Virginia

UNIFORM APPLICATION
FY 2024/2025 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 04/19/2021 - Expires 04/30/2024
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Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2024

End Year 2025

State SAPT Unique Entity Identification

Unique Entity ID KBKZM4SJ7D65

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Virginia Department of Behavioral Health and Developmental Services

Organizational Unit Office of Adult Community Behavioral Health

Mailing Address P. O. Box 1797

City Richmond

Zip Code 23219-1797

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Ellen

Last Name Harrison

Agency Name Virginia Department of Behavioral Health and Developmental Services

Mailing Address P. O. Box 1797

City Richmond

Zip Code 23219-1797

Telephone 804-625-1273

Fax 804-786-9248

Email Address ellen.harrison@dbhds.virginia.gov

State CMHS Unique Entity Identification

Unique Entity ID KBKZM4SJ7D65

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Virginia Department of Behavioral Health and Developmental Services

Organizational Unit Office of Adult Community Behavioral Health

Mailing Address P.O. Box 1797

City Richmond

Zip Code 23218-1797

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Margaret

Last Name Steele

Agency Name Virginia Department of Behavioral Health and Developmental Services

Mailing Address PO Box 1797

City Richmond

Zip Code	23218
Telephone	804-655-4432
Fax	804-786-9248
Email Address	margaret.steele@dbhds.virginia.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name	
Last Name	
Agency Name	
Mailing Address	
City	
Zip Code	
Telephone	
Fax	
Email Address	

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From	
To	

V. Date Submitted

Submission Date	
Revision Date	

VI. Contact Person Responsible for Application Submission

First Name	Nathanael
Last Name	Rudney
Telephone	804-944-1037
Fax	804-786-9248
Email Address	nathanael.rudney@dbhds.virginia.gov

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SUPTRS]

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: John Littel

Signature of CEO or Designee[1]: _____

Title: Commonwealth Secretary of Health and Human Services

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

COMMONWEALTH of VIRGINIA

NELSON SMITH
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

July 11, 2023

DECISION MEMORANDUM

TO: The Honorable John Littel
Secretary of Health and Human Resources

THROUGH: Nelson Smith
Commissioner, DBHDS

FROM: Nathanael Rudney
State Block Grant Planner, DBHDS

SUBJECT: Federal Mental Health Community Services and Substance Abuse Prevention and Treatment Block Grant Funding Agreements

I. PURPOSE

The purpose of this decision memorandum is to provide background information on the past FFY 2022 and 2023 block grant awards for the purpose of requesting to have Secretary Littel sign the 2024 funding agreements for both the Mental Health Block Grant (MHBG) and the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRSBGBG).

II. BACKGROUND

Grantees use the block grant programs for prevention, treatment, recovery support, and other services to supplement Medicaid, Medicare, and private insurance services. Specifically, block grant recipients use the awards for the following purposes:

- Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.
- Fund those priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery that are not covered by Medicaid, Medicare, or private insurance.
- Fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment.
- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support.

Substance Use Prevention Treatment and Recovery Services Block Grant (SUPTRSBG)
*****formerly Substance Abuse Prevention and Treatment (SAPT) Block Grant***

Virginia received SUPTRSBG awards of $43.6M for federal fiscal year 2022 and $47.6M for 2023. Both the MHBG and SUPTRSBG awards provide funding support for community services boards, peer run programs, and contracts with organizations for peer, family, and workforce education/training support.
Grantees use the funds to plan, implement, and evaluate activities that prevent and treat substance abuse and promote public health.
The SUPTRSBG funds treatment and prevention services which include all levels of community-based treatment services as well as education, outreach, and community coordination/team building at the prevention level. The SUPTRSBG also includes a special focus on services to pregnant and parenting women, as well as individuals who inject drugs.

Community Mental Health Services Block Grant (MHBG)

Virginia received MHBG awards in federal fiscal year 2022 of $20.9M and in 2023 of $24.5M.

MHBG funds are designated to reduce states' reliance on hospitalization and develop effective community-based MH services for adults with adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED)

The MHBG and SUPTRSBG awards provide funding support for community services boards, peer run programs, and contracts with organizations for peer, family, and workforce education/training support.

III. JUSTIFICATION

SAMHSA's SUPTRSBG and MHBG are designed to provide states with the flexibility to design and implement activities and services to address the complex needs of individuals, families, and communities impacted by mental and substance use disorders and associated problems. The goals of the block grant programs are consistent with SAMHSA's vision for a high-quality and satisfying community-based life for everyone in America. This life in the community includes: (a) A physically and emotionally healthy lifestyle (health):

a. (b) A stable, safe and supportive place to live (a home);
b. (c) Meaningful daily activities such as a job, school, volunteerism, family caretaking, or creative endeavors and the independence, income, and resources to participate in society (a purpose); and
c. (d) Relationships and social networks that provide support, friendship, love, and hope (a community).

Additional aims of the block grant programs reflect SAMHSA's overall mission and values, specifically:

- To promote participation by people with mental and substance use disorders in shared decision making and self-direction of their services and supports.

- To ensure access to effective culturally and linguistically appropriate services for underserved populations including Tribes, racial and ethnic minorities, and LGBTQ+ individuals.
- To promote recovery, resiliency, and community integration for adults with serious mental illness and children with serious emotional disturbances and their families.
- To prevent the use, misuse, and abuse of alcohol, tobacco products, illicit drugs, and prescription medications.
- To conduct outreach to encourage individuals injecting or using illicit and/or licit drugs to seek and receive treatment.
- To provide early intervention services for HIV at the sites at which individuals receive substance use disorder treatment services.
- To coordinate behavioral health prevention, early identification, treatment and recovery support services with other health and social services.
- To increase accountability for prevention, early identification, treatment, and recovery support activities through uniform reporting regarding substance use and abstinence, criminal justice involvement, education, employment, housing, and recovery support services.
- To ensure access to a comprehensive system of care, including education, employment, housing, case management, rehabilitation, dental services, and health services, as well as behavioral health services and supports.
- To provide continuing education regarding substance abuse prevention and substance use disorder treatment services to any facility or program receiving amounts from the SUPTRSBGBG for such activities or services.

SAMHSA's and other federal agencies' focus on accountability, person directed care, family driven care for children and youth, underserved minority populations, Tribal sovereignty, and comprehensive planning across health and specialty care services are reflected in these goals.

IV. RECOMMENDATION

Sign the 2024 MHBG and SUPTRSBGBG funding agreements.

V. APPROVAL:

☑ Recommend ☐ Recommend with Modification ☐ Deny

Nelson Smith, DBHDS Commissioner — Date 11/14/2023

☑ Recommend ☐ Recommend with Modification ☐ Deny

John Littel, Secretary of Health and Human Services — Date 7/12/23

COMMONWEALTH of VIRGINIA

Office of the Governor

Glenn Youngkin
Governor

March 25, 2022

Odessa Crocker, Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
5600 Fisher Lane, Rm. 17E20
Rockville, MD 20857

Dear Ms. Crocker:

I am delegating responsibility for the administration of Virginia's Community Mental Health Services (CMHS) Block Grant and Substance Abuse Prevention and Treatment (SAPT) Block Grant to Nelson Smith, Commissioner of the Virginia Department of Behavioral Health and Developmental Services, effective this date. Questions concerning these grants should be directed to the Commissioner's office at:

Virginia Department of Behavioral Health and Developmental Services
Post Office Box 1797
Richmond, VA 23218
Telephone: (804) 786-3921

I am also authorizing John Littel, Secretary of Health and Human Resources for the Commonwealth, to sign the required certifications and assurances required for application to the Substance Abuse and Mental Health Services Administration of the CMHS and SAPT Block Grants for this and subsequent years of my administration.

Sincerely,

Glenn Youngkin

cc: The Honorable John Littel., Secretary of Health and Human Resources
Nelson Smith, Virginia Department of Behavioral Health and Developmental Services

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Block Grants General Overview

Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)

Grantees use the funds to plan, implement, and evaluate activities that prevent and treat substance abuse and promote public health.

Community Mental Health Services Block Grant (MHBG)

Grantees use the funds to provide comprehensive, community-based mental health services to adults with serious mental illnesses and to children with serious emotional disturbances and to monitor progress in implementing a comprehensive, community-based mental health system.

What are the Purposes of a Block Grant?

Grantees use the block grant programs for prevention, treatment, recovery support, and other services to supplement Medicaid, Medicare, and private insurance services. Specifically, block grant recipients use the awards for the following purposes:

- Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.
- Fund those priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery that are not covered by Medicaid, Medicare, or private insurance.
- Fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment.
- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services.

Block Grants in Virginia

Virginia received MHBG awards of $20.9M in 2022 and $24.5M respectively as well as SABG awards of $43.6M for 2022 and $47.6M for 2023. The MHBG and SABG awards provide funding support for community services boards, peer run programs, and contracts with organizations for peer, family, and workforce education/training support.

The MHBG funds treatment and support services for adults with SMI, children and youth with SED, geriatric mental health services, evidence-based practices, and consumer-directed programs offering specialized services promoting wellness, recovery, and improved self-management.

The SABG funds treatment and prevention services which include all levels of community-based treatment services as well as education, outreach, and community coordination/team building at the prevention level. The SABG also includes a special focus on services to pregnant and parenting women, as well as individuals who inject drugs.

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SUPTRS]

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52

Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.), (f) conformity of Federal actions

to State (Clear Air Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U S C §§7401 et seq), (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205)

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U S C §§1271 et seq) related to protecting components or potential components of the national wild and scenic rivers system
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U S C §§469a-1 et seq.).
14. Will comply with P.L 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U S C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State Virginia

Name of Chief Executive Officer (CEO) or Designee John E. Littel

Signature of CEO or Designee[1]

Title Secretary of Health & Human Resources

Date Signed 7/12/23

mm/dd/yyyy

[1] If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

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Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Section 1920	Early Serious Mental Illness	42 USC § 300x-9
Section 1920	Crisis Services	42 USC § 300x-9
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U S C 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions (If needed, Standard Form-LLL "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352 U S Code Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true complete and accurate to the best of his or her knowledge and that he or she is aware that any false fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health daycare early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments by Federal grant contract loan, or loan guarantee The law also applies to children's services that are provided in indoor facilities that are constructed operated or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment. service providers whose sole source of applicable Federal funds is Medicare or Medicaid or facilities where WIC coupons are redeemed

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80) to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX Part B Subpart II and Subpart III of the Public Health Service (PHS) Act as amended and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement

I also certify that the state or territory will comply with the Assurances Non Construction Programs and Certifications summarized above

Name of Chief Executive Officer (CEO) or Designee John E. Littel

Signature of CEO or Designee[1]

Title Secretary of Health & Human Resources

Date Signed 7/12/23 mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached

Please upload your state's Bipartisan Safer Communities Act (BSCA) 2nd allotment proposal to here in addition to other documents You may also upload it in the Attachments section of this application

Based on the guidance issued on October 11th 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment The performance period for the second allotment is from September 30th 2023 to September 29th 2025, and the proposal should be titled "BSCA Funding Plan 2024 The proposed plans are due to SAMHSA by September 1 2023

OMB No. 0930-0168 Approved 04/19/2021 Expires 04/30/2024

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**

Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

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b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
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   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
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1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
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Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

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The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

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The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: John Littel

Signature of CEO or Designee[1]: _____

Title: Secretary of Health and Human Services Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

COMMONWEALTH of VIRGINIA

NELSON SMITH
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

July 11, 2023

DECISION MEMORANDUM

TO: The Honorable John Littel
Secretary of Health and Human Resources

THROUGH: Nelson Smith
Commissioner, DBHDS

FROM: Nathanael Rudney
State Block Grant Planner, DBHDS

SUBJECT: Federal Mental Health Community Services and Substance Abuse Prevention and Treatment Block Grant Funding Agreements

I. PURPOSE

The purpose of this decision memorandum is to provide background information on the past FFY 2022 and 2023 block grant awards for the purpose of requesting to have Secretary Littel sign the 2024 funding agreements for both the Mental Health Block Grant (MHBG) and the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRSBGBG).

II. BACKGROUND

Grantees use the block grant programs for prevention, treatment, recovery support, and other services to supplement Medicaid, Medicare, and private insurance services. Specifically, block grant recipients use the awards for the following purposes:

- Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.
- Fund those priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery that are not covered by Medicaid, Medicare, or private insurance.
- Fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment.
- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support.

Substance Use Prevention Treatment and Recovery Services Block Grant (SUPTRSBG)
*****formerly Substance Abuse Prevention and Treatment (SAPT) Block Grant***

Virginia received SUPTRSBG awards of $43.6M for federal fiscal year 2022 and $47.6M for 2023. Both the MHBG and SUPTRSBG awards provide funding support for community services boards, peer run programs, and contracts with organizations for peer, family, and workforce education/training support.
Grantees use the funds to plan, implement, and evaluate activities that prevent and treat substance abuse and promote public health.
The SUPTRSBG funds treatment and prevention services which include all levels of community-based treatment services as well as education, outreach, and community coordination/team building at the prevention level. The SUPTRSBG also includes a special focus on services to pregnant and parenting women, as well as individuals who inject drugs.

Community Mental Health Services Block Grant (MHBG)

Virginia received MHBG awards in federal fiscal year 2022 of $20.9M and in 2023 of $24.5M.

MHBG funds are designated to reduce states' reliance on hospitalization and develop effective community-based MH services for adults with adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED)

The MHBG and SUPTRSBG awards provide funding support for community services boards, peer run programs, and contracts with organizations for peer, family, and workforce education/training support.

III. JUSTIFICATION

SAMHSA's SUPTRSBG and MHBG are designed to provide states with the flexibility to design and implement activities and services to address the complex needs of individuals, families, and communities impacted by mental and substance use disorders and associated problems. The goals of the block grant programs are consistent with SAMHSA's vision for a high-quality and satisfying community-based life for everyone in America. This life in the community includes: (a) A physically and emotionally healthy lifestyle (health):

a. (b) A stable, safe and supportive place to live (a home);
b. (c) Meaningful daily activities such as a job, school, volunteerism, family caretaking, or creative endeavors and the independence, income, and resources to participate in society (a purpose); and
c. (d) Relationships and social networks that provide support, friendship, love, and hope (a community).

Additional aims of the block grant programs reflect SAMHSA's overall mission and values, specifically:

- To promote participation by people with mental and substance use disorders in shared decision making and self-direction of their services and supports.

- To ensure access to effective culturally and linguistically appropriate services for underserved populations including Tribes, racial and ethnic minorities, and LGBTQ+ individuals.
- To promote recovery, resiliency, and community integration for adults with serious mental illness and children with serious emotional disturbances and their families.
- To prevent the use, misuse, and abuse of alcohol, tobacco products, illicit drugs, and prescription medications.
- To conduct outreach to encourage individuals injecting or using illicit and/or licit drugs to seek and receive treatment.
- To provide early intervention services for HIV at the sites at which individuals receive substance use disorder treatment services.
- To coordinate behavioral health prevention, early identification, treatment and recovery support services with other health and social services.
- To increase accountability for prevention, early identification, treatment, and recovery support activities through uniform reporting regarding substance use and abstinence, criminal justice involvement, education, employment, housing, and recovery support services.
- To ensure access to a comprehensive system of care, including education, employment, housing, case management, rehabilitation, dental services, and health services, as well as behavioral health services and supports.
- To provide continuing education regarding substance abuse prevention and substance use disorder treatment services to any facility or program receiving amounts from the SUPTRSBGBG for such activities or services.

SAMHSA's and other federal agencies' focus on accountability, person directed care, family driven care for children and youth, underserved minority populations, Tribal sovereignty, and comprehensive planning across health and specialty care services are reflected in these goals.

IV. RECOMMENDATION

Sign the 2024 MHBG and SUPTRSBGBG funding agreements.

V. APPROVAL:

☑ Recommend ☐ Recommend with Modification ☐ Deny

Nelson Smith, DBHDS Commissioner — Date 11/14/2023

☑ Recommend ☐ Recommend with Modification ☐ Deny

John Littel, Secretary of Health and Human Services — Date 7/12/23

COMMONWEALTH of VIRGINIA

Office of the Governor

Glenn Youngkin
Governor

March 25, 2022

Odessa Crocker, Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
5600 Fisher Lane, Rm. 17E20
Rockville, MD 20857

Dear Ms. Crocker:

I am delegating responsibility for the administration of Virginia's Community Mental Health Services (CMHS) Block Grant and Substance Abuse Prevention and Treatment (SAPT) Block Grant to Nelson Smith, Commissioner of the Virginia Department of Behavioral Health and Developmental Services, effective this date. Questions concerning these grants should be directed to the Commissioner's office at:

Virginia Department of Behavioral Health and Developmental Services
Post Office Box 1797
Richmond, VA 23218
Telephone: (804) 786-3921

I am also authorizing John Littel, Secretary of Health and Human Resources for the Commonwealth, to sign the required certifications and assurances required for application to the Substance Abuse and Mental Health Services Administration of the CMHS and SAPT Block Grants for this and subsequent years of my administration.

Sincerely,

Glenn Youngkin

cc: The Honorable John Littel., Secretary of Health and Human Resources
Nelson Smith, Virginia Department of Behavioral Health and Developmental Services

Patrick Henry Building • 1111 East Broad • Richmond, Virginia 23219
(804) 786-2211 • TTY (800) 828-1120
www.governor.virginia.gov

Block Grants General Overview

Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)

Grantees use the funds to plan, implement, and evaluate activities that prevent and treat substance abuse and promote public health.

Community Mental Health Services Block Grant (MHBG)

Grantees use the funds to provide comprehensive, community-based mental health services to adults with serious mental illnesses and to children with serious emotional disturbances and to monitor progress in implementing a comprehensive, community-based mental health system.

What are the Purposes of a Block Grant?

Grantees use the block grant programs for prevention, treatment, recovery support, and other services to supplement Medicaid, Medicare, and private insurance services. Specifically, block grant recipients use the awards for the following purposes:

- Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.
- Fund those priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery that are not covered by Medicaid, Medicare, or private insurance.
- Fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment.
- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services.

Block Grants in Virginia

Virginia received MHBG awards of $20.9M in 2022 and $24.5M respectively as well as SABG awards of $43.6M for 2022 and $47.6M for 2023. The MHBG and SABG awards provide funding support for community services boards, peer run programs, and contracts with organizations for peer, family, and workforce education/training support.

The MHBG funds treatment and support services for adults with SMI, children and youth with SED, geriatric mental health services, evidence-based practices, and consumer-directed programs offering specialized services promoting wellness, recovery, and improved self-management.

The SABG funds treatment and prevention services which include all levels of community-based treatment services as well as education, outreach, and community coordination/team building at the prevention level. The SABG also includes a special focus on services to pregnant and parenting women, as well as individuals who inject drugs.

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SUPTRS]

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52

Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683 and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.), (f) conformity of Federal actions

to State (Clear Air Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U S C §§7401 et seq), (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205)

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U S C §§1271 et seq) related to protecting components or potential components of the national wild and scenic rivers system
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U S C §§469a-1 et seq.).
14. Will comply with P.L 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U S C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: Virginia

Name of Chief Executive Officer (CEO) or Designee: John E. Littel

Signature of CEO or Designee[1]: John Littel

Title: Secretary of Health & Human Resources

Date Signed: 7/12/23

mm/dd/yyyy

[1] If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Section 1920	Early Serious Mental Illness	42 USC § 300x-9
Section 1920	Crisis Services	42 USC § 300x-9
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award, and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U S C §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P L 93-523), and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U S C 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions (If needed, Standard Form-LLL "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352 U S Code Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true complete and accurate to the best of his or her knowledge and that he or she is aware that any false fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health daycare early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments by Federal grant contract loan, or loan guarantee The law also applies to children's services that are provided in indoor facilities that are constructed operated or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid or facilities where WIC coupons are redeemed

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80) to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
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4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX Part B Subpart II and Subpart III of the Public Health Service (PHS) Act as amended and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement

I also certify that the state or territory will comply with the Assurances Non Construction Programs and Certifications summarized above

Name of Chief Executive Officer (CEO) or Designee John E. Littel

Signature of CEO or Designee[1]

Title Secretary of Health & Human Resources

Date Signed 7/12/23 mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached

Please upload your state's Bipartisan Safer Communities Act (BSCA) 2nd allotment proposal to here in addition to other documents You may also upload it in the Attachments section of this application

Based on the guidance issued on October 11th 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment The performance period for the second allotment is from September 30th 2023 to September 29th 2025, and the proposal should be titled "BSCA Funding Plan 2024 The proposed plans are due to SAMHSA by September 1 2023

OMB No. 0930-0168 Approved 04/19/2021 Expires 04/30/2024

Footnotes:

Virginia 9-8-8 Supplemental Grant and Bipartisan Safer Communities Act 2nd Allotment Proposal to Expand Marcus Alert and Warmline

December 29, 2022

1220 BANK STREET • P.O. BOX 1797 • RICHMOND, VIRGINIA 23218-1797 PHONE: (804) 786-3921 FAX: (804) 371-6638 • WEB SITE: WWW.DBHDS.VIRGINIA.GOV

Table of Contents

A. Population of Focus and Statement of Need

In general, suicide deaths in Virginia have increased slowly since 1999. Trends include an increase of 25% between 2010 and 2018, as well as a recent slight decrease (4.3% decrease from 2018 to 2019)[1]. During this time period, Virginia has been making concerted efforts to improve and increase crisis services available to Virginians, including investments in Suicide Prevention and Mental Health First Aid initiatives, crisis stabilization units for youth and adults, mobile crisis for individuals with developmental disabilities, and mobile crisis for youth, and most recently, adults. Regarding infrastructure for accessing crisis services, Virginia currently utilizes 40 crisis lines managed by geographically based Community Services Boards and Behavioral Health Authority (CSB/BHA) for the provision of emergency behavioral health services, including prescreening for psychiatric hospitalization (24/7/365). In preparation for the implementation of 9-8-8 and in line with moving towards a Crisis Now model of crisis services, Virginia is in the process of building regional infrastructure for increased phone support capacity as well as mobile crisis and the integration of a statewide data platform for coordination across the continuum.

1. List of Interrelated Projects or Initiatives

Given the local, regional, and state components of the system build out, there are a number of groups and projects with overlapping interest in the successful implementation of 98-8—a non-exhaustive list is provided here to demonstrate the range of interrelated projects or initiatives.

Name of Group or Initiative	Description
Suicide Prevention Interagency Advisory Group (SPIAG)	Coordination of suicide prevention efforts across the lifespan. Most recent plan for download: Virginia Suicide Prevention Plan

[1] Virginia Department of Health Office of the Chief Medical Examiner, https://www.vdh.virginia.gov/content/uploads/sites/18/2021/06/Annual-Report-2019-FINAL.pdf

STEP-VA	Systems Transformation, Excellence, and Performance (STEP-VA) is a Virginia legislative initiative to improve access, quality, consistency, and accountability in Virginia's public behavioral health safety net system. It includes 9 core services ("STEPs") which, upon full implementation, will be code mandated at each of 40 CSB/BHAs. One STEP includes crisis services and the funding for this STEP has been used to build regional mobile crisis response teams.
Project BRAVO	Project BRAVO (Behavioral health Redesign for Access, Value, and Outcomes) refers to an ongoing initiative to enhance Virginia's behavioral health Medicaid services. Phase 1 included 4 new crisis rates to support the broader crisis system transformation and include mobile crisis response, community stabilization, 23-hour observation, and crisis stabilization unit (per diem).
Marcus Alert	"Marcus Alert" refers to local protocols and other requirements per the Marcus-David Peters Act. These include protocols for diverting calls from 9-1-1 to 9-8-8, protocols for coordination between 9-8-8 and law enforcement, and law enforcement specific protocols related to individuals in behavioral health crisis. It has been initially implemented in 5 areas and is required statewide by 2026.
REACH and DOJ Settlement	The REACH (Regional Education Assessment Crisis Services Habilitation) Program is a regional crisis program for individuals with developmental disabilities. Under a DOJ settlement, Virginia is required to build out crisis services for individuals with developmental disabilities. Virginia is building infrastructure for 9-8-8 and crisis dispatch to be cross-disability and respond to anyone regardless of disability.

B. Critical Needs

These initiatives, as well as the activities supported by the recent 9-8-8 Vibrant planning grant and the passage of Senate Bill 1302 (McPike) which establishes a surcharge on wireless plans to provide sustainable funding to 9-8-8 call centers and mobile crisis, provide a foundation for the implementation of 9-8-8 in Virginia, but extensive work remains.

Prior to the Vibrant capacity building grant, Virginia's in state answer rate was at 69% from January-March 2019. In the first year of the grant, the in-state answer rate was 66% for 29,728 NSPL calls with an average monthly call volume of 2,477 calls. Virginia had an increase in monthly call volume in the following year 2021 seeing an average in-state call volume of 4045 (74.7% increase from 2019). This increase in volume led to a lag in answer rate initially, with answer rate falling to 51% (5,684/11,148) in July-September 2020. Efforts to improve the capabilities of the call centers and enhance staffing led to the answer rate beginning to climb in May and culminating in an answer rate of 69% (9117/13268) for July - September 2021, which represents a 29.3% increase in volume from the January-March 2019. Specific needs have been identified through the last year of planning which include a need to increase our in-state answer rate, increase staff capacity through training, recruitment, and retention efforts and innovations, improve coordination, communication, and proactive consideration of privacy concerns, and begin planning for chat and text.

Centers currently answering the NSPL in the state of Virginia include Peer Recovery Services CrisisLink (PRS CL) in Fairfax County, Frontier Health, and ACTS in Prince William County. All centers have Dual Tone Multi-Frequency (DTMF) capability. Recently, the five DBHDS regions sought and selected proposals for call center services on a regional basis. PRS CL was contracted by Regions 1, 2, 4, and 5, and Frontier was contracted by Region 3. Thus, it is a critical need that we continue to build out the infrastructure needed, including back-up call centers as well as workforce development initiatives that are needed statewide. A description of each participating call center is provided here:

PRS CL provides 24/7/365 hotline service to Regions 1, 2, 4 and 5 through the NSPL and has dedicated phone line for NSPL rollover calls in addition to local crisis hotlines, PSAP diversion, and mobile crisis requests. PRS CL is a current provider of National Back-Up for the NSPL and is a Core Chat Center. PRS CL is fully accredited by the American Association of Suicidology (AAS) through April 2025 and through The International Council for Helplines (ICH) through January 2025 in both hotline and online emotional support. PRS CL was recognized in 2020 as an AAS Crisis Center of Excellence due to the impressive shift from fully in-person to fully remote in response to COVID-19 and developing a model for the virtual call center space. PRS CL has been an active and engaged crisis center throughout the Capacity Building Grant process, increasing the overall capacity of the state. PRS CL's capacity growth has increased monthly answered calls from 871 (81%) in January 2021 to 2,455 (89%) in December 2021, an 181% increase in volume and achieving nearly 9% answer rate increases. PRS CL has achieved a reduction in ASA from 00:39 seconds in January 2021 to 00:21 seconds in

December 2021. Not only has capacity increased, but performance has also paced parallel to the growth. PRS CL uses a blended staffing model of licensed staff, paid crisis workers (specialists/counselors), and volunteers with lived experience diversifying staffing and expanding capacity without compromising quality.

Frontier Health currently operates a centralized 24/7/365 Crisis Call Center which supports eight counties in NE TN as the designated crisis provider and is currently accredited through CARF. Frontier also participated in a capacity building grant last year in collaboration with the TN Department of Mental Health and Substance Abuse Services and NSPL to provide crisis call center services to additional counties outside their existing service area. The Call Center currently supports a total of approximately 15,000 calls annually with a 90% answer rate. Our average time to answer is 00.00.06. Frontier has a dedicated phone line for NSPL calls and supports NSPL as a National Back-up Center as well. Frontier has a robust training for Call Center staff that includes HELP, QPR, ASIST, CALM, SafeTalk, Lifeline Simulated calls, Active Shooter, Military/LGBTQ Competence to name a few. Frontier has completed numerous nationwide Active Rescues along with warmline transfers. Frontier also provides qualified clinical staff on site at all times to assist with active rescues, support to call center staff in need of debriefing or to provide assistance with challenging calls.

C. Proposed Implementation Approach

Our proposed implementation approach is designed to build critical capacity and meet goals in four areas: chat/text and peer warmline capacity, API linkage to 211, localized communication, marketing, and improved coordination with PSAP/911 through technical assistance.

1. Improving Chat/Text/Peer warmline capacity

Currently, text, chat and the integration of peers warmline activities have not been implemented in Virginia despite a growing need for both resources. State demand for chat has risen from 115 in August of 2021 to 1,511 for June of this year, with the text state demand also increasing from 139 to 1,537 over the same time frame. The two state call centers currently do not offer in-state text/chat support and require staffing, technological, and licensing needs addressed to be able to successfully achieve this goal.

In tandem with this text/chat project, we would like to increase access to peer warmline services as an analogous project that can either leverage existing peer warmline services in state or build off staff enhancements at in state NSPL call centers to provide a backbone of that functionality as we formalize relationships within state warmlines and enhance the capacity moving forward.

Planned activities for each call center

1. PRS CrisisLink will utilize and assess current chat/text capabilities and necessary licenses to achieve 24/7 coverage of this service within state. PRS is currently a core chat provider for

Vibrant and may be able attain accreditation for in-state coverage if the appropriate resources are allocated to this goal.

2. Frontier Health would utilize grant funds to increase capacity through obtaining the technological needs necessary and address the staffing compliment that could be utilized once the appropriate accreditation is obtained. Potential licenses for staff and other capacity needs for achieving chat/text capability would be utilized with these funds.
3. Both Frontier and PRS will explore the potential ability to gain economy of scale in peer warmline services through this effort or identify partners to assist with peer warmline transfers that may be subject to ongoing funding the state will seek to provide.

Items Addressed through effort:

1. Identify multidisciplinary mobile crisis team(s) that can be deployed rapidly, 24/7, throughout the state to address the mental health components during an emergency/crisis.
2. Develop culturally and linguistically tailored messaging about behavioral health to provide in a crisis/mental health emergency and/or identify culturally/linguistically appropriate supports for diverse populations. Leverage relationships with Lifeline 988, statewide call centers, peer recovery organizations, faith-based organizations, warmlines, telehealth and provider mutual aid agreements to disseminate. Ensure that electronic bed registries include information about the availability of culturally/linguistically accessible services.

D. Staff and Organizational Experience

The purpose of a crisis continuum of services is to ensure the availability of care to meet people where they are when they are experiencing a crisis because of an acute mental health or behavioral emergency. Crisis services are intended to help ensure people with behavioral health needs can live successfully and productively in their own communities, to reduce use of hospital emergency departments, limit hospitalizations, and decrease unnecessary incarcerations. DBHDS and the office of crisis services and supports is committed to working with the localities to identify funding to sustain the gains made during the two years of the grant period through efforts to develop regional crisis lines that will either merge, collaborate, or partner with the NSPL call centers to assure continued sustainability of the progress made by the state call centers. DBHDS intends to work with our current Lifeline Partners in collaboration with our existing system to ensure a comprehensive crisis line that meets the needs of Virginians and that will be able to link them to appropriate supports and services. The Director of Crisis Services and Supports works to advance the model of a comprehensive, best practice crisis service system for all via strategic systems planning and policy development, maximize efficiencies agency and system wide, and leverage expertise and resources to have as broad an impact as possible in Virginia.

E. Performance Assessment and Data

Virginia is currently implementing a statewide call center data platform. This platform will be where required, and other data points will be captured and also the platform for generating reports regarding system and call center performance. These data will be what is leveraged by the Quality Management System at the state level (described above, Data Management and Reporting activities).

At the time of the grant initiation, the majority of datapoints will be being captured in real-time in the call center data platform. This will include reports which can be run regionally or by call center in addition to statewide for metrics including call volume and patterns in call volume, answer speed, and call-specific information to assess outcomes such as mobile crisis dispatch and linkages and referral to treatment. A phased approach to implementation of the call center data platform is being taken, thus, there are some elements which may not be built into the system at the time of the grant initiation. For any components which are not built into the data platform for real time reporting, monthly reporting will be required of each call center. Based on the current call center data platform implementation plan, all required elements except number of staff supported and number of staff trained will be integrated into the system at the time of this grant initiation. These data will be collected as part of the invoicing/reporting process under each subrecipient funding agreement (Infrastructure, Prevention and Promotion [IPP] report will be submitted along with invoices).

In addition to completing required reporting for purposes of grant administration, performance data will also be used for state-level quality improvement and planning purposes. It will be the responsibility of the Project Evaluator to ensure that timely reports of statewide data are provided once per month at the NSPL biweekly meeting for review, particularly in the initial grant year where the broader quality management system will still be under development. Ultimately, the quality management system structure (e.g., committees, governance) will be responsible for taking a data driven approach to quality improvement and develop quality improvement initiatives to ensure that the KPIs are sustained beyond the timeframe of the grant.

F. Overview of data collection and reporting plan

Data Point/Required Indicator	Source	Staff Responsible for Reporting
# People supported by these funds in the MH and related workforce	Infrastructure, Prevention, and Promotion Indicator (IPP) reported by month, attached to invoice report by each call center	Project Evaluator (will collate between call centers)

% Of people supported by these funds who have received all required and recommended training	IPP reported by month, attached to invoice report by each call center	Project Evaluator
The number of individuals referred to mental health or related services as a result of the grant	Call center data platform (will be added to IPP report if not integrated into platform)	Project Evaluator
The number of individuals screened for mental health or related interventions	Call center data platform	Project Evaluator
The number and percentage of individuals receiving mental health or related services after referral.	Call center data platform	Project Evaluator
The number of organizations that entered into formal written/intraorganizational agreements (e.g., MOUs, MOAs) to improve mental health related practices/activities that are consistent with the goals of the grant.	IPP reported by month, attached to invoice report by each call center (Note: it is not clear at this point whether documentation of MOU/MOAs will be captured in the call center data platform)	Project Evaluator
Contacts that result in (1) emergency rescue; (2) suicide attempts in progress; and (3) mobile crisis outreach referrals	Call center data platform	Project Evaluator
Total calls, chats, and texts received	Call center data platform	Project Evaluator

Total calls, chats, and texts answered	Call center data platform	Project Evaluator
Speed to answer	Call center data platform	Project Evaluator
Abandonment rate	Call center data platform	Project Evaluator
Rollover to national back up	Call center data platform	Project Evaluator

G. Bipartisan Safer Communities Act

Updates for Second Allotment

Virginia is planning to continue the current scope of work from the first allotment with the addition of the following:

Item: Local Marcus Alert System Development					
Activity	Justification	Cost per Unit	**Qty**	**Year 1**	**Year 2**
Evaluation Tools	Evaluation software allowances	$ 3,524.50	1	$ 3,524.50	$ 3,524.50

Second Allotment FEP/ESMI Set Aside

Virginia is also planning to use the additional $12,920 difference from the first allotment amount to continue expanding Coordinated Specialty Care Services for program and staff development within the original scope of work as seen below:

Item: Coordinated Specialty Care					
				Year 1	**Year 2**
Activity	Justification	Cost per Unit	**Qty**		
Coordinated Specialty Care	This line item will provide additional funds to up to five existing or newly formed CSC	$14,000	5	70000	70000

Program Development	programs across Virginia. Funds can be used to meet new program requirements including epiNET participation, funding to fill hard-to-fill team positions, and other one time costs. These will be distributed in the form of grants to teams.					
CSC staff development	This will allow funding for central office staff to remain up to date on training and professional development associated with the CSC program as well as data collection techniques and outcomes.	$6,382	1	6382	6382	
				76382	**76382**	
						Total
						$ 152,764.00

Scope of Work

Virginia is proposing to utilize the Bipartisan Safer Communities Act funds to expand Marcus Alert which is the coordination of 9-8-8 and law enforcement in response to behavioral health crises as well as expand 9-8-8 response capacity statewide. These BSCA funds would be directed to treatment services for individuals with Serious Mental Illness (SMI) through crisis services expansion and continued 9-8-8 development.

The two areas of focus for the BSCA funds based on needs outlined in this proposal would be to provide improved access to mobile crisis services throughout the state. Mobile crisis response teams are deployed via geo location and staffed regionally to ensure that individuals in crisis have access to the unique array of crisis services and ongoing resources within their area. The proposed BSCA funds would allow the call centers to finalize a partially funded startup effort around chat/text and Peer Warmline services at the point of the call center by enhancing the peer staffing compliment at the call centers with the specialized purpose of warmline functions and adding staff to both call centers to achieve in-state answering of chat/text which is not currently done within Virginia.

1. Expanding Marcus Alert and 9-8-8 System Utilizing BSCA Funds

Virginia's plan to utilize the BSCA supplemental funds includes expanding the state's Marcus Alert Systems. A Marcus Alert system requires the local behavioral health, law enforcement, and 9-1-1 call centers to work together to better respond to behavioral health crisis situations.

The three primary components are:

1. Diverting behavioral health calls from 9-1-1 to the Regional Crisis Call Centers (9-8-8 infrastructure)
2. Creation of formalized agreements between law enforcement and mobile crisis teams for emergency backup and
3. A "specialized response" from law enforcement when responding to behavioral health calls.

This requires that the 9-1-1 Call Centers receive additional training, education, and guidance on identifying behavioral health calls that are appropriate for a 9-8-8 transfer versus those calls that may have behavioral health involvement yet still need a traditional first responder dispatch.

Law enforcement agencies are required to create an internal policy that addresses responding to Marcus Alert calls, which are identified by the 9-1-1 Center. At a minimum CIT and Mental Health First Aid officers will be dispatched to identified behavioral health calls. In addition to these nationally recognized trainings the state is also creating cross-disciplinary trainings on equity topics that are relevant when responding to behavioral health crisis with underserved communities.

2. Proposed activity

Though Virginia has made efforts to expand Mobile Crisis response at the regional level, there are still gaps in service availability. The Marcus Alert offers the opportunity for localities to develop either local co-response teams with first responders or create a local behavioral health only mobile crisis team. These teams will help support achieving a 24/7 system to serve individuals in their communities with accessing behavioral health support. Funds would also be utilized to enhance the availability of necessary trainings for law enforcement and 9-1-1 Call Centers.

3. Set-Aside for Early Serious Mental Illness/First Episode Psychosis

Virginia plans to utilize the BSCA ESMI/FEP 10% set aside for coordinated specialty care (CSC) which provides evidence-based multi-systemic comprehensive services to the young adult population first experiencing psychotic symptoms or early significant mental health issues. Virginia has utilized this approach since 2014 and has needs for expanding CSC services to underserved parts of the state.

Virginia's Coordinated Specialty Care program currently includes a total of 11 teams, eight of which are fully operational. Individuals served by each team are as follows:

Community Services Board	Individuals Served in FY23 to date	Total Individual Served Since Start of CSC
Fairfax – Falls Church	39	190
Western Tidewater	45	120
Highlands	21	113
Alexandria	17	160
Loudoun	37	134
Henrico	32	173
Prince William	23	277
Rappahannock-Rapidan	19	50
TOTAL	**233**	1017

In addition to the eight CSBs, there are three new teams being formed at Blue Ridge Behavioral Health, Mount Rogers, and Arlington CSBs. Neither Mount Rogers nor Blue Ridge currently have any participants in the program, and Arlington has served 7 participants total to date.

This year, the Virginia General Assembly directed Virginia Medicaid and DBHDS to complete a five year strategic plan for the CSC program. It was required that the plan include enhancing current programs, expanding the intervention to underserved areas, develop a foundational funding strategy, and develop a private insurance funding strategy. The additional funds coming to the mental health block grant via BSCA for this purpose will be used to support the implementation of the strategic plan, specifically, to enhance and expand services. It is estimated that five programs will be enhanced through this additional grant opportunity, in addition to the technical assistance developed and delivered from DBHDS central office. Milestones relevant to enhancement and expansion in the first two years are as follows:

Year 1
1. Establish plan for engaging training and support from ONTrackNY or NAVIGATE.
2. Establish recommendations for detection of early psychosis.

3. Establish plan for enhanced data collection and outcomes analysis base on agreed upon core set of measures.
4. DBHDS has expanded support to 3 new CSC teams.
5. Conduct assessment of underserved areas for strategic team development.
Year 2
1. Roll out training and support to existing and new CSC providers through DBHDS
2. Put recommendations to action for detection of early psychosis.
3. Roll out enhanced data collection and analysis for DBHDS to existing CSC CSB providers for DBHDS.

4. Crisis Set-Aside

The 5% Crisis Set-Aside will be utilized to fund positions providing evidence-based crisis services recommended in the SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit which include mobile crisis, crisis care service coordination between law enforcement and mental health services, crisis triage, and public safety answering points (PSAP). Additionally, the set-aside will be utilized to fund training for evidence-based services and methodology related to centrally deployed 24/7 mobile crisis units, short-term residential crisis stabilization beds, evidence-based protocols for delivering services to individuals with suicide risk, and regional or State-wide crisis call centers coordinating in real time.

SAMHSA requests that the crisis set-aside is utilized to fund crisis call centers and mobile crisis. 988 Virginia is the entry point for crisis services and response in the state and therefore is a crisis call center system. Additionally, Marcus Alert is the system developed utilizing evidence-based practices recommended by SAMHSA that diverts 911 calls to 988 for appropriate mental health crisis response in a mental health crisis situation.

Crisis Set-Aside- BSCA funds

Activities	Year 1	Year 2	Total	Justification
Mobile Crisis or Coordinated-	**$300,000.00**	**$300,000.00**	**$600,000.00**	**Responsible for coordinating 911, Law Enforcement, and Mental Health agency to**

Response Team Staff				**develop a plan for implementation and ongoing evaluation of the program. Responsible for collaborating with Virginia DBHDS. Salary $80,000 x 20% fringe = $100,000.**
Crisis / Triage Specialist	**$122,050.00**	**$122,050.00**	**$244,100.00**	**Staff responsible for answering texts/cats/calls coming through 988; Salary $44,221 x 38% fringe = $61,025.00**
Local Program Coordinator	**$100,000.00**	**$100,000.00**	**$200,000.00**	**Responsible for coordinating 911, Law Enforcement, and Mental Health agency to develop a plan for implementation and ongoing evaluation of the program. Responsible for collaborating with Virginia DBHDS. Salary $80,000 x 20% fringe = $100,000.**
Regional Marcus Alert Coordinator	**$34,510.75**	**$34,510.75**	**$69,021.50**	**Contribution to the salary of the regional Marcus alert coordinator position, who coordinates regional mobile crisis responses, connecting locality resources across the entire region and coordinates with DBHDS to ensure program objectives are being met.**
PSAP Fees (Marcus Alert Data)	**$15,000.00**	**$10,600.00**	**$25,600.00**	**Estimated fees for Public Safety Answering Points to update their computer aided dispatch (CAD) systems to**

				capture data for Marcus Alert evaluation
Evidence-Based Crisis Services Training	**$25,000.00**	**$25,000.00**	**$50,000.00**	**Training for evidence-based services and methodology related to centrally deployed 24/7 mobile crisis units, short-term residential crisis stabilization beds, evidence-based protocols for delivering services to individuals with suicide risk, and regional or State-wide crisis call centers coordinating in real time.**
Total	**$596,560.75**	**$592,160.75**	**$1,188,721.50**	

Appendix A- Budget for BSCA Funds

Item: Local Marcus Alert System Development

Activity	Justification	Cost per Unit	**Qty**	**Year 1**	**Year 2**
Mobile Crisis or Co-Response Team Staff	This team will respond to behavioral health crisis occurring in the community. Mobile crisis teams are dispatched by the crisis call centers per the Crisis Now Model and Co-Response teams consist of law enforcement or emergency medical services along with behavioral health staff for treatment and recovery services for SED/SMI. Salary $80,000 x 20% fringe = $100,000.	$ 100,000.00	3	$ 300,000.00	$ 300,000.00
Uniforms	Polos, rain jackets, etc. for mobile crisis delivery in treatment and recovery services for SMI/SED	$ 250.00	3	$ 750.00	
Cell Phones	For communication with supervisors and gps for mobile crisis dispatch for treatment and recovery services for SMI/SED; year 1 phones and lines; year 2 lines	$ 500.00	3	$ 1,500.00	$ 200.00
Computers	For documentation and utilization of crisis data platform for delivery of treatment and recovery services for SMI/SED	$ 1,500.00	3	$ 4,500.00	
Travel Expenses	Gas, maintenance, etc. for mobile crisis services for treatment and recovery for SMI/SED	$ 2,500.00	1	$ 2,500.00	$ 2,500.00
Local Program Coordinator	Responsible for coordinating 911, Law Enforcement, and Mental Health agency to develop a plan for implementation and ongoing evaluation of the program. Responsible for collaborating with	$ 100,000.00	1	$ 100,000.00	$ 100,000.00

	Virginia DBHDS. Salary $80,000 x 20% fringe = $100,000.					
Training and Conferences for Staff	Attendance at conferences and other training opportunities in treatment and recovery services for SMI/SED for key staff	$ 5,000.00	3	$ 15,000.00	$ 15,000.00	
Training	Implementation of state developed trainings for crisis response, Mental Health First Aid, and Crisis Intervention Training for the treatment and recovery services for SMI/SED	$ 10,000.00		$ 10,000.00	$ 10,000.00	
PSAP Fees	Estimated fees for Public Safety Answering Points to update their computer aided dispatch (CAD) systems to capture data for Marcus Alert evaluation	$ 15,000.00	1	$ 15,000.00		
Regional Marcus Alert Coordinator	Contribution to the salary of the regional Marcus alert coordinator position, who coordinates regional mobile crisis responses, connecting locality resources across the entire region and coordinates with DBHDS to ensure program objectives are being met.			$ 34,510.75	$ 34,510.75	
Data Analysis	Contribution to the salary of analyst to provide evaluation services to the mobile crisis program. Salary $50,000 x 20% fringe = $60,000.	$ 60,000.00	1	$ 60,000.00	$ 60,000.00	**2nd Allotment Addition**
Evaluation Tools	Evaluation software allowances	$ 3,524.50	1	$ 3,524.50	$ 3,524.50	**2nd Allotment Addition**
				$ 547,285.25	**$ 525,735.25**	

Item: Chat/Text and Peer Warmline development for 988 crisis services delivery for SMI/SED						
Activity	Justification	Cost per Unit	**Qty**	**Year 1**	**Year 2**	
Crisis/Triage Specialist	Staff responsible for answering texts/chats/calls coming through 988; Salary $44,221 x 38% fringe = $61,025.00	$ 61,025.00	2	$ 122,050.00	$ 122,050.00	
Supplies	Including Supplies, Telephone, Postage & Shipping, Occupancy, Equipment Rental & Maintenance, Printing & Publications			$ 9,790.75	$ 9,790.75	
Occupancy - Utilities / Maintenance per policy	Fees associated with occupancy for 988 crisis call center agents			$ 2,785.00	$ 2,785.00	
Computers	Technology needed for access to 988 crisis call center platform			$ 4,200.00	$ -	
Federally Approved Indirect Cost Rate	Administrative ~ Indirect Costs 10%			$ 14,202.50	$ 14,202.50	
				$ 153,028.25	**$ 148,828.25**	**Total**
				$ 153,028.25	**$ 148,828.25**	**$ 301,856.50**
Item: Coordinated Specialty Care						
				Year 1	**Year 2**	
Activity	Justification	Cost per Unit	**Qty**			
Coordinated Specialty Care Program Development	This line item will provide additional funds to up to five existing or newly formed CSC programs across Virginia. Funds can be used to meet new program requirements including epiNET participation, funding to fill hard-to-fill team positions, and other one time costs. These will be distributed in the form of grants to teams.	$14,000	5	70000	70000	

CSC staff development	This will allow funding for central office staff to remain up to date on training and professional development associated with the CSC program as well as data collection techniques and outcomes.	$6,382	1	6382	6382	
				76382	**76382**	
						Total
					Additional Amount Added for 2nd Allotment $12,921.20	$ 152,764.00
				Total Projects for BSCA		
				Year 1	**Year2**	
				$ 776,695.50	$ 750,945.50	
						Grand Total
						$ 1,527,641.00

Information Systems	$ 15,000.00	$ -	$ 15,000.00
Infrastructure Support	$ 532,278.25	$ 521,528.25	$ 1,053,806.50
Partnerships	$ 134,510.75	$ 134,510.75	$ 269,021.50
Planning Council	$ -		
Quality Assurance	$ -		
Research and Eval	$ 63,524.50	$ 63,524.50	$ 127,049.00
Training and Education	$ 31,382.00	$ 31,382.00	$ 62,764.00
	Year 1 Total	**Year 2 Total**	**Total**
	$ 776,695.50	$ 750,945.50	$ 1,527,641.00

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).

Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

Step 1: Assess Strengths and Needs

Description of Virginia's Public Behavioral Health System

The Department of Behavioral Health and Developmental Services (DBHDS) is tasked with providing public behavioral health (mental health and substance use disorders) as well as developmental and intellectual disability services in Virginia. Title 37.2 of the Code of Virginia establishes DBHDS as the state authority for Virginia's public behavioral health and developmental services system, thus designating the agency as the Single State Alcohol and Drug Agency (SSA) and State Mental Health Authority (SMHA).

Virginia operates 12 facilities: eight behavioral health hospitals for adults, one training center, a behavioral health hospital for children and adolescents, a medical center, and a center for behavioral rehabilitation. State facilities provide highly structured, intensive services for individuals with mental illness, intellectual disability or are in need of substance use disorder services. The Commonwealth Center for Children and Adolescents (CCCA) in Staunton remains the only state hospital for children with serious emotional disturbance. Community Services at the local level are provided by 39 community services boards and 1 behavioral health authority (referred to as CSBs). Local governments that provide services directly to consumers or through contracts with private providers across the Commonwealth have established these CSBs. Maps of CSB service areas and the locations of state facilities are included in this section of the application.

A state policy board, appointment by Virginia's Governor, advises BDBHDS.

The following diagram illustrates the relationships among these services system components. Solid lines depict a direct operational relationship between the involved entities (e.g., DBHDS operates state facilities). Broken lines represent non-operational relationships (e.g., policy direction, contract, licensing, or coordination).

DBHDS' central office provides leadership and service to support and improve Virginia's system of

quality treatment, prevention services, as well as supports for individuals and families whose lives are affected by mental health or substance use disorders or developmental disabilities. The DBHDS Central Office seeks to promote a culture of recovery, self-determination, and wellness in all aspects of life for these individuals.

Responsibilities of DBHDS include:

- Providing leadership that promotes strategic partnerships among and between CSBs, state facilities, and the central office and effective relationships with other agencies and providers;
- Providing services and supports in state hospitals (civil and forensic) and training centers;
- Supporting the provision of accessible and effective evidence based behavioral health and developmental services and supports provided by CSBs and other providers;
- Assuring that public and private providers of behavioral health or developmental services and supports adhere to licensing standards; and
- Protecting the human rights of individuals receiving behavioral health or developmental services.

The Community Services Board System

The 133 local governments in Virginia, pursuant to Chapters 5 and 6 of Title 37.2 of the Code of Virginia established CSBs. CSBs may serve single or multiple jurisdictions. CSBs provide services directly to consumers within their catchment area, as well as through contracts with private providers. Private providers are identified as partners who play an important role in delivering behavioral health and developmental services. CSBs function as the single points of entry into publicly funded behavioral health and developmental services, including access to state facility services through preadmission screening, case management and coordination of services. It is important to note discharge planning for individuals leaving state facilities is also performed at the CSB level. They function as advocates for individuals who are receiving services and those in need of services. In addition, CSB staff act as community educators, organizers, and planners through community outreach. In some cases, they educate and advise their local governments about behavioral health and developmental services and needs.

While not part of DBHDS, CSBs are key operational partners with DBHDS and its state facilities in Virginia's public behavioral health and developmental services system. The relationship between DBHDS and the CSBs involves the community services performance contract, provisions of Title 37.2 of the Code of Virginia, State Board policies and regulations, and other applicable state or federal statutes or regulations. DBHDS contracts with, provides consultation to, funds, monitors, licenses, and regulates CSBs.

Although the pandemic has subsided, we are still navigating the system and everchanging need and workforce. During the pandemic, services at the CSBs had changed dramatically in response to their community needs and locality expectations. DBHDS was able to help support CSB partners with the transition to telehealth services, which had not been available in most cases statewide prior to the pandemic. Block grant funds aided providers in the heavy lift for telehealth allowing services to remain open and available throughout

the course of Virginia's COVID-19 response and continues to support the CSBs in this manner. While these impacts are ongoing and still being thoroughly evaluated it is important to note that providers have reported an increase in the engagement of individuals served in many programs, especially SUD services. Workforce has continued to prove challenging due to competing agencies/providers around work life balance, with a strong promotion of remote work responsibilities.

CSB Mental Health Services

CSBs provide a wide array of mental health services to children and adults. In State Fiscal Year (SFY) 2022, an unduplicated 123,936 individuals received CSB mental health services. Services include: Outpatient Services, Case Management, Assertive Community Treatment, Day Treatment/Partial Hospitalization, Ambulatory Crisis Stabilization, Rehabilitation, Sheltered Employment, Individual and Group Supported Employment, Residential Crisis Stabilization Services, Highly Intensive and Intensive Residential Services, and Supervised and Supportive Residential Services. A significant number of these individuals have severe mental illness; of the individuals receiving mental health services in SFY2022 69% of all adults served had a serious mental illness and 73% of all children served had or were at risk of having a serious emotional disturbance. Between SFY 2008 and SFY 2022, the number of individuals receiving CSB mental health services increased from 101,796 to 123,936, an increase of about 22%.

CSB Substance Use Disorder Services

In SFY 2022, an unduplicated 25,356 individuals received substance use disorder services from CSBs. Services included: Inpatient Services, Community-Based SA Medical Detox Inpatient Services, Outpatient Services, Intensive Outpatient Services, Case Management Services, Medication Assisted Treatment, Day Treatment/Partial Hospitalization, Rehabilitation, Individual Supported Employment, Highly Intensive Residential Services, Residential Crisis Stabilization Services, Intensive Residential Services, Supervised Residential Services, Supportive Residential Services and Prevention Services.
Alcohol was reported as the primary drug of abuse for 27.8% of these individuals, opiates for 27.9%, marijuana/hashish for 14.0% and methamphetamines for 15.1%. Thirty-four of the 40 CSBs
provided medication assisted treatment (methadone or buprenorphine), either directly or through a contract with a local private provider, serving 4,777 individuals in SFY 2022. All CSBs provide some specialized services to pregnant women and women with dependent children. There are four regional programs that provide residential services to pregnant and postpartum women and women with dependent children and nine programs that provide intensive wrap-around case management services to pregnant and postpartum women in close collaboration with local social services and health departments (Project Link).

CSB Prevention

Virginia's focus on behavioral health is changing the prevention context by supporting the creation of thriving communities that promote healthy outcomes. This is happening

through state and community level-change, structural and systems change as well as integrating more seamlessly mental health and substance use approaches to address shared root causes. Virginia's Block Grant activities have been selected through an intentional, data-driven process at the state and local provider levels based on the Strategic Prevention Framework (SPF) developed by SAMHSA. The SPF consists of a set of steps and principles that are designed to ensure effective substance use disorder prevention services and relevant outcomes. The Virginia State Epidemiological Outcomes Workgroup (SEOW) provided data through the Virginia Social Indicator Study Data Dashboard, which was accessible to the 40 Community Services

Boards and their partner coalitions. DBHDS' OBHW Needs Assessment and Evaluation contractor, OMNI Institute, continue to provide SPF capacity building at the state and local levels resulting in 40 local needs assessments, logic models and evaluation plans linked to their local needs assessments. Our state level needs assessment guides the identification of prioritized risk and protective factors and an evaluation road map that includes a logic model, measurement plan, and a data entry plan. This comprehensive approach to identifying need is the foundation for best practices in prevention science.

State Hospital System

DBHDS operates eight state mental health hospitals for adults across Virginia. The hospitals are Catawba Hospital in Salem, Central State Hospital in Petersburg, Eastern State Hospital in Williamsburg, Piedmont Geriatric Hospital in Burkeville, Northern Virginia Mental Health Institute in Falls Church, Southern Virginia Mental Health Institute in Danville, Southwestern Virginia Mental Health Institute in Marion, and Western State Hospital in Staunton. The Commonwealth Center for Children and Adolescents, the only state hospital for children and adolescents with serious emotional disturbance, is located in Staunton. State hospitals provide highly structured intensive inpatient services, including a range of psychiatric, psychological, psychosocial rehabilitation, nursing support, and ancillary services. Specialized programs are provided to older adults, children and adolescents, and individuals with a forensic status.

DBHDS has made strides towards operating the 12 state facilities as one healthcare system to support efficient and effective operations and to ensure quality service delivery for individuals with behavioral health needs and developmental disabilities. DBHDS continues to work with our community service boards and other stakeholders, to address the qualification and training needs of the emergency custody and preadmission screeners. Other improvements include updated communications infrastructures between the courts and behavioral health care providers. DBHDS has established contracts with private providers and agreements with CSBs to provide residential supports that fill a service gap. These contracted residential supports target individuals who are in state hospitals and are clinically ready to be discharged but need a particular level of supervision and support in the community. DBHDS has developed teams to assist individuals with their transition from hospital to community, see that they have the proper services, and provide consultation regarding the care needs of individuals with mental illness to their residential providers.

System Transformation

System Transformation Excellence and Performance (STEP-VA) – DA pathway to excellence in behavioral healthcare and to a healthy Virginia, or System Transformation Excellence & Performance (STEP-VA). STEP-VA features a uniform set of required services, consistent quality measures, and improved oversight in all Virginia communities.

STEP-VA is orchestrated in a stepwise fashion, each including 3 phases, incorporating services over multiple years, each providing the infrastructure and expertise needed to build on the next. Specific details include:

1. A stakeholder and policy-informed model, built on the two-year transformation team effort and lessons learned during the CCBHC planning grant.
2. Nine core required services, plus care coordination as the linchpin, evidence-based best practices and key quality measures to assess performance and outcomes
3. Same day access, medication assisted treatment, in-home children's services and linkages to critical social services, like housing, employment and education.

The result is a Virginia-specific CCBHC model tailored to meet current and future needs of Virginians with behavioral health disorders. STEP-VA's services were identified by the transformation teams as part of the CCBHC process to meet the needs of Virginians and fill gaps in the system.

Services include:

4. Same Day Access

(Phase 3, full implementation, began July 1, 2021)

5. Outpatient Services

(Phase 3 Initial Implementation initiated before July 1, 2020)

6. Primary Care Integration

(Phase 3 as of July 1, 2021; data requirements modified during COVID-19)

7. Case Management/Care Coordination

(Phase 2 as of July 2022)

8. Peer and Family Support

(Phase 2 as of July 2022)

9. Psychosocial Rehabilitation/Skill Building

(Phase 2 as of July 2022)

10. Veterans Services

(Phase 3 as of July 2022

11. Mobile Crisis Services

(Phase 2 initial implementation for Child Mobile Crisis started July 1, 2020; first funding for adult mobile crisis services began July 1, 2021)

DBHDS continues to expand certain existing services as well as implement new services with the goal of increased access in all locales, and strengthening the quality of services provided, building consistency among training and expectations. Notably, STEP-VA services intent to foster a focus on wellness among individuals with behavioral health disorders

and prevent crises before they arise.

Same Day Access-

Same day access is when a person calls or appears at the CSB and is assessed the same day. Based on assessment, the person is offered an appointment for appropriate initial treatment within ten days. Same day access is a best practice with the goal of eliminating "no show" appointments, increasing adherence to follow-up appointments, reducing the "wait time" for initial appointments and makes more cost-effective use of staff resources. Implementation requires a change in CSBs' business practices, such as scheduling, documentation, caseload management, and utilization of shorter term, more focused and practical therapies.

Benchmarks have been set collaboratively as 86% of individuals in need of an appointment will be offered one within ten business days, and 70% of individuals will attend a scheduled follow up appointment within 30 calendar days. Tracking and accountability began July 1, 2021, and remains ongoing. It is important to note that SDA has been heavily impacted by behavioral health workforce shortages across the state. While this service is not always available at every office every day, intake appointments are still being offered to individuals and families who would prefer to make an appointment for entry to care.

Primary Care Screening-

Individuals with serious mental illness (SMI), a population primarily served by the CSBs, are known to be at higher risk for poor physical health outcomes largely due to unidentified chronic conditions. Therefore, it is important for behavioral health staff to provide primary care screening to identify and provide related care coordination to ensure access to needed physical health care. The long-term goal of this step is to provide a primary care screening on a yearly basis for all children with SED and adults with SMI who have established care with the CSB and are receiving behavioral health services on an ongoing basis. There is also recognition that individuals with SMI or serious emotional disturbance may be prescribed medications such as antipsychotics, with side effects that can lead to chronic disease such as metabolic syndrome. In addition to primary care screening, the recommendations from the American Diabetes Association are also being used, specifically for individuals who are receiving targeted case management services at the CSB who are prescribed an antipsychotic medication, to ensure that metabolic screening occurs. Below is the FY 2022 data collected:

	Primary Care	Metabolic Screens
Screenings	59224	29734
Unique Individuals	29806	13950

Outpatient Services-

The purpose of the Outpatient Services step is to ensure the provision of high quality, evidence-based, trauma-informed, culturally competent, accessible behavioral health services that addresses a broad range of diagnoses and considers an individual's course of illness across the lifespan from childhood to adulthood.
Outpatient service means treatment provided to individuals on an hourly schedule, on an individual, group, or family basis, and usually in a clinic or similar facility or in another location. Outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services.
Outpatient mental health and substance use services are considered foundational services for any behavioral health system. Over 100 additional clinician positions have been funded in the public system with STEP-VA outpatient funding ($15 million in state fiscal year 2021, increasing to
$21 million in state fiscal year 2022). These positions provide assessment, group, individual and family therapy, psychiatric services, and other outpatient behavioral health contacts for youth and adults (mental health and substance use). Funding is also used to support regional investments in evidence- based practices, including regional training coordinator positions and training costs for prioritized EBPs. The Daily Living Assessment-20 (DLA-20) has been implemented statewide to ensure there is a standard measure of functional impairment to provide meaningful information across conditions.

Peer and Family Support Services-

Peer Supporters have lived experience with mental health and/or substance use challenges and recovery from these challenges. Additionally, Peer Supporters are trained to offer support and assistance to individuals in developing and maintaining a path to recovery, resiliency, and wellness. Services include targeted self-disclosure by the Peer Supporter of lived experience in a manner that promotes hope and teaches individuals about paths to recovery and overcoming barriers. Services seek to foster connections to natural supports, community resources; and assist individuals in identifying existing strengths, skills, and how to apply them. Services assist the individual to develop goals and plans for recovery, resiliency, and wellness through the maintenance of mutuality, trust-building, and education. Services are person-centered, providing the opportunity for self-reflection and the development of personalized solutions and recovery strategies. Virginia continues to build capacity for certified peer recovery specialist throughout Virginia. This assures there are qualified people providing services and it builds capacity to have peers eligible to be registered with the Virginia Board of Counseling which is a requirement for Medicaid reimbursement of Peer Recovery Support Services

Family Support Partner services are strength-based, individualized, person-centered, and growth- oriented supports provided to the parent/caregiver of a youth or young adult under the age of 21, hereafter to be referred to as individual, with a behavioral health or developmental or substance use challenge or co-occurring mental health, substance use or developmental challenge that is the focus of support. The services provided to the parent/caregiver must be directed exclusively toward the benefit of the individual in need of services. Services are expected to improve outcomes for the individual and increase the individual's and family's confidence and capacity to manage their own services and supports while promoting wellness and healthy relationships.

Family Support Partners may provide education, modeling, active listening, and the disclosure of personal experiences. Through this process, parents/caregivers are empowered to use their voice to express their needs, strengths and preferences related to care. Family Support Partner services are rendered by a parent/caregiver of a minor or adult child with a similar mental health or developmental or substance use challenge or co-occurring mental health, substance use or developmental challenge with experience navigating developmental, substance use or behavioral health care services. Building capacity for certification and registration assures there are qualified people providing services and it builds capacity for Medicaid reimbursement.

Mobile Crisis Services

Mobile crisis services under STEP-VA have been implemented under the broader umbrella of Virginia's Crisis System transformation through the Marcus Davis Peters Act. The Act modifies the Code of Virginia to add § 9.1-193. Mental health awareness response and community understanding services (Marcus) alert system; law-enforcement protocols, which outlines the role of DCJS and local law enforcement in the development of three protocols for behavioral health crisis situations, sets seventeen goals for law enforcement participation in the Marcus Alert system, assigns purview between DCJS and DBHDS, and requires localities to develop a voluntary database. The Act also modifies the Code of Virginia to add § 37.2-311.1. Comprehensive crisis system; Marcus alert system; powers and duties of the Department related to comprehensive mental health, substance abuse, and developmental disability crisis services. This requires DBHDS to develop a comprehensive crisis system based on national best practice models including evidence-based mobile crisis services. Funding was distributed regionally to form regional mobile crisis hubs, which ultimately integrate existing mobile crisis supports for individuals with developmental disabilities with STEP-VA funds for mental health and substance use crisis response in the community. Children's mobile crisis teams were prioritized in 2020 and have responded via telehealth and in person when needed. Funding for adult mobile crisis teams later was also distributed in a similar manner.

Statewide coverage by mobile crisis teams (one-hour response) continues to grow and is expected to be robust, statewide, and available 24/7 by July 1, 2024. Local protocols were implemented statewide on July 1, 2022. These three local protocols included: 1) diversion of certain 911 calls to crisis call centers, 2) agreements between mobile crisis regional hubs and law enforcement, and 3) policies for law enforcement participation in the Marcus Alert system The level of additional local supports for community coverage to be achieved statewide will be contingent on the level of funding available as well as the local planning processes that are currently underway.

The statewide crisis data platform was initiated to gather data about crisis services across the Commonwealth from both private and public providers of crisis services. The vendor has built out the intake and mobile crisis portion of the platform and is working on developing a new bed registry. 988 launched in Virginia on July 16, 2022. DBHDS proactively prepared for this initiative through partnering with National Suicide Prevention Lifeline Providers in the Commonwealth to operationalize Virginia's call center. Through this process Virginia increased it's in state answer rate from 55 percent to 85 percent.

Project BRAVO/ Medicaid Behavioral Health Enhancement (formerly Redesign)

Medicaid is the largest payer of behavioral health services in the Commonwealth. Medicaid redesign's goal is to keep Virginians well and thriving in their communities, as well as shift our system's need to focus on crisis by investing in prevention and early intervention with mental illness. Transitioning of funding toward a more robust array of outpatient services, integrated behavioral health services in primary care and schools, and intensive community-based and clinic-based supports will yield improved outcomes and reduce downstream costs of emergency department visits and hospitalizations to the Medicaid program and the State General Fund. On July 1, 2021, Virginia began implementation of the transformation of the community based behavioral health services offered through Medicaid. This initial phase of this implementation included high quality, evidence-based services that diverted from inpatient psychiatric care. A number of these services were already available in Virginia but were not accompanied by a Medicaid rate that incentivizes evidence-based practice. The services implemented were Mental Health Partial Hospitalization Programs, Mental Health Intensive Outpatient Programs, Assertive Community Treatment, Multisystemic Therapy, Functional Family Therapy, and Comprehensive Crisis Services.

Certified Community Behavioral Health Clinics (CCBHC) Planning Phase & Needs Assessment

Virginia is about to embark on a comprehensive needs assessment to meet the preparatory requirements of the Certified Community Behavioral Health Clinics model which is included in the Governor's Right Help Right Now Plan. Virginia is currently in the planning phase of CCBHC integration which includes:

- Plan for CCBHC1Demonstration Program (e.g., data infrastructure, payment system)
- Training 12 CSBs (e.g., CCBHC) to establish data-sharing approach, assess CSB shared savings, and ease CSB billing
- Training 28 CSBs (e.g., CCBHC) to ensure DD, emergency, other services continue across CSBs
- Developing outcome-based payment strategies
- Designing and planning for launch of CCBHC model (e.g., develop reimbursement model)
- Creating an outcomes-based payment model that holds MCOs accountable for BH quality and outcomes
- Building out CCBHC reimbursement model Award Medicaid MCO contracts that include BH outcomes-based payment standards (e.g., that increase YOY)
- Refining and scaling CCBHC reimbursement model
- Continually refining and strengthening behavioral health outcomes-based payment model in Medicaid MCO contracts

Services System Partnerships

DBHDS partners with other state agencies and organizations that are involved in the provision of services and supports to or interact with individuals who have behavioral health, intellectual or other developmental disabilities, or co-occurring disorders. These relationships allow for additional supports to individuals in need and to help raise awareness of the needs and challenges of individuals receiving behavioral health and developmental services face. They also provide opportunities for coordinating state-level policy direction provisions of guidance to Virginia's local services systems, and support statewide and community-based initiatives that promote access to and continuity of needed services and supports across populations.

Many state agencies contribute to the development of and provide ongoing guidance for DBHDS' strategic plan, along with state-level advocacy organizations and persons with lived experience:

Medicaid: Administered by the Department of Medical Assistance Services (DMAS), Medicaid is the largest single source of funds for community mental health services across Virginia. DBHDS works closely with DMAS in policy development, provider expansion, provider education and training, development of quality assurance measures, and provider oversight.

Social Services: DBHDS and the Department of Social Services (DSS) collaborate through a variety of programs and services to help individuals cope with and recover from the effects of poverty, abuse, or neglect and achieve self-sufficiency. This includes services to families who are TANF recipients, to families confronting child custody issues, and to substance-exposed infants and their families.

In 2022 the Governor of Virginia launched the Safe and Sound task force to ensure safe placements for children in foster care. This task force brings together state and local government agencies, all three branches of government, private providers, health networks, advocacy groups, the faith community and other community partners, the task force works to find solutions for safe and appropriate placements for children in foster care.

Housing: Virginia's legislative reform commission, the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the Twenty-first Century, identified housing for individuals with serious mental illness as a priority area in 2015. Since that time, Virginia has invested more than $45 million in state general funds in permanent supportive housing (PSH) for individuals with SMI and pregnant or parenting women with substance use disorders. DBHDS oversees 25 PSH providers who housed nearly 1500 individuals with SMI in 2022. DBHDS supports implementation of evidence-based practice standards for PSH with its providers who prioritize individuals with histories of institutional use and homelessness. Additionally, DBHDS partners with other state agencies to implement a Housing Action Plan for individuals with SMI. This plan, approved by the leadership of both state housing and disability services agencies, identifies strategies to develop state infrastructure to fund housing development and operations as well as the supportive services needed to assist individuals with securing and maintaining housing. At the direction of the General Assembly, the Virginia Department of Housing and Community

Development produces an annual report on the progress toward the action items in the plan.

Primary Health Care: There are a number of published studies showing that individuals with serious mental health disorders have higher rates of physical disability, significantly poorer health, and higher mortality rates than the general population. Physical health care is considered a core component of basic services for individuals with behavioral health disorders although this care is often fragmented for these individuals. DBHDS maintains partnerships with appropriate agencies and entities, including the Virginia Department of Health (VDH), Department of Health Professions (DHP), the Virginia Community Healthcare Association, Virginia Rural Health Resource Center, Virginia Hospital and Healthcare Association, Virginia College of Emergency Physicians, Virginia Chapter of the American Academy of Pediatrics, and Virginia Association of Free Clinics. In addition, a variety of primary medical and behavioral health partnerships exist across the state between CSBs and community health centers in their catchment areas.

Addressing issues of substance use disorders and addiction presents many opportunities to work closely with public health agencies, including referring individuals for HIV, hepatitis and TB testing and treatment, assisting women with infants and young children in accessing primary health care, including childhood immunization and primary healthcare, and working closely with the Office of the Chief Medical Examiner to utilize mortality data as a tool for identifying emerging substance use issues.
DBHDS staff also works closely with VDH to coordinate policy and services for at-risk families identified through the Home Visiting Network.

DBHDS also works closely with the DHP in a number of areas. Those focused on public health include serving on the Advisory Committee of the Prescription Monitoring Program and working to improve knowledge of addiction among healthcare providers to improve identification and referral efforts, as well as to improve access to medication assisted treatment and knowledge about the impact of addiction on physical health. DBHDS has worked very closely with DHP and VDH in implementing a pilot project to train friends and family members of individuals at risk for opioid overdose to utilize naloxone. The pilot required the individual to obtain a prescription for naloxone from a physician. This project was recently expanded to statewide and, thanks to the close collaboration between agencies, statutory changes now allow pharmacists working under a specific protocol to prescribe naloxone, thus making it more accessible.

In addition, primary care practices have become one of the most common places where mental health conditions are first identified. DBHDS has worked with the Virginia Chapter of the American Academy of Pediatrics and the Medical Society of Virginia to implement the Virginia Mental Health Access Program (VMAP) which connects pediatric providers with consultation with a child psychiatrist. This is a novel program that aims to address the shortage of the child mental health workforce, build capacity of other child health professionals, to identify and treat mental health conditions in children and adolescent. This program was first implemented regionally in 2020 through support from the General Assembly and due to its early successes, received additional support in the 2021 General Assembly for statewide implementation. DBHDS works closely with the state Medicaid program to increase the use of mental health screening tools in the primary care setting by

ensuring reimbursement for the use of the tools and working closely with the managed care organizations dedicated care coordinators. DBHDS is currently collaborating with the Psychiatric Society of Virginia to explore other collaborative care models that facilitate the direct support between primary care providers and psychiatrists. Lastly, DBHDS has brought expertise to behavioral health providers to build their capacity to support individuals with physical illness and advocate for need health care or train behavioral health providers on health literacy topics. As an example, DBHDS infection prevention specialists have participated in the statewide medical Assertive Community Treatment team meetings to bring information related to management of acute infections and other infection prevention strategies, such as vaccine education, prevention of sexually transmitted diseases, management of louse infections, recurrent skin infections, and other respiratory illnesses. Building a bi-directional support system between medical health and behavioral health is an important component to the effectiveness of the work.

Employment Services and Supports: Individuals with mental health or substance use disorders, or co- occurring disorders face challenging obstacles to obtaining and maintaining competitive employment. Mental health and substance use disorder employment initiatives between DBHDS, and the Department of Aging and Rehabilitative Services (DARS) provide specialized vocational assistance services in CSBs. A multi-agency initiative involving DBHDS, DARS, DMAS, and the academic community has further developed Virginia-specific WorkWORLDTM decision support software to support people with disabilities who are making decisions about gainful work activity and the use of work incentives. DBHDS supports use of this software to expand training on Social Security work incentives and other benefits counseling. DBHDS also funds 22 positions that are placed in 19 CSBs for the sole purpose of providing vocational counseling to individuals recovering from substance use disorders. The partnership focuses on assisting job seekers access and prepare for employment as well as match employers with the skilled workers needed. Individuals struggling with social, economic, or personal barriers receive customized services, such as job search assistance or training, in their effort to become self-sufficient. Individuals through career pathways to enter the workforce in sustainable jobs with substantial wages that decrease poverty improve their economic quality of life and address potential reliance on public benefits. DARS has the authority to operate under an Order of Selection, which requires states to establish priority categories of individuals to serve when DARS does not have funding to serve all eligible individuals. This creates a waiting list for services. However, DARS order of selection has not created a waiting list during the last two years. The pandemic's unintended consequence was a slowdown in the provision of services, which resulted in unexpended funds. These funds were allocated to remove individuals from the waitlist since September 2020.

DBHDS and DARS successfully were awarded a technical assistance grant through Westat in collaboration with ODEP to increase access and support to evidence-based employment through Individual Placement and Support (IPS). DBHDS and DARS have developed an implementation plan to increase IPS in the Commonwealth and have formulated a Steering Committee with a variety of employment partners in the Commonwealth. DBHDS is requesting funds to support an IPS training who will be hired and employed through DARS and DBHDS will supplement and provide through existing staff an IPS Fidelity monitor.

Criminal Justice and Juvenile Justice Services: DBHDS works diligently with the Department of Corrections (DOC), Department of Juvenile Justice (DJJ), and Department of Criminal Justice Services (DCJS) with the goal of improving access to screening, appropriate treatment and supports within the criminal justice setting. This partnership provides enhancements related to interagency planning and coordination in the hopes of better meeting the needs of individuals involved with the criminal justice system. As part of this process, we have provided enhanced support for jail diversion programs such as Crisis Intervention Teams (CIT) and CSB provisions related to short-term behavioral health services within the jails as well as juvenile detention centers. DOC works with DBHDS for increased access to community treatment and inpatient needs for those recently released from incarceration as well as providing screening for inmates who may qualify for civil commitment related to being identified as sexually violent predators. DCJS and DBHDS jointly provide training in behavioral health evaluation and treatment methods for law enforcement personnel who may include jail security staff.

Education: DBHDS partners with the Department of Education (DOE) to support collaborative activities between schools and the behavioral health and developmental services system. In State Fiscal Year 2023, the Virginia General Assembly allocated $2.5 million for school-based mental health pilot project to include technical assistance. The DBHDS partnered with the DOE to provide technical assistance to local school districts as well as to help determine the pilot sites. In each pilot site, the local school division is contracting with either public or private agencies to provide mental health services in schools.
For children birth to three, DBHDS is the lead agency for the services under Part C of the Individuals with Disabilities Education Act. DOE is involved with all state initiatives focused on Part C services, including the state Virginia Interagency Coordinating Council for Part C.

For the school age population, DBHDS and DOE work closely on a variety of interagency initiatives to improve in-school support for school-age children with behavioral health problems and improve outcomes for Virginia's children. This includes intensive efforts to keep children in their homes and community schools. In addition, DOE holds a designated seat on the Virginia Behavioral Health Advisory Council.

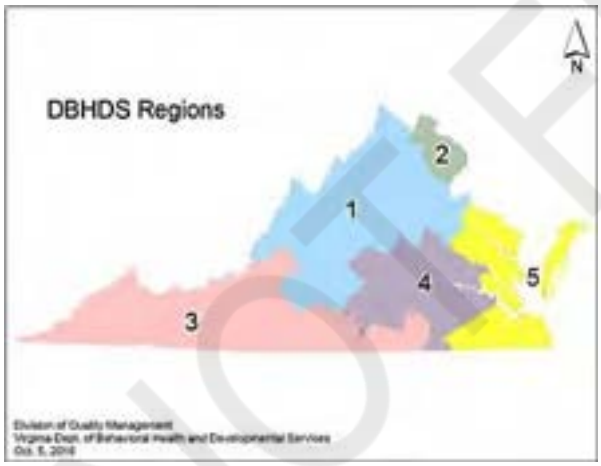
Advocacy: DBHDS central office and state facilities work cooperatively with the disAbility Law Center of Virginia (dLCV) to protect and advocate for the human and legal rights of individuals receiving behavioral health or developmental services. Section 51.5-37.1 of the Code of Virginia requires DBHDS to report all deaths and critical incidents to the dLCV within 48 hours of occurrence or discovery and provide follow- up reports.

Local Interagency and Regional Planning Partnerships: Local governments continue to collaborate with DBHDS in most cases through the CSBs in order to develop plans and create a sustainable system of care not just within their own locality but within their identified region of the Commonwealth as well.

At the local level, CSBs maintain critical interagency partnerships with local agencies, including school systems, social services, local health departments, and area agencies on aging. Services provided by these local agencies include Medicaid rehabilitation services,

waiver services, and auxiliary grants for assisted living facilities, Medicaid eligibility determinations, various social services, guardianship programs, health care, vocational training, housing assistance, and services for TANF recipients. Some local agencies also participate on Part C local interagency coordinating councils and provide Part C services to infants and toddlers.

Five regional partnerships including one region with two sub-regional partnerships (Region 3) have been established to facilitate regional planning for services system transformation and promote regional utilization management. These partnerships provide forums to address regional challenges and service needs and collaboratively plan and implement regional initiatives. Partnership participants include CSBs, state facilities, community inpatient psychiatric hospitals and other private providers, individuals receiving services, family members, advocates, and other stakeholders. Each regional partnership has established a regional utilization review team or committee to manage the region's use of inpatient beds and funds allocated to purchase local inpatient psychiatric crisis care and residential substance abuse treatment, including state general funds as well as federal Community Mental Health Services (CMHS), and Substance Abuse Prevention and Treatment (SAPT) block grant monies. The following map depicts the five regional partnership areas.



Partnerships with Private Providers: One of the statutory duties of DBHDS is licensing behavioral health and developmental services in the state. In FY 2022, DBHDS licensed 1,434 providers of behavioral health (mental health and substance misuse and developmental services) and licensed 3,664 services. Licensed providers must meet and adhere to regulatory standards of health, safety, service provision, and individual rights.

The private sector remains an important partner with CSBs in serving people with behavioral health needs. In addition to serving many individuals through varied contracts with CSBs across populations, private providers can also serve other individuals directly. Private providers are an especially important resource for substance use disorder treatment for persons with an opioid use disorder (OUD). Individuals receiving treatment for an OUD often include injection drug users (IDUs). Contractual agreements with private

providers allow individuals to be referred for methadone or other medication-assisted treatment. These private OTPs continue to expand treatment access statewide. Virginia has 47 OTPs statewide assisting individuals in need of MOUD.

Peer/Recovery Support Services: Peer services are provided by independent recovery community organizations (RCOs) and CSBs, and through collaboration between CSBs and RCOs. Services include (but are not limited to) outreach, crisis intervention, individual and group peer support, individual and group family support, education on recovery and wellness, assistance with meeting basic needs, job skill development, employment readiness activities, community integration, housing supports, and social/recreational opportunities.

The Office of Recovery Services, established by DBHDS in January 2015, has coordinated the efforts of multiple and diverse stakeholders involved in creating a peer recovery specialist certification and registration process. Effective July 1, 2017, the Department of Medical Assistance Services (DMAS) expanded the Medicaid benefit to allow for credentialing and reimbursement of Peer Recovery Support Services to include Peer Support Services and Family Support Partners. Individuals do need to be registered with the Department of Health Professionals and the Virginia Counseling Board to be able to bill Medicaid. The DBHDS certification recognizes the training, knowledge, and abilities of peers to provide recovery support services to individuals with mental illnesses and/or substance use disorders. It is also the basic training required for Family Peer Partners. Peer Recovery Specialists (PRS) are seen as an integral part of the Virginia's response to the opioid epidemic at all ASAM levels of care. This is evidenced by the growing numbers of peers in Office-Based Opioid Treatment (OBOT) clinics and in demonstration projects utilizing peers in emergency overdose response.

As of April 1, 2023, there were 1011 Certified Peer Recovery Specialists in Virginia. Of those 1011 PRS, 577 are registered to bill Medicaid through the Department of Health Professional Board of Counseling (DHP). Virginia also offers Peer Recovery Specialist Supervisor Training. Supervision by someone who has completed this training is required for any PRS whose services will be billed to Medicaid. Virginia has 505 trained PRS supervisors, pre-COVID, and 187 trained since going online/on demand which increased the total PRS supervisor trained as of April 1, 2023, to 692.

The staff of the Office of Recovery Services, supported with federal block grant funds, has had a role in implementing the SAMHSA Opioid State Opioid Response Grant (SOR), expanding the penetration of peer-provided, recovery- oriented services throughout Virginia's behavioral health care delivery system. In addition, CMHS and SUPTRS funds were used to support the work of statewide individual and family advocacy organizations, such as the Virginia Chapter of the National Alliance on Mental Illness (NAMI Virginia), the Virginia Organization of Consumers Asserting Leadership (VOCAL), Mental Health America of Virginia, and the Substance Abuse and Addiction Recovery Alliance (SAARA). These organizations advocate for the needs of individuals with behavioral health disorders and their families and offer a variety of information, referral and support services across the state.

Updates to COVID-19 Impact on Community Services Boards (CSBs)

During the pandemic, CSBs cooperated to provide quick transition to telehealth in lieu of face-to-face visits when clinically appropriated. Currently, CSBs are able to maintain code mandated services by providing hybrid models of care for those seeking services. Virginia continues to be in a workforce shortage, and this has majorly impacted the CSBs. The CSBs, with support of DBHDS, have continued to offer in-house solutions to promote public community level service delivery by means of sign on bonuses and remote work. Although these flexibilities remain in place on the CSB level, competition still remains a strong force comparative to private providers.

COVID-19 Residual Impact on State Hospitals System

The COVID-19 pandemic tested the entire behavioral health system and showed the very precarious nature of Virginia's state hospitals. State hospitals experienced significant increases in total admissions and temporary detention order (TDO) admissions as private sector psychiatric hospitals became increasingly restrictive in their admission requirements peaking in FY19 prior to the pandemic. Since Virginia's Bed of Last Resort laws mandate that state hospitals must admit any referred patient with a Temporary Detention Order who is not accepted by a private-sector hospital within 8 hours, private sector behavioral health hospitals' bed closures funneled increasingly large numbers of individuals into the public healthcare and state psychiatric hospital system. State hospitals have operated at or beyond capacity since that time. The accompanying nursing shortage further impacted state hospitals' ability to provide immediate admission for all referrals. There have been numerous limited bed closures in state hospitals due to COVID outbreaks and direct care staffing shortages. At the current time, beds off-line are only impacting two adult state hospitals and one child/adolescent hospital. As a result of all these factors, some individuals have experienced admission delays, which has caused considerable strain on state and local partners.

The staff at the facilities made significant efforts in managing COVID-19 and controlling outbreaks when they presented, while at the same time managing a high census and staffing shortages. Early visitation restrictions and aggressive plans for infection control and isolation kept facilities COVID-free for the first four months of the pandemic. As statewide re-opening began, outbreaks resulted in admission holds at several hospitals. As the COVID infections declined in 2021, the state hospital system was able to manage outbreaks within facilities in partnership with state local health departments and have maintained continued vigilance. DBHDS collaborated with Virginia Department of Health on the rapid distribution of available vaccine within Virginia's facilities and has practiced continued health monitoring and safety protocols per state and federal health guidelines. Due to changes in the symptom severity and in management of COVID, along with shifts in guidance from the VDH and CMS, temporary bed closures have become a rarity in the DBHDS state psychiatric hospital system due to COVID-19 alone.

COVID-19 and the accompanying staff shortages compounded an existing hospital bed census crisis, and significant changes are being made to ensure facilities operate more efficiently and effectively for both patients and staff. Part of these continuing efforts include improving operations at state hospitals and identifying individuals more rapidly when they are clinically ready for discharge. DBHD is now increasing efforts in engaging with private providers, forging contracts for diversion or step-down, and increasing private-sector involvement in accepting individuals referred for inpatient admission. Finally, the partnership with CSBs has been critical to strengthening community-based services. DBHDS is working in tandem to develop and

enhance accountable strategies for diverting from inpatient care and developing effective discharge plans.

Virginia System Transformation in Excellence and Performance (STEP-VA) Adaptations to COVID-19 Pandemic

DBHDS continues to pursue innovation with the goal of addressing the significant challenges in Virginia's mental health and substance-use disorder services across the lifespan: a pathway to excellence in behavioral healthcare and to a healthy Virginia, or System Transformation Excellence & Performance (STEP-VA). STEP-VA features a uniform set of required services, consistent quality measures, and improved oversight in all Virginia communities.

As we continue to address the impacts of the pandemic Virginia has a workforce crisis in the field of behavioral health. As such, DBHDS' local community partners, including the CSBs are often struggling for appropriate levels of staffing and in some cases have expressed significant difficulty in meeting the goal posts for STEP-VA. DBHDS has embarked on a strategic plan to streamline several factors which will help support those local providers as well as taking an active role in the Governor's Right Help Right Now plan to support, improve, and transform Virginia's behavioral health systems.

Racial Injustice and Need for Community Based Crisis Care

Finally, as many states across the nation, Virginia experienced a mass call to action regarding racial injustice and discrimination in the aftermath of George Floyd's death, which resulted in Governor Northam calling for a Special Legislative Session to address COVID-19 budget impacts as well as criminal justice reform. In addition to a number of other reforms, Virginia passed the Marcus-David Peters Act, which was largely the result of advocacy by the family of Marcus-David Peters, a young, black, biology teacher who was killed, while unarmed, by Richmond Police experiencing a behavioral health crisis. This legislation focuses on ensuring that individuals in a behavioral health crisis receive a behavioral health response, with a particular focus providing a behavioral health response for behavioral health crises. Local law enforcement and behavioral health professionals for co-response teams based on a triage of situation by 911 dispatchers. Key components include diverting calls from 911 to 988 when appropriate to full response by law enforcement preferably trained in CIT with behavioral health professionals hovering nearby. The state plan was completed July 1, 2021. Four community services boards and one behavioral health authority have been operating co-response between law enforcement and behavioral health with at least one of their local law enforcement agencies opting to participate in the response. As of July 1, 2023, five additional CSBs will begin their Marcus Alert co-response teams with at least one of their local law enforcement agencies.

Thus, the federal guidance supporting the use of supplemental block grant funding to build out a continuum of best practice community-based crisis services provides a remarkable opportunity for Virginia to develop the services that we know are needed to meet the goal of the Marcus Alert—otherwise, the issue of "divert to what?" will remain.

[1] Virginia Department of Health; Supplemental 2020 Overdose Report: https://www.vdh.virginia.gov/content/uploads/sites/13/2021/01/Emergency-Department-Visits-for- Unintentional-Drug-Overdose-2020-COVID-19-report_Final.pdf

A key feature is an "Equity at Intercept 0" (referring to Intercept 0 of the Sequential Intercept Model) initiative that focuses on collaborative, coordinated relationships between the regional

mobile crisis call centers and community-based providers who are Black led, peer led, BIPOC led, and working from a disability justice framework. A general heuristic of Virginia's crisis system transformation plans is provided here:

In addition to a focus on the newly developed Crisis set-aside, Virginia continues to prioritize prevention of substance use services, substance use services for pregnant and parenting women, early intervention for first episode psychosis, and child-focused services for serious emotional disturbance. Additionally, DBHDS have sought to leverage this opportunity for additional funding to work with providers in the area of what we are conceptualizing as an adolescent "carve out" of the SABG, which is a new initiative for Virginia. Finally, Virginia plans pursue continuing to improve data collection and reporting infrastructure. The COVID-19 pandemic has emphasized deficiencies in communication between community providers and DBHDS, as well as between DBHDS and Medicaid (DMAS). By modernizing our data exchange relationship with CSBs, we will be able to provide much improved prediction, comparison across sites, as well as general oversight of community services in a standardized format across providers and also in a standardized format between Medicaid reimbursement and state federal reporting.

Services for Populations of Interest

Cultural, Racial/Ethnic and Language Minorities

Consumers in Virginia's public behavioral health system are highly diverse. According to the 2012-2017
U.S. Census 5 Year American Community Survey estimates, 68% of Virginia's general population is white; however, nearly 40% of individuals receiving CSB mental health and substance use services are of some other race, including those who self-identify as biracial or multi-racial. In addition, more than 7% of MH/SA consumers self-identify as Hispanic/Latino, which is one of the largest and fastest-growing ethnic groups in the state.

DBHDS recognizes the striking disparities in mental health and substance abuse services and supports for cultural, racial, and ethnic minorities, both in our state and nationwide. The U.S. Surgeon General's Report on Mental Health: Culture, Race, and Ethnicity (2001) found that behavioral health disparities are inextricably linked to race, culture, and ethnicity where people of color, as well as members of other underserved cultural groups, have less access to, and availability of, behavioral health care services.
Even when services are available, members of these groups tend to receive a poorer quality of care that does not meet their unique needs. The findings in this comprehensive study continue to be valid as more recent analyses have examined disparities in the behavioral health system and developed similar conclusions.

