. The definition, indeed, includes both:

"Provider means any person, entity, or organization, excluding an agency of the federal government by whatever name or designation, that delivers services to individuals with mental illness, developmental disabilities, or substance abuse… It shall ***not*** *include any individual practitioner who holds a license issued by a health regulatory board of the Department of Health Professions…"*

That the dual use of the term may be a cause of confusion was reflected through differences that emerged between governmental employee interpretations of the law and provider or practitioner interpretations. Preliminary findings suggest it is likely that many QMHPs are employed by private companies unlicensed by DBHDS, and that state regulations do allow many privately owned organizations to bypass the burden of DBHDS oversight and licensing. DBHDS regulations do include a provision that contracting QMHPs to provide services is acceptable when services are supervised under an individual's DHP license. However, it is possible that state agency officials are unaware of the full extent of how many private companies are able to take advantage of this allowance for individual licensed practitioners. Companies headed or managed by individuals licensed by DHP may be presumed to negate the need to abide by the DBHDS licensure requirement to license regardless of whether QMHPs deliver the bulk of a company's services.

DBHDS may wish to clarify when a private company owned by a licensed practitioner becomes the type of *provider* that would require a DBHDS license. A standard language across all agencies would help clarify where QMHPs are allowed to practice further. For instance, DHP's Board of Counseling appears to follow DBHDS dual-use without noting the transition from defining a professional as an individual to defining the same professional as a company (i.e., provider as an entity), in their definition of a QMHP:

A qualified mental health professional… shall provide such services as an employee or independent contractor of the Department of Behavioral Health and Developmental Services or the Department of Corrections, or as a provider licensed by the Department of Behavioral Health and Developmental Services.

Similarly, DMAS uses both definitions but does so inconsistently across guidance. For example, the DMAS Member Handbook includes both of the following excerpts from different sections.

'Provider' is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that provide your health care services, medical equipment, and long-term services and supports…

'Provider: A person who is authorized to provide your health care or services. Many kinds of providers participate with [Plan], including doctors, nurses, behavioral health providers and specialists.'

2. MHP definition v. QMHP title

Another point of confusion may be evident in the title of QMHP. The Board of Counseling uses the words *qualified* and *licensed* to define the basic foundation of a mental health professional:

*'Mental health professional' means a person who by education and experience is professionally qualified and **licensed** in Virginia to provide counseling interventions designed to facilitate an individual's achievement of human development goals and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health and development.*

More than likely, DHP's definition of mental health professional was established prior to QMHP's transfer over from DMAS. This is because a QMHP would not be included in this definition despite that the phrase MHP is in their title with the word Qualified in front.

3. Conflicting guidance for QMHPs

Interviewees believed that the issue of whether a QMHP could perform a service or not, i.e., *was it in their scope of practice?,* was directly related to whether it contained a certain word. Several interviewees disclosed the protected word to be *therapy.* In actuality, the BoC protected word is *counseling*.

According to DBHDS service category guidance, QMHPs can provide ***treatment*** and ***therapeutic interventions.*** DBHDS defines the IIH service category as including "individual and family counseling,.. life, parenting, and ***communication skills***; and case management and coordination with other services."

In contrast, QMHPs are not legally permitted to classify themselves as a *counselor* nor engage in ***counseling*** practice according to DHP. The BoC does acknowledges that the term is not a special service distinct from other tasks shared by behavioral health professions, and this sentiment may be reflected in the BoC's multifaceted **definition of counseling**:

*…application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using **treatment interventions** to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health.*

DHP's definition of a protected term, counseling, includes activities that DBHDS allows QMHPs to do in accordance with their designated service category. **This means DBHDS may relegate QMHPs to service elements that are included in the BoC's definition of counseling, which is outside of a QMHP's scope of practice.**

Further, according to DMAS guidance:

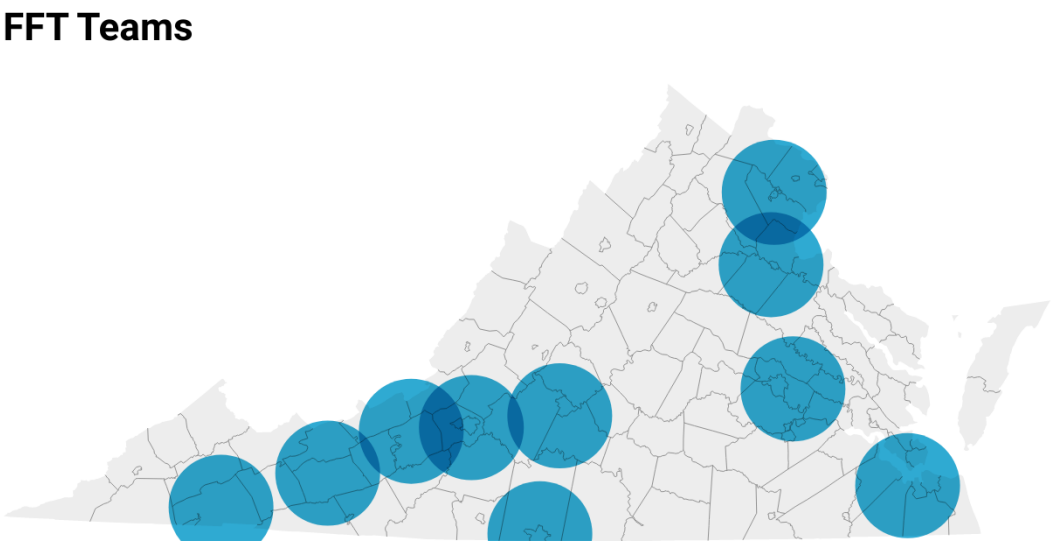
*Intensive in-home services (IIH)... are intensive **therapeutic interventions** provided in the youth's residence (or other community settings as medically necessary… to improve family functioning, and significant functional impairments in major life activities that have occurred due to the youth's mental, behavioral or emotional illness… All IIH services shall be designed to specifically improve family dynamics, provide modeling, and include **clinically necessary interventions** that increase functional and therapeutic interpersonal relations between family*

*members in the home… [Service requirements:] **…**Training to increase appropriate **communication skills** (e.g., **counseling** to assist the youth and his parents or guardians…)... **Therapeutic interventions**, crisis intervention and care coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-E, QMHPC, CSAC or CSAC-supervisee who meets the qualifications of this section.*

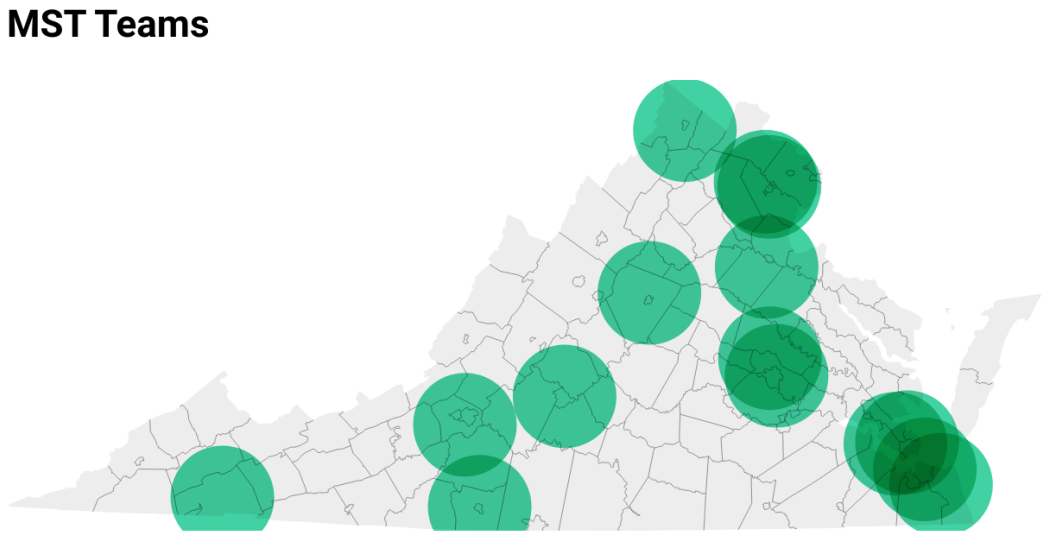
Similar to DBHDS, DMAS includes ***therapeutic interventions*** to be within the purview of QMHPs working within the service category of IIH. Additionally, DMAS includes the term ***counseling*** to further describe the service requirement of ***communication skills training***, which is not permitted to be delivered by QMHPs according to DHP.