The Behavioral Health Equity Coordinator with the Office of Behavioral Health Wellness focuses on promoting wellness and achieving behavioral health equity for all Virginians. DBHDS previously had a more linguistic focus whereas currently there is a broader focus on equity throughout the behavioral health system. The Behavioral Health Equity Coordinator's current primary focuses have been:

DBHDS continued their partnership with VCU Center on Society and Health to transform The Behavioral Health Equity Index into a data visualization platform, now being referred

to as the Virginia Wellbeing Dashboard which predicts mental health and substance use disorders using statistical modeling and data from communities across Virginia. Using the All Payer Claims Database along with measurement of various social determinant of health the dashboard is able to predict a communities opportunity to thrive. Several workforce development opportunities have been provided to behavioral healthcare providers across the state including Crisis Response & Criminalization and The Rise of Eating Disorders in Marginalized and Overlooked Populations. A statewide focus group and needs assessment was completed on identity-based discrimination in school settings. The results of the focus group were presented at a two day Supporting Socially Marginalized Youth Summit that emphasized health racial and ended identity development among marginalized identities. DBHDS also expects to conclude a statewide focus group on LGBTQ+ Virginias experiences in accessing mental health care. Finally, DBHDS is wrapping up evaluating our fourth year of behavioral health equity grants. This year between 10 - 15 CSBs and 15 - 20 community organizations will receive funding to implement equity oriented behavioral health programing in their communities.

Military Personnel and Their Families

Virginia has the sixth largest veteran population (approx. 690,000 in 2022) and approximately 129,000 Active-Duty Service Members. In addition, the Virginia National Guard has 8,700 Service Members with Army and Air components. In FY18, DBHDS, partnered with VHA, SAMHSA, Virginia Department of Veterans Services (DVS), and various state and local agencies to host the Richmond City Mayor's Challenge to Prevent Suicide Among SMVF (started in March 2018) and the Statewide Governor's Challenge to Prevent Suicide Among SMVF (started in December 2018). Both Challenges are ongoing and provide a strategic and comprehensive approach to suicide prevention emphasizing access to culturally competent behavioral health services, lethal means safety, and systemic partnerships between mainstream/civilian (CSBs, State and Private Hospitals etc.) and SMVF resources (VHA, Military Treatment Facilities, National Guard programs etc.).

As part of the Governor's Challenge, DBHDS expanded upon statewide partnerships to provide the Virginia Identify SMVF, Screen for Suicide Risk, and Refer to Services (VISR) pilot throughout 2020. This pilot program provided military culture, suicide prevention, and safety planning infrastructure, and expand risk screening in state and community agencies. The pilot enhanced SMVF resource connectivity before crisis and the delivery of life saving services in a crisis. We are currently implementing VISR 2.0 (January – December 2023) which allows for the engagement of broader community stakeholders who provide health and/or behavioral health services.

DBHDS and CSBs partner with DVS to refer SMVF to the Virginia Veteran and Family Support (VVFS) Program. VVFS provides care coordination services, peer, and family support statewide. VVFS also provides military culture training to CSB staff and other community stakeholders. DBHDS and DVS also operate a joint advisory body on community-based behavioral health services for SMVF, the Virginia Military and Veterans Coordinating Committee (VMVCC). Since 2016, the VMVCC has worked closely with the SAMHSA Service Member, Veteran, and Family (SMVF) TA Center to expand military culture training for community providers, peer services and suicide prevention for SMVF.

SMVF are a priority population for the System Transformation Excellence and Performance initiative in Virginia (or STEP VA). Modeled after the SAMHSA Certified Community Behavioral Health Clinic model, STEP VA emphasizes access to community-based behavioral health services for SMVF. DBHDS is working collaboratively with CSBs to consistently identify SMVF seeking services, train staff in military culture and clinical best practices for treatment of trauma related to combat and/or military service and collaborate with Federal, State, and local resources for SMVF.

Homeless Individuals

Individuals with serious mental illness (SMI) and those with co-occurring substance use disorders (SUD) are at disproportionately high risk of homelessness. As of January 2022, Virginia had 6,529 households experiencing homelessness on any given night, as reported by Continuums of Care to the U.S. Department of Housing and Urban Development (HUD). According to this annual Point in Time Count, 1,329 individuals with SMI and 864 individuals with SUD were homeless. Since 2015, Virginia has decreased overall homelessness by 7%; however, homelessness among individuals with SMI has increased by 23%.

The continued support of the MHBG will assist in targeting needed resources to persons with SMI. In the fourteen (14) areas of the state with the highest prevalence rates, DBHDS allocates federal funds from the Projects for Assistance in Transition from Homelessness (PATH) Program to CSBs to provide outreach, engagement, and case management services to homeless persons with SMI/SUD. Through collaborative relationships with the continuum of homeless service providers in local catchment areas, Virginia's PATH programs assist consumers in accessing housing, mental health and substance abuse treatment services, entitlement benefits and other services needed to support them in the process of recovery. Those who are literally homeless – meaning either living on the streets, in encampments, or other locations that are unfit for human habitation -- are the priority population served by Virginia's PATH providers. Providers expect to contact an estimated 3,000 individuals and enroll 1,500 individuals during Federal Fiscal Year 2023; approximately 88% of these individuals are anticipated to be literally homeless.

The majority of Virginia's 14 PATH programs operates in urban areas and spends significant time conducting street and shelter outreach to identify individuals with SMI who meet the PATH definition of homeless. Those programs operating in suburban and rural areas conduct outreach to homeless individuals in woods, encampments, under bridges and in other places where unsheltered persons congregate. The end goal of PATH is always to assist the individual to obtain housing, engage in behavioral health services, and access disability and other benefits. The SSI/SSDI Outreach, Access, and Recovery (SOAR) model of engagement is an additional service provided to PATH-enrolled consumers by five of Virginia's PATH programs. Access to Social Security benefits also provides access to medical insurance, making it more likely that PATH consumers, many of whom are medically vulnerable, can access medical treatment as well as behavioral healthcare. As the state SOAR lead, DBHDS continues to actively facilitate strong community-level collaboration with the Social Security Administration and Virginia's Disability Determination Services. This unique SOAR model provides homeless persons with SMI a greater chance of approval for Supplemental Security Income (SSI)

or Social Security Disability Insurance (SSDI) benefits. Virginia's SOAR program is recognized as a top national performer. Additional increases in successful applications are anticipated with regional SOAR certified trainings being offered to enable streamlined pre-release forensic and state hospital discharge planning processes.

Homeless Prevention for Veterans

Virginia became the first state in 2015 to effectively end veteran homeless meaning "functional zero" had been reached through the development of local systems established to make homelessness rare, non-recurring and brief for veterans whose homelessness could not be prevented. In November 2018, Governor Northam signed Executive Order 25, which affirmed cross-secretariat efforts aimed at: addressing the shortage of quality affordable housing; reducing the rate of evictions throughout the state; and increasing the supply of permanent supportive housing units (PSH). Many of the PSH units are targeted for chronically homeless persons with SMI and SUD. Virginia recognizes the importance of promoting best practices in serving homeless individuals with SMI and SUD and will continue to support and strengthen local systems established to prevent and end homelessness for these populations.

Individuals with Criminal Justice Involvement

It is well known that individuals identified as living with a serious mental illness (or co-occurring disorder) are at notably higher risk for being incarcerated, and in many cases may remain incarcerated for longer periods of time than the general population. Ongoing concerns related to potential negative impact of longer-term incarceration on their behavioral health needs and overall wellbeing as well as their risk of reoffending continue to drive efforts related to earlier intervention on their behalf as early as possible within their interactions with the criminal justice system. It is the hope that linking them to appropriate behavioral health treatment services can change the trajectory of an individual's future mental health recovery.

In Virginia, an annual survey of mental illness in jails is administered by the State's Compensation Board. Per the 2022 Mental Illness in Jails Survey, Virginia's local and regional jails held on average 20,287 inmates at any given time. At the time of the survey, 43.71% of the female and 24.85% of the male inmates were known or suspected of having mental illness. 18.22% of the inmates were known or suspected to suffer from a serious mental illness. At the time of the survey there were 9,205 inmates known or suspected to have a mental illness. This is 1,753 inmates higher than were identified the year before. Since 2012, the percentage of inmates known or suspected of having a mental illness has grown from 11% to 31.64%.

The Commonwealth of Virginia is keenly aware of the multiple challenges it faces and actions needed to improve response to and outcomes for individuals with mental health issues at risk for arrest or involved in the criminal justice system. Three statewide efforts: Virginia's Cross Systems Mapping initiative (2008- 2013), the Governor's Task Force for Improving Mental Health Services and Crisis Response (2013-2014), and DBHDS's Transformation Team initiative (2014-2016) each provided critical insights into the totality of the problem, specific areas of concern, and recommendations for improvement.

Some of those recommendations for improvement included:

Crisis Intervention Teams: Crisis Intervention Team (CIT) programs are nationally recognized, police- based, mental health crisis response initiatives that are interdisciplinary, collaborative, and community based. CIT programs enhance law enforcement's capability to respond to situations involving individuals with symptomatic behavioral health issues. In FY2017, one of the first fully state supported years of CIT, over 7,700 first responders were trained and throughout the history of CIT in Virginia, over 11,000 staff from law enforcement, mental health, the court system, hospitals, and peer support specialists have participated in a CIT training. Training continues in all localities through local stakeholder groups with an increasing scope of involvement among justice and mental health related professions. In concert with local CIT programs, as of FY'21 DBHDS provides funding for the operation of 38 CIT Assessment sites, previously known as "Drop Off Centers", operating in partnership with 38 CSBs. These Assessment Sites exist across the Commonwealth to provide a non-criminal justice setting where persons with mental illness can be taken by law enforcement officers in lieu of arrest or incarceration for behavioral health assessment and linkage to services. As of FY2019, over 14,000 assessments occur annually at CITAC program sites (FY'19 14,322, FY'20 14,783). By 2023, a total of over 100,000 assessments have occurred at CITAC locations since its inception in FY2013. These assessments are provided to individuals experiencing a behavioral health related crisis who might have otherwise gone to jail.

Jail Diversion Programs: DBHDS supports a number of Jail Diversion Initiatives, all of which reside within the Office of Forensic Services. Jail Diversion programs vary across the Commonwealth based on a number of factors, but all essentially strive to identify and serve individuals diagnosed with mental illness who are involved in the criminal justice system, across all five intercepts. In total, twenty-seven CSB's across the Commonwealth have received Jail Diversion funding between 2007 and 2023. Some of the funds have been for one-time expenditures, while others are ongoing initiatives. There are currently twenty-three CSBs receiving ongoing funds for Jail Diversion programs in the Commonwealth. A more complete review of Virginia's various Jail Diversion programs can be found in the FY22 Jail Diversion Annual Report. In FY22, 1,444 individuals were screened for eligibility, and 799 were enrolled in a Jail Diversion Program.

Mental Health Screening in Jails: During the 2017 General Assembly session, budget language was approved requiring all local and regional jails to screen inmates upon admittance for mental health issues using a scientifically validated tool designated by the Commissioner of the Department of Behavioral Health and Developmental Services (DBHDS)[5]. DBHDS recommended two tools: the Brief Jail Mental Health Screen (BJMHS) and the Correctional Mental Health Screen for women or for men (CMHS-W or CMHS-M).

To support the jails as they moved towards implementation, DBHDS developed a 1 ½ hour training on basic mental health awareness and identification, basic interviewing skills and an overview of how to administer the Brief Jail Mental Health Screen (BJMHS) and the Correctional Mental Health Screen (CMHS) for jail staff and others serving this population.

Multiple web-based trainings were also made available for viewing after the live trainings concluded. At the completion of the live trainings, nearly 700 individuals representing jail intake/booking staff, mental health staff and qualified mental health practitioners (QMHP), correctional officers, and others were estimated to have attended the training. Jails in the Commonwealth have been offered the opportunity to request additional training as needed.

Behavioral Healthcare Standards for Jails: During the 2019 General Assembly Session, bills were passed to require the Board of Corrections (BOC), in consultation to DBHDS to establish minimum standards for behavioral healthcare in jails. DBHDS took the lead on this initiative and assisted the BOC with drafting a report with suggested standards for behavioral health in the jails. It is expected that the standards will improve both access and quality of behavioral healthcare provided in jails. The BOC is currently working with the Department of Criminal Justice Services and the Compensation Board to determine the cost of implementing the suggested standards in all jails in Virginia.

Forensic Discharge Planning: During the 2018 General Assembly Session, funds were allocated to DBHDS to distribute to Community Services Boards to provide forensic discharge planning services for individuals with SMI in local and regional jails. Currently, there are two regional programs and eleven local programs across the Commonwealth, with twenty CSBs in total receiving funding for forensic discharge planning. The CSBs are providing the services within the jails (which will enhance continuity of care) and continue with these services for a minimum of 30 days post-release.

Problem Solving Dockets: The Chief Justice of the Supreme Court of Virginia issued a Rule of Court in 2017 allowing jurisdictions to establish problem-solving dockets for individuals with behavioral health challenges who become involved in the criminal justice system. This Rule coincided with DBHDS' release of best practice standards for mental/behavioral health dockets. DBHDS funds six Behavioral Health Dockets and is in the process of collecting data on the effectiveness of these programs. One of the requirements for a community to establish a docket is for all partners to participate in standardized training on best practices for dockets. DBHDS actively participates with the Office of the Executive Secretary of the Supreme Court in providing this training and has representation on the Chief Justice's Behavioral Health Docket Advisory Committee.

Sexual Minority Groups

Many individuals who are Lesbian, Gay, Bisexual, Transgendered, or Questioning (LGBTQ) have behavioral health needs. The 2015 National Survey on Drug Use and Mental Health found that LGBTQ+ individuals experience mental health issues such as depression, anxiety, and suicide ideation much more frequently than their heterosexual counterparts. Additionally, sexual minorities are more likely have substance use issues and need substance use treatment. DBHDS is participating in efforts to have Virginia's CSBs and state hospitals serve LGBTQ individuals and communities equally, and address issues of sexual orientation in the context of individual and group therapy, supportive services, and other behavioral health care.

DBHDS has partnered with Side by Side, a Virginia organization dedicated to creating supportive communities for LGBTQ+ youth to develop the Safer Space Training and Action Planning Workshops. In 2021, DBHDS hosted a half day training on "Enhancing Care for Transgender and Gender Diverse Youth" with Dr. Lisa Griffin and Delton Harris. Additionally, in March of 2023, two trainings were hosted for with DeHaven Sawyer Mays on serving LGBTQ+ Youth. One training was directed towards the general behavioral healthcare workforce and the other specifically to staff working in the Crisis Stabilization Units.

Rural Populations

The Commonwealth of Virginia covers a wide range of geographic regions. Depending on its location, one CSB might serve a combined population of urban, suburban and ex-urban or rural areas. According to the most recent decennial census, the Census Bureau indicated that 75.5% of the population in Virginia resided in urban areas and 24.5% in rural areas. Twenty-six of the 40 CSBs contain one or more counties in their jurisdiction that are majority rural.

CSBs vary according to budget size and population density, and many in rural areas do not have the infrastructure to support the services needed within the community. In addition to this concern, an individual in a rural area may have experienced different levels of access to transportation, availability of psychiatric and medical care, difficulty with linkages to supports, capacity to handle life tasks such as having access to a grocery store. CSBs use different approaches, such as sharing services regionally with other CSBs and collaborating with local and regional contract agencies to meet the service needs of their consumers. Telepsychiatry and telecommunication, for example, are in use in some rural areas to facilitate specialty psychiatric services for adult consumers, children, and their families, and veterans.

In 2022, DBHDS oversaw collaborative efforts to ensure Virginia's most vulnerable SUD populations have safe and supportive housing choices. Virginia Association of Recovery Residencies (VARR) and Oxford House have expanded its coverage area to encompass the rural southwest regions of Virginia. Oxford Houses of Virginia provide over 3,000 beds and VARR almost 1,100 in the state.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

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Footnotes:

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Footnotes:

Step 2: Identify the Unmet Service Needs and Critical Gaps within the Current System

Health Disparities and Intersectionality between Race and Behavioral Health Outcomes

Virginia is a geographically diverse state with large coastal and mountainous regions, large metropolitan areas with significant populations, and large rural areas with. Similarly with other states, Virginia is challenged with providing behavioral health care to all populations while overcoming challenges with access to care, workforce shortages, poverty, and systemic racial inequalities and as a result its healthcare system fails in some areas to serve all communities equitably. According to the Virginia Mental health Access Program (VMAP), "Minority adults and youth, individuals of low socioeconomic status, and residents in certain geographic locations (e.g., rural) continue to face disparities in access to adequate care and subsequent health outcomes. On top of this, a lack of medical professionals to provide care has led to large, underserved areas within the state."

As the state behavioral health and developmental service agency, DBHDS provides state level programmatic oversight, resources, training and technical assistance, subject matter expertise, and a core belief in people's resiliency, ability to live integrated and independent lives, and ability to recover from mental health and substance use disorders. The following statement represents the Division of Community Services, as we are a division with internal responsibilities to address systemic racism, as well a division with external responsibilities for behavioral health and developmental services across Virginia. DBHDS' vision statement is: A life of possibilities for all Virginians. DBHDS embraces and exemplifies its mission statement: "Supporting individuals by promoting recovery, self-determination, and wellness in all aspects of life". Further, DBHDS draws from concepts in its Orientation Manual for Direct Support Professionals (DSP): Supporting People in their Homes and Communities which states the following Principles of Person-Centered Practices:

- DBHDS sees a Virginia where individuals of all ages and abilities have the supports they need to enjoy the rights of life, liberty and the pursuit of happiness and the opportunity to have a good life.
- Having a good life means different things to different people. It includes joy and happiness, health, and safety, hopes, meaningful activities, intimate relationships with family and friends, having a home, transportation, work, money, and opportunities to contribute to family and community.
- DBHDS believes that a good life is best led by the voice of the individual and by following these person-centered principles.

At the same time, there is an extensive body of research on the undeniable connection and intersectionality between racism, racial violence and health, behavioral health, and developmental status. Based on key research findings and the values described above, the following were critical highlights:

- Racial discrimination damages individuals, hurts health (physical and behavioral) and shortens lives. Research on Adverse Childhood Experiences (ACEs) has evolved to include racism and social determinants, known as the "Pair of Aces", and has been linked to shortened life spans as a result of decreased physical, mental and emotional wellness. Racial trauma impacts the behavioral health of victims and witnesses, individuals, and entire communities. Those who have been directly victimized are likely to develop post-traumatic stress disorder (PTSD). Moreover, SAMHSA's Office

of Behavioral Health Equity notes, and we affirm: “The burden of being a person of color in America includes the stress from the anticipation of violence in everyday life; diminished access to good health care and education; and, more broadly, socioeconomic differences that might not exist if the individuals were not targeted, marginalized and deprived of the tools to make their lives better.” In other words, the behavioral health burden of race-based trauma can be identified and better understood by understanding sub-clinical symptoms, stress, wellbeing, and ability to thrive, more so than rates of diagnosis of specific behavioral health disorders.

- There is definitive evidence that Black Americans and People of Color receive lower quality behavioral healthcare as compared to white Americans, including lower access to care (including lack of insurance coverage), direct discrimination from healthcare providers, and decreased efficacy of treatment. Coupled with stigma around mental illness, valid lack of trust for the “system” and Black Americans relying primarily on the faith community for behavioral health support, traditional systems have not adequately addressed the needs of Black Americans (Institute of Medicine, 2003). The report “Mental Health: A Report of the Surgeon General” and its supplement, “Mental Health, Culture, Race and Ethnicity” highlight some examples. After entering care, clients who are Black, Indigenous, and People of Color are less likely than white Americans to receive the best available treatments for depression and anxiety. Among adults with diagnosis-based need for mental health or substance abuse care, 37.6% of whites, but only 22.4% of Latinos and 25.0% of African Americans, receive treatment (McGuire et al., 2008). Research on healthcare disparities in autism spectrum disorder (ASD) from 2017 indicated disparities in access to quality diagnostics and care: Black and Latinx children are significantly less likely to receive timely diagnoses. Due to the important of early intervention services for ASD, this disparity likely contributes to overall chronicity and severity across development. Further, there is evidence that Black children with ASD are significantly more likely to be misdiagnosed with behavior problems when evaluated (2007 research indicates a five-fold increase in misdiagnoses compared to white children with ASD), and initial misdiagnoses also contribute to delayed services.

- Further, health care disparities relate not only to systemic inequities but also dyadic discrimination at the provider client level. There is evidence that when Black clients receive behavioral health and developmental services from Black providers, they experience improved retention and outcomes. No such finding has been identified for any other racial groups/pairings between clients and clinicians—which underscores the importance of a diverse behavioral health workforce. Systemic barriers to building a diverse workforce include a number of factors, including barrier crimes. Black people have been shown to receive harsher and longer sentences than similarly situated white people for the same offenses (U.S. Sentencing Commission, 2017). Thus, barrier crimes, which keep people out of the behavioral health workforce, are a larger barrier for Black people.

- It is critically important to focus on suicide prevention and interventions among Communities of Color and increase upstream youth and family support that is culturally salient and informed. This includes approaching our work implementing behavioral health crisis response diligently and with an equity and trauma-informed lens. Nationally, suicide attempts increased by 73% between 1991-2017 for Black adolescents while injury attempts increased by 122% for adolescent Black boys during that time period (Lindsey, et al., 2019). In Virginia, the number of suicide deaths increased 62% from 2014-2018 among Black or African Americans. Black youth are less likely to report feeling down, anxious, or depressed which can mask risk for behavioral health crisis and/or suicide. Rates of engagement in treatment are also lower in black adolescents compared to white adolescents

which may be due to negative perceptions of treatment systems and reluctance to recognize behavioral health symptoms. However, youth and family support and culturally sensitive interventions can buffer youth and adults from risk factors for suicide (personal or family history of suicide, depression and/or other behavioral health concerns, incarceration, easy access to lethal means, alcohol and/or drug use etc.). Protective factors help youth adapt to hardship and protect against suicide risk and may include strong familial support/relationships, religious and spiritual engagement, community and social support, personal feelings of well-being and resilience, and stable housing, income, and employment. It is critical that our efforts increase feelings of value and connectedness among Black youth and families and access to culturally informed treatment and support services in all communities of color. These interventions include the development of a robust crisis response system that functions as a first responder to behavioral health crises. We note both the Crisis Now Model and Sequential Intercept Model (Intercept Zero) as best practice models/frameworks to draw from.

- Supporting Anti-Racist Communities (SPARC), issued a national report in 2018 based on data analysis among people experiencing homelessness. The report affirmed that People of Color (specifically, Black and Native American individuals) were dramatically over-represented among people experiencing homelessness in a consistent pattern across communities that could not be explained by poverty rates among these groups. According to the report, "the vast and disproportionate number of people in the homeless population in communities across the United States is a testament to the historic and persistent structural racism that exists in this country." Additionally, people with behavioral health disorders are disproportionately likely to experience homelessness in Virginia, as in communities across the country. More work is needed to better understand the racial disparities among individuals with behavioral health disorders who are experiencing homelessness. We believe that ending homelessness is an important part of racial justice work.

- The challenge that Virginia faces during this ongoing time in the US of local, state, and national events calling for social and racial justice is that often our mission and vision are actually part of a system that has been supported and sustained by structural racism. This can have profound negative effects on the people we serve as well as the people we work with. The Aspen Institute defines structural racism as:

- “A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with “whiteness” and disadvantages associated with “color” to endure and adapt over time. Structural racism is not something that a few people or institutions choose to practice. Instead, it has been a feature of the social, economic, and political systems in which we all exist.”

- For these and many other reasons, it is incumbent upon DBHDS to acknowledge that structural racism limits the mental health, safety, health, educational, and other opportunities of Black people and other People of Color we serve and how they participate in and receive services that are part of our organization and systems that DBHDS impacts and limits their ability to recruit and retain a diverse behavioral health workforce. The individuals, their families, and communities affected by this matter because as an agency, DBHDS believe that black lives do matter and supports the ideals that the movement stands for, and cannot claim values of person-centered, trauma-informed care if the agency does not analyze their practices from this perspective. Further, DBHDS also

acknowledges and affirms that, although systemic racism is a longstanding problem that has not been given adequate attention within the behavioral health system in a broader sense, the recent local, state, and national events for racial justice present a test because they show how far the Commonwealth has to go to dismantle and rebuild the systems created by hundreds of years of oppression, racism, and institutional discrimination. Lastly, DBHDS acknowledges that the stress and trauma of racism and its manifestation affects victims, individuals, and entire communities, and the burden falls disproportionately on our Black coworkers who must continue to show up to work and often feel pressure to appear emotionally unaffected, and/or continue to care for others at home, perhaps those they fear may be in harm's way.

- To that end, the Division of Community Services at DBHDS commits to:
    - Continue conversations internally related to social disparity and racial bias, accepting feedback with an open heart and mind from staff members related to how we can be more inclusive.
    - Conduct anti-bias, anti-racism, and cultural humility trainings that delve into implicit and explicit biases and how we can approach this work both internally and with DBHDS' external partners.
    - Provide educational opportunities to acknowledge, learn and celebrate diverse communities and their accomplishments, including distinguished individuals from these communities that address disparities in behavioral and public health.
    - Ensure that all initiatives associated with diversity, equity, and inclusion consider and celebrate all Black, Indigenous, and People of Color, while also considering the specific pervasiveness and impacts of anti-Blackness as well as intersections of racial disparities with other marginalized identities and stigmatized conditions.
    - Work within its own Division to ensure diversity at all levels of staffing including having recruitment policies that yield a diverse group of applicants for all hiring positions.
    - Ensure that human resources policies on discrimination and harassment are easily accessible by all staff and visitors and have clear systems in place for employees to provide feedback without fear of retaliation.
    - Work collaboratively toward improved data collection and analysis to identify disparities within our system of care and to create and promote programming that reflects progressive responses to these identified needs.
    - Continue regional training for cultural competence and cultural humility and ensure these trainings are available at every level of service with those in management also encouraged to participate.
    - Work with various partners and stakeholders to recommend changes to existing policies, regulations, programmatic, funding, and laws to better support equity and racial justice.
    - Ensure diversity and representation is woven into the fabric of all programmatic implementation put forth by our division.
    - Be a voice for sustainable change within state government reflecting our vision and mission

in all that DBHDS does.

Data and Utilization in Assessment and Planning around Health Disparities

The data sources used to inform DBHDS's behavioral health needs assessment and ongoing planning and development process encompass the full spectrum of available data sources on mental health and substance use disorders. They range from a wide scope of sources including the National Survey on Drug Use and Health and the Treatment Episode Data Set, to the Community Consumer Submission - Virginia's unique community services data system, to individual surveys conducted of various stakeholders and individuals served throughout the Commonwealth. DBHDS utilizes data to identify the needs and gaps in the Commonwealth's behavioral health service continuum in addition to a way of defining and tracking progress related to system transformation and program improvement. These data sources have been described below in more detail.

Core DBHDS Databases

Community Consumer Submission 3 (CCS3) – CCS is Virginia's unique, consumer-level data collection system that is used in partnership with CSBs statewide. CCS is a compilation of demographic, clinical, service utilization, and performance outcome data for all individuals receiving services from CSBs.

AVATAR – This is the client-level DBHDS inpatient facility database, including demographic, clinical and service information about individuals receiving inpatient services in DBHDS state hospitals.

Cardinal – This is the financial reporting system for CSBs that replaced the CARS system, showing revenues by source and expenditures and costs by service category.

Databases External to DBHDS

Virginia Health Information (VHI) – DBHDS obtains quarterly demographic, clinical, and service utilization data from VHI about users of community psychiatric hospitals.

Performance Based Prevention System (PBPS) - The PBPS database houses data on prevention activities across multiple funding streams. It is a data management, evaluation, and reporting system. The PBPS site is managed by Collaborative Planning Group, Inc.

DMAS – DBHDS obtains reports from DMAS about utilization of behavioral health services reimbursed through Medicaid.

Office of Comprehensive Services (OCS) – DBHDS uses OCS data about service recipients and services provided to children with behavioral health disorders under the Comprehensive Services Act.

Other Global Data Sources

Treatment Episode Data Set (TEDS) – TEDS is part of SAMHSA's Drug and Alcohol Services Information

System (DASIS). TEDS is a compilation of data on the demographic and substance abuse characteristics of admissions to (and more recently, on discharges from) substance abuse treatment. TEDS involved data on almost two million admissions reported by over 10,000 facilities to the 50 States, District of Columbia, and Puerto Rico over the 12-month period of a calendar year.

National Outcome Measures (NOMs) – NOMs were developed jointly by SAMHSA, the states, and the District of Columbia to track and measures real-life outcomes for people in recovery from mental health and substance abuse disorders. The identifiers selected as NOMs, including metrics such as housing, employment, retention, and social connectedness embody meaningful outcomes for people who are striving to attain and sustain recover, build resilience, and work, learn, live, and participate in their communities.

National Survey on Drug Use and Health (NSDUH) – The NSDUH provides national and state level data on the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States. Virginia uses Nationwide as well as state-level estimate from the NSDUH to inform other state agency collaborators as well as the General Assembly on substance use and mental health disorders in Virginia. NSDUH data also aids needs assessment processes throughout the Commonwealth and state-level estimate data is used in future program-planning processes.

Ad Hoc Data Sources

Joint Commission of Health Care (JCHC) – The JCHS is a standing joint commission of the Virginia General Assembly that conducts needs assessments and policy studies in a wide range of health care areas, including behavioral health.

Commission on Youth – The Commission on Youth is a standing joint commission of the Virginia General Assembly that conducts needs assessments and policy studies in a wide range of topics relevant to supporting Virginia's youth, including youth with behavioral health disorders.

Crime Commission – The Crime Commission is a standing joint commission of the Virginia General Assembly that conducts needs assessments and policy studies in a wide range of topics relevant to criminal justice, including persons with behavioral health disorders involved in the criminal justice system.

Office of the Chief Medical Examiner (OCME) – Part of the Virginia Department of Health, the OCME provides surveillance data on violent deaths including suicide and drug-related deaths.

Office of the State Inspector General (OSIG) for Behavioral Health and Developmental Services – The OSIG regularly conducts ad hoc studies of specific behavioral health issues, services and operations to identify needs and solutions for the behavioral health service system.

Joint Legislative Audit and Review Commission (JLARC) – The General Assembly's "watchdog" entity, JLARC conducts policy studies for the Legislature, including those involving behavioral health.

Partnerships with other State Agencies

DBHDS participates with a number of other agencies in data sharing efforts including the Department of Education, Department of Criminal Justice Services, Department of Motor Vehicles, Department of Alcoholic Beverage Control, Department of Health (including the Office of the Chief Medical Examiner), Department of Social Services, and the Virginia Employment Commission. Additionally, many state and local agencies have joined an initiative called FAACT related to Virginia's growing overdose rate. The FAACT project allows for data sharing around multiple state and local agencies to identify areas in significant need of services and supports to engage the communities in harm reduction needs and additional services.

Transforming the Behavioral Healthcare System

DBHDS began a transformation process in 2014 that included a comprehensive review of the state behavioral health and developmental services system. Today this process continues to focus on access, quality, stewardship of resources, workforce, equity, and accountability. Virginia's behavioral health system faces many challenges. It is important to note many of these issues existed prior to the pandemic and have been exacerbated by it's impact on systems, workforce, and individuals. These include:

- insufficient service capacity coupled with high demand;
- inconsistent access to best practices;
- inadequate integration of care for individuals with BH and SUD, consumers with complex, co-morbid health and behavioral health care needs, and/or behavioral health and criminal justice involvement;
- Need for increased peer and family involvement and support;
- Criminalization of individuals with BH and SUD; and fragmentation of services due to lack of care coordination.
- Ongoing workforce issues exacerbated by the impact of the COVID-19 pandemic across both community based and facility based services.

These challenges continue to be compounded by broader, external factors including an aging workforce, inadequate resources, regulatory stressors, complexities with system-wide implementation/infrastructural support of electronic health record technology, and lack of access to critical support services such as transportation, employment, and affordable housing. Throughout 2020 and 2021 these preexisting issues were compounded by an abrupt shift to telehealth statewide in response to the COVID-19 pandemic. In 2023 telehealth continues to be an option for many providers, supporting the overall behavioral health workforce as well as engaging individuals seeking care at an ever-increasing rate. This change to previous status quo has had an impact on the behavioral health workforce who work within environments requiring in person services across community and facility providers.

Community based partners lacked resources and training to fully engage with the individuals they serve. The individuals seeking/receiving services were often confronted with barriers to include the fiscal impact of job loss, poor reception for the use of telehealth at their residence, and increased need to care for children/other family members.

Identifying the Need

Virginia has been working since approximately 2014 to shift the public behavioral health system from a

limited array of two code-mandated services required statewide to a more robust, preventive array of community behavioral health services available consistently throughout the state. Since that time, the Systems Transformation, Excellence, and Performance - Virginia (STEP-VA) initiative has been defined and is currently in implemented throughout the state.

STEP-VA

The services prioritized under the STEP-VA initiative mirror the CCBHC model. Currently, six of the nine core services have received (as of July 2021) some level of state general funds. Current funding is outlined below:

Step	Current Annual Funding
Same Day Access	$10,795,651
Primary Care	$7,440,000
Outpatient	$21,924,825
Mobile Crisis Services	$16,954,924
Crisis Call Center	$4,200,000
Crisis Services - Detox	$2,000,000
Peer & Family Svcs	$5,334,000
Military Services	$3,840,490
Case Management	$0
Psychiatric Rehab	$0
Care Coordination	$0
Infrastructure	$3,200,000
TOTAL	**$75,689,890**

Original cost projections were as follows:

	FY 2018		FY 2019		FY 2020		FY 2021		FY 2022+	
	GF	NGF	GF	NGF	GF	NGF	GF	NGF	GF	NGF
Same Day Access	$ 8.21	$ 1.33	$ 14.71	$ 2.60	$ 14.71	$ 2.60	$ 14.71	$ 2.60	$ 14.71	$ 2.60
Outpatient Services							$ 20.83	$ 3.68	$ 41.65	$ 7.35
Primary Care Integration			$ 17.60		$ 17.60		$ 17.60		$ 17.60	
Detoxification							$ 2.03	$ 2.03	$ 4.05	$ 4.05
Peer Services							$ 3.69	$ 0.65	$ 7.38	$ 1.30
Pschological Rehab/Skills							$ 2.61	$ 0.46	$ 5.21	$ 0.92
Care Coordination Services							$ 9.20		$ 18.40	
Targeted Case Management							$ 3.44	$ 0.61	$ 6.87	$ 1.21
Veterans Services							$ 2.37	$ 0.42	$ 4.73	$ 0.84
Mobile Crisis Services							$ 14.84	$ 2.62	$ 29.68	$ 5.23
New Services Total	$ 8.21	$ 1.33	$ 32.31	$ 2.60	$ 32.31	$ 2.60	$ 91.30	$ 13.05	$ 150.28	$ 23.50
Additional Infratructure Needs	$ 4.50		$ 30.22		$ 21.50		$ 15.40		$ 0.99	
Total Cost	$ 12.71	$ 1.33	$ 62.53	$ 2.60	$ 53.81	$ 2.60	$ 106.70	$ 13.05	$ 151.27	$ 23.50

(Costs shown are amounts in million-dollar increments)
(GF refers to state general funds, NGF refers to state non-general funds)

Overall, significant investments into STEP-VA services have been made, including those planned for this year (state fiscal year 2022, beginning July 1, 2021). These have had positive impacts on service delivery in the public system, including increased accessibility to initial evaluation and treatment services. In 2013, the DBHDS Comprehensive State Plan indicated (from a point-in-time survey of CSBs) that 45% of the individuals needing mental health services and 37% of those needing SUD services wait more than four months to receive them. With the implementation of Same Day Access, individuals are able to receive a comprehensive evaluation on the day they present for assessment (no appointment needed). Then, the state goal is for 86% of individuals to be offered an appointment for follow-up services (the appropriate service needed) within 10 days and for 70% of individuals to attend that follow-up appointment. Currently, 69.6% of individuals who received a SDA assessment are being offered appointments within 10 days, and , across the state, 80.6% of individuals seen in SDA attended the scheduled follow up appointment at the recommended service within 30 days. Beyond Same Day Access, Outpatient investments have supported the hiring of over 100 licensed or license eligible therapists for the public system.

In the upcoming biennium, new funding for crisis services (adult mobile crisis teams), peer and family supports, and Veterans' services will be distributed to the CSBs for implementation. Thus, the three remaining STEPs of case management, psychiatric rehabilitation, and care coordination will be in the planning stages. It is important to note that since the original conceptualization of STEP-VA, a number of significant system changes have taken place, most notably the expansion of Medicaid and the carve-in of behavioral health services to plans with 6 managed care companies statewide. Our most recent Comprehensive Needs Assessment (results were received in January 2020, prior to the COVID-19 pandemic) indicated a need for better cross-agency coordination between DBHDS and DMAS. Thus, an important aspect of planning for the final three STEPs of STEP-VA is integrated planning with our Medicaid partners. As Medicaid has undertaken significant redesign of behavioral health Medicaid rates, the agencies continue to partner to ensure that changes made through STEP-VA are in coordination with a larger sustainability plan through supportive Medicaid rates that incentivize high quality, evidence based, and cost-effective services. As Virginia is working toward the goal of CCBHC implementation in the upcoming fiscal years this relationship between DMAS and DBHDS will continue in support of the goal of providing sustainable, accessible care for all Virginians.

Services for Pregnant and Parenting Women

DBHDS requires that programs provide substance use treatment to pregnant and parenting women and offer priority admission to pregnant women. Programs are informed through the DBHDS performance contract that they must publicize the following information: that they provide substance use treatment services to pregnant woman; that pregnant women receive priority admission for substance use women; that pregnant women receive priority admission for substance use and that these women will be seen within 48 hours of their service request.

DBHDS posts the SAPT regulations for pregnant and parenting women on its website and distributes a

memo to programs each year with these expectations. The document includes the expectation that programs provide interim services to pregnant women whenever they are unable to provide services within the 48-hour required time frame and mandates that they contact the Women's Services Coordinator at DBHDS to request assistance to develop an alternate service plan.

As part of the DBHDS review process, DBHDS verifies that each program has policies and procedures directing staff to accord treatment priority to pregnant women. This information is also reflected on the program's website and included in the brochures and posters that are disseminated in the community. DBHDS women's services coordinator, behavioral health consultants and audit office address this expectation as part of their routine monitoring and oversight efforts.

In addition to the services outlined in the SAPT regulations, DBHDS requires that programs assess withdrawal risk and provide the woman with appropriate guidance as part of their interim services.

All CSBs serve pregnant and parenting women, however, lack of funding makes it more difficult for parenting women to access MAT due to pregnant women having priority. CSBs usually absorb the cost of MAT for pregnant women and consequently they have fewer funds available to spend on these services for postpartum and/or parenting women and other individuals. DBHDS funds ten Project LINK programs that are specifically designed for pregnant and parenting women with substance use. Project LINK was established in 1992, and provides intensive, targeted case management services to this population, but lacks funding to expand into each of the remaining 30 CSBs, with dedicated staff with subject matter expertise. DBHDS oversees 40 CSBs which provide substance use services. All are required to provide outpatient services to pregnant and parenting women or contract out these services with a formal MOU. Four CSBs provide residential services for pregnant and parenting women and are able to admit women from other CSBs.

During the COVID-19 pandemic, CSBs faced difficult decisions that included closings of programs and loss of staff. Although this was an issue seen across the state, CSBs were able to continue to provide direct services to this population, with little to no interruption in continuing to meet the 48-hour guidance above. There were, however, increased challenges for those CSBs in the southwestern portion of the state, due to telehealth bandwidth and the rural nature of area, but again, did not affect the dire programming needs of this population.

Services for Individuals who Inject Drugs

DBHDS continued to define IVDUs in need of treatment as persons who typically use injected drugs, such as heroin, and those abusing or dependent on opioid prescription drugs, such as OxyContin or Oxycodone. The Centers for Disease Control's National Notifiable Diseases Surveillance System reported that Virginia was above the Healthy People 2020 goal of 0.25 Acute Hepatitis C cases/100,000 people.[1] Many Hepatitis C cases are linked to injection-drug use. Opioid IVDUs were treated in Opioid Treatment Programs (OTPs), in office-based settings using buprenorphine, Naltrexone, and in drug-free settings. Non-opioid IVDUs were treated in other modalities (e.g., outpatient, intensive outpatient, day treatment, case management, and residential). During FY2020 19,105 individuals receiving substance use disorder and/or mental health services from CSBs reported some degree of opioid use.

All 40 CSBs offer outpatient medication assisted services to opioid dependent individuals who enroll in treatment services; however, the ability to access these services varies by community. Virginia has five public and 42 private opioid treatment programs. Alexandria, Norfolk, Portsmouth, Hampton, Newport News CSBs, and Richmond Behavioral Health Authority (RBHA) are each licensed to dispense methadone within their respective catchment areas for individuals who participate in treatment services at the CSB. Additionally, Alexandria CSB also contracts to provide methadone to individuals enrolled in opioid use disorder treatment at four other northern Virginia CSBs. The remaining programs in the Commonwealth refer participants to private OTP programs in their community or nearby. All Forty (40) CSBs provide or contract out for MAT. Five of the CSBs provide methadone treatment and several CSBs provide Vivitrol.
Hampton Newport News (HNN) CSB, Richmond Behavioral Health Authority (RBHA) and Region Ten CSB offer residential treatment for pregnant women and ensure that opioid dependent women enrolled in their residential program are able to access methadone services. Opioid dependent pregnant women enrolled at HNN CSB's Southeastern Family Project receive methadone services through HNN CSB's OTP. RBHA provides methadone treatment services through their Recovery Plus program. If other MAT is preferred, the individual is scheduled to see the OBOT physician. The Women's Center at Moore's Creek at Region Ten receive methadone services through a contracted provider but may access the OBAT if other MAT is desired.

Accessing MAT is difficult in Virginia due to the scarcity of programs. Virginia's five public opioid treatment programs accept Medicaid reimbursement. All OTPS's in Virginia are participants in the ARTS Program which provides medication assisted treatment reimbursement. This has had a significant impact on the population served for OUD. There are pockets throughout the Commonwealth where access to MAT varies from poor to non-existent. There has been a tremendous growth of Office Based Opioid Treatment (OBOT) throughout Virginia. DBHDS however does not regulate these facilities and cannot provide information on the actual capacity. Although DBHDS licensed 19 additional OTPs between 2011 and 2020, opioid-dependent individuals who live in the catchment areas for Alleghany Highlands, Eastern Shore, Piedmont, Rappahannock Rapidan, or Planning District One CSBs must travel one to four hours each way to receive treatment for an opioid use disorder at an OTP.

Services for Persons at Risk for Tuberculosis
DBHDS began systematically screening and recording data for all individuals admitted to Substance Use Disorder services in SFY2021 (beginning July 1, 2020). If an individual is screened at-risk, the person is referred to the local public health department. The MOE calculation is based on the number of positive TB cases during the year. The MOE base and annual compliance figure is calculated by totaling state general fund expenditures for TB Prevention and Control, TB Drugs, TB Outreach and TB Drugs-Resistance. In 2022, the latest year of available TB data, the CDC determined that there was a total of 195 positive TB cases statewide which was an increase from 2021.[2] Virginia's incidence of contracting tuberculosis also increased in 2022. Due to the increase of positive cases over the last several years, finding and treating at-risk-for-latent TB testing has continued to be a high priority.

DBHDS continued to adhere to a "targeted testing" methodology. This strategy has reduced the numbers of false positives and maximized scarce resources by skin testing only persons with symptoms of TB and

certain risk factors. DBHDS continued to work with the Department of Health (VDH) and the CSBs to ensure that services to consumers continue to focus on identifying who may have tuberculosis infection. DBHDS continued to make available tuberculosis screening protocols and continued to require sub recipients to utilize them to screen persons entering publicly funded substance abuse treatment programs. DBHDS continued to work closely with the Virginia Department of Health (VDH) to review existing protocols for efficacy. DBHDS staff was involved in several ongoing work groups with VDH on infectious disease control (CPG HIV/AIDS, Hepatitis, and Disaster/Pandemic Planning). VDH provided technical assistance to programs upon request. DBHDS continued to require CSBs to refer, track and monitor persons referred for treatment for tuberculosis.

All programs in the Commonwealth are licensed by DBHDS, which conducts unannounced inspections at least annually (12VAC 35-105-70). The licensing regulations require that all persons entering treatment be screened for communicable diseases. The Office of Licensure requires the provider to submit a corrective action plan in the event a non-compliance issue arises. The State Opioid Treatment Authority (SOTA) is working with the Office of Licensure to strengthen communication between the offices regarding non-compliance with this requirement, and discussing clinical protocols to be implemented when screening indicates the need for additional diagnostic attention.

All OTPs are required to have and maintain accreditation with an entity approved under federal regulations. Accreditation requires a TB baseline skin test for anyone seeking treatment upon admission and then annually thereafter. If a person has ever had a positive skin test then a chest x-ray is required to insure the person is free of M. tuberculosis infection.

Services for Individuals in Need of Primary Substance Abuse Prevention

DBHDS Office of Behavioral Health and Wellness (OBHW) convened a Virginia State Epidemiological Workgroup (SEOW). The SEOW brings together representatives from a variety of traditional behavioral health partners and nontraditional sectors (see membership at left) to share data and expertise. While the original intent of the group was to focus on substance use prevention and behavioral health, the group's focus has grown over time to include the role that health disparities and health equity play in behavioral health. This data is essential in creating state and local planning, target determination and outcome achievement. This data allows the examination of relationships between risk and protective factors with subsequent behavioral health outcomes and are identifying areas of focus and opportunity for prevention efforts. These data have also provided the foundation for the Virginia Office of Behavioral Health Wellness' Needs Assessment, Strategic plan, and Logic model. Local providers, known as Community Services boards (CSBs), have used this data as the foundation for local needs assessments. They have coupled this with focus groups, additional local data and a resource assessment to development a strategic plan and logic model for local planning and a strategy implementation effort. The SEOW created a report that identifies behavioral health disparities and inequities which will be key in moving forward with targeted efforts at the state and community levels. Even though the state still utilizes environmental strategies to reach the majority of the Commonwealth's populations through universal strategies, we are also more targeted efforts to the selective population impacted by ACEs to prevent this population from moving further up the continuum of care.

Support Services for Children

The Virginia Office of Children's Services conducted its Service Gap Analysis from FY2022, surveying local community policy and management teams. The survey analysis demonstrated the lack of a complete array of children's services in all areas of the State. It identified the following seven statewide gaps by services: community based behavioral health, residential, crisis, evidence based, foster care, family support, and educational. The survey also identified increased or new barriers for FY2022. These gaps include provider availability, staffing, wait (lists/times), transportation, foster care homes, evidence-based, funding and multi-lingual services. Within the top three broad categories the following services were identified:

Category	Services
Family Support Services	• Respite • Parent coaching • Intensive Care Coordination
Community Based Behavioral Health Services	• Trauma Focused/Informed Services • Applied Behavioral Analysis • Medication Management
Foster Care	• Family Foster Care Homes • Therapeutic Foster Care Homes • Independent Living Services

Services for Military Service Members, Veterans, and their Families (SMVF)

Virginia has the sixth largest veteran population (approx. 690,000 in 2022) and approximately 129,000 Active-Duty Service Members. In addition, the Virginia National Guard has 8,700 Service Members with Army and Air components. In FY18, DBHDS, partnered with VHA, SAMHSA, Virginia Department of Veterans Services (DVS), and various state and local agencies to host the Richmond City Mayor's Challenge to Prevent Suicide Among SMVF (started in March 2018) and the Statewide Governor's Challenge to Prevent Suicide Among SMVF (started in December 2018). Both Challenges are ongoing and provide a strategic and comprehensive approach to suicide prevention emphasizing access to culturally competent behavioral health services, lethal means safety, and systemic partnerships between mainstream/civilian (CSBs, State and Private Hospitals etc.) and SMVF resources (VHA, Military Treatment Facilities, National Guard programs etc.).

As part of the Governor's Challenge, DBHDS expanded upon statewide partnerships to provide the Virginia Identify SMVF, Screen for Suicide Risk, and Refer to Services (VISR) pilot throughout 2020. This pilot program provided military culture, suicide prevention, and safety planning infrastructure, and expand risk screening in state and community agencies. The pilot enhanced SMVF resource connectivity before crisis and the delivery of life saving services in a crisis. We are currently implementing VISR 2.0 (January – December 2023) which allows for the engagement of broader community stakeholders who provide health and/or behavioral health services.

DBHDS and CSBs partner with DVS to refer SMVF to the Virginia Veteran and Family Support (VVFS) Program. VVFS provides care coordination services, peer, and family support statewide. VVFS also provides military culture training to CSB staff and other community stakeholders. DBHDS and DVS also operate a joint

advisory body on community-based behavioral health services for SMVF, the Virginia Military and Veterans Coordinating Committee (VMVCC). Since 2016, the VMVCC has worked closely with the SAMHSA Service Member, Veteran, and Family (SMVF) TA Center to expand military culture training for community providers, peer services and suicide prevention for SMVF.

SMVF are a priority population for the System Transformation Excellence and Performance initiative in Virginia (or STEP VA). Modeled after the SAMHSA Certified Community Behavioral Health Clinic model, STEP VA emphasizes access to community-based behavioral health services for SMVF. DBHDS is working collaboratively with CSBs to consistently identify SMVF seeking services, train staff in military culture and clinical best practices for treatment of trauma related to combat and/or military service and collaborate with Federal, State, and local resources for SMVF.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area:

Priority Type: SUP, SUT

Population(s): PWWDC, PP, PWID, TB

Goal of the priority area:

Provide adequate early intervention services to individuals receiving community SUD treatment services to decrease the likelihood of the need of more intensive services.

Strategies to attain the goal:

1. Encourage and provide support to providers to use engagement strategies such as Motivational Enhancement Therapy, Motivational Interviewing techniques, peer support services, by providing training on these evidence-based practices.

2. Encourage providers to utilize Contingency Management as an evidence-based practice where appropriate, and provide training to providers in this practice.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: In last 12 months, percentage of adults and children who are 13 years old or older with a new episode of substance use disorder (SUD) services as a result of a new SUD diagnosis (a new Diagnosis record for the SUD diagnosis) (denominator) who initiated any SUD services within 14 days of the new SUD diagnosis (numerator).

Baseline Measurement: 70%

First-year target/outcome measurement: In SFY 2024, 72% of those with a new SUD diagnosis will initiate treatment within 14 days.

Second-year target/outcome measurement: In SFY 2025, 74% of those with a new SUD diagnosis will initiate treatment within 14 days.

Data Source:

Virginia Community Consumer Submission (CCS-3) Data System; DBHDS Data Warehouse

Description of Data:

Data will track individuals who have been diagnosed with SUD and are quickly receiving their first service within 14 days. Indicator aligns with national HEDIS measure.

Data issues/caveats that affect outcome measures:

None at this time.

Indicator #: 2

Indicator: Indicator: In the last 12 months, number of CSBs in compliance with requirement to have policy and procedures in place to admit clients into SUD treatment who are using substances intravenously within 14 days of intake after they have completed comprehensive needs assessment indicating level of care

Baseline Measurement: Baseline: 20 CSBs in compliance with measure

First-year target/outcome measurement: First-year target/outcome measurement 2024: 21 CSBs

Second-year target/outcome measurement: Second-year target/outcome measurement 2025: 22 CSBs

Data Source:

Data Source: Block Grant Specialist Yearly evaluations

Description of Data:

Description of Data: Qualitative measure; Aggregate number of CSBs in compliance; Block Grant Specialists evaluate their regional CSBs each state fiscal year and will be adding this measure in FY 22;

Data issues/caveats that affect outcome measures:

Data issues/caveats that affect outcome measures: None at this time

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Indicator #: 3

Indicator: Indicator: In the last 12 months, percentage of individuals who completed TB risk assessment within 30 days after being admitted to SUD Treatment Services in order to identify those individuals who are at high risk of becoming infected

Baseline Measurement: Baseline: 35%

First-year target/outcome measurement: First-year target/outcome measurement 2024: 36%

Second-year target/outcome measurement: Second-year target/outcome measurement 2025: 37%

Data Source:

Data Source: CCS3 (Community Consumer Submission- data extract)

Description of Data:

Description of Data: total # of individuals who received TB screenings (numerator) after SUD Tx Program admission/ total # of individuals admitted to SUD Tx Program (denominator)

Data issues/caveats that affect outcome measures:

Data issues/caveats that affect outcome measures: None at this time

Priority #: 2

Priority Area: Priority Area: Increasing initiation and engagement of pregnant and parenting women in SUD services

Priority Type: SUT

Population(s): PWWDC, PP, PWID

Goal of the priority area:

Goal of the priority area: Increasing initiation and intensity of engagement of pregnant and parenting women in SUD services provided by the Community Services Boards (CSBs) in Virginia

Strategies to attain the goal:

- Evaluation and Research Specialist with DBHDS will query results in CCS3 using data element created by Data Warehouse

- Evaluation and Research Specialist, Block Grants State Planner, and Adult Community Behavioral Health Services Director will meet to evaluate the results

- If results do not meet the target, than a work group will be created including also the supervisor for the CSB regional specialists to determine appropriate next steps which could include education, training, evaluation, and compliance activities

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Indicator: In last 12 months, percentage of pregnant women and women with dependent children with a new episode of substance use disorder (SUD) services as a result of a new SUD diagnosis (a new Diagnosis record for the SUD diagnosis) (denominator) who initiated any SUD services within 14 days of the new SUD diagnosis (numerator).

Baseline Measurement: Baseline: 75%

First-year target/outcome measurement: 2024 Target: In SFY 2024, 77% of those with a new SUD diagnosis will initiate treatment within 14 days.

Second-year target/outcome measurement: 2025 Target: In SFY 2025, 79% of those with a new SUD diagnosis will initiate treatment within 14 days.

Data Source:

Data Source: Community Consumer Submission 3 (CCS3) Data Extract

Description of Data:

Description of Data: Data will track pregnant women and women with dependent children who have been diagnosed with SUD and are receiving their first service within 14 days. Indicator aligns with national HEDIS measure.

Data issues/caveats that affect outcome measures:

None at this time.

Indicator #: 2

Indicator: Indicator: In last 12 months, percentage of pregnant women and women with dependent children a new episode of substance use disorder (SUD) services as a result of a new SUD diagnosis (a new Diagnosis record for the SUD diagnosis) (denominator) who initiated any SUD services within 14 days of the new SUD diagnosis and who received two or more additional SUD services within 30 days of the first service (numerator).

Baseline Measurement: Baseline: 65%

First-year target/outcome measurement: 2024 Target: In SFY 2024, 67% of those who initiated SUD treatment will have two or more additional SUD services within 30 days.

Second-year target/outcome measurement: 2025 Target: In SFY 2025, 69% of those who initiated SUD treatment will have two or more additional SUD services within 30 days.

Data Source:

Data Source: Community Consumer Submission 3 (CCS3) Data Extract

Description of Data:

Description of Data: Data will track pregnant women and women with dependent children who have received services within 30 days of being admitted into the SUD services program area. Changed to align with national HEDIS measure.

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 3

Priority Area: Priority Area: Adherence to the standard that pregnant women receive priority admission for SUD services being seen within 48 hours of their request for services

Priority Type: SUT

Population(s): PWWDC, PP, PWID

Goal of the priority area:

Goal of the priority area: Increasing percentage of pregnant women in Virginia who are receiving priority admission for SUD services at the Community Services Boards (CSBs).

Strategies to attain the goal:

- Evaluation and Research Specialist will query the data in Community Consumer Submission 3 (CC3) to extract percentage

- Evaluation and Research Specialist, Block Grant State Planner, and Adult Community Behavioral Health Director will meet to evaluate results

- If targets are not met, a work group will be formed that includes the regional specialist supervisor for the CSBs to determine appropriate responses which could include education, training, evaluation, or compliance activities

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Indicator: In last 12 months, percent of pregnant women seen within 48 hours of their request for a valid SUD service

Baseline Measurement: Baseline: 75%

First-year target/outcome measurement: 2024 Target: In SFY2024, at least 76% of all pregnant women requesting SUD services will be seen within 48 hours.

Second-year target/outcome measurement: 2025 Target: In SFY2025, at least 77% of all pregnant women requesting SUD services will be seen within 48 hours.

Data Source:

Data Source: Community Consumer Submission 3 (CCS3) Data Extract

Description of Data:

Description of Data: The data compares the date an individual who identifies as pregnant requests SUD services and the date the first appointment was held.

Data issues/caveats that affect outcome measures:

The dataset does not currently include hours/minutes of appointment times or service requests. To measure we will look 2 business days after the day of request.

Priority #: 4

Priority Area: Priority Area: Increase Peer Support Services

Priority Type: SUP, SUT, SUR, MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS, PWWDC, PP, PWID

Goal of the priority area:

Increase peer services and supports in the public behavioral health system.

Strategies to attain the goal:

Increase the number of peer support specialists in Virginia's public behavioral health system through inclusion of peer support as a Medicaid reimbursable service.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Indicator: Number of peer staff offering recovery support services in substance use disorder service settings.

Baseline Measurement: Baseline: 127

First-year target/outcome measurement: 2024 Target: The number of peer staff offering recovery support services in SUD settings will increase to 133 FTEs in SFY 2024.

Second-year target/outcome measurement: 2025 Target: The number of peer staff offering recovery support services in SUD settings will increase to 140 FTEs in SFY 2025.

Data Source:

Data to be collected by DBHDS from CSBs.

Description of Data:

Data is the number of FTE peer support specialists providing recovery support services in CSBs SUD treatment programs.

Data issues/caveats that affect outcome measures:

None at this time.

Indicator #: 2

Indicator: Indicator: Number of peer staff offering mental health peer support services in mental health treatment settings.

Baseline Measurement: Baseline: 137 FTE

First-year target/outcome measurement: 2024 Target: The number of peer staff offering recovery support services in MH settings will increase to 143 FTEs in SFY 2024.

Second-year target/outcome measurement: 2025 Target: The number of peer staff offering recovery support services in MH settings will increase to 150 FTEs in SFY 2025.

Data Source:

Data will be collected by DBHDS from CSBs and state hospitals.

Description of Data:

The number of FTE mental health peer support specialists reported by CSBs and state hospitals.

Data issues/caveats that affect outcome measures:

None at this time.

Indicator #: 3

Indicator: Indicator: Increase the number of available certified Peer Recovery Specialists to better meet demand within the public, private, and non-profit sectors.

Baseline Measurement: Baseline: 863 individuals

First-year target/outcome measurement: 2024 Target: The number of available certified Peer Recovery Specialists will increase to 949 individuals in SFY 2024.

Second-year target/outcome measurement: 2025 Target: The number of available certified Peer Recovery Specialists will increase to 997 individuals in SFY 2025.

Data Source:

Virginia Certification Board

Description of Data:

The number of peers certified to provide services throughout the state.

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 5

Priority Area: Priority Area: Engagement in SUD services

Priority Type: SUT, SUR

Population(s): PWWDC, PP, PWID

Goal of the priority area:

Maintain engagement level of individuals' engagement in community SUD treatment services.

Strategies to attain the goal:

1. Work with providers to establish guidance concerning case load sizes that supports adequate frequency of treatment services.

2. Work with providers to ensure that current resources are used efficiently.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Indicator: In last 12 months, percentage of percentage of adults and children who are 13 years old with a new episode of substance use disorder (SUD) services as a result of a new SUD diagnosis (a new Diagnosis record for the SUD diagnosis) (denominator) who initiated any SUD services within 14 days of the new SUD diagnosis and who received two or more additional SUD services within 30 days of the first service (numerator).

Baseline Measurement: Baseline: 55%

First-year target/outcome measurement: 2024 Target: In SFY 2024, 55% of those who initiated SUD treatment will have two or more additional SUD services within 30 days.

Second-year target/outcome measurement: 2025 Target: In SFY 2025, 55% of those who initiated SUD treatment will have two or more additional SUD services within 30 days.

Data Source:

Virginia Community Consumer Submission (CCS-3) System; DBHDS Data Warehouse

Description of Data:

Data will track individuals who have received services within 30 days of being admitted into the SUD services program area. Indicator aligns with national HEDIS measure.

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 6

Priority Area: Priority Area: Engagement in child mental health outpatient services

Priority Type: MHS, ESMI

Population(s): SED, ESMI

Goal of the priority area:

Goal of the priority area: Increase child and family engagement in mental health outpatient services.

Strategies to attain the goal:

1. Monitor access to a uniform array of children's behavioral health services using the System Transformation Excellence and Performance (STEP-VA) model.

2. Focus on strategic initiatives to fill gaps in the STEP-VA array of services for children through the implementation of the outpatient services step of STEP-VA.

3. Continue to expand workforce development initiatives. There is an extreme shortage of licensed professionals in CSBs to meet the challenging needs of children with behavioral health problems. Workforce development initiatives from DBHDS provide continuing education for the children's behavioral health workforce. This training is provided free of charge to assist clinicians in getting licensed or maintaining current licenses. (This strategy is currently implemented with federal funding.)

4. Improve DBHDS quality management and quality assurance and oversight capacity for child and adolescent behavioral health services. Additional resources are needed for this initiative. (This strategy is contingent on state funding.)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Indicator: Percent of children admitted to the mental health services program area during the previous 12 months who received one hour of outpatient services within 30 days of admission (denominator) who received at least two additional hours of outpatient services within 60 days of admission (numerator).

Baseline Measurement: Baseline: 71%

First-year target/outcome measurement: 2024 Target: In SFY 2024, 72% of children in the MH program area will receive at least an additional 2 hours of Outpatient Services within 60 days of admission.

Second-year target/outcome measurement: 2025 Target: In SFY 2025, 73% of children in the MH program area will receive at least an additional 2 hours of Outpatient Services within 60 days of admission.

Data Source:

Virginia Community Consumer Submission (CCS-3) System; DBHDS Data Warehouse.

Description of Data:

Data will track children who received services within 30 days of admission into the mental health services program area.

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 7

Priority Area: Priority Area: Address the housing needs of individuals with mental health and/or substance use disorders.

Priority Type: SUT, SUR, MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS, PWWDC, PP, PWID

Goal of the priority area:

Address the housing needs of individuals with behavioral health disorders to support a secure and stable recovery.

Strategies to attain the goal:

1. Continue participation in cross-secretarial and interagency activities to leverage housing resources and create affordable housing options for individuals receiving public behavioral health services.

2. Continue providing training and consultation to service providers to increase affordable housing and appropriate supports by leveraging housing resources and

implementing supportive housing models.

3. Continue including housing stability of individuals receiving CSB behavioral health services as a Performance Contract goal and responsibility, and track outcomes on a regular basis.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Indicator: Number of individuals housed in Permanent Supportive Housing programs through DBHDS.

Baseline Measurement: Baseline: 1,600

First-year target/outcome measurement: 2024 Target: As of SFY 2024, 1,850 individuals will have been housed in Permanent Supportive Housing programs through DBHDS since the program started.

Second-year target/outcome measurement: 2025 Target: As of SFY 2025, 2,000 individuals will have been housed in Permanent Supportive Housing programs through DBHDS since the program started.

Data Source:

DBHDS Permanent Supportive Housing Database

Description of Data:

Data are the total number of individuals housed since the inception of the DBHDS Permanent Supportive Housing Initiative.

Data issues/caveats that affect outcome measures:

None at this time.

Indicator #: 2

Indicator: Indicator: Individuals who are supported by the PSH programs and remain stably housed for at least 12 months.

Baseline Measurement: Baseline: 87%

First-year target/outcome measurement: 2024 Target: As of SFY 2024, at least 87% of individuals supported by PSH programs will remain stably housed for at least 12 months.

Second-year target/outcome measurement: 2025 Target: As of SFY 2025, at least 87% of individuals supported by PSH programs will remain stably housed for at least 12 months.

Data Source:

DBHDS Permanent Supportive Housing Database

Description of Data:

A rolling number of persons year over year, who are classified as DBHDS SMI in the PSH database. Creating the proper filter for the MoveInDate and creating calculations to determine how long that person stayed in the PSH program. The Denominator is the unique number of clients after the filters are applied, then by using the Calculated filed "Movin_Discharge" which calculates years, you remove the ones that are 0 and below which will give you the Numerator.

Data issues/caveats that affect outcome measures:

MoveInDates and DischargeDates must be entered timely and accurately.

Priority #: 8

Priority Area: Priority Area: Intensity of engagement in adult mental health outpatient services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase the intensity of engagement of adults with SMI in mental health outpatient services

Strategies to attain the goal:

1. Continue to expand access to a uniform array of adult behavioral health services using the, existing, System Transformation Excellence and Performance (STEPVA) model and implementation efforts of Certified Community Behavioral Health Clinics (CCBHC).

2. As the efforts for TA continue for STEP-VA, Same Day Access (SDA) will be monitored by continued check-ins and training and TA offered to increase appointment status, post comprehensive needs assessment.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Indicator: Percent of adults admitted to the mental health services program area during the previous 12 months with serious mental illness who received one hour of outpatient services within 30 days of admission (denominator) who received at least two additional hours of outpatient services within 60 days of admission (numerator).

Baseline Measurement: Baseline: 60%

First-year target/outcome measurement: 2024 Target: In SFY 2024, 61% of adults with SMI in MH program area will receive at least 2

additional hours of Outpatient Services within 60 days of admission.

Second-year target/outcome measurement: 2025 Target: In SFY 2025, 62% of adults with SMI in MH program area will receive at least 2 additional hours of Outpatient Services within 60 days of admission.

Data Source:

Virginia Community Consumer Submission (CCS-3) Data System; DBHDS Data Warehouse.,

Description of Data:

Individuals who have received services within 30 days of admission into a mental health services program area. Changed to align with child measure.

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 9

Priority Area: Priority Area: Suicide Prevention

Priority Type: SUP, MHS

Population(s): SMI

Goal of the priority area:

Creation and maintenance of a suicide prevention infrastructure at the state and community levels.

Strategies to attain the goal:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Indicator: Total number of firearm retailer partners established.

Baseline Measurement: Baseline: 300

First-year target/outcome measurement: 2024 Target: There will be a total 325 firearm retail partners established by the end of SFY 2024.

Second-year target/outcome measurement: 2023 Target: There will be a total 350 firearm retail partners established by the end of SFY 2025.

Data Source:

Collaborative Planning Group (CPG) Performance Based Prevention System (PBPS)

Description of Data:

Indicator for the overall reach of wellness activities supporting Suicide Prevention in the State.

Data issues/caveats that affect outcome measures:

None at this time.

Indicator #: 2

Indicator: Indicator: Total number of “Lock and Talk Virginia” outreach via lethal means safety deterrents (such as medication lock boxes, gun locks, locking pill caps, locking medical bags).

Baseline Measurement: Baseline: 30,000

First-year target/outcome measurement: 2024 Target: There will be a total of 33,000 materials distributed by the end of SFY 2024.

Second-year target/outcome measurement: 2025 Target: There will be a total of 36,300 materials distributed by the end of SFY 2025.

Data Source:

Collaborative Planning Group (CPG) Performance Based Prevention System (PBPS)

Description of Data:

Indicator for the overall reach of wellness activities supporting Suicide Prevention in the State.

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 10

Priority Area: Priority Area: Youth retail access to all tobacco products, including smokeless, cigarillos, e-cigarettes, and other vapor products

Priority Type: SUP

Population(s):

Goal of the priority area:

Decrease the number of minors being sold tobacco and nicotine products

Strategies to attain the goal:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Indicator: The percent of all retail outlets in Virginia that have violated sale of tobacco and nicotine products to minors (Retail Violation Rate).

Baseline Measurement: Baseline: 16.5%

First-year target/outcome measurement: 2024 Target: In SFY 2024, the retail violation rate will be 15.5%.

Second-year target/outcome measurement: 2025 Target: In SFY 2025, the retail violation rate will be 14.5%.

Data Source:

Collaborative Planning Group (CPG) Performance Based Prevention System (PBPS)

Description of Data:

Indicator for the overall impact of the reduction of retail outlets selling tobacco and nicotine products to underage youth in the State.

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 11

Priority Area: Priority Area: Increase the public's knowledge about mental illness and decrease the associated stigma

Priority Type: MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

Decrease the stigma associated with mental illness through increased public knowledge and understanding of mental illness and its effects on individuals, families and communities.

Strategies to attain the goal:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Indicator: The total number of Mental Health First Aid Trainers from inception of program.

Baseline Measurement: Baseline: 789

First-year target/outcome measurement: 2024 Target: In SFY 2024, there will be 853 trainers since program inception.

Second-year target/outcome measurement: 2025 Target: In SFY 2025, there will be 917 trainers since program inception.

Data Source:

Collaborative Planning Group (CPG) Performance Based Prevention System (PBPS)

Description of Data:

Indicator for the overall reach of trainers available to increase public's knowledge about mental illness and reduce stigma.

Data issues/caveats that affect outcome measures:

None at this time.

Indicator #: 2

Indicator: Indicator: The total number of individuals trained in Mental Health First Aid by certified Trainers in Virginia each year of the program.

Baseline Measurement: Baseline: 3,500

First-year target/outcome measurement: 2024 Target: In SFY 2024, there will be at least 3,500 individuals trained in MHFA.

Second-year target/outcome measurement: 2025 Target: In SFY 2025, there will be at least 3,500 individuals trained in MHFA.

Data Source:

Collaborative Planning Group (CPG) Performance Based Prevention System (PBPS)

Description of Data:

Indicator for the overall impact of MH First Aid outreach to increase public's knowledge about mental illness and reduce stigma.

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 12

Priority Area: Priority Area: Addressing Adverse Childhood Experiences (ACEs) as a community to reduce the impact of childhood trauma leading to problem behaviors, i.e. substance use disorder, suicide, and anxiety.

Priority Type: SUP, MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

To better service individuals with Adverse Childhood Experiences so that the likelihood that trauma leads to problem behaviors is significantly reduced.

Strategies to attain the goal:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Indicator: The total number of Virginia Community Service Boards (CSBs) that are trained to serve individuals with ACE

Baseline Measurement: Baseline: 40

First-year target/outcome measurement: 2024 Target: In SFY 2022, all 40 CSBs will maintain proficiency in being able to provide services to individuals with ACES after their training.

Second-year target/outcome measurement: 2025 Target: In SFY 2023, all 40 CSBs will maintain proficiency in being able to provide services to individuals with ACES after their training.

Data Source:

Collaborative Planning Group (CPG) Performance Based Prevention System (PBPS)

Description of Data:

Measure of State's ability to serve individuals with ACE by number of CSBs trained to serve as catchment areas.

Data issues/caveats that affect outcome measures:

None at this time.

Indicator #: 2

Indicator: Indicator: Within each of the next three fiscal years, at least 3,600 individuals will be trained in Adverse Childhood Experiences (ACES)

Baseline Measurement: Baseline: 3,600

First-year target/outcome measurement: 2024 Target: In SFY 2024, at least 3,600 individuals will be trained in ACES.

Second-year target/outcome measurement: 2025 Target: In SFY 2025, at least 3,600 individuals will be trained in ACES.

Data Source:

Collaborative Planning Group (CPG) Performance Based Prevention System (PBPS)

Description of Data:

Measure of State's ability to serve individuals with ACE by number of individuals trained across the state.

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 13

Priority Area: Priority Area: Community mobilization organized to prevent substance use disorders

Priority Type: SUP

Population(s):

Goal of the priority area:

Greater connections between a variety of community coalitions across the state will have an impact on reducing the number of Virginians who become diagnosed with a substance use disorder.

Strategies to attain the goal:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Indicator: The total number of community coalitions in Virginia that have established a network with CADCA and/or CCOVA

Baseline Measurement: Baseline: 100

First-year target/outcome measurement: 2024 Target: In SFY 2024, there will be a total 102 coalitions that established a network with CADCA and/or CCOVA.

Second-year target/outcome measurement: 2025 Target: In SFY 2025, there will be a total 104 coalitions that established a network with CADCA and/or CCOVA.

Data Source:

Data Source:
CADCA and CCOVA paid Membership rosters

Description of Data:

Measure of networking and engagement touchpoints between community coalitions and CADCA and/or CCOVA.

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 14

Priority Area: Priority Area: Address episodes of institutional confinement in state psychiatric hospitals and local/state correctional settings of individuals with Serious Mental Illness (SMI) served by Virginia's Assertive Community Treatment (ACT) teams.

Priority Type: MHS, ESMI, BHCS

Population(s): SMI, SED, BHCS

Goal of the priority area:

To divert adults with serious and persistent mental illness from state hospitalizations and incarceration in local and/or state correctional facilities through the provision of high-fidelity Assertive Community Treatment.

Strategies to attain the goal:

1. Continue providing training and consultation to service providers on the provision of high-fidelity Assertive Community Treatment.

2. Monitor fidelity of Virginia's ACT programs via the use of the Tool for the Measurement of Assertive Community Treatment (TMACT).

3. Continue to require ACT teams to report hospitalization and incarceration episodes of individuals served, and track outcomes on a regular basis.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Indicator: Percent reduction in state hospitalization by comparing individuals' number of bed days in the two years prior to ACT admission with the number of bed days the two years following admission to ACT.

Baseline Measurement: Baseline: 46%

First-year target/outcome measurement: 2024 Target: In SFY 2024, there will be at least a 46% reduction in bed days utilized by adults with SMI in the ACT program between 2 years before ACT admission and 2 years after ACT admission.

Second-year target/outcome measurement: 2025 Target: In SFY 2025, there will be at least a 46% reduction in bed days utilized by adults with SMI in the ACT program between 2 years before ACT admission and 2 years after ACT admission.

Data Source:

Virginia Community Consumer Submission (CCS-3) Data System; DBHDS Data Warehouse.,

Description of Data:

Reduction in state hospital bed days utilized by individuals receiving ACT services.

Data issues/caveats that affect outcome measures:

There is a one year delay in this measure. To meaningfully measure the effectiveness of diverting individuals from state hospitals and stabilizing them in the community, we determined that we needed to review at least two years of hospitalization data for each individual after receiving ACT services. The latest complete fiscal year data available at the time of drafting the report was data through

FY2023.

Indicator #: 2

Indicator: Indicator: Percent reduction in incarceration by comparing individuals' total days in confinement in the two years prior to ACT admission with the number of total days in confinement the two years following admission to ACT.

Baseline Measurement: Baseline: 56%

First-year target/outcome measurement: 2024 Target: In SFY 2023, there will be at least a 56% reduction in total days in confinement by adults with SMI in the ACT program between 2 years before ACT admission and 2 years after ACT admission.

Second-year target/outcome measurement: 2025 Target: In SFY 2024, there will be at least a 56% reduction in total days in confinement by adults with SMI in the ACT program between 2 years before ACT admission and 2 years after ACT admission.

Data Source:

Virginia Community Consumer Submission (CCS-3) Data System; DBHDS Data Warehouse.,

Description of Data:

Reduction in total days in confinement by individuals receiving ACT services.

Data issues/caveats that affect outcome measures:

There is a one year delay in this measure. To meaningfully measure the effectiveness of diverting individuals from incarceration and stabilizing them in the community, we determined that we needed to review at least two years of incarceration data for each individual after receiving ACT services. The latest complete fiscal year data available at the time of drafting the report was data through FY2023.

Priority #: 15

Priority Area: Priority Area: Same Day Access Services for Community Behavioral Health

Priority Type: MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

Offer individuals seeking treatment for behavioral health same day evaluation services and quick follow-up services.

Strategies to attain the goal:

SDA provides comprehensive assessments to individuals at the time the assessment is requested. Appointments are not necessary. SDA means an individual may walk into or contact a CSB to request mental health or substance use disorder services and receive a comprehensive clinical behavioral health assessment from a licensed or license-eligible clinician the same day. Based on the results of the comprehensive assessment, if the individual is determined to need services, the goal of SDA is that he or she receives an appointment for face-to-face or other direct services in the program offered by the CSB that best meets his or her needs within 10 business days, sooner if indicated by clinical circumstances. SDA serves children, adolescents, and adults seeking behavioral health services. Military status will be considered and appropriate services and referrals made based on that status

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Indicator: Percent of individuals who receive a Same Day Access Assessment, and needing follow-up services, will be offered and keep an appointment within 30 calendar days.

Baseline Measurement: Baseline: 70%

First-year target/outcome measurement: 2024 Target: In SFY 2024, 80% or more of individuals will keep and attend a follow-up appointment within 30 calendar days.

Second-year target/outcome measurement: 2025 Target: In SFY 2025, 80% or more of individuals will keep and attend a follow-up appointment within 30 calendar days.

Data Source:

Virginia Community Consumer Submission (CCS-3) Data System; DBHDS Data Warehouse.,

Description of Data:

Percent of individuals receiving Same Day Access assessment who return for a follow-up service within 30 days.

Data issues/caveats that affect outcome measures:

None at this time.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SUPTRS]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds									
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$71,368,263.00		$25,979,188.80	$36,851,947.58	$146,225,598.66	$0.00	$0.00		$26,705,699.00	$0.00
a. Pregnant Women and Women with Dependent Children[c]	$7,907,134.00		$0.00	$0.00	$2,759,732.00	$0.00	$0.00		$3,953,867.00	
b. Recovery Support Services	$2,860,966.00		$0.00	$5,547,051.21	$3,800,000.00	$0.00	$0.00		$1,280,000.00	
c. All Other	$60,600,163.00		$25,979,188.80	$31,304,896.37	$139,665,866.66	$0.00	$0.00		$21,471,832.00	
2. Primary Prevention[d]	$19,031,536.80		$0.00	$4,759,873.18	$0.00	$0.00	$0.00		$10,675,000.00	$0.00
a. Substance Use Primary Prevention	$19,031,536.80		$0.00	$4,759,873.18	$0.00	$0.00	$0.00		$10,675,000.00	
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
6. Early Intervention Services for HIV	$0.00		$0.00	$0.00	$2,471,362.00	$0.00	$0.00		$0.00	
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Crisis Services (5 percent set-aside)										
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	$4,757,884.20		$6,543,891.07	$3,825,195.96	$20,030,273.81	$0.00	$344,415.32		$1,967,405.00	
12. Total	**$95,157,684.00**	**$0.00**	**$32,523,079.87**	**$45,437,016.72**	**$168,727,234.47**	**$0.00**	**$344,415.32**	**$0.00**	**$39,348,104.00**	**$33,982,454.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

[c] Prevention other than primary prevention

[d] The 20 percent set-aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds										
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]		$4,907,714.00	$0.00	$0.00	$8,000,000.00	$0.00	$0.00	$2,071,846.00		$3,578,643.00	
4. Other Psychiatric Inpatient Care			$15,098,398.00	$0.00	$45,940,525.00	$0.00	$0.00	$0.00		$0.00	
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital			$68,348,614.00	$6,117,853.00	$887,140,015.00	$0.00	$6,030,760.00	$0.00		$0.00	
8. Other 24-Hour Care		$0.00	$4,054,337.00	$0.00	$29,841,476.00	$0.00	$0.00	$0.00		$0.00	
9. Ambulatory/Community Non-24 Hour Care		$39,261,712.00	$207,696,215.00	$33,595,519.00	$726,495,706.00	$0.00	$0.00	$16,574,769.00		$28,629,146.00	
10. Crisis Services (5 percent set-aside)[f]		$2,453,857.00	$1,017,058.00	$5,425,742.00	$35,465,098.00	$0.00	$0.00	$1,035,923.00		$1,789,322.00	
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]		$2,453,857.00	$35,827,344.00	$5,693,970.00	$141,958,914.00	$0.00	$1,885,650.00	$1,035,923.00		$1,789,321.00	
12. Total	**$0.00**	**$49,077,140.00**	**$332,041,966.00**	**$50,833,084.00**	**$1,874,841,734.00**	**$0.00**	**$7,916,410.00**	**$20,718,461.00**	**$0.00**	**$35,786,432.00**	**$2,926,069.00**

[a]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[b]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[d]While the state may use state or other funding for prevention services, the MHBG funds must be directed toward adults with SMI or children with SED.

[e]Column 3 should include Early Serious Mental Illness programs funded through MHBG set aside.

[f]Row 10 should include Behavioral Health Crisis Services (BHCS) programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

[g]Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

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Footnotes:
BSCA Funds Calculated By Adding First and Second Allotment Payments and then adding set asides together for both allotments

Planning Tables

Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's National Survey on Drug Use and Health (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment column, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	4,873	337
2. Women with Dependent Children	102,075	3,237
3. Individuals with a co-occurring M/SUD	228,123	39,151
4. Persons who inject drugs	83,660	5,449
5. Persons experiencing homelessness	3,824	1,417

Please provide an explanation for any data cells for which the state does not have a data source.

Our Data and Evaluations Coordinator, Benjamin Marks reviewed the survey data SAMHSA asked DBHDS to reference (NDSDUH) for the first column and the topics they covered were not available or not able to be located.

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Footnotes:

Planning Tables

Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	FFY 2024		
Expenditure Category	**FFY 2024 SUPTRS BG Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[3]	$34,253,648.50	$28,231,078.00	$18,575,580.50
2 . Substance Use Primary Prevention	$9,515,768.40	$7,869,620.80	$6,796,490.80
3 . Early Intervention Services for HIV[4]	$0.00	$0.00	$0.00
4 . Tuberculosis Services	$0.00	$0.00	$0.00
5 . Recovery Support Services[5]	$1,430,483.00	$1,280,000.00	$6,911,260.00
6 . Administration (SSA Level Only)	$2,378,942.10	$1,967,405.20	$1,699,122.70
7. Total	**$47,578,842.00**	**$39,348,104.00**	**$33,982,454.00**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a “designated state” in any of the three years prior to the year for which a state is applying for SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG funds for EIS/HIV even though the state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SUPTRS BG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

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Footnotes:

Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

A		B		
Strategy	IOM Target	FFY 2024		
		SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
1. Information Dissemination	Universal	$2,271,414	$2,548,123	$1,814,120
	Selected	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$2,271,414**	**$2,548,123**	**$1,814,120**
2. Education	Universal	$2,873,762	$3,223,850	$2,295,200
	Selected	$15,225	$17,080	$12,160
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$2,888,987**	**$3,240,930**	**$2,307,360**
3. Alternatives	Universal	$104,673	$117,425	$83,600
	Selected	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$104,673**	**$117,425**	**$83,600**
4. Problem Identification and Referral	Universal	$0	$0	$0
	Selected	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$0**	**$0**	**$0**
	Universal	$2,891,842	$3,244,133	$2,309,640

5. Community-Based Processes	Selected	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$2,891,842**	**$3,244,133**	**$2,309,640**
6. Environmental	Universal	$1,358,852	$1,524,390	$1,085,280
	Selected	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$1,358,852**	**$1,524,390**	**$1,085,280**
7. Section 1926 (Synar)-Tobacco	Universal	$0	$0	$0
	Selected	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$0**	**$0**	**$0**
8. Other	Universal	$0	$0	$0
	Selected	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$9,515,768**	**$10,675,001**	**$7,600,000**
Total SUPTRS BG Award[3]		**$47,578,842**	**$39,348,104**	**$33,982,454**
Planned Primary Prevention Percentage		**20.00 %**	**27.13 %**	**22.36 %**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Planning Tables

Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award[1]	FFY 2024 ARP Award[2]
Universal Direct	$5,523,014	$6,195,840	$4,411,090
Universal Indirect	$3,977,744	$4,462,321	$3,176,922
Selected	$15,010	$16,839	$11,988
Indicated	$0	$0	$0
Column Total	**$9,515,768**	**$10,675,000**	**$7,600,000**
Total SUPTRS BG Award[3]	**$47,578,842**	**$39,348,104**	**$33,982,454**
Planned Primary Prevention Percentage	**20.00 %**	**27.13 %**	**22.36 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Planning Tables

Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☐	☐	☐
Heroin	☐	☐	☐
Inhalants	☐	☐	☐
Methamphetamine	☑	☑	☑
Fentanyl	☑	☑	☑
Prioritized Populations			
Students in College	☑	☑	☑
Military Families	☑	☑	☑
LGBTQI+	☑	☑	☑
American Indians/Alaska Natives	☐	☐	☐
African American	☑	☑	☑
Hispanic	☑	☑	☑
Persons Experiencing Homelessness	☐	☐	☐
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☐	☐	☐
Rural	☑	☑	☑

Underserved Racial and Ethnic Minorities	☑	☑	☑

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

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Planning Tables

Table 6 Non-Direct-Services/System Development [SUPTRS]

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Expenditure Category	FFY 2024				
	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems	$248,917.00	$366,282.00	$0.00	$508,774.00	$439,396.00
2. Infrastructure Support	$123,044.00	$141,667.00	$0.00	$218,918.00	$189,065.00
3. Partnerships, community outreach, and needs assessment	$297,105.00	$285,000.00	$0.00	$481,406.00	$415,759.00
4. Planning Council Activities (MHBG required, SUPTRS BG optional)	$0.00	$0.00	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$217,847.00	$265,985.00	$0.00	$400,133.00	$345,570.00
6. Research and Evaluation	$49,207.00	$141,667.00	$0.00	$157,854.00	$136,328.00
7. Training and Education	$100,556.00	$141,667.00	$0.00	$200,320.00	$173,004.00
8. Total	**$1,036,676.00**	**$1,342,268.00**	**$0.00**	**$1,967,405.00**	**$1,699,122.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

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Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: MHBG Planning Period End Date:

Activity	FY Block Grant	FY [1] COVID Funds	FY [2] ARP Funds	FY [3] BSCA Funds
.	$	$	$	$
8. Total			**$**	**$**

Please wait while data loads...

[1] The 24-month expenditure period for the COVID-19 Rel **21 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the ins res captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for mo oved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states.

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

f) Persons with substance use disorders in the justice system

g) Persons using substances who are at risk for overdose or suicide

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) Individuals with co-occurring mental and substance use disorders

Please see attached 1. Access to Care, Integration, and Care Coordination

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

Please see attached 1. Access to Care, Integration, and Care Coordination

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

Please see attached 1. Access to Care, Integration, and Care Coordination

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

Please see attached 1. Access to Care, Integration, and Care Coordination

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

Please see attached 1. Access to Care, Integration, and Care Coordination

Please indicate areas of technical assistance needed related to this section.

None at this time

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Footnotes:

Environmental Factors and Plan
1. The Health Care System, Parity and Integration

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]

SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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1. The Health Care System, Parity, and Integration

1. **Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:**

The Commonwealth of Virginia continues to work toward implementation of the model and a transition plan to CCBHC. Although Virginia was not granted the CCBHC Implementation grant in 2023, the System Transformation Excellence and Performance model (STEP-VA), that Virginia has been engaged in since 2017, has continued to further our efforts and planning around moving towards CCBHC certification.

STEP VA focuses on the development and sustainment of needed services to improve and sustain access to care for Virginians in need of support related to their behavioral health issues. These services include same day access for assessment; primary care screening, referral, and follow up; behavioral health crisis services; outpatient behavioral health; psychiatric rehabilitation; peer support and family support services; veterans behavioral health services; care coordination; and targeted case management. This model has continued to have support from stakeholders including the Virginia General Assembly and is now part of the Code of Virginia.

The STEP VA model comes from a person-centered, trauma-informed, and recovery-oriented approach, seeking to be inclusive of the needs of all Virginians. The services listed above are available across the life span for individuals with mental health, substance use, and co-occurring disorders, and reflect the priority populations specified by SAMHSA such as pregnant women and women with children. All steps have been implemented with input from stakeholders as of July 1, 2022. Currently, DBHDS is working with agency partners to implement compliance measures to assure consistency and readiness to move into CCBHC certification.

2. **Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.**

Funding streams in the Commonwealth vary related to their level of support for an integrated system of care. The block grants for mental health and substance use remain separate and must be reported as such although providers work to integrate services in order to work with individuals wholistically in the context of his or her environment rather than seeing the individual in compartments. State general funds are most often used for specific populations or program related support. DBHDS continues to seek more collaboration with behavioral health, substance use, co-occurring disorders, and intellectual and developments disabilities. This is highlighted by the development of a Substance Use Disorder Office, and addition of a Crisis Services Office under the Community Behavioral Health Assistant Commissioner. This larger division has a central assistant commissioner and has combined the staff traditionally separated by funding streams into one functional division with a specific skill set. It is the hope that changes such as these at the central office level will encourage community changes across the state to become less separate and more cohesive to the consumers.

A key development in Virginia is the transformation of the behavioral health system, we call “Right Help, Right Now” (governor driven initiative for state agencies and stakeholders). This transformative initiative

seeks to align subject matter experts, from various state agencies and stakeholders, with the build out of comprehensive community behavioral health services. The key workstreams from this initiative are: Same Day Care/Crisis, Law Enforcement and Behavioral Health, Expansion of capacity, Substance use, Behavioral Health workforce, and Innovations.

DBHDS continues to partner with our state Department of Medical Assistance (DMAS) in order to ensure appropriate, equitable, and consistent Medicaid reimbursement across the Commonwealth for services. As part of Virginia's ongoing movement toward CCBHC parity in reimbursement remains a priority to be evaluated and explored. As DMAS and DBHDS work together to serve the individuals in our care the rates of reimbursement, the actual costs of services, the engagement and enforcement of the previously mentioned rates continues to be discussed as not only a part of the internal DBHDS communications but as part of the Governor's plan as well.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

There continue to be a number of published studies showing that individuals with serious mental health disorders have higher rates of physical disability, significantly poorer health, and higher mortality rates than the general population. Physical health care is considered a core component of basic services for individuals with behavioral health disorders although this care is often fragmented for these individuals. DBHDS maintains partnerships with appropriate agencies and entities, including the Virginia Department of Health (VDH), Department of Health Professions (DHP), the Virginia Community Healthcare Association, Virginia Rural Health Resource Center, Virginia Hospital and Healthcare Association, Virginia College of Emergency Physicians, Virginia Chapter of the American Academy of Pediatrics, and Virginia Association of Free Clinics. In addition, a variety of primary medical and behavioral health partnerships exist across the state between CSBs and community health centers in their catchment areas.

Addressing issues of substance use disorders and addiction presents many opportunities to work closely with public health agencies, including referring individuals for HIV, hepatitis and TB testing and treatment, assisting women with infants and young children in accessing primary health care, including childhood immunization and primary healthcare, and working closely with the Office of the Chief Medical Examiner to utilize mortality data as a tool for identifying emerging substance use issues.

DBHDS staff also works closely with VDH to coordinate policy and services for at-risk families identified through the Home Visiting Network.

DBHDS also works closely with the DHP in a number of areas. Those focused on public health include serving on the Advisory Committee of the Prescription Monitoring Program and working to improve knowledge of addiction among healthcare providers to improve identification and referral efforts, as well as to improve access to medication assisted treatment and knowledge about the impact of addiction on physical health. DBHDS has worked very closely with DHP and VDH in implementing a pilot project to train

friends and family members of individuals at risk for opioid overdose to utilize naloxone. The pilot required the individual to obtain a prescription for naloxone from a physician. This project was recently expanded to statewide and, thanks to the close collaboration between agencies, statutory changes now allow pharmacists working under a specific protocol to prescribe naloxone, thus making it more accessible.