Appendix 3: Maps of MST and FFT as of February 2023

MST and FFT services are delivered in the state by multiple service providers. Maps are provided below to display location of these services and are based on information available from FFT LLC and MST Services website directories. Teams are expected to provide coverage within a 90 minute driving radius of their location and the circles on the maps very broadly estimate this driving radius catchment area.



FFT map includes 10 FFT teams coordinated by 9 providers.



MST map includes 15 MST teams coordinated by 7 providers.

Appendix 4: Terms Glossary

Implementation	Multi-phasic process of integrating scientific findings into routine practice that emphasizes identification of factors that affect uptake of a novel practice or intervention
Providers	Companies or agencies that deliver mental / behavioral health services, not individual “direct service providers” or therapists
Practitioners	Individual therapists, clinicians, counselors delivering services directly to children and/or families in any setting; includes bachelor-level clinicians
Purveyors	Program developers, trainers, or vetted spokespeople who represent an evidence-based program, its developers, or certifying entity, and have a clear stake in how the program is delivered
Workshop	A teaching strategy involving the presentation of new knowledge, and in some cases, experiential application to enhance learning
Cohort	A group of individuals who move through a sequence of milestone events with each other to reach a common goal
Consultation	A style of teaching where information is provided by an external agent, or someone outside of a particular system
Supervision	A regulatory component embedded within a system, typically for the purposes of quality assurance and patient safety
Sustainment	The ultimate goal of implementation; the active maintenance of gains or defined outcomes related to an innovation

Appendix 5: Acronyms

ADHD – Attention Deficit Hyperactivity Disorder
BA – Bachelor of Arts
BHA – Behavioral Health Authority
BoC – Board of Counseling
BRAVO – Behavioral Health Redesign for Access Value & Outcomes
BSFT – Brief Strategic Family Therapy
CE – Continuing Education
CEP-Va – Center for Evidence-Based Partnerships in Virginia
CMS – Centers for Medicare and Medicaid Services
CPS – Child Protective Services
CRP – Certified Rehabilitation Provider
CSA – Children's Services Act
CSAC – Certified Substance Abuse Counselor
CSB – Community Services Board
DBHDS – Department of Behavioral Health and Developmental Services
DHP – Department of Health Professions
DJJ – Department of Juvenile Justice
DMAS – Department of Medical Assistance Services
EBP – Evidence-based program
FCU – Family Check-Up
FF – Family First
FFPP – Family First Prevention Plan
FFPSA – Family First Prevention Services Act
FFT – Functional Family Therapy
FSP – Family Support Partner
GED – General Education Development
HWDC – Healthcare Workforce Data Center
ISP – Individual Service Plan
JLARC – Joint Legislative Audit and Review Commission
LBSW – Licensed Baccalaureate Social Worker
LCP – Licensed Clinical Psychologist
LCSW – Licensed Clinical Social Worker
LDSS – Local Department of Social Services
LLC – Limited Liability Company
LMFT – Licensed Marriage and Family Therapist
LMHP – Licensed Mental Health Professional
LMHP-R – Licensed Mental Health Professional-Resident
LMHP-RP – Licensed Mental Health Professional-Resident in Psychology
LMHP-S – Licensed Mental Health Professional-Supervisee
LPC – Licensed Professional Counselor
LSATP – Licensed Substance Abuse Treatment Practitioners
MA – Master of Arts
MCO – Managed Care Organization
MFT – Marriage and Family Therapist
MI – Motivational Interviewing
MINT – Motivational Interviewing Network Trainers
MST – Multisystemic Therapy
NAGA – Needs Assessment Gaps Analysis
OCS – Office of Children's Services
OP – Outpatient
PCIT – Parent-Child Interaction Therapy
PO – Probation Officer
PRS – Peer Recovery Specialist
QMHP – Qualified Mental Health Professional
QMHP-A – Qualified Mental Health Professional-Adult
QMHP-C – Qualified Mental Health Professional-Child
QMHP-E – Qualified Mental Health Professional-Eligible
QMHP-T – Qualified Mental Health Professional-Trainee
QPPMH- Qualified Paraprofessional in Mental Health
RFA – Request for Applications
RPRS – Registered Peer Recovery Specialist
SNAIL – State Needs Assessment Information Library
STEP-VA – System Transformation Excellence and Performance
VAC – Virginia Administrative Code
VDSS – Virginia Department of Social Services
Virginia HEALS – Helping Everyone Access Linked Systems