In addition, primary care practices have become one of the most common places where mental health conditions are first identified. DBHDS has worked with the Virginia Chapter of the American Academy of Pediatrics and the Medical Society of Virginia to implement the Virginia Mental Health Access Program (VMAP) which connects pediatric providers with consultation with a child psychiatrist. This is a novel program that aims to address the shortage of the child mental health workforce, build capacity of other child health professionals, to identify and treat mental health conditions in children and adolescent.

This program was first implemented regionally in 2020 through support from the General Assembly and due to its early successes, received additional support in the 2021 General Assembly for statewide implementation. DBHDS works closely with the state Medicaid program to increase the use of mental health screening tools in the primary care setting by ensuring reimbursement for the use of the tools and working closely with the managed care organizations dedicated care coordinators. DBHDS is currently collaborating with the Psychiatric Society of Virginia to explore other collaborative care models that facilitate the direct support between primary care providers and psychiatrists. Lastly, DBHDS has brought expertise to behavioral health providers to build their capacity to support individuals with physical illness and advocate for need health care or train behavioral health providers on health literacy topics. As an example, DBHDS infection prevention specialists have participated in the statewide medical Assertive Community Treatment team meetings to bring information related to management of acute infections and other infection prevention strategies, such as vaccine education, prevention of sexually transmitted diseases, management of louse infections, recurrent skin infections, and other respiratory illnesses. Building a bi-directional support system between medical health and behavioral health is an important component to the effectiveness of the work.

4. **Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs.**

   Describe care coordination available to:

   a) Adults with serious mental illness

   b) Adults with substance use disorders

   c) Children and youth with serious emotional disturbances or substance use disorders

DBHDS provided State and Local Fiscal Recovery (SLFR) funding to the 40 Community Services Boards (CSBs) as of July 1, 2022, in order to enhance Care Coordination activities within their respective agencies and regions. CSBs utilized the funding in various ways, to support the needs of the adults and children with Serious Mental Illnesses (SMI), Substance Use Disorders (SUD) and/or Co-Occurring Disorders. The metrics for success for this activity is the Survey, which is completed annually.

Examples of these care coordination activities included:

- Technical assistance to develop a comprehensive care coordination framework and strategic plan to meet the STEP-VA care coordination definition
- Care Coordinator or nurse coordinator Positions (i.e. provide Care coordination to individuals without health insurance; or complete referrals), embedded coordination positions in community
- Training supports for staff, position enhancements to allow for enhanced care coordination
- Comprehensive needs assessment/gap analysis regarding transitions in and out of CSB care, state hospitals, and in and out of services with community partners.
- Provide Care Coordination services to uninsured or underinsured individuals

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

Adults

Virginia view integrated care as a priority for our constituents. Individuals needing supports in their communities frequently are experiencing difficulties not only across their lifespan, but in multiple facets of their lives including substance use, mental health concerns, access to primary care providers, legal trouble, housing instability, and lack of sustainable supports for recovery. Therefore, our system of care must be nimble in order to address these concerns collaboratively, concurrently, and sustainably. Part of STEP VA, Same Day Access, is an option for individuals to walk into any public provider and receive screening and assessment for care related to their needs regardless of substance use or mental health, age, gender, or ability to pay.

Services provided post Same Day Access are tailored to the individuals needs and may include a combination of substance use treatment, peer services, case management, individual therapy, and psychiatric care, while also linking the individual to outside resources such as primary care providers, supported employment options, housing supports, and other indicated by the individual's needs. While the availability of these options will vary based on locality, population density, and other factors the holistic treatment of an individual has long shown the best outcomes for those seeking help and the community at large.

Youth

In the Fall of 2021, DBHDS launched the SAMHSA-funded Virginia Youth SBIRT (VA-YSBIRT) Project which is based on the screening, brief intervention, and referral to treatment (SBIRT) protocol. This initiative is not available in all communities. It is designed to expand/enhance the continuum of care for substance use disorder (SUD) services and reduce alcohol and other drug (AOD) consumption and its negative health impact, VA-YSBIRT provides a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Risk stratification is followed by an abbreviated version Motivational Interviewing – the Brief Negotiated Interview (BNI) and an Active Referral to Treatment (ART) if needed. BNI is a specialized brief intervention with a focus to generate behavior change plans in

a brief amount of time. ART involves finding the appropriate and affordable resources and services and ensuring a warm hand-off.

In addition to the VA-YSBIRT Project, the Office of Child and Family Services at DBHDS has contracted with the OMNI Institute to complete a multi-component approach to the overarching *Capacity-Building* and *Strategic Planning* project which will identify the gaps along the substance use continuum of care (prevention, harm reduction, early intervention, treatment, and recovery) that are limiting the system's ability to adequately meet the needs of adolescents and their families. The work of OMNI will build from the needs assessment to engage in an in-depth strategic planning and implementation process at the state and regional levels. Additionally, this process will set the stage for data-driven, thoughtful, and responsive implementation of adolescent substance use system of care improvements throughout Virginia.

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[5]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[6]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

[5] **https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status**

[6] **https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf**

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race	(•) Yes	( ) No
b) Ethnicity	(•) Yes	( ) No
c) Gender	(•) Yes	( ) No
d) Sexual orientation	( ) Yes	(•) No
e) Gender identity	(•) Yes	( ) No
f) Age	(•) Yes	( ) No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? (•) Yes ( ) No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ( ) Yes (•) No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ( ) Yes (•) No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? ( ) Yes (•) No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ( ) Yes (•) No

7. Does the state have any activities related to this section that you would like to highlight?

DBHDS continued our partnership with VCU Center on Society and Health to transform The Behavioral Health Equity Index into a data visualization platform, now being referred to as the Virginia Wellbeing Dashboard which predicts mental health and substance use disorders using statistical modeling and data from communities across Virginia. Using the All Payer Claims Database along with measurement of various social determinant of health the dashboard is able to predict a communities opportunity to thrive. Several workforce development opportunities have been provided to behavioral healthcare providers across the state including Crisis Response & Criminalization and The Rise of Eating Disorders in Marginalized and Overlooked Populations. A statewide focus group and needs assessment was completed on identity based discrimination in school settings. The result of the focus group were presented at a two day Supporting Socially Marginalized Youth Summit that emphasized health racial and ended identity development among marginalized identities. DBHDS also expects to conclude a statewide focus group on LGBTQ+ Virginias experiences in accessing mental health care. Finally, we are wrapping up evaluating our fourth year of behavioral health equity grants. This year between 10 - 15 CSBs and 15 - 20 community organizations will receive funding to implement equity oriented behavioral health programing in their communities.

Virginia Refugee Healing Partnership

Virginia Refugee Healing Partnership held behavioral health interpreter training attended by 119 interpreters in educational and in clinical setting. We continued our partnership with Virginia Tech to offer the Training of Trainers of BHIC in the Clinical Setting help support the program's sustainability. Key partner of the Office of New Americans to secure a $3 million grant for mental health support to implement Services to Afghan Survivors Impacted by Combat. DBHDS is currently managing the implementation of this program which targets 350 clients receiving mental health care and support.

DBHDS connected with 11 community coalitions for the Summer Youth Substance Use Prevention Grant. They validated the Virginia Behavioral Health Interpreting Curriculum in Educational Setting after two years of pilot training and extensive revisions. This is currently being edited for publication. DBHDS hosted a volunteer-based Language Access Conference with over 450 participants. It also provided four webinars on language access with a total participation of over 400 participants.

Conducted community mental health awareness training in collaboration with community trainers and refugee resettlement groups. The English Script was translated into nine different languages. Developed an eight-hour interpreting curriculum for volunteers, community leaders, and lay persons.

Developed sustainable partnership with local refugee mental health councils in areas where refugees are resettled, community partners, and special interest groups (i.e., LGBTQ, faith-based communities, etc.). Completed and translated the Pathways to Integration Curriculum into Spanish.

Please indicate areas of technical assistance needed related to this section

None at this time

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence for the efficacy and value of various mental and substance use prevention, SUD treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM/NASEM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center (EBPRC) assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's EBPRC provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[6] SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[8] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. Each KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice

demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

[2] United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[3] The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance use disorder and Mental Health Services Administration.

[4] National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

[5] **https://www.samhsa.gov/ebp-resource-center/about**

[6] **http://psychiatryonline.org/**

[7] **http://store.samhsa.gov**

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☑ Leadership support, including investment of human and financial resources.
- **b)** ☑ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☐ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☐ Provider involvement in planning value-based purchasing.
- **e)** ☑ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☑ Quality measures focused on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value-based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

DBHDS continues to progress toward quality measures in all processes both fiscal and otherwise. As such, a move toward a focus is on consumer outcomes is currently underway as part of an alignment with national standards and a planned demonstration for CCBHC transformation.

Please indicate areas of technical assistance needed related to this section.

None at this time

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Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
Coordinated Specialty Care	11

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
2085603	2453857

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.

There is no Medicaid rate for reimbursement of CSC in the Commonwealth of Virginia. Programs are left to try to bill for individual components of the model such as case management and have had varying degrees of success in doing so.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

Virginia's General Assembly has allocated ongoing State General Funds to support and sustain Coordinated Specialty Care.

5. Does the state monitor fidelity of the chosen EBP(s)?

○ Yes ◉ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?

◉ Yes ○ No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

Please see attached 4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

1. Seeking additional funding from the General Assembly to support expansion of CSC across the Commonwealth 2. Seeking funding for additional DBHDS staff with expertise in ESMI/FEP practices to assist with training, TA, and fidelity monitoring. 3. Awaiting word on SAMHSA ACT grant, which if awarded will be utilized to fund a pilot transition-aged youth ACT team and an "institute of best practices" partnership with the Virginia Commonwealth University School of Social Work. *All of these activities have been submitted for inclusion in the Governor's Right Help Right Now Initiative as well.

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

Diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder, or other specified schizophrenia spectrum or other psychotic disorder. Affective disorder with psychosis may also be used for admission. Individuals with a sole diagnosis of substance use disorder or intellectual disability will not be eligible for services. Individuals with a co-occurring diagnosis of substance use disorder can be admitted if the substance use is not a determining factor of their psychosis. Individuals with a co-occurring diagnosis of intellectual disability will need to be able to demonstrate understanding of the concepts utilized in the treatment modalities.

10. What is the estimated incidence of individuals with a first episode psychosis in the state?

This is data is being sought in order to best identify localities and communities where CSC or other ESMI services are most needed.

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

Budget request made to continue support to the state's 11 existing CSC programs with goal of expanding access to the service by adding new programs in areas without access.

Please indicate areas of technical assistance needed related to this section.

Fidelity monitoring, managing staffing shortages

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Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

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States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Eight of Virginia's Community Services Boards (CSBs) have been operating Coordinated Specialty Care (CSC) programs for the treatment of transition age youth experiencing their first episode of psychosis (FEP) since 2015. These providers continue to be allocated the MHBG 10% set-aside for Early Serious Mental Illness (ESMI), plus an additional $4 million per year State General Funds allocated by the Virginia General Assembly annually to address emerging serious mental illness in young people. Additionally, DBHDS has allocated ARPA dollars to fund the startup of three additional CSC programs and to augment the capacity and reach of existing programs.

DBHDS has also continued to strengthen its' partnership with the Virginia Department for Aging and Rehabilitative Services (DARS) in the Advancing State Policy Integration for Recovery and Employment (ASPIRE) initiative as one of seven states selected by the U.S. Department of Labor's Office of Disability Employment Policy (ODEP). A key aspect of Virginia's plan involves enhancing services for students and youth in transition utilizing the Supported Employment/Individual Placement & Support (SE/IPS) model.

Coordinated Specialty Care Programs Coordinator meets quarterly with team leaders to discuss and review practice, routinely alerts providers to available resources/ training opportunities, and encourages provider participation in listservs such as the Psychosis Risk and Early Psychosis Program Network (peppnet) http://med.stanford.edu/peppnet.html.

In addition, new teams will be required to utilize some of the funds that they receive to contract with subject matter experts (such as OnTrackNY or NAVIGATE) for training on EBPs.

Virginia's eleven Coordinated Specialty Care programs follow either the "OnTrack" or "NAVIGATE" program models.

Planned activities for FFY 2024 & 2025 are

- Continued support and technical assistance
- Specialized training and technical assistance in SE/IPS for CSC teams via the ASPIRE initiative.
- Further integration into the Early Psychosis Intervention Network (EPINET) and continued development of WEBCab for Virginia's CSC programs.

Current Data Collection Process

DBHDS, through collaboration with EPINET and Westat is utilizing a Virginia-specific WebCAB for data collection.

State Reporting

Due to key positions being either cut or vacated within DBHDS since reporting began in 2016, the data collected was not analyzed in any meaningful way until early 2019 when DBHDS filled a Behavioral Health Evaluation & Research Specialist position within its Office of Adult Community Behavioral Health. Coordinated Specialty Care Coordinator began working with this individual almost immediately, and in April 2019, DBHDS Evaluation Specialist produced a report titled "*Early Impacts of the Coordinated Specialty Care (CSC) Program".* That initial report is available here: http://dbhds.virginia.gov/assets/doc/BH/mhs/csc-report-final.pdf

With key positions now filled, DBHDS intends to continue reporting on its CSC programs with more regularity. CSC Coordinator and Behavioral Health Evaluation & Research Specialist have taken the lead internally to identify ways to include data on key functional outcome indicators such as educational/employment gains, decreased use of crisis services/hospitalizations, and housing stability, for example, in future reports.

8. Please list the diagnostic categories identified for your state's ESMI programs.

Basic fidelity standard for CSC admission includes diagnoses along the Schizophrenia Spectrum. Programs are allowed variances for Affective Psychosis if all other basic standards continue to be met, and a clinically valid justification for the variance is provided.

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required for MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

Please see attachment 5. Person Centered Planning (PCP) - Required for MHBG

4. Describe the person-centered planning process in your state.

Please see attachment 5. Person Centered Planning (PCP) - Required for MHBG

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's **A Practical Guide to Psychiatric Advance Directives**)?"

Please see attachment 5. Person Centered Planning (PCP) - Required for MHBG

Please indicate areas of technical assistance needed related to this section.

None at this time

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Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

Environmental Factors and Plan
5. Person Centered Planning (PCP) - Required MHBG

Does your state have policies related to person centered planning? YES

Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

Describe the person-centered planning process in your state.

What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's A Practical Guide to Psychiatric Advance Directives)?"

As part of Commonwealth's ongoing dedication to *System Transformation, Excellence and Performance in Virginia* (STEP VA), and the foreseeable implementation of CCBHC elsewhere in this application, the continued expectation remains that all services must integrate not only person-centered planning but also trauma-informed and recovery- oriented approaches as a standard part of care and service development. In regards to specific health care decisions, Primary Care, identified earlier as a part of the STEP VA process, engages the clinician with the consumer in navigating not only their behavioral health and wellbeing but their medical concerns as well. This is done through screening at the provider level and appropriate engagement of care givers, medical providers, and other supports in the network of change for the individual receiving services. This allows for a network of communication and follow up based on the individuals preferences and concerns.

Virginia continues to maintain its dedication to recovery-oriented approaches, as these approaches complement person-centered planning. The Office of Recovery Services, continues to support, maintain, and encourage the recovery centered focus used as part of the STEP VA process and has ongoing relationships with local community services boards as well as Virginia Medicaid. This office was just recently expanded to include Recovery Services Consultants that span each behavioral health region, to provide further assistance and organization. Virginia Medicaid continues to reimburse for services delivered by peer recovery coaches in both mental health and substance use engagement. Effective July 1, 2022, the Department of Medical Assistance Services increased the Medicaid rates for peer recovery and family support services in private and public community-based recovery services settings. While there is always more work to be done DBHDS remains committed to the process of individuals making their own decisions related to their service options as an equal partner.

Person-Centered Planning for Psychiatric Crisis
One area in which the Commonwealth has expanded its person-centered approach is in the area of pre-planning for mental health crisis. In 2009, the Virginia Health Care Decisions Act, a state law which allows for the use of advance directives to plan for end-of-life care and other health care decisions, was amended to include the ability to pre-plan for psychiatric crisis. Some states offer this option through the use of a stand-alone psychiatric advance directive, but in Virginia, policymakers opted to integrate mental health crisis planning into the larger health care advance directive. Through the use of MHBG funds, DBHDS partners with the University of Virginia Institute of Law, Psychiatry and Public Policy (ILPPP) to educate consumers with SMI, family members, advocates and providers about this option. DBHDS and the ILPPP provide training across our system on advance directives as an important mechanism for pre-planning for psychiatric care, and in collaboration with other system partners, including Mental Health America of Virginia, the Virginia Organization of Consumers Asserting Leadership, and the disAbility Law Center of Virginia, have developed a Certified Advance Directive

Facilitator training program which trains peer support specialists to assist individuals with SMI to develop their own advance directives. Research demonstrates that individuals with SMI who create their own advance directives with the assistance of a trained facilitator are more likely to be engaged in treatment, have better relationships with service providers, and are less likely to need more expensive and restrictive levels of care such as hospitalization. With the advent of Medicaid reimbursement of peer support in Virginia, the facilitator training, in which trainees participate in two full days of didactic training plus an observed facilitation, is becoming more popular. In addition, as part of this effort, DBHDS and the ILPPP have developed a resource website, VirginiaAdvanceDirectives.org, which is maintained by Mental Health America of Virginia.

a. Describe the person-centered planning process in your state.

Currently, Virginia does not have a blanket person-centered planning policy statewide. DBHDS continues to maintain the outlook that person-centered planning remains a best practice to ensure individuals in our system of care receive recovery-oriented, trauma-informed services meeting their expectations of services focused on their individual needs. DBHDS continues to support Virginia independent providers in making this practice a priority for consumer care.

One change in terms of person-centered planning at the practice level is with the Uniform Preadmission Screening Report. This does include a section to remind screeners to ask about Advanced Directives and the location of them. This is noted on the form as well as a section on notifying health care agent or personal representative of the results of the evaluation.

As Virginia moves forward with CCBHC demonstration, we have the opportunity to increase the use of an Advanced Directive and focus our efforts and attention on a systemic approach to having a person-centered planning process in the near future.

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

   See attached FY 2022 AND FY 2023 COMMUNITY SERVICES PERFORMANCE CONTRACT, block grant requirements start on p. 24

   Please indicate areas of technical assistance needed related to this section

   None at this time

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

COMMONWEALTH of VIRGINIA

NELSON SMITH
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

June 1, 2022

RE: FY22-23 Community Services Board Performance Contract Amendments

Dear Community Serviced Board and Behavioral Health Authority (collectively, the "CBS") Executive Directors,

The Office of Management Services (OMS) would like to thank you all for working with us through this amendment period of the FY22-23 Community Services Performance Contract (PC). This performance contract does not expire until June 1, 2023. For this review we are only amending certain documents and not the entire performance contract. We welcome any other suggested changes for consideration with the next iteration of the PC and they should be shared with the VACSB Performance Contract Review Committee, Ellen Harrison as your point of contact.

Please keep in mind that the performance contract is a transactional document and revisions may be necessary for clarification and better alignment with the strategic initiatives of the Commonwealth. The OMS has reviewed the current PC with other DBHDS internal stakeholders and the VACSB Performance Contract Review Committee and have determined the need to amend certain documents to provide clarity, remove outdated or redundant information, and to add language for the implementation of the new federal funding reimbursement model.

We would like to bring your attention to certain documents for this amendment period. Please take the time to review these documents to understand what will be required of your CSB.

1. FY2022 and 2023 Community Services Performance Contract – Section 9 is a material change that provides the requirements for billing and payments based on the federal funding reimbursement model.

2. Exhibit B: Continuous Quality Improvement (CQI) Process and CSB Performance Measures – Section I.A.1. implementation of the Suicide Screening Measure 86% benchmark.

3. Exhibit F: Federal Grant Requirements – These are required material changes that are not negotiable as a Subrecipient of federal funds. This exhibit has been revised to reflect the current federal grants and their general and specific terms and conditions. Other grants have also been deleted because they have expired. Section II Defined Terms, Major Medical Equipment cost requirement has been increased from $1K to $5K per unit. Section VI provides the current federal grants that DBHDS passes-through to CSB and the required identifying information that should be used to categorize and track these funds. We encourage you to familiarize yourself with this exhibit as a Subrecipient of federal funds.

4. Exhibit G: Master Program Services Requirements – This exhibit has been revised to provide general terms and conditions for certain programs services that a CSB may provide with the intent to reduce the amount of Exhibits D the Department and CSBs will have to review, process, and track. Keep in mind that this exhibit is not inclusive of all programs/services a CSB may provide and it will not replace the need for Exhibits D.

5. Exhibit I: Behavioral Health Wellness - Language has been added related to Gambling prevention funding.

6. Addendum I: Administrative Requirements and Processes and Procedures- Appendix C: Unspent Balances Principles and Procedures, Section 1.b. language was added to align with the new federal reimbursement model. Section 1.d. removed outdated language. Section 1.e. language added for clarity. Section 3 b and c removed outdated and/or conflicting language.

7. Exhibit M: The Department of Justice Settlement Agreement – Changes are part of the DOJ settlement agreement (DOJSA) and are required material changes that are not negotiable. Item 29 provides additional language for all CSBs to review and provide annual feedback on the QRT (Quality Review Team) End of Year Report. Also, Item 4.b. provides modifications to the frequency of completion of the OSVT (On-Site Visit Tool) in response to CSB Support Coordinator (SC) turnover and staffing concerns. Specifically, DBHDS has required that the OSVT be completed once per month in months where visits occur regardless of whether the person had TCM (Targeted Case Management) or ECM (Enhanced Case Management). This schedule of completion was initially a compromise to meet DOJSA requirements and manage the workload for SCs, which was not reflected in the last version of the Performance Contract. Given current recruitment and retention challenges, an altered schedule of completion for TCM will assist with addressing staffing challenges and workload while maintaining current expectations for people with more complex needs (i.e. ECM). This change is recommended by the DBHDS Case Management Steering Committee in response to ongoing staffing concerns across CSBs.

   Item 11.b. is also modified to provide the addition of "as provided under Therapeutic Consultation waiver services" which aligns with the training mentioned and helps clarify that the plans reviewed are in line with the scope of the SC. The training clarifies the basic elements reviewed and how to document related information.

8. Exhibit K: State Hospital Census Management Admission and Discharge Requirements – Clinical Readiness for Discharge Scale revised to prevent non-clinically ready NGRI

(Not Guilty by Reason of Insanity) patients from appearing, inappropriately, on the Extraordinary Barriers to Discharge list.

Timeline for Execution
The amendments to the PC shall be effective as of **July 1, 2022**. Please keep in mind the Department cannot provide any state-controlled funds after September 30th if the contract has not been signed by your CSB. It is important for the smooth continuity of the process to have signed performance contracts returned to the Department as soon as practicable.

The Department would like to thank you all for your service and partnering with us. All your hard work and dedication to both your communities and our community services system is much valued and appreciated.

If you need help or have questions about this process, please email performancecontractsupport@dbhds.virginia.gov or contact our technical assistance number at 804-225-4242.

Thank you,

Chaye Neal-Jones
Project and Program Manager
Office of Management Services

AMENDMENT 1
FY 2022 AND FY 2023 COMMUNITY SERVICES PERFORMANCE CONTRACT

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Other Amended Performance Contract Document Attachments

☒Exhibit A: Resources and Services (Only available through the CARS application)
☒Exhibit B: Continuous Quality Improvement (CQI) Process and CSB Performance Measures
☐Exhibit C: Regional Discharge Assistance Program (RDAP) Requirements
☐Exhibit D: Individual CSB Performance Measures
☒Exhibit E: Performance Contract Schedule and Process
☒Exhibit F: Federal Grant Requirements
☐Exhibit F(B): Single Audit Exemption Form
☒Exhibit G: Community Services Boards Master Programs Services Requirements
☐Exhibit H: Regional Local Inpatient Purchase of Services (LIPOS) Requirements
☒Exhibit I: Behavioral Health Wellness
☐Exhibit J: Intentionally Left Black for Future Use
☒Exhibit K: State Hospital Census Management Admission and Discharge Requirements
☒Exhibit M: Department of Justice Settlement Agreement
☒Addendum I: Administrative Requirements and Processes and Procedures
☐Addendum II: Partnership Agreement
☐Addendum III: Core Services Taxonomy 7.3

AMENDMENT 1
FY 2022 AND FY 2023 COMMUNITY SERVICES PERFORMANCE CONTRACT

1. Purpose

The Department of Behavioral Health and Developmental Services (the "Department) and the Community Service Board or Behavioral Health Authority (the "CSB") enter into this contract for the purpose of funding services provided directly or contractually by the CSB in a manner that ensures accountability to the Department and quality of care for individuals receiving services and implements the mission of supporting individuals by promoting recovery, self-determination, and wellness in all aspects of life.

Title 37.2 of the Code of Virginia, hereafter referred to as the Code, establishes the Virginia Department of Behavioral Health and Developmental Services, hereafter referred to as the Department, to support delivery of publicly funded community mental health (MH), develop mental (DD), and substance use (SUD), services and supports and authorizes the Department to fund those services.

Sections 37.2-500 through 37.2-512 of the Code require cities and counties to establish community services boards for the purpose of providing local public mental health, developmental, and substance use disorder services; §§ 37.2-600 through 37.2-615 authorize certain cities or counties to establish behavioral health authorities that plan and provide those same local public services.

This contract refers to the community services board, local government department with a policy-advisory community services board, or behavioral health authority named in this contract as the CSB. Section 37.2-500 or 37.2-601 of the Code requires the CSB to function as the single point of entry into publicly funded mental health, developmental, and substance use disorder services. The CSB fulfills this function for any person who is located in the CSB's service area and needs mental health, developmental, or substance use disorder services.

Sections 37.2-508 and 37.2-608 of the Code and State Board Policy 4018, establish this contract as the primary accountability and funding mechanism between the Department and the CSB, and the CSB is applying for the assistance provided under Chapter 5 or 6 of Title 37.2 by submitting this contract to the Department.

The CSB exhibits, addendums, appendices, Administrative Requirements and Processes and Procedures, CCS Extract, Core Services Taxonomy, and Partnership Agreement documents are incorporated into and made a part of this contract by reference. The documents may include or incorporate ongoing statutory, regulatory, policy, and other requirements that are not contained in this contract. The CSB shall comply with all provisions and requirements. If there is a conflict between provisions in that document and this contract, the language in this contract shall prevail.

2. Defined Terms

Appropriation Act is defined as an Act for the appropriation of the Budget submitted by the Governor of Virginia in accordance with the provisions of § 2.2-1509 of the Code of Virginia and to provide a portion of the revenues for a two year period.

Federal Fiscal Year the Federal Fiscal Year begins on October 1 of the calendar and ends on September 31 of the subsequent calendar year.

Federal Funds the Federal Funds are funds that are allocated by the federal government and are provided to the Department of Behavioral Health and Developmental Services as the State of Virginia's authority for the allocation, management, and oversight for the use of these specific funds. The funds are considered restricted and must be used or encumbered during the federal fiscal year or extensions. Any unused funds are required to be returned to the Department by the CSB and from there to the federal government in a timely manner.

Fiscal Agent the Fiscal Agent has two specific purposes.

The specific local government that is selected by the local governments or government participating in the establishment of a specific CSB and identified in the local resolutions passed by each locality in its creation of the CSB. If the participating governments decide to select a different fiscal agent, it must be done through a local resolution passed by each participating local government that created the CSB.

The second purpose of Fiscal Agent is the specific CSB that has been selected by the CSB Region to receive state controlled funds from the Department and manage those funds in a way that has been identified in a memorandum of understanding (MOU) agreed to by each participating CSB in a regionally funded activity. If the CSB acting as Fiscal Agent changes by decision of the Regional CSB, then that change must be noted in a revision to the existing MOU.

Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA) is an agreed upon process for the management of services, funds, or any rules or regulations that govern the processes all participating parties agree to follow for the common good of the participating parties. In the case of the Community Services Performance Contract, or any activities funded through the Community Service Performance Contract, the MOU is agreed upon and signed for the delivery of services identified and funded through the Region the participating community services boards or behavioral health authority provide services in.

Populations Served adults with serious mental illnesses, children with or at risk of serious emotional disturbance, individuals with developmental disabilities, or individuals with substance use disorders to the greatest extent possible within the resources available to it for this purpose.

Restricted Funds are funds identified separately in letters of notification, performance contracts, Exhibits D and Community Automated Reporting System (CARS) reports to be used for specified purposes; CSB must account for and report expenditures associated with these funds to the Department. This requirement is reflected in the CARS report forms with columns for expenditures and balances that are completed for any restricted funds received by a CSB .The uses of restricted funds usually are controlled and specified by a funding source, such as federal mental health and substance abuse block grants or the Appropriations Act passed by the General Assembly. The Department restricts funds that would otherwise be. An example is Other Funds, which are restricted in order to calculate balances of unexpended funds.

State Fiscal Year the State Fiscal Year (FY) begins July 1 of the calendar year and ends June 30 of the subsequent calendar year.

State General Funds these are funds that are appropriated by the Virginia General Assembly and are identified in each current Appropriation Act. The act is not considered law until it is signed by the Governor of Virginia.

Unrestricted Funds are funds identified separately in letters of notification, performance contracts, and CARS reports but without specified purposes; CSB do not have to account for or report expenditures associated with them separately to the Department.

3. Relationship

The Department functions as the state authority for the public mental health, developmental, and substance use disorder services system, and the CSB functions as the local authority for that system. The relationship between and the roles and responsibilities of the Department, the state hospitals and the CSB are described in the Partnership Agreement between the parties. This contract shall not be construed to establish any employer-employee or principal-agent relationship between employees of the CSB or its board of directors and the Department.

4. Term and Termination

Term: This contract shall be in effect for a term of two years, commencing on July 1, 2021 and ending on June 30, 2023 unless either party gives ninety 90 days or more advance written notice of intent not to renew.

Termination: The Department may terminate all or a portion of this contract immediately at any time during the contract period if funds for this activity are withdrawn or not appropriated by the General Assembly or are not provided by the federal government. In this situation, the obligations of the Department and the CSB under this contract shall cease immediately. The CSB and Department shall make all reasonable efforts to ameliorate any negative consequences or effects of contract termination on individuals receiving services and CSB staff.

The CSB may terminate all or a portion of this contract immediately at any time during the contract period if funds for this activity are withdrawn or not appropriated by its local government(s) or other funding sources. In this situation, the obligations of the CSB and the Department under this contract shall cease immediately. The CSB and Department shall make all reasonable efforts to ameliorate any negative consequences or effects of contract termination on individuals receiving services and CSB staff.

5. Contract Amendment

This contract, including all exhibits and incorporated documents, constitutes the entire agreement between the Department and the CSB and may be amended only by mutual agreement of the parties, in writing and signed by the parties hereto, except for the services identified in Exhibit A, amendments to services under Exhibit A shall be in accordance with the performance contract revision instructions contained in Exhibit E.

6. Services

Exhibit A of this contract includes all mental health, developmental, and substance use disorder services provided or contracted by the CSB that are supported by the resources described in this contract. Services and certain terms used in this contract are defined in the current Core Services Taxonomy.

7. Service Change Management

The CSB shall notify the Department 30 days prior to seeking to provide a new category or subcategory or stops providing an existing category or subcategory of services if the service is funded with more than 30 percent of state or federal funds or both. The CSB shall provide sufficient information to the Office of Management Services (OMS) through the performancecontractsupport@dbhds.virginia.gov for its review and approval of the change, and the CSB shall receive the Department's approval before implementing the new service or stopping the existing service.

Pursuant to 12VAC35-105-60 of the *Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services*, the CSB shall not modify a licensed service without submitting a modification notice to the Office of Licensing in the Department at least 45 days in advance of the proposed modification.

The CSB operating a residential crisis stabilization unit (RCSU) shall not increase or decrease the licensed number of beds in the RCSU or close it temporarily or permanently without providing 30 days advance notice to the Office of Licensing and the OMS, and receiving the Department's approval prior to implementing the change.

8. Funding Requirements

A. Funding Resources

Exhibit A of this contract provides an example of the following resources: state funds and federal funds appropriated by the General Assembly and allocated by the Department to the CSB and any other funds associated with or generated by the services shown in Exhibit A. CSB must review their CARS application for the most recent version of Exhibit A.

B. Funding Allocations

1. The Department shall inform the CSB of its state and federal fund allocations in the letter of

notification (LON). Allocations of state and federal funds shall be based on state and federal statutory and regulatory requirements, provisions of the Appropriation Act, State Board policies, and previous allocation amounts.

2. The Department may reduce restricted or state or federal funds during the contract term if the CSB reduces significantly or stops providing services supported by those funds as documented in CCS Extract or CARS reports. These reductions shall not be subject to provisions in Section 14.A.and B. of this contract. The Commissioner or designee shall communicate all adjustments to the CSB in writing.
3. Continued disbursement and /or reimbursement of restricted or state or federal funds by the Department to the CSB may be contingent on documentation in the CSB's CCS Extract and CARS reports that it is providing the services supported by these funds.

C. Expenses for Services

The CSB shall provide those services funded within the funds and for the costs set forth in Exhibit A and documented in the CSB's financial management system. The CSB shall distribute its administrative and management expenses across the program areas (mental health, developmental, and substance use disorder services), emergency services, and ancillary services on a basis that is auditable and satisfies Generally Accepted Accounting Principles. CSB administrative and management expenses shall be reasonable and subject to review by the Department.

D. Use of Funds

1. The Department has the authority to impose additional conditions or requirements for use of funds, separate from those established requirements or conditions attached to appropriations of state-controlled funds by the General Assembly, the Governor, or federal granting authorities. The Department shall when possible provide sufficient notice in writing to the CSB of changes to the use of funds.
2. The CSB shall maximize billing and collecting Medicaid payments and other fees in all covered services to enable more efficient and effective use of the state and federal funds allocated to it.

E. Availability of Funds

The Department and the CSB shall be bound by the provisions of this contract only to the extent of the funds available or that may hereafter become available for the purposes of the contract.

F. Local Match

Pursuant to § 37.2-509 of the Code allocations from the Department to any community services board for operating expenses, including salaries and other costs, or the construction of facilities shall not exceed 90 percent of the total amount of state and local matching funds provided for these expenses or such construction, unless a waiver is granted by the Department and pursuant State Board Policy 4010.

State Board Policy 6005 and based on the Appropriation Act prohibition against using state funds to supplant funds provided by local governments for existing services, there should be no reduction of local matching funds as a result of a CSB's retention of any balances of unspent state funds.

G. Local Contact for Disbursement of Funds

1. If the CSB is an operating CSB and has been authorized by the governing body of each city or county that established it to receive state and federal funds directly from the Department and act as its own fiscal agent pursuant to Subsection A.18 of § 37.2-504 of the Code, must send notification to include:
   a. Name of the Fiscal Agent's City Manager or County Administrator or Executive
   b. Name of the Fiscal Agent's County or City Treasurer or Director of Finance
   c. Name, title, and address of the Fiscal Agent official or the name and address of the CSB if it acts

as its own fiscal agent to whom checks should be electronically transmitted

2. The notification must be sent to:

   Fiscal and Grants Management Office
   Virginia Department of Behavioral Health and Developmental Services
   Eric.Billings@dbhds.virginia.gov

H. Unanticipated Changes in the Use of Funds Due to a Disaster

The Department reserves the right to re-purpose the currently allocated funds to a CSB. This action will not be done without clear deliberations between the Department and the CSB. The decision can rest on the requirements outlined in an Executive Order Issued by the Governor, changes to the ability of the Department or the CSB to provide contracted services to the preservation of health and safety of individuals receiving services or the health and safety of staff providing services, or to decisions made by local government forbidding the provision of services, the funding allocations, the specific services intended to be funded, and the types and numbers of individuals projected to be served.

9. Billing and Payment Terms and Conditions

A. Federal Funds Invoicing

The CSB shall invoice the Department on a monthly basis no later than the 20th of the following month for which reimbursement is being requested. The CSB will utilize the federal funds reimbursement template provided to them by the Office of Fiscal Services and Grants Management (FSGMO) to invoice the Department for federal funds reimbursement. The CSB may be asked to include supporting documentation when the Department determines it is necessary to meet federal grant requirements.

1. The CSB understands and agrees to all of the following:
   a. CSB shall only be reimbursed for actual, reasonable, and necessary costs based on its award amounts.
   b. An invoice under this agreement shall include only reimbursement requests for actual, reasonable, and necessary expenditures.
   c. Expenditures required in the delivery of services shall be subject to any other provision of this agreement relating to allowable reimbursements.
   d. An invoice under this agreement shall not include any reimbursement request for future expenditures.
   e. An invoice under this agreement shall be processed when the Department's FSGMO is in receipt of any required documentation.

B. Payment Terms

1. Federal Funds shall be dispersed on a reimbursement basis with the exception of an initial upfront one-time payment and circumstances where funded programs incur one-time start-up costs. The initial upfront one-time payment will be 1/8th of the amount of the total budget for executed Exhibits D, Notices of Award, other DBHDS correspondence (for programs with existing service requirements for funding pursuant to the Performance Contract), and for new Mental Health Block Grants and Substance Abuse Block Grants that are scheduled to commence payments in July of the new fiscal year.

   All Exhibit Ds, Notice of Award, and DBHDS correspondence must be finalized by June 10th of the prior fiscal year in order to be eligible for the initial upfront one-time payment. All other federal funds payments to CSB will be made monthly on a reimbursement basis. To receive payment, the CSB must invoice the Department as provided in the policies and procedures established by the Office of Fiscal Services and Grants Management.

2. State Funds shall be disbursed by the Department's Fiscal Services and Grants Management Office as set forth in its established policies and procedures.

C. Reconciliation and Closeout Disclosures.

The CSB shall reconcile all Exhibits D, Notice of Awards, and other required correspondence by June 10th of current fiscal year in order to receive the initial funding by July 1 for the new fiscal year. If a CSB does not return its signed Exhibits D, Notices of Award or other required documentation in a timely manner this may result in a delay of or ineligibility for receiving payment of its invoice(s).

a. The CSB shall comply with applicable federal grant reconciliation and closeout disclosures as provided in Exhibit F of the performance contract and established by the FSGMO.

b. Unexpended federal funds must either be returned in the form of a check made payable to the Treasurer of Virginia and sent to:
DBHDS
Office of Fiscal and Grants Management
PO Box 1797
Richmond, VA 23218-1797
C/O Ramona Howell

Or CSB may return the funds electronically through an ACH transfer. The transfer would be made to DBHDS' Truist account. The account information and DBHDS' EIN is as follows:

Account Number: 201141795720002
Routing Number: 061000104
EIN: 546001731

Name and Address of Bank:
Truist Bank
214 North Tryon Street
Charlotte, NC 28202

If the ACH method of payment is utilized, please send an email indicating your intent to submit funds electronically to:

Eric.Billings@dbhds.virginia.gov
Ramona.Howell@dbhds.virginia.gov
Dillon.Gannon@dbhds.virginia.gov
Christine.Kemp@dbhds.virginia.gov
Kim.Barton@dbhds.virginia.gov

Approval to execute an ACH payment is not required, but DBHDS must be aware that the payment is coming in order to account for it properly.

10. CSB Responsibilities

A. Exhibit A

Shall be submitted electronically through the CARS application provided by the Department. In Exhibit A of the CARS application the CSB shall provide the projected array of services, the projected cost of those services, the projected service capacity to provide those services, and the projected cost for those services.

B. Populations Served

The CSB shall provide needed services to adults with serious mental illnesses, children with or at risk of serious emotional disturbance, individuals with developmental disabilities, or individuals with substance use disorders to the greatest extent possible within the resources available to it for this purpose. The current Core Services Taxonomy defines these populations.

C. Scope of Services

Exhibit G of this performance contract provides a scope of certain Code mandated and other program services a CSB may be responsible for providing but are not limited to those in Exhibit G.

D. Response to Complaints

Pursuant to § 37.2-504 or § 37.2-605 of the Code, the CSB shall implement procedures to satisfy the requirements for a local dispute resolution mechanism for individuals receiving services and to respond to complaints from individuals receiving services, family members, advocates, or other stakeholders as expeditiously as possible in a manner that seeks to achieve a satisfactory resolution and advises the complainant of any decision and the reason for it. The CSB shall acknowledge complaints that the Department refers to it within five business days of receipt and provide follow up commentary on them to the Department within 10 business days of receipt. The CSB shall post copies of its procedures in its public spaces and on its web site, provide copies to all individuals when they are admitted for services, and provide a copy to the Department upon request.

E. Quality of Care

1. **Department CSB Performance Measures:** CSB staff shall monitor the CSB's outcome and performance measures in Exhibit B, identify and implement actions to improve its ranking on any measure on which it is below the benchmark, and present reports on the measures and actions at least quarterly during scheduled meetings of the CSB board of directors.
2. **Quality Improvement and Risk Management:** The CSB shall develop, implement, and maintain a quality improvement plan, itself or in affiliation with other CSB, to improve services, ensure that services are provided in accordance with current acceptable professional practices, and address areas of risk and perceived risks. The quality improvement plan shall be reviewed annually and updated at least every four years.
    a. The CSB shall develop, implement, and maintain, itself or in affiliation with other CSB, a risk management plan or participate in a local government's risk management plan. The CSB shall work with the Department to identify how the CSB will address quality improvement activities.
    b. The CSB shall implement, in collaboration with other CSB in its region, the state hospital(s) and training centers serving its region, and private providers involved with the public mental health, developmental, and substance use disorder services system, regional utilization management procedures and practices.
3. **Critical Incidents:** The CSB shall implement procedures to insure that the executive director is informed of any deaths, serious injuries, or allegations of abuse or neglect as defined in the Department's Licensing (12VAC35-105-20) and Human Rights (12VAC35-115-30) Regulations when they are reported to the Department. The CSB shall provide a copy of its procedures to the Department upon request.

F. Reporting Requirements and Data Quality

1. **Individual Outcome and CSB Provider Performance Measures**
    a. **Measures**: Pursuant to § 37.2-508 or § 37.2-608 of the Code, the CSB shall report the data for individual outcome and CSB provider performance measures in Exhibit B of this contract to the Department.

b. **Individual CSB Performance Measures**: The Department may negotiate specific, time-limited measures with the CSB to address identified performance concerns or issues. The measures shall be included as Exhibit D of this contract.

c. **Individual Satisfaction Survey**: Pursuant to § 37.2-508 or § 37.2-608 of the Code, the CSB shall participate in the Annual Survey of Individuals Receiving MH and SUD Outpatient Services, the Annual Youth Services Survey for Families (i.e., Child MH survey), and the annual QSRs and the NCI Survey for individuals covered by the DOJ Settlement Agreement.

2. **Electronic Health Record**

The CSB shall implement and maintain an electronic health record (EHR) that has been fully certified and is listed by the Office of the National Coordinator for Health Information Technology-Authorized Testing and Certification Body to improve the quality and accessibility of services, streamline and reduce duplicate reporting and documentation requirements, obtain reimbursement for services, and exchange data with the Department and its state hospitals and training centers and other CSB.

3. **Reporting Requirements**

For purposes of reporting to the Department, the CSB shall comply with State Board Policy 1030 and shall:

a. provide monthly Community Consumer Submission (CCS) extracts that report individual characteristic and service data to the Department, as required by § 37.2- 508 or § 37.2-608 of the Code, the federal Substance Abuse and Mental Health Services Administration, and Part C of Title XIX of the Public Health Services Act - Block Grants, § 1943 (a) (3) and § 1971 and § 1949, as amended by Public Law 106- 310, and as permitted under 45 CFR §§ 164.506 (c) (1) and (3) and 164.512 (a) (1) and (d) of the HIPAA regulations and §32.1-127.1:03.D (6) of the Code, and as defined in the current CCS Extract Specifications, including the current Business Rules.

b. follow the current Core Services Taxonomy and CCS Extract Specifications, when responding to reporting requirements established by the Department;

c. complete the National Survey of Substance Abuse Treatment Services (N-SSATS) annually that is used to compile and update the National Directory of Drug and Alcohol Abuse Treatment Programs and the on-line Substance Abuse Treatment Facility Locator;

d. follow the user acceptance testing process described in Appendix D of the CSB Administrative Requirements for new CCS Extract releases and participate in the user acceptance testing process when requested to do so by the Department;

e. report service data on substance abuse prevention and mental health promotion services provided by the CSB that are supported wholly or in part by the SABG set aside for prevention services through the prevention data system planned and implemented by the Department in collaboration with the VACSB DMC, but report funding, expenditure, and cost data on these services through CARS); and report service, funding, expenditure, and cost data on any other mental health promotion services through CCS Extract and CARS;

f. report data and information required by the current Appropriation Act; and

g. report data identified collaboratively by the Department and the CSB working

h. through the VACSB DMC

4. **Routine Reporting Requirements**

The CSB shall account for all services, funds, expenses, and costs accurately and submit reports to the Department in a timely manner using current CARS, CCS, or other software provided by the Department. All reports shall be provided in the form and format prescribed by the Department. The

CSB shall provide the following information and meet the following reporting requirements:

a. types and service capacities of services provided, costs for services provided, and funds received by source and amount and expenses paid by program area and for emergency and ancillary services semi-annually in CARS, and state and federal block grant funds expended by service category with the end-of-the-fiscal year CARS report;

b. demographic characteristics of individuals receiving services and types and amounts of services provided to each individual monthly through the current CCS;

c. Federal Balance Report;

d. PATH reports (mid-year and at the end of the fiscal year);

e. amounts of state, local, federal, Medicaid, other fees, other funds used to pay for services by service category in each program area and emergency and ancillary services in the end of the fiscal year CARS report; and

f. other reporting requirements in the current CCS Extract Specifications.

5. **Subsequent Reporting Requirements:** In accordance with State Board Policy 1030, the CSB shall work with the Department through the VACSB DMC to ensure that current data and reporting requirements are consistent with each other and the current Core Services Taxonomy, the current CCS Extract, and the federal substance abuse Treatment Episode Data Set (TEDS) and other federal reporting requirements. The CSB also shall work with the Department through the VACSB DMC in planning and developing any additional reporting or documentation requirements beyond those identified in this contract to ensure that the requirements are consistent with the current taxonomy, the current CCS Extract, and the TEDS and other federal reporting requirements.

6. **Data Elements:** The CSB shall work with the Department through the DMC to standardize data definitions, periodically review existing required data elements to eliminate elements that are no longer needed, minimize the addition of new data elements to minimum necessary ones, review CSB business processes so that information is collected in a systematic manner, and support efficient extraction of required data from CSB electronic health record systems whenever this is possible.

7. **Streamlining Reporting Requirements:** The CSB shall work with the Department through the VACSB DMC to review existing reporting requirements including the current CCS Extract to determine if they are still necessary and, if they are, to streamline and reduce the number of portals through which those reporting requirements are submitted as much as possible; to ensure reporting requirements are consistent with the current CCS Extract Specifications and Core Services Taxonomy; and to maximize the interoperability between Department and CSB data bases to support the electronic exchange of information and comprehensive data analysis.

8. **Data Quality:** The CSB shall review data quality reports from the Department on the completeness and validity of its CCS Extract data to improve data quality and integrity. When requested by the Department, the CSB executive director shall develop and submit a plan of correction to remedy persistent deficiencies in the CSB's CCS Extract submissions and, upon approval of the Department, shall implement the plan of correction.

9. **Providing Information:** The CSB shall provide any information requested by the Department that is related to the services, funds, or expenditures in this contract or the performance of or compliance with this contract in a timely manner, considering the type, amount, and availability of information requested. Provision of information shall comply with applicable laws and regulations governing confidentiality, privacy, and security of information regarding individuals receiving services from the CSB.

10. **Reviews:** The CSB shall participate in the periodic, comprehensive administrative and financial review of the CSB conducted by the Department to evaluate the CSB's compliance with requirements in the

contract and CSB Administrative Requirements and the CSB's performance. The CSB shall address recommendations in the review report by the dates specified in the report or those recommendations may be incorporated in an Exhibit D.

11. Subcontracting

A subcontract means a written agreement between the CSB and another party under which the other party performs any of the CSB's obligations. Subcontracts, unless the context or situation supports a different interpretation or meaning, also may include agreements, memoranda of understanding, purchase orders, contracts, or other similar documents for the purchase of services or goods by the CSB from another organization or agency or a person on behalf of an individual.

If the CSB hires an individual not as an employee but as a contractor (e.g., a part- time psychiatrist) to work in its programs, this does not constitute subcontracting under this section. CSB payments for rent or room and board in a non-licensed facility (e.g., rent subsidies or a hotel room) do not constitute subcontracting under this section, and the provisions of this section, except for compliance with the Human Rights regulations, do not apply to the purchase of a service for one individual.

The CSB may subcontract any requirements in this contract. The CSB shall remain fully and solely responsible and accountable for meeting all of its obligations and duties under this contract, including all services, terms, and conditions, without regard to its subcontracting arrangements.

Subcontracting shall comply with applicable statutes, regulations, and guidelines, including the Virginia Public Procurement Act, § 2.1-4300 et seq. of the Code. All subcontracted activities shall be formalized in written contracts between the CSB and subcontractors. The CSB agrees to provide copies of contracts or other documents to the Department on request.

A. Subcontracts

The written subcontract shall, as applicable and at a minimum, state the activities to be performed, the time schedule and duration, the policies and requirements, including data reporting, applicable to the subcontractor, the maximum amount of money for which the CSB may become obligated, and the manner in which the subcontractor will be compensated, including payment time frames. Subcontracts shall not contain provisions that require a subcontractor to make payments or contributions to the CSB as a condition of doing business with the CSB.

B. Subcontractor Compliance

The CSB shall require that its subcontractors comply with the requirements of all applicable federal and state statutes, regulations, policies, and reporting requirements that affect or are applicable to the services included in this contract. The CSB shall require that its subcontractors submit to the CSB all required CCS Extract data on individuals they served and services they delivered in the applicable format so that the CSB can include this data in its CCS Extract submissions to the Department.

1. The CSB shall require that any agency, organization, or person with which it intends to subcontract services that are included in this contract is fully qualified and possesses and maintains current all necessary licenses or certifications from the Department and other applicable regulatory entities before it enters into the subcontract and places individuals in the subcontracted service.

2. The CSB shall require all subcontractors that provide services to individuals and are licensed by the Department to maintain compliance with the Human Rights Regulations adopted by the State Board.

3. The CSB shall, to the greatest extent practicable, require all other subcontractors that provide services purchased by the CSB for individuals and are not licensed by the Department to develop and implement policies and procedures that comply with the CSB's human rights policies and procedures

or to allow the CSB to handle allegations of human rights violations on behalf of individuals served by the CSB who are receiving services from such subcontractors. When it funds providers such as family members, neighbors, individuals receiving services, or others to serve individuals, the CSB may comply with these requirements on behalf of those providers, if both parties agree.

C. Subcontractor Dispute Resolution

The CSB shall include contract dispute resolution procedures in its contracts with subcontractors.

D. Quality Improvement Activities

The CSB shall, to the extent practicable, incorporate specific language in its subcontracts regarding the quality improvement activities of subcontractors. Each vendor that subcontracts with the CSB should have its own quality improvement system in place or participate in the CSB's quality improvement program.

12. Compliance with Laws

CSB shall comply with all applicable federal, state, and local laws and regulations. If any laws or regulations that become effective after the execution date of this contract substantially change the nature and conditions of this contract, they shall be binding upon the parties, but the parties retain the right to exercise any remedies available to them by law or other provisions of this contract.

A. HIPPA

1. The CSB shall comply with the HIPAA and the regulations promulgated thereunder by their compliance dates, except where the HIPAA requirements and applicable state law or regulations are contrary and state statutes or regulations are more stringent, as defined in 45 CFR § 160.202, than the related HIPAA requirements.
2. The CSB shall execute a Business Associate Agreement (BAA) initiated by the Department for any HIPAA- or 42 CFR Part 2- protected health information (PHI), personally identifiable information (PII), and other confidential data that it exchanges with the Department and its state facilities that is not covered by Section 10.F.3.a. to ensure the privacy and security of sensitive data.
3. The CSB shall ensure sensitive data, including HIPAA-PHI, PII, and other confidential data, exchanged electronically with the Department, its state hospitals and training centers, other CSB, other providers, regional or persons meets the requirements in the FIPS 140-2 standard and is encrypted using a method supported by the Department.
4. The Department and its state hospitals and training centers shall comply with HIPAA and the regulations promulgated thereunder by their compliance dates, except where the HIPAA requirements and applicable state law or regulations are contrary and state statutes or regulations are more stringent, as defined in 45 CFR § 160.202, than the related HIPAA requirements.
5. The Department shall initiate a BAA with the CSB for any HIPAA- or 42 CFR Part 2-PHI, PII, and other confidential data that it and its state facilities exchange with the CSB that is not covered by Section 10.F.3.a. to ensure the privacy and security of sensitive data.
6. The CSB shall execute a BAA with the Department's authorized business associate for the access of PHI, PII, and other confidential data that the CSB may be required to provide to the Department's business associate to ensure the privacy and security of sensitive data.
7. The Department and its state hospitals and training centers shall ensure that any sensitive data, including HIPAA-PHI, PII, and other confidential data, exchanged electronically with CSB, other providers, or persons meets the requirements in the FIPS 140-2 standard and is encrypted using a method supported by the Department and CSB.

B. Employment Anti-Discrimination

1. The CSB shall conform to the applicable provisions of Title VII of the Civil Rights Act of 1964 as amended, the Equal Pay Act of 1963, Sections 503 and 504 of the Rehabilitation Act of 1973, the Vietnam Era Veterans Readjustment Act of 1974, the Age Discrimination in Employment Act of 1967,

the Americans With Disabilities Act of 1990, the Virginians With Disabilities Act, the Virginia Fair Employment Contracting Act, the Civil Rights Act of 1991, regulations issued by Federal Granting Agencies, and other applicable statutes and regulations, including § 2.2-4310 of the Code. The CSB agrees as follows:

2. The CSB will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability, or other basis prohibited by federal or state law relating to discrimination in employment, except where there is a bona fide occupational qualification reasonably necessary to the normal operation of the CSB. The CSB agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.
3. The CSB, in all solicitations or advertisements for employees placed by or on behalf of the CSB, will state that it is an equal opportunity employer.
4. Notices, advertisements, and solicitations placed in accordance with federal law, rule, or regulation shall be deemed sufficient for the purpose of meeting these requirements.

C. Service Delivery Anti-Discrimination

1. The CSB shall conform to the applicable provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans With Disabilities Act of 1990, the Virginians with Disabilities Act, the Civil Rights Act of 1991, regulations issued by the U.S. Department of Health and Human Services pursuant thereto, other applicable statutes and regulations, and as further stated below.
2. Services operated or funded by the CSB have been and will continue to be operated in such a manner that no person will be excluded from participation in, denied the benefits of, or otherwise subjected to discrimination under such services on the grounds of race, religion, color, national origin, age, gender, or disability.
3. The CSB and its direct and contractual services will include these assurances in their services policies and practices and will post suitable notices of these assurances at each of their facilities in areas accessible to individuals receiving services.
4. The CSB will periodically review its operating procedures and practices to insure continued conformance with applicable statutes, regulations, and orders related to non- discrimination in service delivery.

D. General State Requirements

The CSB shall comply with applicable state statutes and regulations, State Board regulations and policies, and Department procedures, including the following requirements.

E. Conflict of Interests

Pursuant to § 2.2-3100.1 of the Code, the CSB shall ensure that new board members are furnished with receive a copy of the State and Local Government Conflict of Interests Act by the executive director or his or her designee within two weeks following a member's appointment, and new members shall read and become familiar with provisions of the act.

The CSB shall ensure board members and applicable CSB staff receive training on the act. If required by § 2.2-3115 of the Code, CSB board members and staff shall file annual disclosure forms of their personal interests and such other information as is specified on the form set forth in § 2.2-3118 of the Code. Board members and staff shall comply with the Conflict of Interests Act and related policies adopted by the CSB board of directors.

F. Freedom of Information

Pursuant to § 2.2-3702 of the Code, the CSB shall ensure that new board members are furnished with a copy of the Virginia Freedom of Information Act by the executive director or his or her designee within two weeks following a member's appointment, and new members shall read and become familiar with provisions of the act.

The CSB shall ensure board members and applicable staff receive training on the act. Board members and staff shall comply with the Freedom of Information Act and related policies adopted by the CSB by the CSB board of directors.

G. Protection of Individuals Receiving Services

1. **Human Rights:** The CSB shall comply with the current *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services*. In the event of a conflict between any of the provisions in this contract and provisions in these regulations, the applicable provisions in the regulations shall apply.

   The CSB shall cooperate with any Department investigation of allegations or complaints of human rights violations, including providing any information needed for the investigation as required under state law and as permitted under 45 CFR § 164.512 (d) in as expeditious a manner as possible.

2. **Disputes:** The filing of a complaint as outlined in the Human Rights Regulations by an individual or his or her family member or authorized representative shall not adversely affect the quantity, quality, or timeliness of services provided to that individual unless an action that produces such an effect is based on clinical or safety considerations and is documented in the individual's individualized services plan.

H. Licensing

The CSB shall comply with the *Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services.* The CSB shall establish a system to ensure ongoing compliance with applicable licensing regulations. CSB staff shall provide copies of the results of licensing reviews, including scheduled reviews, unannounced visits, and complaint investigations, to all members of the CSB board of directors in a timely manner and shall discuss the results at a regularly scheduled board meeting. The CSB shall adhere to any licensing guidance documents published by the Department.

13. Department Responsibilities

A. Program and Service Reviews

The Department may conduct or contract for reviews of programs or services provided or contracted by the CSB under this contract to examine their quality or performance at any time as part of its monitoring and review responsibilities or in response to concerns or issues that come to its attention, as permitted under 45 CFR § 164.512 (a), (d), and (k) (6) (ii) and as part of its health oversight functions under § 32.1-127.1:03 (D) (6) and § 37.2-508 or § 37.2-608 of the Code or with a valid authorization by the individual receiving services or his authorized representative that complies with the *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services*, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule. The CSB shall provide ready access to any records or other information necessary for the Department to conduct program or service reviews or investigations of critical incidents.

B. State Facility Services

1. **Availability:** The Department shall make state facility services available, if appropriate, through its state hospitals and training centers when individuals located in the CSB's service area meet the admission criteria for these services.
2. **Bed Utilization:** The Department shall track, monitor, and report on the CSB's utilization of state hospital and training center beds and provide data to the CSB about individuals receiving services from its service area who are served in state hospitals and training centers as permitted under 45 CFR

§§ 164.506 (c) (1), (2), and (4) and 164.512(k) (6) (ii). The Department shall distribute reports to CSB on state hospital and training center bed utilization by the CSB for all types of beds (adult, geriatric, child and adolescent, and forensic) and for TDO admissions and bed day utilization.

3. **Continuity of Care:** The Department shall manage its state hospitals and training centers in accordance with State Board Policy 1035, to support service linkages with the CSB, including adherence to the applicable continuity of care procedures, and the current Exhibit K and other applicable document provided by the Department. The Department shall assure state hospitals and training centers use teleconferencing technology to the greatest extent practicable to facilitate the CSB's participation in treatment planning activities and fulfillment of its discharge planning responsibilities for individuals in state hospitals and training centers for whom it is the case management CSB.
4. **Medical Screening and Medical Assessment**: When working with CSB and other facilities to arrange for treatment of individuals in the state hospital, the state hospital shall assure that its staff follows the current Medical Screening and Medical Assessment Guidance Materials. The state hospital staff shall coordinate care with emergency rooms, emergency room physicians, and other health and behavioral health providers to ensure the provision of timely and effective medical screening and medical assessment to promote the health and safety of and continuity of care for individuals receiving services.
5. **Planning:** The Department shall involve the CSB, as applicable and to the greatest extent possible, in collaborative planning activities regarding the future role and structure of state hospitals and training centers.

C. Quality of Care

The Department in collaboration with the VACSB Data Management and Quality Leadership Committees and the VACSB/DBHDS Quality and Outcomes Committee shall identify individual outcome, CSB provider performance, individual satisfaction, individual and family member participation and involvement measures, and quality improvement measures, pursuant to § 37.2-508 or § 37.2-608 of the Code, and shall collect information about these measures and work with the CSB to use them as part of the Continuous Quality Improvement Process described in Appendix E of the CSB Administrative Requirements to improve services.

D. Department CSB Performance Measures Data Dashboard

The Department shall develop a data dashboard to display the CSB Performance Measures in Exhibit B, developed in collaboration with the CSB, and disseminate it to CSB. The Department shall work with the CSB to identify and implement actions to improve the CSB's ranking on any outcome or performance measure on which it is below the benchmark.

E. Utilization Management

The Department shall work with the CSB, state hospitals and training centers serving it, and private providers involved with the public mental health, developmental, and substance use disorder services system to implement regional utilization management procedures and practices.

F. Human Rights

The Department shall operate the statewide human rights system described in the current *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental* Services, by monitoring compliance with the human rights requirements in those regulations.

G. Licensing

The Department shall license programs and services that meet the requirements in the current *Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services*,

and conduct licensing reviews in accordance with the provisions of those regulations. The Department shall respond in a timely manner to issues raised by the CSB regarding its efforts to coordinate and monitor services provided by independent providers licensed by the Department.

H. Peer Review Process

The Department shall implement a process in collaboration with volunteer CSB to ensure that at least five percent of community mental health and substance abuse programs receive independent peer reviews annually, per federal requirements and guidelines, to review the quality and appropriateness of services. The Department shall manage this process to ensure that peer reviewers do not monitor their own programs.

I. Electronic Health Record (EHR)

The Department shall implement and maintain an EHR in its central office and state hospitals and training centers that has been fully certified and is listed by the Office of the National Coordinator for Health Information Technology- Authorized Testing and Certification Body to improve the quality and accessibility of services, streamline and reduce duplicate reporting and documentation requirements, obtain reimbursement for services, and exchange data with CSB.

J. Reviews

The Department shall review and take appropriate action on audits submitted by the CSB in accordance with the provisions of this contract and the CSB Administrative Requirements. The Department may conduct a periodic, comprehensive administrative and financial review of the CSB to evaluate the CSB's compliance with requirements in the contract and CSB Administrative Requirements and the CSB's performance. The Department shall present a report of the review to the CSB and monitor the CSB's implementation of any recommendations in the report.

K. Reporting and Data Quality Requirements

In accordance with State Board Policy 1030, the Department shall work with CSB through the VACSB DMC to ensure that current data and reporting requirements are consistent with each other and the current Core Services Taxonomy, the current CCS Extract, and the Treatment Episode Data Set (TEDS) and other federal reporting requirements.

1. The Department also shall work with CSB through the DMC in planning and developing any additional reporting or documentation requirements beyond those identified in this contract to ensure that the requirements are consistent with the current taxonomy, current CCS Extract, and TEDS and other federal reporting requirements.
2. The Department shall work with the CSB through the DMC to develop and implement any changes in data platforms used, data elements collected, or due dates for existing reporting mechanisms, including CCS Extract, CARS, WaMS, FIMS, and the current prevention data system and stand-alone spreadsheet or other program- specific reporting processes.

L. Community Consumer Submission

The Department shall collaborate with CSB through the DMC in the implementation and modification of the current CCS Extract, which reports individual characteristic and service data that is required under § 37.2-508 or § 37.2-608 of the Code, the federal Substance Abuse and Mental Health Services Administration, and Part C of Title XIX of the Public Health Services Act - Block Grants, §1943 (a) (3) and § 1971 and § 1949, as amended by Public Law 106-310, to the Department and is defined in the current CCS Extract Specifications, including the current Business Rules.

1. The Department will receive and use individual characteristic and service data disclosed by the CSB through CCS Extract as permitted under 45 CFR§§ 164.506 (c) (1) and (3) and 164.512 (a) (1) of the

HIPAA regulations and § 32.1- 127.1:03.D (6) of the Code and shall implement procedures to protect the confidentiality of this information pursuant to § 37.2-504 or § 37.2-605 of the Code and HIPAA.

2. The Department shall follow the user acceptance testing process described in Addendum I Administrative Requirements and Processes and Procedures for new CCS Extract releases.

M. Data Elements

The Department shall work with CSB through the DMC to standardize data definitions, periodically review existing required data elements to eliminate elements that are no longer needed, minimize the addition of new data elements to minimum necessary ones, review CSB business processes so that information is collected in a systematic manner, and support efficient extraction of required data from CSB electronic health record systems whenever this is possible.

The Department shall work with the CSB through the DMC to develop, implement, maintain, and revise or update a mutually agreed upon electronic exchange mechanism that will import all information related to the support coordination or case management parts of the ISP (parts I-IV) and VIDES about individuals who are receiving DD Waiver services from CSB EHRs into WaMS. If the CSB does not use or is unable to use the data exchange, it shall enter this data directly into WaMS.

N. Streamlining Reporting Requirements

The Department shall work with CSB through the DMC to review existing reporting requirements including the current CCS Extract to determine if they are still necessary and, if they are, to streamline and reduce the number of portals through which those reporting requirements are submitted as much as possible; to ensure reporting requirements are consistent with the current CCS Extract Specifications and Core Services Taxonomy; and to maximize the interoperability between Department and CSB data bases to support the electronic exchange of information and comprehensive data analysis.

O. Data Quality

The Department shall provide data quality reports to the CSB on the completeness and validity of its CCS Extract data to improve data quality and integrity. The Department may require the CSB executive director to develop and implement a plan of correction to remedy persistent deficiencies in the CSB's CCS Extract submissions. Once approved, the Department shall monitor the plan of correction and the CSB's ongoing data quality.

P. Surveys

The Department shall ensure that all surveys and requests for data have been reviewed for cost effectiveness and developed through a joint Department and CSB process. The Department shall comply with the Procedures for Approving CSB Surveys, Questionnaires, and Data Collection Instruments and Establishing Reporting Requirements, reissued by the Commissioner.

Q. Communication

1. The Department shall provide technical assistance and written notification to the CSB regarding changes in funding source requirements, such as regulations, policies, procedures, and interpretations, to the extent that those changes are known to the Department.

2. The Department shall resolve, to the extent practicable, inconsistencies in state agency requirements that affect requirements in this contract.

3. The Department shall provide any information requested by the CSB that is related to performance of or compliance with this contract in a timely manner, considering the type, amount, and availability of the information requested.

4. The Department shall issue new or revised policy, procedure, and guidance documents affecting CSB via letters, memoranda or emails from the Commissioner, Deputy Commissioner, or applicable Assistant Commissioner to CSB executive directors and other applicable CSB staff and post these documents in an easily accessible place on its web site within 10 business days of the date on which the documents are issued via letters, memoranda, or emails.

R. Department Comments or Recommendations on CSB Operations or Performance

The Commissioner of the Department may communicate significant issues or concerns about the operations or performance of the CSB to the executive director and CSB board members for their consideration, and the Department agrees to collaborate as appropriate with the executive director and CSB board members as they respond formally to the Department about these issues or concerns.

The executive director and CSB board members shall consider significant issues or concerns raised by the Commissioner of the Department at any time about the operations or performance of the CSB and shall respond formally to the Department, collaborating with it as appropriate, about these issues or concerns.

14. Compliance and Dispute Resolution

The Department may utilize a variety of remedies, including requiring a corrective action plan, delaying payments, reducing allocations or payments, and terminating the contract, to assure CSB compliance with this contract. Specific remedies, described in Exhibit E of this contract, may be taken if the CSB fails to satisfy the reporting requirements in this contract.

In accordance with subsection E of § 37.2-508 or § 37.2-608 of the Code, the Department may terminate all or a portion of this contract, after unsuccessful use of the remediation process described in this section and after affording the CSB an adequate opportunity to use the dispute resolution process described in this of this contract. The Department shall deliver a written notice specifying the cause to the CSB's board chairperson and executive director at least 75 days prior to the date of actual termination of the contract. In the event of contract termination under these circumstances, only payment for allowable services rendered by the CSB shall be made by the Department.

A. Disputes

Resolution of disputes arising from Department contract compliance review and performance management efforts or from actions by the CSB related to this contract may be pursued through the dispute resolution process in this section, which may be used to appeal only the following conditions: reduction or withdrawal of state general or federal funds, unless funds for this activity are withdrawn by action of the General Assembly or federal government or by adjustment of allocations or payments pursuant to Section 8 of this contract; termination or suspension of the contract, unless funding is no longer available; 3.) refusal to negotiate or execute a contract modification;
disputes arising over interpretation or precedence of terms, conditions, or scope of the contract; or determination that an expenditure is not allowable under this contract.

B. Dispute Resolution Process

Disputes arising from any of the conditions in this section of this contract shall be resolved using the following process:

1. Within 15 calendar days of the CSB's identification or receipt of a disputable action taken by the Department or of the Department's identification or receipt of a disputable action taken by the CSB, the party seeking resolution of the dispute shall submit a written notice to the Department's OMS Director, stating its desire to use the dispute resolution process. The written notice must describe the condition, nature, and details of the dispute and the relief sought by the party.
2. The OMS Director shall review the written notice and determine if the dispute falls within the conditions listed in Section 15. If it does not, the OMS Director shall notify the party in writing within

seven days of receipt of the written notice that the dispute is not subject to this dispute resolution process. The party may appeal this determination to the Commissioner in writing within seven days of its receipt of the Director's written notification.

3. If the dispute falls within the conditions listed in this section, the OMS Director shall notify the party within seven days of receipt of the written notice that a panel will be appointed within 15 days to conduct an administrative hearing.
4. Within 15 days of notification to the party, a panel of three or five disinterested persons shall be appointed to hear the dispute. The CSB shall appoint one or two members; the Commissioner shall appoint one or two members; and the appointed members shall appoint the third or fifth member. Each panel member will be informed of the nature of the dispute and be required to sign a statement indicating that he has no interest in the dispute.
5. Any person with an interest in the dispute shall be relieved of panel responsibilities and another person shall be selected as a panel member.
6. The OMS Director shall contact the parties by telephone and arrange for a panel hearing at a mutually convenient time, date, and place. The panel hearing shall be scheduled not more than 15 days after the appointment of panel members. Confirmation of the time, date, and place of the hearing will be communicated to all parties at least seven days in advance of the hearing.
7. The panel members shall elect a chairman and the chairman shall convene the panel. The party requesting the panel hearing shall present evidence first, followed by the presentation of the other party. The burden shall be on the party requesting the panel hearing to establish that the disputed decision or action was incorrect and to present the basis in law, regulation, or policy for its assertion. The panel may hear rebuttal evidence after the initial presentations by the CSB and the Department. The panel may question either party in order to obtain a clear understanding of the facts.
8. Subject to provisions of the Freedom of Information Act, the panel shall convene in closed session at the end of the hearing and shall issue written recommended findings of fact within seven days of the hearing. The recommended findings of fact shall be submitted to the Commissioner for a final decision.
9. The findings of fact shall be final and conclusive and shall not be set aside by the Commissioner unless they are (a.) fraudulent, arbitrary, or capricious; (b.) so grossly erroneous as to imply bad faith; (c.) in the case of termination of the contract due to failure to perform, the criteria for performance measurement are found to be erroneous, arbitrary, or capricious; or (d.) not within the CSB's purview.
10. The final decision shall be sent by certified mail to both parties no later than 60 days after receipt of the written notice from the party invoking the dispute resolution process.
    Multiple appeal notices shall be handled independently and sequentially so that an initial appeal will not be delayed by a second appeal.
11. The CSB or the Department may seek judicial review of the final decision to terminate the contract in the Circuit Court for the City of Richmond within 30 days of receipt of the final decision.

C. Remediation Process

The Department and the CSB shall use the remediation process mentioned in subsection E of § 37.2-508 or § 37.2-608 of the Code to address a particular situation or condition identified by the Department or the CSB that may, if unresolved, result in termination of all or a portion of the contract in accordance with the provisions of this section. The parties shall develop the details of this remediation process and add them as an Exhibit D of this contract. This exhibit shall:

1. Describe the situation or condition, such as a pattern of failing to achieve a satisfactory level of performance on a significant number of major outcome or performance measures in the contract, that if unresolved could result in termination of all or a portion of the contract;

2. Require implementation of a plan of correction with specific actions and timeframes approved by the Department to address the situation or condition; and

3. Include the performance measures that will document a satisfactory resolution of the situation or condition.

4. If the CSB does not implement the plan of correction successfully within the approved timeframes, the Department, as a condition of continuing to fund the CSB, may request changes in the management and operation of the CSB's services linked to those actions and measures in order to obtain acceptable performance. These changes may include realignment or re-distribution of state-controlled resources or restructuring the staffing or operations of those services. The Department shall review and approve any changes before their implementation. Any changes shall include mechanisms to monitor and evaluate their execution and effectiveness.

15. Liability

The CSB shall defend or compromise, as appropriate, all claims, suits, actions, or proceedings arising from its performance of this contract. The CSB shall obtain and maintain sufficient liability insurance to cover claims for bodily injury and property damage and suitable administrative or directors and officers liability insurance. The CSB may discharge these responsibilities by means of a proper and sufficient self-insurance program operated by the state or a city or county government. The CSB shall provide a copy of any policy or program to the Department upon request. This contract is not intended to and does not create by implication or otherwise any basis for any claim or cause of action by a person or entity not a party to this contract arising out of any claimed violation of any provision of this contract, nor does it create any claim or right on behalf of any person to services or benefits from the CSB or the Department.

16. Severability

Each paragraph and provision of this contract is severable from the entire contract, and the remaining provisions shall nevertheless remain in full force and effect if any provision is declared invalid or unenforceable.

Counterparts and Electronic Signatures: Except as may be prohibited by applicable law or regulation, this Agreement and any amendment may be signed in counterparts, by facsimile, PDF, or other electronic means, each of which will be deemed an original and all of which when taken together will constitute one agreement. Facsimile and electronic signatures will be binding for all purposes.

17. Signatures

In witness thereof, the Department and the CSB have caused this performance contract to be executed by the following duly authorized officials.

VIRGINIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

By: _____

Name: Nelson Smith

Title: Commissioner

Date: _____

COMMUNITY SERVICES BOARD NAME

By: _____

Name: [CHAIRPERSON NAME]

Title: Chairperson

Date: _____

By: _____

Name: [EXECUTIVE DIRECTOR NAME]

Title: Executive Director

Date: _____

18. Exhibit L: List of Acronyms

Acronym	Name	Acronym	Name
ACE	Adverse Childhood Experiences	NCI	National Core Indicators
ACT	Assertive Community Treatment (ACT) – Effective 7.1.2021		
BAA	Business Associate Agreement (for HIPAA compliance)	NGRI	Not Guilty by Reason of Insanity
CARS	Community Automated Reporting System	OMS	Office of Management Services
CCS	Community Consumer Submission	PACT	Program of Assertive Community Treatment– Retired as of 7.1.2021, See Assertive Community Treatment (ACT)
CFR	Code of Federal Regulations	PATH	Projects for Assistance in Transition from Homelessness
CIT	Crisis Intervention Team	PHI	Protected Health Information
CPMT	Community Policy and Management Team (CSA)	PII	Personally Identifiable Information
CQI	Continuous Quality Improvement	PSH	Permanent Supportive Housing
CRC	Community Resource Consultant (DD Waivers)	QSR	Quality Service Reviews
CSA	Children's Services Act (§ 2.2-5200 et seq. of the Code)	RCSU	Residential Crisis Stabilization Unit
CSB	Community Services Board	RDAP	Regional Discharge Assistance Program
DAP	Discharge Assistance Program	REACH	Regional Education Assessment Crisis Services Habilitation
DBHDS	Department	RFP	Request for Proposal
DD	Developmental Disabilities	RMG	Regional Management Group
Department	Department of Behavioral Health and Developmental Services	RST	Regional Support Team (DD Waivers)
DMAS	Department of Medical Assistance Services (Medicaid)	RUMCT	Regional Utilization Management and Consultation Team
DOJ	Department of Justice (U.S.)	SABG	Federal Substance Abuse Block Grant
EBL	Extraordinary Barriers to Discharge List	SDA	Same Day Access
EHR	Electronic Health Record	sFTP	Secure File Transfer Protocol
FTE	Full Time Equivalent	SPF	Strategic Prevention Framework
HIPAA	Health Insurance Portability and Accountability Act of 1996	TDO	Temporary Detention Order
ICC	Intensive Care Coordination (CSA)	VACSB	Virginia Association of Community Services Boards
ICF	Intermediate Care Facility	VIDES	Virginia Individual DD Eligibility Survey
IDAPP	Individualized Discharge Assistance Program Plan	WaMS	Waiver Management System (DD Waivers)
LIPOS	Local Inpatient Purchase of Services	SPQM	Service Process Quality Management

FY 2022 AND FY 2023 COMMUNITY SERVICES PERFORMANCE CONTRACT

FY 2022 Exhibit A: Resources and Services

CSB: _____

Consolidated Budget (Pages AF-3 Through AF-10)				
Funding Sources	**Mental Health (MH) Services**	**Developmental (DV) Services**	**Substance Use Disorder (SUD) Services**	**TOTAL**
State Funds				
Local Matching Funds				
Total Fees				
Transfer Fees (In)/Out				
Federal Funds				
Other Funds				
State Retained Earnings				
Federal Retained Earnings				
Other Retained Earnings				
Subtotal: Ongoing Funds				
State Funds One-Time				
Federal Funds One-Time				
Subtotal: One-Time Funds				
Total: All Funds				

Cost for MH, DV, SUD Services				
	Cost for Emergency Services (AP-4)			
	Cost for Ancillary Services (AP-4)			
	Total Cost for Services			

Local Match Computation	
Total State Funds	
Total Local Matching Funds	
Total State and Local Funds	
Total Local Match Percentage (Local ÷ Total State + Local Funds)	

CSB Administrative Percentage	
Administrative Expenses	
Total Cost for Services	
Administrative Percentage (Admin ÷ Total Expenses)	

Note: Exhibit A is submitted to the Department by the CSB electronically using the CARS software application.

CSB:_____

Financial Comments

Comment 1	
Comment 2	
Comment 3	
Comment 4	
Comment 5	
Comment 6	
Comment 7	
Comment 8	
Comment 9	
Comment 10	
Comment 11	
Comment 12	
Comment 13	
Comment 14	
Comment 15	
Comment 16	
Comment 17	
Comment 18	
Comment 19	
Comment 20	
Comment 21	
Comment 22	
Comment 23	
Comment 24	
Comment 25	

Use of Retained Earnings

FY 2022 Exhibit A: Resources and Services for Mental Health (MH) Services

CSB: _____

Funding Sources	Funds
FEES	
MH Medicaid Fees	
MH Fees: Other	
Total MH Fees	
MH Fees Transfer In/(Out)	
MH NET FEES	
FEDERAL FUNDS	
MH FBG SED Child & Adolescent (93.958)*	
MH FBG Young Adult SMI (93.958)*	
MH FBG Crisis Services (93.958)*	
MH FBG SMI (93.958)*	
MH FBG SMI PACT (93.958)*	
MH FBG SMI SWVBH Board (93.958)*	
Total MH FBG SMI Funds*	
MH FBG Geriatrics (93.958)*	
MH FBG Peer Services (93.958)*	
Total MH FBG Adult Funds*	
MH Federal PATH (93.150)*	
MH Federal COVID Emergency Grant (93.665)*	
MH Other Federal - DBHDS*	
MH Other Federal – COVID Support*	
MH Other Federal - CSB*	
TOTAL MH FEDERAL FUNDS	
STATE FUNDS	
Regional Funds	
MH Acute Care (Fiscal Agent)*[1]	
MH Acute Care Transfer In/(Out)	
Total Net MH Acute Care - Restricted	
MH Regional DAP (Fiscal Agent)*[1]	
MH Regional DAP Transfer In/ (Out)	
Total Net MH Regional DAP - Restricted MH	
MH Regional Residential DAP - Restricted	
MH Crisis Stabilization (Fiscal Agent)*[1]	
MH Crisis Stabilization Transfer In/(Out)	
Total Net MH Crisis Stabilization – Restricted	
MH Transfers from DBHDS Facilities (Fiscal Agent)*	
MH Transfers from DBHDS Facilities - Transfer In/(Out)	
Total Net MH Transfers from DBHDS Facilities	
MH Expanded Community Capacity (Fiscal Agent)*	
MH Expanded Community Capacity Transfer In/(Out)	
Total Net MH Expanded Community Capacity	
MH First Aid and Suicide Prevention (Fiscal Agent)*	
MH First Aid and Suicide Prevention Transfer In/(Out)	

Total Net MH First Aid and Suicide Prevention

MH STEP-VA Outpatient (Fiscal Agent)*
MH STEP-VA Outpatient Transfer In/(Out)
Total Net MH STEP-VA Outpatient

MH STEP-VA Crisis (Fiscal Agent)*
MH STEP-VA Crisis Transfer In/(Out)
Total Net MH STEP-VA Crisis

MH STEP-VA Clinician's Crisis Dispatch (Fiscal Agent)*
MH STEP-VA Clinician's Crisis Dispatch Transfer In/(Out)
Total Net MH STEP-VA Clinician's Crisis Dispatch

MH STEP-VA Peer Support (Fiscal Agent)*
MH STEP-VA Peer Support Transfer In/(Out)
Total Net MH STEP-VA Peer Support

MH STEP-VA Veteran's Services (Fiscal Agent)*
MH STEP-VA Veteran's Services Transfer In/(Out)
Total Net MH STEP-VA Veteran's Services

MH Forensic Discharge Planning (Fiscal Agent)*
MH Forensic Discharge Planning Transfer In/(Out)
Total Net MH Forensic Discharge Planning

MH Permanent Supportive Housing (Fiscal Agent)*
MH Permanent Supportive Housing Transfer In/(Out)
Total Net MH Permanent Supportive Housing

MH Recovery (Fiscal Agent) ‡
MH Other Merged Regional Funds (Fiscal Agent) ‡
MH State Regional Deaf Services (Fiscal Agent) ‡
MH Total Regional Transfer In/(Out)
Total Net MH Unrestricted Regional Funds
Total Net MH Regional State Funds
Children's State Funds
MH Child & Adolescent Services Initiative*
MH Children's Outpatient Services*
MH Juvenile Detention*
Total MH Restricted Children's Funds
MH State Children's Services‡
MH Demo Project - System of Care (Child) ‡
Total MH Unrestricted Children's Funds
MH Crisis Response & Child Psychiatry (Fiscal Agent)*
MH Crisis Response & Child Psychiatry Transfer In/(Out)
Total Net MH Crisis Response & Child Psychiatry
Total MH Children's State Funds (Restricted)

Other State Funds

MH Law Reform*
MH Pharmacy - Medication Supports*
MH Jail Diversion Services*
MH Rural Jail Diversion*
MH Docket Pilot JMHCP Match*
MH Adult Outpatient Competency Restoration Services*
MH CIT Assessment Sites*
MH Expand Telepsychiatry Capacity*
MH PACT*
MH PACT Forensic Enhancement*
MH Gero-Psychiatric Services*
MH Step-VA – SDA, Primary Care Screening, and Ancillary Services*
MH Young Adult SMI*

Total MH Restricted Other State Funds
MH State Funds‡
MH State NGRI Funds‡
MH Geriatric Services‡
Total MH Unrestricted Other State Funds
Total MH Other State Funds
TOTAL MH STATE FUNDS

OTHER FUNDS
MH Other Funds*
MH Federal Retained Earnings*
MH State Retained Earnings*
MH State Retained Earnings - Regional Programs*
MH Other Retained Earnings*
TOTAL MH OTHER FUNDS

LOCAL MATCHING FUNDS
MH Local Government Appropriations‡
MH Philanthropic Cash Contributions‡
MH In-Kind Contributions‡
MH Local Interest Revenue‡
TOTAL MH LOCAL MATCHING FUNDS
TOTAL MH FUNDS

ONE-TIME FUNDS
MH FBG SMI (93.958)*
MH FBG SED Child & Adolescent (93.958)*
MH FBG Peer Services (93.958) *
MH State Funds
MH One-Time Restricted State Funds*
TOTAL MH ONE-TIME FUNDS

TOTAL MH ALL FUNDS

1 MH acute care (LIPOS), regional DAP, and crisis stabilization funds are restricted, but each type of funds can be used for the other purposes in certain situations approved by the Department.

* These funds are restricted and expenditures of them are tracked and reported separately.

‡ These are unrestricted funds; expenditures are reported as a sum for all of the lines within the overall funding category.

FY 2022 Exhibit A: Resources and Services for Developmental (DV) Services

CSB: _____

Funding	Funds
FEES	
DV Medicaid DD Waiver Fees	
DV Other Medicaid Fees	
DV Medicaid ICF/IDD Fees	
DV Fees: Other	
Total DV Fees	
DV Fees Transfer In/(Out)	
DV NET FEES	
FEDERAL FUNDS	
DV Other Federal - DBHDS*	
DV Other Federal – COVID Support*	
DV Other Federal - CSB*	
TOTAL DV FEDERAL FUNDS	
STATE FUNDS	
DV State Funds‡	
DV OBRA Funds‡	
Total DV Unrestricted State Funds	
DV Trust Fund*	
DV Rental Subsidies*	
DV Guardianship Funding*	
DV Crisis Stabilization (Fiscal Agent)*	
DV Crisis Stabilization Transfer In/(Out)	
Total Net DV Crisis Stabilization*	
DV Crisis Stabilization - Children (Fiscal Agent)*	
DV Crisis Stabilization - Children Transfer In/(Out)	
Total Net DV Crisis Stabilization - Children	
DV Transfers from DBHDS Facilities (Fiscal Agent)*	
DV Transfers from DBHDS Facilities - Transfer In/(Out)	
Total Net DV Transfers from DBHDS Facilities	
Total DV Restricted State Funds	
TOTAL DV STATE FUNDS	
OTHER FUNDS	
DV Workshop Sales*	
DV Other Funds*	
DV State Retained Earnings*	
DV State Retained Earnings - Regional Programs*	
DV Other Retained Earnings*	
TOTAL DV OTHER FUNDS	
LOCAL MATCHING FUNDS	
DV Local Government Appropriations‡	
DV Philanthropic Cash Contributions‡	
DV In-Kind Contributions‡	
DV Local Interest Revenue‡	
TOTAL DV LOCAL MATCHING FUNDS	
TOTAL DV FUNDS	

ONE-TIME FUNDS

DV State Funds

DV One-Time Restricted State Funds*

TOTAL DV ONE-TIME FUNDS

TOTAL DV ALL FUNDS

* These funds are restricted and expenditures of them are tracked and reported separately.

‡ These are unrestricted funds; expenditures are reported as a sum for all of the lines within the overall funding category.

FY 2022 Exhibit A: Resources and Services for Substance Use Disorder (SUD) Services

CSB: _____

Funding Sources	Funds
FEES	
SUD Medicaid Fees	
SUD Fees: Other	
Total SUD Fees	
SUD Fees Transfer In/(Out)	
SUD NET FEES	
FEDERAL FUNDS	
SUD FBG Alcohol/Drug Treatment (93.959) *	
SUD FBG SARPOS (93.959) *	
SUD FBG Jail Services (93.959) *	
SUD FBG Co-Occurring (93.959) *	
SUD FBG New Directions (93.959) *	
SUD FBG Recovery (93.959) *	
SUD FBG Medically Assisted Treatment (93.959) *	_____
Total SUD FBG Alcohol/Drug Treatment Funds	
SUD FBG Women (Includes LINK at 6 CSBs) (93.959)*	_____
Total SUD FBG Women Funds	
SUD FBG Prevention (93.959) *	
SUD FBG Prevention Family Wellness (93.959) *	_____
Total SUD FBG Prevention Funds	
SUD Federal COVID Emergency Grant (93.665)*	
SUD Federal YSAT – Implementation (93.243)*	
SUD Federal Opioid Response Recovery (93.788)*	
SUD Federal Opioid Response Prevention (93.788)*	
SUD Federal Opioid Response Treatment (93.788)*	
Total SUD Federal Opioid Response (93.788)*	
SUD Other Federal - DBHDS*	
SUD Other Federal – COVID Support*	
SUD Other Federal - CSB*	
	_____
FEDERAL FUNDS	**TOTAL SUD**
STATE FUNDS	
Regional Funds	
SUD Facility Reinvestment (Fiscal Agent)*	
SUD Facility Reinvestment Transfer In/(Out)	_____
Total Net SUD Facility Reinvestment Funds	
SUD Transfers from DBHDS Facilities (Fiscal Agent)*	

SUD Transfers from DBHDS Facilities – Transfer In/(Out)	_____
Total Net SUD Transfers from DBHDS Facilities	
SUD Community Detoxification (Fiscal Agent)*	

FY 2022 Exhibit A: Resources and Services for Substance Use Disorder (SUD) Services

CSB: _____

Funding Sources	Funds
SUD Community Detoxification Transfer In/(Out)	
Total Net SUD Community Detoxification	
SUD STEP-VA (Fiscal Agent)*	
SUD STEP-VA Transfer In/(Out)	
Total Net SUD STEP-VA	
Total Net SUD Regional State Funds	
Other State Funds	
SUD Women (Includes LINK - 4 CSBs)*	
SUD MAT - Medically Assisted Treatment*	
SUD Permanent Supportive Housing Women*	
SUD SARPOS*	
SUD Recovery*	
Total SUD Restricted Other State Funds	
SUD State Funds‡	
SUD Region V Residential‡	
SUD Jail Services/Juvenile Detention‡	
SUD HIV/AIDS‡	
Total SUD Unrestricted Other State Funds	
Total SUD Other State Funds	
TOTAL SUD STATE FUNDS	
OTHER FUNDS	
SUD Other Funds*	
SUD Federal Retained Earnings*	
SUD State Retained Earnings*	
SUD State Retained Earnings - Regional Programs*	
SUD Other Retained Earnings*	
TOTAL SUD OTHER FUNDS	
LOCAL MATCHING FUNDS	
SUD Local Government Appropriations‡	
SUD Philanthropic Cash Contributions‡	
SUD In-Kind Contributions‡	
SUD Local Interest Revenue‡	
TOTAL SUD LOCAL MATCHING FUNDS	
TOTAL SUD FUNDS	

FY 2022 Exhibit A: Resources and Services for Substance Use Disorder (SUD) Services

CSB: _____

Funding Sources	Funds
ONE-TIME FUNDS	
SUD FBG Alcohol/Drug Treatment (93.959)*	
SUD FBG Women (includes LINK - 6 CSBs) (93.959)*	
SUD FBG Prevention (93.959)*	
SUD FBG Recovery (93.959)*	
SUD State Funds	
SUD One-Time Restricted State Funds*	
TOTAL SUD ONE-TIME FUNDS	
TOTAL SUD ALL FUNDS	

* These funds are restricted and expenditures of them are tracked and reported separately.

‡ These are unrestricted funds; expenditures are reported as a sum for all of the lines within the overall funding category.

Local Government Tax Appropriations

City or County	Tax Appropriation
Total Local Government Tax Funds	

Reconciliation of Projected Resources and Services Costs by Program Area CSB:

	MH Services	DV Services	SUD Services	Emergency Services	Ancillary Services	Total
Total All Funds (Page AF-1)						
Cost for MH, DV, SUD, Emergency, and Ancillary Services (Page AF-1)						
Difference						

Difference results from Explanation of Other in Table Above

Other:

CSB 100 Mental Health Services

Form 11: Mental Health (MH) Services Program Area (100)			
Services	Projected Service Capacity	Projected Numbers of Individuals Receiving Services	Projected Total Service Costs
250 Acute Psychiatric Inpatient Services	Beds		
310 Outpatient Services	FTEs		
312 Medical Services	FTEs		
350 Assertive Community Treatment	FTEs		
320 Case Management Services	FTEs		
410 Day Treatment or Partial Hospitalization	Slots		
420 Ambulatory Crisis Stabilization Services	Slots		
425 Mental Health Rehabilitation	Slots		
430 Sheltered Employment	Slots		
465 Group Supported Employment	Slots		
460 Individual Supported Employment	FTEs		
501 MH Highly Intensive Residential Services (MH Residential Treatment Centers)	Beds		
510 Residential Crisis Stabilization Services	Beds		
521 Intensive Residential Services	Beds		
551 Supervised Residential Services	Beds		
581 Supportive Residential Services	FTEs		
610 Prevention Services	FTEs		
Totals			

Form 11 A: Pharmacy Medication Supports	Number of Consumers
803 Total Pharmacy Medication Supports Consumers	

CSB 200 Developmental Services

Form 21: Developmental (DV) Services Program Area (200)			
Services	**Projected Service Capacity**	**Projected Numbers of Individuals Receiving Services**	**Projected Total Service Costs**
310 Outpatient Services	FTEs		
312 Medical Services	FTEs		
320 Case Management Services	FTES		
420 Ambulatory Crisis Stabilization Services	Slots		
425 Developmental Habilitation	Slots		
430 Sheltered Employment	Slots		
465 Group Supported Employment	Slots		
460 Individual Supported Employment	FTEs		
501 Highly Intensive Residential Services (Community-Based ICF/IDD Services)	Beds		
510 Residential Crisis Stabilization Services	Beds		
521 Intensive Residential Services	Beds		
551 Supervised Residential Services	Beds		
581 Supportive Residential Services	FTEs		
610 Prevention Services	FTEs		
Totals			

CSB 300 Substance Use Disorder Services

Form 31: Substance Use Disorder (SUD) Services Program Area (300)			
Services	**Projected Service Capacity**	**Projected Numbers of Individuals Receiving Services**	**Projected Total Service Costs**
250 Acute Substance Use Disorder Inpatient Services	Beds		
260 Community-Based Substance Use Disorder Medical Detoxification Inpatient Services	Beds		
310 Outpatient Services	FTEs		
312 Medical Services	FTEs		
313 Intensive Outpatient Services	FTEs		
335 Medication Assisted Treatment	FTEs		
320 Case Management Services	FTEs		
410 Day Treatment or Partial Hospitalization	Slots		
420 Ambulatory Crisis Stabilization Services	Slots		
425 Substance Use Disorder Rehabilitation	Slots		
430 Sheltered Employment	Slots		
465 Group Supported Employment	Slots		
460 Individual Supported Employment	FTEs		
501 Highly Intensive Residential Services (Medically Managed Withdrawal Services)	Beds		
510 Residential Crisis Stabilization Services	Beds		
521 Intensive Residential Services	Beds		
551 Supervised Residential Services	Beds		
581 Supportive Residential Services	FTEs		
610 Prevention Services	FTEs		
Totals			

CSB 400 Emergency and Ancillary Services

Form 01: Emergency and Ancillary Services (400)			
Services	**Projected Service Capacity**	**Projected Numbers of Individuals Receiving Services**	**Projected Total Service Costs**
100 Emergency Services	**FTEs**		
Ancillary Services			
318 Motivational Treatment Services	**FTEs**		
390 Consumer Monitoring Services	**FTEs**		
720 Assessment and Evaluation Services	**FTEs**		
620 Early Intervention Services	**FTEs**		
730 Consumer-Run Services			
Ancillary Services Totals			

Amendment 1
FY22-23 Community Services Performance Contract
Exhibit B: Continuous Quality Improvement (CQI) Process and CSB Performance Measures

Table of Contents

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Amendment 1
FY22-23 Community Services Performance Contract
Exhibit B: Continuous Quality Improvement (CQI) Process and CSB Performance Measures

Introduction

The Department and CSBs are committed to a collaborative continuous quality improvement (CQI) process aimed at improving the quality, accessibility, consistency, integration, and responsiveness of services across the Commonwealth pursuant to Code § 37.2-508(C) and § 37.2-608(C).

1. Continuous Quality Improvement Framework

The purpose of a standardized CQI process at the state level is to:

1. Increase the reliability and validity of data source(s) for performance metrics and associated accountability/reporting
2. Increase transparency between CSBs and the Department at a federal and state level regarding performance expectations and quality improvement initiatives
3. Strengthen framework for quality improvement at DBHDS that is generally applied across community behavioral health services, developmental services, and state facilities

Meaningful performance expectations are an integral part of the CQI process developed and supported by the Department and CSBs. CSBs' progress in achieving outlined expectations will be monitored and will provide a platform for system-wide improvement efforts. Generally, performance expectations reflect requirements based in statute, regulation, or policy. The capacity to measure progress in achieving performance expectations and goals, provide feedback, and plan and implement CQI strategies shall exist at local, regional, and state levels.

The CQI process will utilize goals and benchmarks to measure progress, as defined below:

"Benchmark" refers to the overall target for the state and each individual CSB. For example, a benchmark of 70% means that the objective is for the state average and each individual CSB to achieve 70% on the metric. Benchmarks are set after a defined period of reviewing initial data, obtaining feedback from CSBs and subject matter experts (SME), and addressing any immediate barriers to the implementation of the metric. Whenever possible, SME groups (for example, Quality and Outcomes Committee) utilize national benchmarks and evidence informed approaches to benchmarking.

"Goal" refers to incremental changes of 10% quarterly when a baseline measure is more than 10% lower than the benchmark. In other words, when there is a >10% discrepancy between the benchmark and either an individual CSB or statewide baseline measure, then aim is to reach the goal, not the benchmark. The aim would be to achieve the goal on a quarterly basis, at which point the goal would increase another 10% until it was within 10% of the benchmark. A state goal would replace the state benchmark when the state average is more than 10% less than the benchmark. An individual CSB goal would replace the individual CSB benchmark when the state average is within 10% of the benchmark but the individual CSB is not.

The Department will implement a graduated response to difficulties in meeting goals or benchmarks.

A. Technical assistance (TA)

TA will be offered/provided at the discretion of the Department. TA will be offered if a CSB is not meeting its incremental goal or the Department's established benchmark (do not have to meet both; have to meet one or the other). TA is provided to support CSBs to meet or exceed the goal every quarter. In cases where goal is >30% below benchmark, TA may be offered even if goal is met first quarter. TA may be requested by a CSB. The Department can provide TA even if the CSB disputes the validity of the dashboard data. The Department will work to address CSB-raised concerns or identified Department data issues as part of the Quality Improvement Plan process.

B. Quality Improvement Plans (QIP)

There are four categories of QIPs. These include CSB Performance QIPs, CSB local system QIPs, Regional QIPs, and Statewide QIPs and are further defined below:

1. **CSB QIPs (Performance and Local system)**. A QIP is not automatically triggered by a certain amount of TA, but should not be entered into before at least 6 months of TA (2 quarters of data) have been provided, unless there are extenuating circumstances. QIPs are written collaboratively between the Department and CSB leadership and staff. If it did not occur during the TA process, data issues and opportunities for CSBs to present data from a source outside of CCS3 will be provided prior to determining that a QIP is needed. QIPs include activities to be completed, timelines for completion, responsible parties, and interim goals that are measurable or observable. QIPs should not be written for less than 6 months unless extenuating circumstances. The average QIP will be 12 months.
   a. A CSB performance QIP is designated when the issue seems to be primarily performance based, and the performance issues could be fixed with changes to processes, procedures, staffing, etc. at the CSB.
   b. A CSB local system QIP is designated when the issue seems to be primarily driven by factors external to the CSB, but nevertheless factors that the CSB has responsibility to address as the local authority. CSB local system QIPs may name other partners in the local system that need to be brought to the table during the QIP process.
2. **Regional Program Performance QIPs**. Regional QIPs can also be designated as "performance" or "regional systems" QIP, or can be non-designated if there are not clear indications of the drivers. Regional performance QIPs are specific to regional programs and determined as such when the performance issues could be fixed with changes to processes, procedures, staffing, etc. at the regional program. The operational manager would be named first and have a primary responsibility for engagement with the Department; if it is operated by an external provider then the fiscal agent would be named first. Other participating CSBs will be named as well and expected to participate in the QIP process.

C. Corrective Action Plans (CAP)

TA and QIPs are the primary interventions when benchmarks and goals are not met. CAPs are pursued under the following circumstances: goals of QIP are not met and/or there is limited engagement in the QIP process. There may be times where an issue is so severe that a CAP would be necessary where there was not a QIP in place, but this would be under extenuating circumstances. The purpose of the QIP is to have a period of collaborative improvement so that CAPs are not needed. CAPs will remain as currently described in the performance contract.

Implementing the CQI process will be a multi-year, iterative, and collaborative effort to assess and enhance CSB and system-wide performance over time through a partnership among CSBs and the Department in which they are working to achieve a shared vision of a transformed services system. In this process, CSBs and the Department engage with stakeholders to perform meaningful self-assessments of current operations, determine relevant CQI performance expectations and goals, and establish benchmarks for goals, determined by baseline performance, to convert those goals to expectations.

The Department and the CSB may negotiate CSB performance measures in Exhibit D of the performance contract reflecting actions or requirements to meet expectations and goals in the CSB's CQI plan. As this joint CQI process evolves and expands, the Department and the Virginia Association of Community Services Boards will utilize data and reports submitted by CSBs to conduct a broader scale evaluation of service system performance and identify opportunities for CQI activities across all program areas.

3. Performance Measures

CSB Core Performance Measures: The CSB and Department agree to use the CSB Performance Measures, developed by the Department in collaboration with the VACSB Data Management, Quality Leadership, and VACSB/DBHDS Quality and Outcomes Committees to monitor outcome and performance measures for CSBs and improve the CSB's performance on measures where the CSB falls below the benchmark. These performance measures include:

A. Suicide Screening Measure

Percentage of adults who are 18 years old or older and have a new MH or SUD case open (denominator) who received a suicide risk assessment completed within 30 days before or 5 days after the case opening (numerator).

Benchmark: The CSB shall conduct a Columbia screening for at least 86% of individuals with a new MH or SUD case opening

B. Same Day Access Measures

Percentage of individuals who received a SDA assessment and were determined to need a follow-up service who:

i. Are offered an appointment at an appropriate service within 10 business days; and
ii. Attend a scheduled follow-up appointment within 30 calendar days.

Benchmark: The CSB shall offer an appropriate follow-up appointment to **at least 86 percent** of the individuals who are determined to need an appointment (a); and **at least 70 percent** of the individuals seen in SDA who are determined to need a follow-up service will return to attend that service within 30 calendar days of the SDA assessment (b).

C. SUD Engagement Measure

Percentage of individuals 13 years or older with a new episode of substance use disorder services as a result of a new SUD diagnosis who initiate services within 14 days of diagnosis and attend at least two follow up SUD services within 30 days.

Benchmark: The CSB shall aim to have **at least 50 percent** of SUD clients engage in treatment per this definition of engagement.

D. DLA-20 Measure

6-month change in DLA-20 scores for youth (ages 6-17) and adults (age 18 or over) receiving outpatient services in mental health or substance use disorder program areas.

Benchmark: **At least 35%** of individuals receiving 310 Outpatient Services in Program Areas 100 and/or 300 scoring below a 4.0 on a DLA-20 assessment will demonstrate at least 0.5 growth within two fiscal quarters.

4. Additional Expectations and Elements Being Monitored

Below are data elements and expectations that were put into place prior to the data quality and benchmarking review process as of March 1, 2022, and are still general, active expectations regarding CSB operations and implementation.

A. Outpatient Primary Care Screening and Monitoring

1. **Primary Care Screening Measures**
   a. **Objective 1:** Any child diagnosed with a serious emotional disturbance and receiving ongoing CSB behavioral health service or any adult diagnosed with a serious mental illness and receiving ongoing CSB behavioral health service will be provided or referred for a primary care screening on a yearly basis.

i. For the implementation of Objective 1, "ongoing behavioral health service" is defined as "child with
SED receiving Mental Health Targeted Case Management or adult with SMI receiving Mental Health Targeted Case Management". These clients are required to be provided with a yearly primary care screening to include, at minimum, height, weight, blood pressure, and BMI.

ii. This screening may be done by the CSB or the individual may be referred to a primary care provider to have this screening completed. If the screening is done by a primary care provider, the CSB is responsible for the screening results to be entered in the patient's CSB electronic health record. The CSB will actively support this connection and coordinate care with physical health care providers for all service recipients.

b. **Objective 2:** Screen and monitor any individual over age 3 being prescribed an antipsychotic medication by CSB prescriber for metabolic syndrome following the American Diabetes Association guidelines. The population includes all individuals over age 3 who receive psychiatric medical services by the CSB.

2. **Benchmark**: CSB and DBHDS will work together to establish.
3. **Outcomes**: To provide yearly primary care screening to identify and provide related care coordination to ensure access to needed physical health care to reduce the number of individuals with serious mental illness (SMI), known to be at higher risk for poor physical health outcomes largely due to unidentified chronic conditions.
4. **Monitoring:** CSB must report the screen completion and monitoring completion in CCS monthly submission to reviewed by the Department.

B. Outpatient Services

Outpatient services are considered to be foundational services for any behavioral health system. The DBHDS Services Taxonomy states that outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychiatry, psychological testing and assessment, laboratory and ancillary services.

1. **Measures**: CSBs shall provide an appointment to a high quality CSB outpatient provider or a referral to a non-CSB outpatient behavioral health service within 10 business days of the completed SDA intake assessment, if clinically indicated.
   a. All CSB will establish a quality management program and continuous quality improvement plan to assess the access, quality, efficiency of resources, behavioral healthcare provider training, and patient outcomes of those individuals receiving outpatient services through the CSBs. This may include improvement or expansion of existing services, the development of new services, or enhanced coordination and referral process to outpatient services not directly provided by the CSB.
   b. Expertise in the treatment of trauma related conditions are to be established
2. **Benchmark**: CSBs should provide a minimum for outpatient behavioral healthcare providers of 8 hours of trauma focused training in treatment modalities to serve adults, children/adolescents and their families within the first year of employment and 4 hours in each subsequent years or until 40 hours of trauma focused treatment can be demonstrated.
3. **Monitoring:** The CSB shall complete and submit to the Department quarterly DLA-20 composite scores through CCS as well as provide training data regarding required trauma training yearly in July when completing federal Block Grant reporting.

5. Service Members, Veterans, and Families

A. Training

Measures: Percentage of CSB direct services staff who receive military cultural competency training

Benchmark: Is provided to 100% of CSB staff delivering direct services to the SMVF population. Direct services include, but are not limited to, those staff providing crisis, behavioral health outpatient and case management services.

B. Presenting for Services
Measures: Percentage of clients with SMVF status presenting for services
Benchmark: Is tracked for 90% of individuals presenting for services

C. Referral Destination
Measures: Percentage served referred to SMVF referral destination
Benchmark: Of those served by the CSB who are SMVF, at least 70% will be referred to Dept. of Veterans Services (DVS), Veterans Health Administration facilities and services (VHA), and/or Military Treatment Facilities and services (MTF) referral destination

D. Columbia Suicide Severity Rating Scale
Measure: Percentage of SMVF for whom suicide risk screening using the Columbia Suicide Severity Rating Scale brief screen is conducted
Benchmark: Is conducted for 60% of SMVF for Year 1 (July 1, 2021 through June 30, 2022)

E. Monitoring
CSB must report all data through its CCS monthly submission.

6. Peer and Family Support Services

A. Certification and Registration
1. **Measure**: Peer Supporters will obtain certification and registration (Board of Counseling) within 18 months of hire.
2. **Benchmark**: 80% of Peer Supporters will become a Peer Recovery Specialist within one year of hire.

B. Unduplicated individuals receiving Peer Services
1. **Measure**: Total number of unduplicated individuals receiving Peer Services will continue to increase.
2. **Benchmark**: Total number of unduplicated individuals receiving Peer Services will continue to increase 5% annually. Year 1 will allow for a benchmark and this percentage will be reviewed going into year two.

C. Individual contacts (repeat/duplicated) receiving Peer or Family Support Services
1. **Measure**: Total number of individual contacts (repeat/duplicated) receiving Peer or Family Support Services will increase annually for individual and group.
2. **Benchmark**: Total number of individual contacts for Peer or Family Support Services will increase 5% annually (only applies to service codes and locations where Peer and/or Family Support Services are delivered). Year 1 will allow for a benchmark and this percentage will be review going into year two for individual and group.

D. Peer Support Service units (15-minute increments)
1. **Measure**: Total number of Peer Support Service units (15-minute increments) provided will increase annually for individual and group.
2. **Benchmark**: Total number of Peer Support Service units (15-minute increments) provided will increase 5% annually (only applies to service codes and locations where Peer and/or Family Support Services are delivered). Year 1 will allow for a benchmark and this percentage will be review going into year two for individual and group.

E. Closing Programs
1. **Measure**: CSB will inform DBHDS when Recovery oriented peer services programs are closing,
2. **Benchmark**: CSB will inform Office of Recovery Services (ORS) Director within 30 days prior to Recovery oriented peer services programs are set to close.

F. Monitoring
CSB must report data through its CCS monthly submission.

8. Continuity of Care for State Hospital Discharges

A. Measure: Percent of individuals for whom the CSB is the identified case management CSB who keep a face-to-face (non-emergency) service appointment within seven calendar days after discharge from a state hospital.

B. Benchmark: At least 80 percent of these individuals shall receive a face-to-face (non- emergency) service from the CSB within seven calendar days after discharge.

C. Monitoring: The Department shall monitor this measure through comparing AVATAR data on individuals discharged from state hospitals to the CSB with CCS data about their dates of mental health outpatient services after discharge from the state hospital and work with the CSB to achieve this benchmark utilizing the process document provided by the Department if it did not meet it.

9. Residential Crisis Stabilization Unit (RCSU) Utilization

A. Measure: Percent of all available RCSU bed days for adults utilized annually.

B. Benchmark: The CSB that operates an RCSU shall ensure that the RCSU, once it is fully operational, achieves an annual average utilization rate of **at least 75 percent** of available bed days.

C. Monitoring: The Department shall monitor this measure using data from CCS service records and CARS service capacity reports and work with the CSB to achieve this benchmark if it did not meet it.

10. General Performance Goal and Expectation

A. For individuals currently receiving services, the CSB has a protocol in effect 24 hours per day, seven days per week (a) for service providers to alert emergency services staff about individuals deemed to be at risk of needing an emergency intervention, (b) for service providers to provide essential clinical information, which should include advance directives, wellness recovery action plans, or safety and support plans to the extent they are available, that would assist in facilitating the disposition of the emergency intervention, and (c) for emergency services staff to inform the case manager of the disposition of the emergency intervention. Individuals with co-occurring mental health and substance use disorders are welcomed and engaged promptly in an integrated screening and assessment process to determine the best response or disposition for continuing care. The CSB shall provide this protocol to the Department upon request. During its inspections, the Department's Licensing Office may examine this protocol to verify this affirmation as it reviews the CSB's policies and procedures.

B. For individuals hospitalized through the civil involuntary admission process in a state hospital, private psychiatric hospital, or psychiatric unit in a public or private hospital, including those who were under a temporary detention or an involuntary commitment order or were admitted voluntarily from a commitment hearing, and referred to the CSB, the CSB that will provide services upon the individual's discharge has in place a protocol to assure the timely discharge of and engage those individuals in appropriate CSB services and supports upon their return to the community. The CSB monitors and strives to increase the rate at which these individuals keep scheduled face-to-face (non-emergency) service visits within seven business days after discharge from the hospital or unit. Since these individuals frequently experience co-occurring mental health and substance use disorders, CSB services are planned as co-occurring capable and promote successful engagement of these individuals in continuing integrated care. The CSB shall provide this protocol to the Department upon request. During its inspections, the Department's Licensing Office may examine this protocol to verify this affirmation as it reviews the CSB's policies and procedures.

11. Emergency Services Performance Goal and Expectation

A. When an immediate face-to-face intervention by a certified preadmission screening evaluator is appropriate to determine the possible need for involuntary hospitalization, the intervention is completed by a certified preadmission screening evaluator who is available within one hour of initial contact for urban CSBs and within two hours of initial contact for rural CSBs.

B. Every preadmission screening evaluator is hired with knowledge, skills, and abilities to establish a welcoming environment for individuals with co-occurring disorders and performing hopeful engagement and integrated screening and assessment.

C. Pursuant to subsection B of § 37.2-817 of the Code of Virginia, a preadmission screening evaluator, or through a mutual arrangement an evaluator from another CSB, attends each commitment hearing, initial (up to 30 days)
or recommitment (up to 180 days), for an adult held in the CSB's service area or for an adult receiving services from the CSB held outside of its service area in person, or, if that is not possible, the preadmission screening evaluator participates in the hearing through two-way electronic video and audio or telephonic communication systems, as authorized by subsection B of § 37.2-804.1 of the Code of Virginia, for the purposes of presenting preadmission screening reports and recommended treatment plans and facilitating least restrictive dispositions.

D. In preparing preadmission screening reports, the preadmission screening evaluator considers all available relevant clinical information, including a review of clinical records, wellness recovery action plans, advance directives, and information or recommendations provided by other current service providers or appropriate significant other persons (e.g., family members or partners). Reports reference the relevant clinical information used by the preadmission screening evaluator. During its inspections, the Department's Licensing Office may verify this affirmation as it reviews services records, including records selected from a sample identified by the CSB for individuals who received preadmission screening evaluations.

E. If the emergency services intervention occurs when an individual has been admitted to a hospital or hospital emergency room, the preadmission screening evaluator informs the charge nurse or requesting medical doctor of the disposition, including leaving a written clinical note describing the assessment and recommended disposition or a copy of the preadmission screening form containing this information, and this action is documented in the individual's service record at the CSB with a progress note or with a notation on the preadmission screening form that is included in the individual's service record. During its inspections, the Department's Licensing Office may verify this affirmation as it reviews services records, including records selected from a sample identified by the CSB for individuals who received preadmission screening evaluations, for a progress note or a copy of the preadmission screening form.

12. Mental Health and Substance Abuse Case Management Services Performance Expectation

A. Case managers are hired with the goal of becoming welcoming, recovery-oriented, and co-occurring competent to engage all individuals receiving services in empathetic, hopeful, integrated relationships to help them address multiple issues successfully.

B. Reviews of the individualized services plan (ISP), including necessary assessment updates, are conducted with the individual quarterly or every 90 days and include significant changes in the individual's status, engagement, participation in recovery planning, and preferences for services; and the ISP is revised accordingly to include an individual-directed wellness plan that addresses crisis self-management strategies and implements advance directives, as desired by the individual. For those individuals who express a choice to discontinue case management services because of their dissatisfaction with care, the provider reviews the ISP to consider reasonable solutions to address the individual's concerns. During its

inspections, the Department's Licensing Office may verify this affirmation as it reviews ISPs, including those from a sample identified by the CSB of individuals who discontinued case management services.

C. The CSB has policies and procedures in effect to ensure that, during normal business hours, case management services are available to respond in person, electronically, or by telephone to preadmission screening evaluators of individuals with open cases at the CSB to provide relevant clinical information in order to help facilitate appropriate dispositions related to the civil involuntary admissions process established in Chapter 8 of Title 37.2 of the Code of Virginia. During its inspections, the Department's Licensing Office may verify this affirmation as it examines the CSB's policies and procedures.

D. For an individual who has been discharged from a state hospital, private psychiatric hospital, or psychiatric unit in a public or private hospital or released from a commitment hearing and has been referred to the CSB and determined by it to be appropriate for its case management services program, a preliminary assessment is initiated at first contact and completed, within 14 but in no case more than 30 calendar days of referral, and an individualized services plan (ISP) is initiated within 24 hours of the individual's admission to a program area for services in its case management services program and updated when required by the Department's licensing regulations. A copy of an advance directive, a wellness recovery action plan, or a similar expression of an individual's treatment preferences, if available, is included in the clinical record. During its inspections, the Department's Licensing Office may verify these affirmations as it reviews services records.

E. For individuals for whom case management services will be discontinued due to failure to keep scheduled appointments, outreach attempts, including home visits, telephone calls, letters, and contacts with others as appropriate, to reengage the individual are documented. The CSB has a procedure in place to routinely review the rate of and reasons for refused or discontinued case management services and takes appropriate actions when possible to reduce that rate and address those reasons. The CSB shall provide a copy of this procedure to the Department upon request. During its inspections, the Department's Licensing Office may examine this procedure to verify this affirmation.

13. Co-Occurring Mental Health and Substance Use Disorder Performance Expectation

The CSB ensures that, as part of its regular intake processes, every adolescent (ages 12 to 18) and adult presenting for mental health or substance use disorder services is screened, based on clear clinical indications noted in the services record or use of a validated brief screening instrument, for co-occurring mental health and substance use disorders. If screening indicates a need, the CSB assesses the individual for co-occurring disorders. During its onsite reviews, staff from the Department's Office of Community Behavioral Health Services may examine a sample of service records to verify this affirmation.

14. Data Quality Performance Expectation

A. The CSB submits 100 percent of its monthly CCS consumer, type of care, and services file extracts to the Department in accordance with the schedule in Exhibit E of the performance contract and the current CCS Extract Specifications and Business Rules, a submission for each month by the end of the following month for which the extracts are due. The Department will monitor this measure quarterly by analyzing the CSB's CCS submissions and may negotiate an Exhibit D with the CSB if it fails to meet this goal for more than two months in a quarter.

B. The CSB monitors the total number of consumer records rejected due to fatal errors divided by the total consumer records in the CSB's monthly CCS consumer extract file. If the CSB experiences a fatal error rate of more than five percent of its CCS consumer records in more than one monthly submission, the CSB develops and implements a data quality improvement plan to achieve the goal of no more than five percent of its CCS consumer records containing fatal errors within a timeframe negotiated with the Department. The Department will monitor this affirmation by analyzing the CSB's CCS submissions.

1. The CSB ensures that all required CCS data is collected and entered into its information system when a case is opened or an individual is admitted to a program area, updated at least annually when an individual remains in service that long, and updated when an individual is discharged from a program area or his case is closed.
2. The CSB identifies situations where data is missing or incomplete and implements a data quality improvement plan to increase the completeness, accuracy, and quality of CCS data that it collects and reports.
3. The CSB monitors the total number of individuals without service records submitted showing receipt of any substance use disorder service within the prior 90 days divided by the total number of individuals with a TypeOfCare record showing a substance use disorder discharge in those 90 days. If more than 10 percent of the individuals it serves have not received any substance use disorder services within the prior 90 days and have not been discharged from the substance use disorder services program area, the CSB develops and implements a data quality improvement plan to reduce that percentage to no more than 10 percent.

C. The Department will monitor this affirmation by analyzing the CSB's CCS submissions.

15. Employment and Housing Opportunities Expectation

The CSB reviews and revises, if necessary, its joint written agreement, required by subdivision A.12 of § 37.2-504 or subsection 14 of § 37.2-605 of the Code of Virginia, with the Department of Aging and Rehabilitative Services (DARS) regional office to ensure the availability of employment services and specify DARS services to be provided to individuals receiving services from the CSB.

A. The CSB works with employment service organizations (ESOs) where they exist to support the availability of employment services and identify ESO services available to individuals receiving services from the CSB. Where ESOs do not exist, the CSB works with other entities to develop employment services in accordance with State Board Policy 1044 (SYS) 12-1 to meet the needs of employment age (18-64) adults who choose integrated employment.

B. Pursuant to State Board Policy 1044, the CSB ensures its case managers discuss integrated, community-based employment services at least annually with adults currently receiving services from it, include employment related goals in their individualized services and supports plans if they want to work, and when appropriate and as practicable engage them in seeking employment services that comply with the policy in a timely manner.

C. The CSB reviews and revises, if necessary, its joint written agreements, required by subdivision 12 of subsection A of § 37.2-504 or subsection 14 of § 37.2-605 of the Code of Virginia, with public housing agencies, where they exist, and works with planning district commissions, local governments, private developers, and other stakeholders to maximize federal, state, and local resources for the development of and access to affordable housing and appropriate supports for individuals receiving services from the CSB.

D. The CSB works with the Department through the VACSB Data Management Committee, at the direction of the VACSB Executive Directors Forum, to collaboratively establish clear employment and stable housing policy and outcome goals and develop and monitor key housing and employment outcome measures.

Exhibit C FY22-23: Regional Discharge Assistance Program (RDAP) Requirements

The Department and the CSB agree to implement the following requirements for management and utilization of all current state regional discharge assistance program (RDAP) funds to enhance monitoring of and financial accountability for RDAP funding, decrease the number of individuals on state hospital extraordinary barriers to discharge lists (EBLs), and return the greatest number of individuals with long lengths of state hospital stays to their communities.

1. The Department shall work with the VACSB, representative CSBs, and regional managers to develop clear and consistent criteria for identification of individuals who would be eligible for individualized discharge assistance program plans (IDAPPs) and acceptable uses of state RDAP funds and standard terminology that all CSBs and regions shall use for collecting and reporting data about individuals, services, funds, expenditures, and costs.
2. The CSB shall comply with the current Discharge Assistance Program Manual issued by the Department.
3. All state RDAP funds allocated within the region shall be managed by the regional management group (RMG) and the regional utilization management and consultation team (RUMCT) on which the CSB participates in accordance with Services Taxonomy.
4. The CSB, through the RMG and RUMCT on which it participates, shall ensure that other funds such as Medicaid payments are used to offset the costs of approved IDAPPs to the greatest extent possible so that state RDAP funds can be used to implement additional IDAPPs to reduce EBLs.
5. On behalf of the CSBs in the region, the regional manager funded by the Department and employed by a participating CSB shall submit mid-year and end of the fiscal year reports to the Department in a format developed by the Department in consultation with regional managers that separately displays the total actual year-to-date expenditures of state RDAP funds for ongoing IDAPPs and for one-time IDAPPs and the amounts of obligated but unspent state RDAP funds.
6. The CSB and state hospital representatives on the RMG on which the CSB participates shall have authority to reallocate state RDAP funds among CSBs from CSBs that cannot use them in a reasonable time to CSBs that need additional state RDAP funds to implement more IDAPPs to reduce EBLs.
7. If CSBs in the region cannot obligate at least 95 percent and expend at least 90 percent of the total annual ongoing state RDAP fund allocations on a regional basis by the end of the fiscal year, the Department may work with the RMG and participating CSBs to transfer state RDAP funds to other regions to reduce EBLs to the greatest extent possible, unless the CSBs through the regional manager provide acceptable explanations for greater amounts of unexpended or unobligated state RDAP funds. This does not include one-time allocations to support ongoing DAP plans for multiple years.
8. On behalf of the CSBs in a region, the regional manager shall continue submitting the quarterly summary of IDAPPs to the Department in a format developed by the Department in consultation with regional managers that displays year-to-date information about ongoing and one-time IDAPPs, including data about each individual receiving DAP services, the amounts of state RDAP funds approved for each IDAPP, the total number of IDAPPs that have been implemented, and the projected total net state RDAP funds obligated for these IDAPPs.
9. The Department may conduct utilization reviews of the CSB or region at any time to confirm the effective utilization of state RDAP funds and the implementation of all approved ongoing and one-time IDAPPs.

Amendment 1
Exhibit E: FY2022 AND FY2023 Performance Contract Schedule and Process

DUE DATE	DESCRIPTION
5-20-22	1. The Office of Fiscal and Grants Management (OFGM) distributes the Letters of Notification to CSBs with of state and federal block grant funds. **NOTE:** *This is contingent on the implementation of the fiscal year budget as passed by the General Assembly and signed into law by the Governor. The Code of Virginia allows the Governor to make certain adjustments to the Budget. Changes in Federal legislation, inclement weather and uncertain revenue collections, are just a few examples of events that may require adjustments to the budget in order to maintain the balanced budget as required by Virginia's constitution.* 2. The Department's Office of Information Services and Technology (OIS&T) distributes the current fiscal year performance contract software through the Community Automated Reporting System (CARS) to CSBs. CSBs must only provide allocations of state and federal funds or amounts subsequently revised by or negotiated and approved by the Department and have actual appropriated amounts of local matching funds.
06-24-22	1. CSB must complete Exhibit A, Table 2 Board Management and Salary Cost and Integrated Behavioral and Primary Health Care Questions through the CARS application. 2. During June and July, the OFGM prepares the electronic data interchange transfers for the first two semi- monthly payments (for July payments) of state and federal for the CSBs. This will include 1/8th of any approved amounts of federal funds that are distributed on a state fiscal year basis. All other federal funds after this disbursements must be invoiced by the CSBs pursuant to the performance contract.
07-01-22	1. The current fiscal year performance contract or contract revisions should be signed and submitted electronically by the CSBs. This should include any applicable Exhibits D that may be due at this time to the Office of Management Services (OMS) sent to the performancecontractsupport@dbhds.virginia.gov email address. 2. If the CSB has not met or maintained the minimum 10 percent local matching funds requirement at the end of the previous fiscal year, it must submit a written request for a waiver, pursuant to § 37.2-509 of the Code and State Board Policy 4010, and the Minimum Ten Percent Matching Funds Waiver Request Guidelines sent to the OMS performancecontractsupport@dbhds.virginia.gov email address. 3. The OFGM prepares the transfers for payments 3 and 4 during July and August (for August payments) of state and federal funds. If the CSB CARS report data is not complete the payment(s) may not be released until the complete report is received. Once received these two semi-monthly payments will be processed and disbursed with the next scheduled payment.
07-15-22	The OIS&T distributes the end of the fiscal year performance contract report through CARS.
07-29-22	CSBs submit their June Community Consumer Submission (CCS) extract files for June.
08-19-22	1. CSBs submit their complete CCS extract files for total (annual) CCS service unit data. The Department will not accept any other corrections to the end of year CCS report after this date. 2. OFGM prepares the transfers for payments 5 and 6 during August and September (September payments) of state and federal funds.

DUE DATE	DESCRIPTION
08-31-22	3. CSBs send complete end of the fiscal year report through the CARS application. 4. The OMS reviews program services sections of the reports for any discrepancies and works with the CSBs to resolves deficiencies. 5. OFGM reviews financial portions of reports for any discrepancies and works with CSBs to resolve deficiencies.
9-16-2022	1. **CSBs must resubmit approved revised program and financial reports through the CARS application no later than 09-16-2022. This is the final closeout date. The Department will not accept CARS report corrections after this date.** 2. CSBs submits their July CCS monthly extract files for July. **This is the initial FY 2023 CCS monthly extract files.** 3. OFGM prepares transfers for payments 7 and 8 during September and October (October payments). Payments may not be released without receipt of a CSB final end of the fiscal year CCS data.
09-30-22	1. All CSB signed performance contracts and applicable Exhibits D are due to the Department for final signature by the Commissioner pursuant to § 37.2-508 of the Code. **Inaccurate or no submission of reports from 9/16/2022 and/or unsigned performance contracts will be out of compliance and may result in a one- time, one percent reduction not to exceed $15,000 of state funds apportioned for CSB administrative expenses.** 2. CSBs submit their CCS monthly extract files for August.
10-03-22	1. After the Commissioner signs the contracts, a fully executed copy of the performance contract and applicable Exhibits D will be sent to the CSBs electronically by OMS. 2. OFGM prepares transfers for payments 9 and 10 during October and November (November payments).
10-14-22	CSBs submit Federal Balance Reports to the OFGM.
10-31-22	1. CSBs submit CCS monthly extract files for September. 2. OFGM prepare transfers for payments 11 and 12 during November and December (December payments). Payments may not be released without receipt of September CCS submissions and final Federal Balance Reports.
11-30-22	CSBs submit their CCS monthly extract files for October.
12-02-22	1. CSBs that are not local government departments or included in local government audits send one copy of their Certified Public Accountant (CPA) audit reports for the previous fiscal year on all CSB operated programs to the Department's Office of Budget and Financial Reporting (OBFR). 2. CSBs submit a copy of CPA audit reports for all contract programs for their last full fiscal year, ending on June 30th, to the OBFR. For programs with different fiscal years, reports are due three

DUE DATE	DESCRIPTION
	months after the end of the year. 3. The CSBs shall have a management letter and plan of correction for identified material deficiencies which must be sent with these reports. 4. Audit reports for CSBs that are local government departments or are included in local government audits are submitted to the Auditor of Public Accounts (APA) by the local government. 5. The CSB must forward a plan of correction for any audit deficiencies to the OBFR. 6. To satisfy federal grant sub-recipient monitoring requirements imposed on the Department under the Single Audit Act, a CSB that is a local government department or is included in its local government audit shall contract with the same CPA audit firm that audits its locality to perform testing related to the federal grants. Alternately, the local government's internal audit department can work with the CSB and the Department to provide the necessary sub-recipient monitoring information. 7. If the CSB receives an audit identifying material deficiencies or containing a disclaimer or prepares the plan of correction referenced in the preceding paragraph, the CSB and the Department will work together to address the deficiencies as required in the performance contract.
12-30-22	1. OFGM prepares transfers during December for payment 13 through 16 (January and February payments). 2. CSBs end of the fiscal year performance contract reports not accurate, incomplete, and/or CCS monthly extracts for October that have not been received, payments may not be released. 3. CSBs submit their CCS monthly extract files for November.
01-06-23	The OIS&T distributes mid-year performance contract report CARS software.
01-31-23	CSBs submit their CCS monthly extract files for December.
02-17-23	1. CSBs send complete mid-year performance contract reports and a revised Table 1: Board of Directors Membership Characteristics through the CARS application. 2. OFGM prepares transfers during February for payment 17 and 18 (March payments) for CSBs whose monthly CCS extract for December and CARS reports not received by the end of January, payments may not be released.
02-28-23	CSBs submit their CCS extract files for January. CSBs whose monthly CCS extract files for January were not received by the end of the month, payments may not be released.
03-31-23	1. CSBs submit their CCS extract files for February. 2. OFGM prepares transfers during March for payments 19 and 20 (April payments) for CSBs whose complete mid-year performance contract reports, payments may not be released. 3. CSB must submit their final, complete and accurate mid-year performance contract reports through CARS.
04-28-23	1. CSBs submit their CCS monthly extract files for March by this date. 2. OFGM prepares transfers during April for payments 21 and 22 (May payments) for CSBs whose mid-year performance contract reports have not been verified as accurate and internally consistent and whose monthly CCS3 extract files for February were not received by the end of the month. Payments may not be released.
05-31-23	1. CSBs submit their CCS monthly extract files for April for CSBs whose monthly CCS extract

DUE DATE	DESCRIPTION
	files for April were received by the end of May. 2. **If April CCS extract files are not received by May 31st, this may delay or even eliminate payment 24 due to time restrictions on when the Department can send transfers to the Department of Accounts for payment 24.** 3. OFGM prepares transfers during May for payment 23 and 24 (June payments) for CSBs whose monthly CCS extract files for March were not received by the end of April, payments may not be released.
06-30-23	CSBs submit their CCS monthly extract files for May.

Amendment 1
Exhibit E: Exhibit E: FY2022 AND FY2023 Performance Contract Schedule and Process

I. Administrative Performance Requirements

The CSB shall meet these administrative performance requirements in submitting its performance contract, contract revisions, and mid-year and end-of-the-fiscal year performance contract reports in the CARS application, and monthly CCS extracts to the Department.

A. The performance contract and any revisions submitted by the CSB shall be:

1. complete all required information is displayed in the correct places and all required Exhibits, including applicable signature pages, are included;
2. consistent with Letter of Notification allocations or figures subsequently revised by or negotiated with the Department;
3. prepared in accordance with instructions by the Department-
4. received by the due dates listed in this Exhibit E

B. If the CSB does not meet these performance contract requirements, the Department may delay future payments of state and federal funds until satisfactory performance is achieved.

C. Mid-year and end-of-the-fiscal year performance contract reports submitted by the CSB shall be:

1. complete, all required information is displayed in the correct places, all required data are included in the CARS application reports, and any other required information not included in CARS are submitted;
2. consistent with the state and federal grant funds allocations in the Letter of Notification or figures subsequently revised by or negotiated with the Department;
3. prepared in accordance with instructions provided by the Department;
4. (i) all related funding, expense, and cost data are consistent, and correct within a report, and (ii) errors identified are corrected; and
5. received by the due dates listed in this Exhibit

D. If the CSB does not meet these requirements for its mid-year and end-of-the-fiscal year CARS reports, the Department may delay future payments until satisfactory performance is achieved. The Department may impose one-time reductions of state funds apportioned for CSB administrative expenses on a CSB for its failure to meet the requirements in its end-of-the-fiscal year CARS report may have a one percent reduction not to exceed $15,000 unless an extension has been granted by the Department.

E. The CSB shall submit monthly extra files by the end of the month following the month for which the data is extracted in accordance with the CCS Extract Specifications, including the current business rules.

F. If the CSB fails to meet the extract submission requirements in this Exhibit, the Department may delay payments until satisfactory performance is achieved. If the Department has not provided the CCS extract application to the CSB in time for it to transmit its monthly submissions this requirement does not apply.

G. If the Department negotiates a corrective action plan with a CSB because of unacceptable data quality, and the CSB fails to satisfy the requirements by the end of the contract term, the Department may impose a one-time one percent reduction not to exceed a total of $15,000 of state funds apportioned for CSB administrative expenses..

H. The CSB shall not allocate or transfer a one-time reduction of state funds apportioned for administrative expenses to direct service or program costs.

I. Administrative Performance Requirements

I. Process for Obtaining an Extension of the End-of-the-Fiscal Year CARS Report Due Date

1. Extension Request: The Department will grant an extension only in very exceptional situations such as a catastrophic information system failure, a key staff person's unanticipated illness or accident, or a local emergency or disaster situation that makes it impossible to meet the due date.
    a. It is the responsibility of the CSB to obtain and confirm the Department's approval of an extension of the due date within the time frames specified below. Failure of the CSB to fulfill this responsibility constitutes prima facie acceptance by the CSB of any resulting one-time reduction in state funds apportioned for administrative expenses.
    b. As soon as CSB staff becomes aware that it cannot submit the end-of-the-fiscal year CARS report by the due date to the Department, the executive director must inform the Office of Management Services (OMS) through the performancecontractsupport@dbhds.virginia.gov email mailbox that it is requesting an extension of this due date. This request should be submitted as soon as possible and describe completely the reason(s) and need for the extension, and state the date on which the report will be received by the Department.
    c. The request for an extension must be received in the OMS no later than 5:00 p.m. on the fourth business day before the due date through the performancecontractsupport@dbhds.virginia.gov email mailbox. Telephone extension requests are not acceptable and will not be processed.
    d. The OMS will act on all requests for due date extensions that are received in accordance with this process and will notify the requesting CSBs of the status of their requests within 2 business of receipt.

J. Performance Contract Revision Instructions:

1. The CSB may revise Exhibit A of its signed contract only in the following circumstances:
2. a new, previously unavailable category or subcategory of services is implemented;
3. an existing category or subcategory of services is totally eliminated;
4. a new program offering an existing category or subcategory of services is implemented;
5. a program offering an existing category or subcategory of services is eliminated;
6. new restricted or earmarked state or federal funds are received to expand an existing service or establish a new one;
7. state or federal block grant funds are moved among program (mental health, developmental, or substance use disorder) areas or emergency or ancillary services (an exceptional situation);
8. allocations of state, federal, or local funds change; or
9. a major error is discovered in the original contract.
10. Revisions of Exhibit A shall be submitted using the CARS application

Exhibit F (B) FY22-23 Single Audit Exemption Form

Audit of Financial Records: The Subrecipient shall comply with the audit and reporting requirements defined by the Federal Office of Management and Budget (OMB) 2 CFR 200 (Audits of States, Local, Governments and Non-Profit organizations) and 45 CFR 75.500 – 75.521 as applicable.

If total federal funds expended are less than $750,000 for a year the Subrecipient is exempt from federal audit requirements (45 CFR 75-501(d)), however, the Subrecipient's records must be made available to the Pass-Through Agency and appropriate officials of HHS, SAMHSA, the U.S. Government Accountability Office and the Comptroller General of the United States upon request, and it must still have a financial audit performed for that year by an independent Certified Public Accountant.

The due date for submission of the audit shall be December 1, the same due date as audits required by OMB 2 CFR 200. *Further, if applicable, within 30 days of the effective date of this Agreement, the Subrecipient must submit to DBHDS' Federal Grants Manager a written statement of exemptions to the single audit requirement and a copy of the most recent audited financial statement along with any findings and corrective action plans.*

Organization Information:

Agency Name and Address		*FEIN(s)*	*Fiscal Year End Date*
Agency Representative		*Title*	
Telephone	*Fax*	*Email*	

Certification:
For the fiscal year indicated above, the agency did not incur expenditures of $750,000 or more for all federal programs and is not required to have an audit of federal programs in accordance with the Federal Single Audit 2 CFR § 200.501 and 45 CFR 75.501. **The agency, however, agrees to submit an independent financial audit performed by an independent Certified Public Accountant.**

Agency Representative's Signature	*Date*

Independent Auditor Information:

Firm Name and Address		
CPA Name		*Virginia State License Number*
Telephone	*Fax*	*Email*

Printed: 7/31/2023 2:45 PM - Virginia - OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Exhibit F (B) FY22-23 Single Audit Exemption Form

If your agency expended less than $750,000 for all federal programs, please complete the following table for all federal programs where expenditures were incurred:

Sample entry:

Federal Agency	Pass Through Entity (if applicable)	Pass Through Entity Identifying Number	Subrecipient Entity Identifying Contract Number	CFDA #	Total Expenditures for Fiscal Year Ending in 2020 *
SAMHSA	*VA DBHDS*			*93.958*	*$153,000*

Agency Name: _____

Federal Agency	Pass Through Entity (if applicable)	Pass Through Entity *Identifying* Number	Subrecipient Entity *Identifying Contract* Number	CFDA #	Total Expenditures for Fiscal Year Ending in 2020 *

Total expenditures for all federal awards _____

* Include the value of federal awards expended in the form of non-cash assistance, the amount of insurance in effect during year, and loans or loan guarantees outstanding at year-end.

Table of Contents

I. Background

State agencies often administer federal awards received as pass-through funds to other non-federal entities. These non-federal recipient entities are called Subrecipients and they assist in carrying out various federally-funded programs. Subrecipients are typically units of local government (i.e. city and county agencies) but also include other entities such as Native American tribes, other state agencies, and institutions of higher education, special districts and non-profits. The nature of these relationships are governed by federal statute, regulations, and policies in addition to state laws and regulations. The source of the funding determines the regulations and policies that govern the provision of the funds. The Substance Abuse and Mental Health Services Administration (SAMHSA) is the primary source of federal funds awarded to DBHDS. DBHDS also receives funds from the U.S. Department of Justice and the U.S. Department of Education.

As a primary recipient of federal funds, state agencies serve a pass-through role in which funds are subawarded to Subrecipients. Federal regulations require that pass-through entities provide monitoring of their Subrecipient which is outlined in Sections 200.300 through 200.346 in 2 C.F.R. Part 200 and Sections 75.300 through 75.391 in 45 C.F.R. Part 75 for SAMHSA awards. Further, audit requirements contained in 2 C.F.R. Part 200, Subpart F and 45 C.F.R. Part 75, Subpart F for SAMHSA awards, require that pass-through entities monitor the activities of their Subrecipient, as necessary, to ensure that federal awards are used appropriately and that performance goals are achieved.

In order to further the provision of necessary goods and services to the community, DBHDS may enter into federally-funded subrecipient relationships with Community Service Boards (CSBs). This exhibit provides certain compliance requirements and other specific and general grant information for the federal grant funds that DBHDS passes-through to the CSBs.

II. Defined Terms

Administrative Proceeding – A non-judicial process that is adjudicatory in nature in order to make a determination of fault or liability (e.g., Securities and Exchange Commission Administrative proceedings, Civilian Board of Contract Appeals proceedings, and Armed Services Board of Contract Appeals proceedings). This includes proceedings at the Federal and State level but only in connection with performance of a Federal contract or grant. It does not include audits, site visits, corrective plans, or inspection of deliverables.

Conference – A meeting, retreat, seminar, symposium, workshop or event whose primary purpose is the dissemination of technical information beyond the non-Federal entity and is necessary and reasonable for successful performance under the Federal award.

Conviction – For purposes of this award term and condition, a judgment or conviction of a criminal offense by any court of competent jurisdiction, whether entered upon a verdict or a plea, and includes a conviction entered upon a plea of nolo contendere.

Drug-Free Workplace – A site for the performance of work done in connection with a specific award to a Subrecipient, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the federally funded project.

Employee - An individual employed by the subrecipient who is engaged in the performance of the project or program under this award; or another person engaged in the performance of the project or program under this award and not compensated by the subrecipient including, but not limited to, a volunteer or individual whose services are contributed by a third party as an in-kind contribution toward cost sharing or matching requirements.

Entity – Any of the following, as defined in 2 CFR Part 25: a Governmental organization, which is a State, local government, or Indian tribe; a foreign public entity; a domestic or foreign nonprofit organization; a domestic or foreign for-profit organization; a Federal agency, but only as a subrecipient under an award or sub-award to a non-Federal entity.

Equipment – Tangible personal property (including information technology systems) having a useful life of more than one year and a per-unit acquisition cost which equals or exceeds the lesser of the capitalization level established by the non-Federal entity for financial statement purposes, or $5,000.

Executive – Officers, managing partners, or any other employees in management positions.

Forced labor - Labor obtained by any of the following methods: the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

Funding Opportunity Announcement (FOA) – The document that all federal agencies utilize to announce the availability of grant funds to the public.

Intangible Property – Intangible property means property having no physical existence, such as trademarks, copyrights, patents and patent applications and property, such as loans, notes and other debt instruments, lease agreements, stock and other instruments of property ownership (whether the property is tangible or intangible).

Major Medical Equipment – An item intended for a medical use that has a cost of more than $5,000 per unit.

Minor Renovation, Remodeling, Expansion, and Repair of Housing – Improvements or renovations to existing facilities or buildings that do not total more than $5,000.

Notice of Award (NOA) – The official award document issued by the federal granting agency that notifies the primary recipient of their award amount.

Obligation – Orders placed for property and services, contracts and subawards made, and similar transactions during the Period of Performance.

Pass-Through Entity - Pass-through entity means a non-Federal entity that provides a subaward to a subrecipient to carry out part of a Federal program.

Period of Performance – The timeframe in which the Subrecipient may incur obligations on funding received as a result of an agreement between DBHDS and the CSB which is funded with federal grant money.

Recipient – The non-federal entity that receives a grant award from a federal entity. The recipient may be the end user of the funds or may serve as a pass-through to subrecipient entities.

Subaward – A legal instrument to provide support for the performance of any portion of the substantive project or program for which the Recipient received the Federal award and that the recipient awards to an eligible subrecipient.

Subrecipient – A non-Federal entity that receives a subaward from the recipient (or Pass-Through Entity) under this award to carry out part of a Federal award, including a portion of the scope of work or objectives, and is accountable to the Pass-Through Entity for the use of the Federal funds provided by the subaward. Grant recipients are responsible for ensuring that all sub-recipients comply with the terms and conditions of the award, per 45 CFR §75.101.

Supplant – To replace funding of a recipient's existing program with funds from a federal grant.

System of Award Management (SAM) – The Federal repository into which an entity must provide information required for the conduct of business as a recipient. Additional information about registration procedures may be found at the SAM Internet site (currently at: http://www.sam.gov).

Total compensation – The cash and noncash dollar value earned by the executive during the recipient's or subrecipient's preceding fiscal year and includes the following (for more information see 17 CFR 229.402(c)(2)): salary and bonus; awards of stock, stock options, and stock appreciation rights (use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments); earnings for services under non-equity incentive plans (this does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives, and are available generally to all salaried employees); change in pension value (this is the change in present value of defined benefit and actuarial pension plans); above-market earnings on deferred compensation which is not tax-qualified and; other compensation, if the aggregate value of all such other compensation (e.g. severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds $10,000. [75 FR 55669, Sept. 14, 2010, as amended at 79 FR 75879, Dec. 19, 2014]

Total value of currently active grants, cooperative agreements, and procurement contracts – Only the Federal share of the funding under any Federal award with a recipient cost share or match; and the value of all expected funding increments under a Federal award and options, even if not yet exercised [81 FR 3019, Jan. 20, 2016].

Unique Entity Identifier (UEI) – The identifier required for SAM registration to uniquely identify business entities.

Unliquidated Obligations – An invoice for which the Subrecipient has already been allocated funding to pay by the pass-through entity that falls within timeframe for expending unliquidated obligations provided in Section III of this Exhibit. Unliquidated Obligations cannot include personnel costs and are limited to goods or services that were purchased or contracted for prior to the end of the Period of Performance but were not yet expensed as the goods or services were not yet received or the Subrecipient had not yet received an invoice.

III. Federal Grant Requirements for DBHDS as the Pass-through Entity

As the pass-through entity for federal grant funds, DBHDS must comply and provide guidance to the subrecipient in accordance with U.S. C.F.R. 2 § 200.332 and CFR 45 § 75.352 (for SAMHSA awards). DBHDS shall:

A. Ensure every subaward is clearly identified to the subrecipient as a subaward and includes the following information at the time of the subaward. If any of these data elements change, include the changes in subsequent subaward modification. When some of this information is not available, the pass-through entity must provide the best information available to describe the Federal award and subaward. This information includes:

1. Subrecipient name (which must match the name associated with its unique entity identifier);
2. Subrecipient's unique entity identifier;
3. Federal Award Identification Number (FAIN);
4. Federal Award Date (see § 200.1 and § 75.2 Federal award date) of award to the recipient by the HHS awarding agency;
5. Subaward Period of Performance Start and End Date;
6. Subaward Budget Period Start and End Date;
7. Amount of Federal Funds Obligated by this action by the pass-through entity to the subrecipient;
8. Total Amount of Federal Funds Obligated to the subrecipient by the pass-through entity including the current obligation;
9. Total Amount of the Federal Award committed to the subrecipient by the pass-through entity;

10. Federal award project description, as required to be responsive to the Federal Funding Accountability and Transparency Act (FFATA);
11. Name of Federal awarding agency, pass-through entity, and contract information for awarding official of the pass-through entity;
12. CFDA Number and Name; the pass-through entity must identify the dollar amount made available under each Federal award and the CFDA number at time of disbursement;
13. Identification of whether the award is R&D; and
14. Indirect cost rate for the Federal award (including if the de minimis rate is charged per § 200.414 and § 75.414).

B. Comply with all Federal statutes, regulations and the terms and conditions of the Federal award.

C. Negotiate with the subrecipient an approved federally recognized indirect cost rate negotiated between the subrecipient and the Federal Government or, if no such rate exists, either a rate negotiated between the pass-through entity and the subrecipient or a de minimis indirect cost rate as defined in § 200.414(f) and § 75.414(f).

D. Be responsible for monitoring the activities of the subrecipient as necessary to ensure that the subaward is used for authorized purposes, in compliance with Federal statutes, regulations, and the terms and conditions of the subaward; and that subaward performance goals are achieved. Pass-through entity monitoring of the subrecipient must include, but is not limited to the following:

1. Reviewing financial and performance reports required by the pass-through entity.
2. Following-up and ensuring that the subrecipient takes timely and appropriate action on all deficiencies pertaining to the Federal award provided to the subrecipient from the pass-through entity detected through audits, on-site reviews, and other means.
3. Issuing a management decision for audit findings pertaining to the Federal award provided to the subrecipient from the pass-through entity as required by § 200.521 and § 75.521.
4. The Department shall evaluate each subrecipient's risk of noncompliance with Federal statutes, regulations, and the terms and conditions of the subaward for purposes of determining the appropriate subrecipient monitoring.
5. The Department shall verify that every subrecipient is audited as required by subpart F when it is expected that the subrecipient's Federal awards expended during the respective fiscal year equaled or exceeded the threshold set forth in § 200.501 and § 75.501.
6. The Department shall consider whether the results of the subrecipient's audits, on-site reviews, or other monitoring indicate conditions that necessitate adjustments to the pass-through entity's own records.

IV. General Federal Grant Requirements for the Department and CSBs

The federal grants listed in Section IV of this Exhibit have requirements that are general to the federal agency that issues the funds. Included below are the general grant terms and conditions for each of the federal agencies for which DBHDS is the pass-through entity to the CSBs.

A. SAMHSA GRANTS

1. **Grant Oversight:** The CSBs and the Department are legally and financially responsible for all aspects of this award including funds provided to sub-recipients, in accordance with 2 CFR 200.331 - 200.333 and 45 CFR 75.351 – 75.353, Sub-recipient monitoring and management.

2. **Acceptance of the Terms of an Award:** By drawing or otherwise obtaining funds from DBHDS that resulted from funds obtained from the Health and Human Services (HHS) Payment Management System), the subrecipient acknowledges acceptance of the terms and conditions of the award and is obligated to perform in accordance with the requirements of the award. If the subrecipient cannot accept the terms, the subrecipient should notify the Program contact at DBHDS prior to the execution

of its Exhibit D or Notice of Award. Once the Exhibit D or Notice of Award is executed by the subrecipient, the contents of the Exhibit D or Notice of Award are binding on the subrecipient until modified and signed by both parties.

Certification Statement: By invoicing DBHDS for funds, the subrecipient certifies that proper financial management controls and accounting systems, to include personnel policies and procedures, have been established to adequately administer Federal awards and drawdown funds. Recipients of Department of Health and Human Services'(DHHS) grants or cooperative agreement awards, and their Subrecipient, must comply with all terms and conditions of their awards, including: (a) terms and conditions included in the HHS Grants Policy Statement in effect at the time of a new, non-competing continuation, or renewal award (https://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf), including the requirements of HHS grants administration regulations; (b) requirements of the authorizing statutes and implementing regulations for the program under which the award is funded; (c) applicable requirements or limitations in appropriations acts; and (d) any requirements specific to the particular award specified in program policy and guidance, the FOA, or the NOA.

3. **Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards**: The NOA issued is subject to the administrative requirements, cost principles, and audit requirements that govern Federal monies associated with this award, as applicable, in the Uniform Guidance 2 CFR Part 200 as codified by HHS at 45 CFR Part 75 (https://www.ecfr.gov/cgibin/retrieveECFR?gp=&SID=0ddb69baec587eeea4ab7e6a68c4acb0&mc=true&r=PART&n=pt45.1.75.)

4. **Award Expectations:** The eligibility and program requirements originally outlined in the FOA must continue to be adhered to as the funded project is implemented. Recipients must comply with the performance goals, milestones, outcomes, and performance data collection as reflected in the FOA and related policy and guidance. Additional terms and/or conditions may be applied to this award if outstanding financial or programmatic compliance issues are identified by Substance Abuse and Mental Health Services Administration (SAMHSA). Subrecipient must comply with the Scope of Services of their award.

5. **Flow down of requirements to sub-recipients:** The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients, in accordance with 45 CFR 75.351 – 75.353, Subrecipient monitoring and management.

6. **Risk Assessment:** SAMHSA's Office of Financial Advisory Services (OFAS) may perform an administrative review of the subrecipient organization's financial management system. If the review discloses material weaknesses or other financial management concerns, grant funding may be restricted in accordance with 45 CFR 75 and 2 CFR 200, as applicable. DBHDS reviews and determines the risk associated with its Subrecipient. As part of the risk assessment process, DBHDS may perform an administrative review of the subrecipient's financial management system.

7. **Improper Payments:** Any expenditure by the Subrecipient which is found by auditors, investigators, and other authorized representatives of DBHDS, the Commonwealth of Virginia, the U.S. Department of Health and Human Services, the U.S. Government Accountability Office or the Comptroller General of the United States to be improper, unallowable, in violation of federal or state law or the terms of the NOA, FOA, or this Exhibit, or involving any fraudulent, deceptive, or misleading representations or activities of the Subrecipient, shall become Subrecipient's liability, to be paid by Subrecipient from funds other than those provided by DBHDS for the given program or any other funding agreements between DBHDS and the Subrecipient. This provision shall survive the expiration or termination of the applicable Performance Contract.

8. **Treatment of Property and Equipment:** If the Program permits the Subrecipient or entities that receive funding from the Subrecipient to purchase real property or equipment with grant funds, the Program retains a residual financial interest, enabling the Program to recover the assets or determine final disposition. This will be accomplished on a case-by-case basis, according to the federal grant guidelines applicable to the grant that is funding the service(s) in accordance with 2 CFR 200.33 and 45 CFR 75.2. Equipment is defined in the defined terms section of this Exhibit.

9. **Program Income:** Program income accrued under this grant award must be reported to the Recipient and must be used to further the objectives of the grant project and only for allowable costs.

10. **Financial Management:** The Subrecipient shall maintain a financial management system and financial records and shall administer funds received in accordance with all applicable federal and state requirements, including without limitation:
    1) the Uniform Guidance, 2 C.F.R. Part 200 and 45 C.F.R. Part 75;
    2) the NOA; and
    3) FOA.

    The Subrecipient shall adopt such additional financial management procedures as may from time to time be prescribed by DBHDS if required by applicable laws, regulations or guidelines from its federal and state government funding sources. Subrecipient shall maintain detailed, itemized documentation and records of all income received and expenses incurred pursuant to this Exhibit.

11. **Audit of Financial Records:** The Subrecipient shall comply with the audit and reporting requirements defined by the Federal Office of Management and Budget (OMB) 2 CFR 200 (Audits of States, Local, Governments and Non-Profit organizations) and 45 CFR 75.500 – 75.521 as applicable. The Subrecipient will, if total Federal funds expended are $750,000 or more a year, have a single or program specific financial statement audit conducted for the annual period in compliance with the General Accounting Office audit standards (45 CFR 75-501(a)).

    If total federal funds expended are less than $750,000 for a year the Subrecipient is exempt from federal audit requirements (45 CFR 75-501(d)), but the Subrecipient's records must be available to the Pass-Through Agency and appropriate officials of HHS, SAMHSA, the U.S. Government Accountability Office and the Comptroller General of the United States, and it must still have a financial audit performed for that year by an independent Certified Public Accountant. Further, the subrecipient shall complete the certification letter included in Exhibit F (B) disclosing that they are not subject to the single audit requirement.

    Should an audit by authorized state or federal official result in disallowance of amounts previously paid to the Subrecipient, the Subrecipient shall reimburse the Pass-Through Agency upon demand.

    Pursuant to 2 CFR 200.334 and 45 CFR 75.361, the Subrecipient shall retain all books, records, and other relevant documents for three (3) years from the end of the calendar year in which the grant period terminates. In the event that any litigation, claim, or audit is initiated prior to the expiration of the 3-year period, all records must be retained until all litigation, claims, or audit findings involving the records have been resolved and final action taken. DBHDS, its authorized agents, and/or federal or state auditors shall have full access to and the right to examine any of said materials during said period.

12. **Accounting Records and Disclosures:** The Subrecipient must maintain records which adequately identify the source and application of funds provided for financially assisted activities, including awards and authorizations, obligations, unobligated balances, assets, liabilities, outlays or

expenditures, and income. The Subrecipient should expect that the Recipient and SAMHSA may conduct a financial compliance audit and on-site program review of this project as outlined in paragraph (11).

13. **Standards for Documentation of Personnel Expenses:** The Subrecipient shall comply with 2 CFR 200.430 and 45 CFR 75.430 Compensation-Personal Services and 2 CFR 200.431 and 45 CFR 75.431 Compensation-Fringe Benefits as required by the Federal Office of Management and Budget (OMB) Circular 2 CFR 200 (Cost Principles for State, Local and Indian Tribal Government). Per Standards for Documentation of Personnel Expenses 45 CFR 75.430(x)(3) in accordance with Department of Labor regulations implementing the Fair Labor Standards Act (FLSA) (29 CFR Part 516), charges for the salaries and wages of nonexempt employees, in addition to the supporting documentation described in this section (45 CFR 75.430), must also be supported by the appropriate records.

14. **Non-Supplant:** Federal award funds must supplement, not replace (supplant) nonfederal funds. Applicants or award recipients and Subrecipient may be required to demonstrate and document that a reduction in non-federal resources occurred for reasons other than the receipt of expected receipt of federal funds.

15. **Unallowable Costs:** All costs incurred prior to the award issue date and costs not consistent with the FOA, 45 CFR Part 75, and the HHS Grants Policy Statement, are not allowable.

16. **Executive Pay:** The Consolidated Appropriations Act, 2021 (Public Law 116-260), signed into law on December 27, 2020 restricts the amount of direct salary to Executive Level II of the Federal Executive Pay scale. Effective January 2, 2022, the salary limitation for Executive Level II is $203,700.

17. **Intent to Utilize Funding to Enter into a Procurement/Contractual Relationship:** If the Subrecipient utilizes any of these funds to contract for any goods or services, the Subrecipient must ensure that the resultant contract complies with the terms of Appendix II, 45 C.F.R. 75 which governs the contractual provisions for non-federal entity contracts under federal awards issued by the Department of Health and Human Services.

18. **Ad Hoc Submissions:** Throughout the project period, SAMHSA or DBHDS may require submission of additional information beyond the standard deliverables. This information may include, but is not limited to the following:
    - Payroll
    - Purchase Orders
    - Contract documentation
    - Proof of Project implementation

19. **Conflicts of Interest Policy:** Subrecipient must establish written policies and procedures to prevent employees, consultants, and others (including family, business, or other ties) involved in grant-supported activities, from involvement in actual or perceived conflicts of interest. The policies and procedures must:
    - Address conditions under which outside activities, relationships, or financial interest are proper or improper;
    - Provide for advance disclosure of outside activities, relationships, or financial interest to a responsible organizational official;
    - Include a process for notification and review by the responsible official of potential or actual violations of the standards; and
    - Specify the nature of penalties that may be imposed for violations.

20. **Administrative and National Policy Requirements:** Public policy requirements are requirements with a broader national purpose than that of the Federal sponsoring program or award that an applicant/recipient/subrecipient must adhere to as a prerequisite to and/or condition of an award. Public policy requirements are established by statute, regulation, or Executive order. In some cases they relate to general activities, such as preservation of the environment, while, in other cases they are integral to the purposes of the award-supported activities. An application funded with the release of federal funds through a grant award does not constitute or imply compliance with federal statute and regulations. Funded organizations are responsible for ensuring that their activities comply with all applicable federal regulations.

21. **Marijuana Restriction:** Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. 75.300(a) (requiring HHS to "ensure that Federal funding is expended in full accordance with U.S. statutory requirements."); 21 U.S.C. § 812(c) (10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the Drug Enforcement Agency and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

22. **Confidentiality of Alcohol and Drug Abuse Patient Records:** The regulations (42 CFR 2) are applicable to any information about alcohol and other drug abuse patients obtained by a "program" (42 CFR 2.11), if the program is federally assisted in any manner (42 CFR 2.12b). Accordingly, all project patient records are confidential and may be disclosed and used only in accordance with 42 CFR Part 2. The recipient and/or subrecipient is responsible for assuring compliance with these regulations and principles, including responsibility for assuring the security and confidentiality of all electronically transmitted patient material.

23. **Drug-Free Workplace:** The Subrecipient agrees to 1) provide a drug-free workplace for the Subrecipient's employees; 2) post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Subrecipient's workplace and specifying the actions that will be taken against employees for violations of such prohibition; 3) state in all solicitations or advertisements for employees placed by or on behalf of the Suprecipient that the Subrecipient maintains a drug-free workplace; and 4) include the provisions of the foregoing clauses in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

24. **Promotional Items:** Pursuant to 2 CFR 200.421 and 45 CFR 75.421, SAMHSA grant funds may not be used for Promotional Items. Promotional items include but are not limited to clothing and commemorative items such as pens, mugs/cups, folders/folios, lanyards, and conference bags. HHS Policy on the Use of Appropriated Funds for Promotional Items: https://www.hhs.gov/grants/contracts/contract-policies-regulations/spending-on-promotionalitems/index.html

25. **SAM and DUNS Requirements:** This award is subject to requirements as set forth in 2 CFR 25.310 Appendix A System of Award Management (SAM) and Data Universal Number System (DUNS) numbers. 2 CFR Part 25 - Appendix A4 SAM and Universal Identifier Requirements. This includes the following:
A. Requirement for SAM: Unless exempted from this requirement under 2 CFR 25.110, the

Subrecipient must maintain its information in SAM, until the end of the calendar year in which the grant(s) from which funding is received expire. The information must be reviewed and updated at least annually after the initial registration, and more frequently if required by changes in the information or the addition of another award term.

B. Requirement for Unique Entity Identifier (UEI) if you are authorized to make subawards under this award, you:
   1. Must notify potential Subrecipient that no governmental organization, foreign public entity, domestic or foreign nonprofit organization, or Federal agency serving as a subrecipient may receive a subaward unless the entity has provided its UEI; and
   2. May not make a subaward to a governmental organization, foreign public entity, domestic or foreign nonprofit organization, or Federal agency serving as a subrecipient, unless the entity has provided its UEI.

26. **Acknowledgement of Federal Funding in Communications and Contracting:** As required by HHS appropriations acts, all HHS recipients and Subrecipient must acknowledge Federal funding when issuing statements, press releases, requests for proposals, bid invitations, and other documents describing projects or programs funded in whole or in part with Federal funds. Recipients and Subrecipient are required to state: (1) the percentage and dollar amounts of the total program or project costs financed with Federal funds; and (2) the percentage and dollar amount of the total costs financed by nongovernmental sources.

27. **Acknowledgement of Federal Funding at Conferences and Meetings:** Allowable conference costs paid by the non-Federal entity as a sponsor or host of the conference may include rental of facilities, speakers' fees, costs of meals and refreshments, local transportation, and other items incidental to such conferences unless further restricted by the terms and conditions of the Federal award. As needed, the costs of identifying, but not providing, locally available dependent-care resources are allowable. Conference hosts/sponsors must exercise discretion and judgment in ensuring that conference costs are appropriate, necessary and managed in a manner that minimizes costs to the Federal award. The HHS awarding agency may authorize exceptions where appropriate for programs including Indian tribes, children, and the elderly. See also 45 CFR 75.438, 75.456, 75.474, and 75.475.

    When a conference is funded by a grant or cooperative agreement, the recipient and/or subrecipient must include the following statement on all conference materials (including promotional materials, agenda, and Internet sites):

    Funding for this conference was made possible (in part) by (insert grant or cooperative agreement award number) from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

    Conference materials and other publications must include language that conveys the following:
    a. The publication, event or conference was funded [in part or in whole] by SAMHSA Grant (Enter Grant Number from the appropriate federal NOA that was sent out to your CSB);
    b. The views expressed in written materials or by conference speakers and moderators do not necessarily reflect the official policies of the U.S. Department of Health and Human Services or the Executive Branch of the Commonwealth of Virginia;
    c. Mention of trade names, commercial practices or organizations does not imply endorsement by the U.S. Government or the Commonwealth of Virginia.

28. **Mandatory Disclosures:** Consistent with 2 CFR 200.113 and 45 CFR 75.113, the Subrecipient must disclose in a timely manner, in writing to the HHS Office of Inspector General (OIG), all information

related to violations, or suspected violations, of Federal criminal law involving fraud, bribery, waste, abuse, or gratuity violations potentially affecting the Federal award. Subrecipient must disclose, in a timely manner, in writing to the prime recipient (pass through entity) and the HHS OIG, all information related to violations, or suspected violations, of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Disclosures must be sent in writing to the awarding agency and to the HHS OIG at the following addresses:

U.S. Department of Health and Human Services
Office of Inspector General ATTN: Mandatory Grant Disclosures, Intake Coordinator
330 Independence Avenue, SW, Cohen Building Room 5527
Washington, DC 20201
Fax: (202) 205-0604
(Include "Mandatory Grant Disclosures" in subject line) or email:
MandatoryGranteeDisclosures@oig.hhs.gov

Failure to make required disclosures can result in any of the remedies described in 45 CFR 75.371 remedies for noncompliance, including suspension or debarment (see 2 CFR parts 180 & 376 and 31U.S.C. 3321).

The Subrecipient will notify DBHDS when violations are reported to HHS Office of Inspector General within three business days.

29. **Lobbying Restrictions:** Pursuant to 2 CFR 200.450 and 45 CFR 75.450, no portion of these funds may be used to engage in activities that are intended to support or defeat the enactment of legislation before the Congress or Virginia General Assembly, or any local legislative body, or to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any federal, state or local government, except in presentation to the executive branch of any State or local government itself. No portion of these funds can be used to support any personnel engaged in these activities. These prohibitions include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

30. **Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(G)), amended by 2 C.F.R. Part 175:** The Trafficking Victims Protection Act of 2000 authorizes termination of financial assistance provided to a private entity, without penalty to the Federal government, if the recipient or subrecipient engages in certain activities related to trafficking in persons. SAMHSA may unilaterally terminate this award, without penalty, if a private entity recipient, or a private entity subrecipient, or their employees:
    a) Engage in severe forms of trafficking in persons during the period of time that the award is in effect;
    b) Procure a commercial sex act during the period of time that the award is in effect; or,
    c) Use forced labor in the performance of the award or subawards under the award. The text of the full award term is available at 2 C.F.R. 175.15(b). See http://www.gpo.gov/fdsys/pkg/CFR-2012-title2-vol1/pdf/CFR-2012-title2-vol1-sec175-15.pdf

31. **Accessibility Provisions:** Recipients and Subrecipient of Federal Financial Assistance (FFA) from HHS must administer their programs in compliance with Federal civil rights law. This means that recipients and Subrecipient of HHS funds must ensure equal access to their programs without regard to a person's race, color, national origin, disability, age, and in some circumstances, sex and religion. This includes ensuring your programs are accessible to persons with limited English proficiency.

    The HHS Office for Civil Rights also provides guidance on complying with civil rights laws enforced by HHS. Please see: http://www.hhs.gov/ocr/civilrights/understanding/section1557/index.html

Recipients and Subrecipient of FFA also have specific legal obligations for serving qualified individuals with disabilities. Please see-
http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html
Please contact the HHS Office for Civil Rights for more information about obligations and prohibitions under Federal civil rights laws at https://www.hhs.gov/civil- rights/index.html or call 1-800-368-1019 or TDD 1-800- 537-7697.

Also note that it is an HHS Departmental goal to ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations. For further guidance on providing culturally and linguistically appropriate services, recipients and Subrecipient should review the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care at https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=6.

32. **Executive Order 13410: Promoting Quality and Efficient Health Care:** This Executive Order promotes efficient delivery of quality health care through the use of health information technology, transparency regarding health care quality and price, and incentives to promote the widespread adoption of health information technology and quality of care. Accordingly, all recipients and Subrecipient that electronically exchange patient level health information to external entities where national standards exist must:

    a) Use recognized health information interoperability standards at the time of any HIT system update, acquisition, or implementation, in all relevant information technology systems supported, in whole or in part, through their federally funded agreement/contract with DBHDS. Please consult www.healthit.gov for more information, and
    b) Use Electronic Health Record systems (EHRs) that are certified by agencies authorized by the Office of the National Coordinator for Health Information Technology (ONC), or that will be certified during the life of the grant. For additional information contact: Jim Kretz, at 240-276-1755 or Jim.Kretz@samhsa.hhs.gov.

33. **Travel:** Funds used to attend meetings, conferences or implement the activities of this grant must not exceed the lodging rates and per diem for Federal travel and Meal/Incidental expenses provided by the General Services Administration. These rates vary by jurisdiction.

34. **English Language:** All communication between the Pass-Through Agency and the Subrecipient must be in the English language and must utilize the terms of U.S. dollars. Information may be translated into other languages. Where there is inconsistency in meaning between the English language and other languages, the English language meaning shall prevail.

35. **Intangible Property Rights:** Pursuant to 2 CFR 200.315 and 45 CFR 75.322:
    A. Title to intangible property (as defined in the Definitions Section of this Exhibit) acquired under a Federal award vests upon acquisition in the non-Federal entity. The non-Federal entity must use that property for the originally authorized purpose, and must not encumber the property without approval of the Federal awarding agency (SAMHSA). When no longer needed for the originally authorized purpose, disposition of the intangible property must occur in accordance with the provisions in 2 CFR 200.313(e) and 45 CFR 75.320(e).
    B. The non-Federal entity may copyright any work that is subject to copyright and was developed, or for which ownership was acquired, under a Federal award. The awarding agency reserves a royalty-free, nonexclusive and irrevocable right to reproduce, publish, or otherwise use the work for Federal purposes and to authorize others to do so.
    C. The non-Federal entity is subject to applicable regulations governing patents and inventions, including government-wide regulations issued by the Department of Commerce at 37 CFR Part 401.

D. The Federal Government has the right to: 1) Obtain, reproduce, publish, or otherwise use the data produced under a Federal Award; and 2) Authorize others to receive, reproduce, publish, or otherwise use such data for Federal purposes.

E. Freedom of Information Act:

1) In response to a Freedom of Information Act (FOIA) request for research data relating to published research findings produced under a Federal award that were used by the Federal Government in developing an agency action that has the force and effect of law, the HHS awarding agency must request, and the non-Federal entity must provide, within a reasonable time, the research data so that they can be made available to the public through the procedures established under the FOIA. If the HHS awarding agency obtains the research data solely in response to a FOIA request, the HHS awarding agency may charge the requester a reasonable fee equaling the full incremental cost of obtaining the research data. This fee should reflect costs incurred by the Federal agency and the non-Federal entity. This fee is in addition to any fees the HHS awarding agency may assess under the FOIA (5 U.S.C. 552(a)(4)(A)).

2) Published research findings means when:

(i) Research findings are published in a peer-reviewed scientific or technical journal; or

(ii) A Federal agency publicly and officially cites the research findings in support of an agency action that has the force and effect of law. "Used by the Federal Government in developing an agency action that has the force and effect of law" is defined as when an agency publicly and officially cites the research findings in support of an agency action that has the force and effect of law.

3) Research data means the recorded factual material commonly accepted in the scientific community as necessary to validate research findings, but not any of the following: Preliminary analyses, drafts of scientific papers, plans for future research, peer reviews, or communications with colleagues. This "recorded" material excludes physical objects (e.g., laboratory samples). Research data also do not include:

(i) Trade secrets, commercial information, materials necessary to be held confidential by a researcher until they are published, or similar information which is protected under law; and

(ii) Personnel and medical information and similar information the disclosure of which would constitute a clearly unwarranted invasion of personal privacy, such as information that could be used to identify a particular person in a research study.

F. The requirements set forth in paragraph (E)(1) of this part do not apply to commercial organizations.

The Pass-Through Agency reserves the irrevocable right to utilize any Intangible Property described above, royalty-free, for the completion of the terms of this Grant and any associated agreement.

36. **National Historical Preservation Act and Executive Order 13287, Preserve America:** The Subrecipient must comply with this federal legislation and executive order.

37. **Welfare-to-Work:** The Subrecipient is encouraged to hire welfare recipients and to provide additional needed training and mentoring as needed.

38. **Applicable Laws and Courts:** Awards of federal funds from DBHDS shall be governed in all respects by the laws of the Commonwealth of Virginia and any litigation with respect thereto shall be brought in the courts of the Commonwealth. The Subrecipient shall comply with all applicable federal, state and local laws, rules and regulations.

39. **Immigration Reform and Control Act of 1986:** The Subrecipient certifies that the Subrecipient does not, and shall not knowingly employ an unauthorized alien as defined in the federal Immigration Reform and Control Act of 1986.

40. **Construction Purchases:** SAMHSA grant funds may not be used for the purchase or construction of any building or structure to house any part of the program (Applicants may request up to $5,000 for renovations and alterations of existing facilities, if necessary and appropriate to the project).

41. **Residential or Outpatient Treatment:** SAMHSA grant funds may not be used to provide residential or outpatient treatment services when the facility has not yet been acquired, sited, approved, and met all requirements for human habitation and services provision. (Expansion or enhancement of existing residential services is permissible).

42. **Inpatient Services:** SAMHSA grant funds may not be used to provide inpatient treatment or hospital-based detoxification services. Residential services are not considered to be inpatient or hospital-based services.

43. **Direct Payments to Individuals:** SAMHSA grant funds may not be used to make direct payments to individuals to enter treatment or continue to participate in prevention or treatment services. Note: A recipient or treatment or prevention provider may provide up to $30 in non-cash incentives to individuals to participate in required data collection follow-up and other treatment or prevention services.

44. **Meals:** Meals are allowable so long as they are part of conferences or allowable non-local travel and do not exceed the per diem reimbursement rate allowed for the jurisdiction by the General Services Administration. Grant funds may be used for light snacks, not to exceed $3.00 per person per day.

45. **Sterile Needles or Syringes:** Funds may not be used to provide sterile needles or syringes for the hypodermic injection of any illegal drug. Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with state and local law.

46. **Compliance with Federal Regulations/Statute/Policy:** The Subrecipient agrees to enforce, administer, and comply with any applicable federal regulations, statutes, or policies that are not otherwise mentioned including 2 C.F.R. § 200, 45 C.F.R. § 75, the Health and Human Services Grants Policy Statement, or any other source.

B. Treasury Grants

1. Grant Oversight: The CSBs and the Department are legally and financially responsible for all aspects of this award including funds provided to sub-recipients, in accordance with 2 CFR 200.331 - 200.333, Sub-recipient monitoring and management.

2. Acceptance of the Terms of an Award: By drawing or otherwise obtaining funds, the Subrecipient acknowledges acceptance of the terms and conditions of the award and is obligated to perform in accordance with the requirements of the award. If the Subrecipient cannot accept the terms, the Subrecipient should notify the Program contact at DBHDS prior to the agreement. Once the

agreement is signed by the Subrecipient, the contents are binding on the Subrecipient unless and until modified by a revised agreement signed by DBHDS.

3. Certification Statement: By invoicing DBHDS for funds, the Subrecipient certifies that proper financial management controls and accounting systems, to include personnel policies and procedures, have been established to adequately administer Federal awards and drawdown funds. Recipients of Coronavirus State and Local Recovery Funds, and their subrecipients, must comply with all terms and conditions of their awards, including: (a) requirements of the authorizing statutes and implementing regulations for the program under which the award is funded; (b) applicable requirements or limitations in appropriations acts; and (c) any requirements specific to the particular award specified in program policy and guidance.

4. Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards: The agreement issued is subject to the administrative requirements, cost principles, and audit requirements that govern Federal monies associated with this award, as applicable, in the Uniform Guidance 2 CFR Part 200.

5. Award Expectations: The eligibility and program requirements originally outlined in the Federal Guidance issued as a result of the American Rescue Plan Act 2021 must continue to be adhered to as the funded project is implemented. Recipients must comply with the performance goals, milestones, outcomes, and performance data collection as determined by DBHDS. Additional terms and/or conditions may be applied to this award if outstanding financial or programmatic compliance issues are identified by or amended guidance is provided by the US Department of Treasury and/or Commonwealth of Virginia Department of Planning & Budget. Subrecipients must comply with the Scope of Services of this agreement as outlined in the Performance Contract.

6. Flow down of requirements to sub-recipients: The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients, in accordance with 2 CFR 200.331-332 - Subrecipient monitoring and management.

7. Risk Assessment: The responsible federal agency may perform an administrative review of the Subrecipient organization's financial management system. If the review discloses material weaknesses or other financial management concerns, grant funding may be restricted in accordance with 2 CFR 200.206, as applicable. DBHDS reviews and determines the risk associated with its subrecipients. As part of the risk assessment process, DBHDS may perform an administrative review of the Subrecipient's financial management system.

8. Improper Payments: Any expenditure by the Subrecipient under the terms of this Agreement which is found by auditors, investigators, and other authorized representatives of DBHDS, the Commonwealth of Virginia, the U.S. Government Accountability Office or the Comptroller General of the United States, or any other federal agency to be improper, unallowable, in violation of federal or state law or the terms of the this Agreement, or involving any fraudulent, deceptive, or misleading representations or activities of the Subrecipient, shall become Subrecipient's liability, to be paid by Subrecipient from funds other than those provided by DBHDS under this Agreement or any other agreements between DBHDS and the Subrecipient. This provision shall survive the expiration or termination of this Agreement.

9. Limitations on Expenditures: Subrecipient shall not be reimbursed or otherwise compensated for any expenditures incurred or services provided prior to the Effective Date of this agreement, or following the end of the Period of Performance. DBHDS shall only reimburse or otherwise compensate the Subrecipient for documented expenditures incurred during this period that are:

1) Reasonable and necessary to carry out the agreed upon Scope of Services in Section III and Attachment C of this Agreement,
2) Documented by contracts or other evidence of liability consistent with established DBHDS and Subrecipient procedures; and
3) Incurred in accordance with all applicable requirements for the expenditure of funds payable under this agreement.

10. Treatment of Property and Equipment: If the Program permits the Subrecipient or entities that receive funding from the Subrecipient to purchase real property or equipment with grant funds, the Program retains a residual financial interest, enabling the Program to recover the assets or determine final disposition. This will be accomplished on a case-by-case basis, according to the federal guidelines in accordance with 2 CFR 200.313.

11. Program Income: Program income accrued under this grant award must be reported to the Recipient and must be used to further the objectives of the grant project and only for allowable costs.

12. Financial Management: The Subrecipient shall maintain a financial management system and financial records and shall administer funds received pursuant to this agreement in accordance with all applicable federal and state requirements, including without limitation:
    a) the Uniform Guidance, 2 C.F.R. Part 200;
    b) State and Local Fiscal Recovery Funds – Compliance and Reporting Guidance Ver 1.1 dated June 24, 2021
    c) The Subrecipient shall adopt such additional financial management procedures as may from time to time be prescribed by DBHDS if required by applicable laws, regulations or guidelines from its federal and state government funding sources. Subrecipient shall maintain detailed, itemized documentation and records of all income received and expenses incurred pursuant to this Agreement.

13. Audit of Financial Records: The Subrecipient shall comply with the audit and reporting requirements defined by the Federal Office of Management and Budget (OMB) 2 CFR 200 (Audits of States, Local, Governments and Non-Profit organizations) as applicable. The Subrecipient will, if total Federal funds expended are $750,000 or more a year, have a single or program specific financial statement audit conducted for the annual period in compliance with the General Accounting Office audit standards (2 CFR 200 Subpart F – Audit Requirements).

    If total federal funds expended are less than $750,000 for a year the Subrecipient is exempt from federal audit requirements (45 CFR 75-501(d)), but the Subrecipient's records must be available to the Pass-Through Agency and appropriate officials of HHS, SAMHSA, the U.S. Government Accountability Office and the Comptroller General of the United States, and it must still have a financial audit performed for that year by an independent Certified Public Accountant. Further, the subrecipient shall complete the certification letter included in Exhibit F (B) disclosing that they are not subject to the single audit requirement.

    Should an audit by authorized state or federal official result in disallowance of amounts previously paid to the Subrecipient, the Subrecipient shall reimburse the Pass-Through Agency upon demand.

    Pursuant to 2 CFR 200.334 and 45 CFR 75.361, the Subrecipient shall retain all books, records, and other relevant documents for three (3) years from the end of the calendar year in which the grant period terminates. In the event that any litigation, claim, or audit is initiated prior to the expiration of the 3-year period, all records must be retained until all litigation, claims, or audit findings involving the records have been resolved and final action taken. DBHDS, its authorized

agents, and/or federal or state auditors shall have full access to and the right to examine any of said materials during said period.

14. Accounting Records and Disclosures: The Subrecipient must maintain records which adequately identify the source and application of funds provided for financially assisted activities, including awards and authorizations, obligations, unobligated balances, assets, liabilities, outlays or expenditures, and income. The Subrecipient should expect that the Primary Recipient or responsible federal agency may conduct a financial compliance audit and on-site program review of this project as outlined in paragraph (11).

15. Standards for Documentation of Personnel Expenses: The Subrecipient shall comply with 2 CFR 200.430 Compensation-Personal Services and 2 CFR 200.431 Compensation-Fringe Benefits as required by the Federal Office of Management and Budget (OMB) Circular 2 CFR 200 (Cost Principles for State, Local and Indian Tribal Government). Per Standards for Documentation of Personnel Expenses 2 CFR 200.430(i) in accordance with Department of Labor regulations implementing the Fair Labor Standards Act (FLSA) (29 CFR Part 516), charges for the salaries and wages of nonexempt employees, in addition to the supporting documentation described in this section (2 CFR 200.430(i)(3)), must also be supported by records

16. Non-Supplant: Federal award funds must supplement, not replace (supplant) nonfederal funds. Applicants or award recipients and subrecipients may be required to demonstrate and document that a reduction in non-federal resources occurred for reasons other than the receipt of expected receipt of federal funds.

17. Unallowable Costs: All costs incurred prior to the award issue date and costs not consistent with the allowable activities under the guidance for the Coronavirus State and Local Fiscal Recovery Funds, 31 CFR 35, and 2 CFR 200 Subpart E – Cost Principles, are not allowable under this award.

18. Executive Pay: The Consolidated Appropriations Act, 2021 (Public Law 116-260), signed into law on December 27, 2020 restricts the amount of direct salary to Executive Level II of the Federal Executive Pay scale. Effective January 2, 2022, the salary limitation for Executive Level II is $203,700.

19. Intent to Utilize Funding to Enter into a Procurement/Contractual Relationship:
If the Subrecipient utilizes any of these funds to contract for any goods or services, the Subrecipient must ensure that the resultant contract complies with the terms of Appendix II, 2 CFR 200 which governs the contractual provisions for non-federal entity contracts under federal awards issued by the US Department of Treasury.

20. Ad Hoc Submissions: Throughout the project period, the responsible federal agency or DBHDS may determine that a grant or Subrecipient Funding Agreement requires submission of additional information beyond the standard deliverables. This information may include, but is not limited to the following:
    - Payroll
    - Purchase Orders
    - Contract documentation
    - Proof of Project implementation

21. Conflicts of Interest Policy: Subrecipients must establish written policies and procedures to prevent employees, consultants, and others (including family, business, or other ties) involved in grant-supported activities, from involvement in actual or perceived conflicts of interest. The

policies and procedures must:
• Address conditions under which outside activities, relationships, or financial interest are proper or improper;
• Provide for advance disclosure of outside activities, relationships, or financial interest to a responsible organizational official;
• Include a process for notification and review by the responsible official of potential or actual violations of the standards; and
• Specify the nature of penalties that may be imposed for violations.

22. Administrative and National Policy Requirements: Public policy requirements are requirements with a broader national purpose than that of the Federal sponsoring program or award that an applicant/recipient/subrecipient must adhere to as a prerequisite to and/or condition of an award. Public policy requirements are established by statute, regulation, or Executive order. In some cases they relate to general activities, such as preservation of the environment, while, in other cases they are integral to the purposes of the award-supported activities. An application funded with the release of federal funds through a grant award does not constitute or imply compliance with federal statute and regulations. Funded organizations are responsible for ensuring that their activities comply with all applicable federal regulations.

23. Marijuana Restriction: Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 2 C.F.R. 200.300(a) (requiring HHS to "ensure that Federal funding is expended in full accordance with U.S. statutory requirements."); 21 U.S.C. § 812(c) (10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the Drug Enforcement Agency and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

24. Confidentiality of Alcohol and Drug Abuse Patient Record: The regulations (42 CFR 2) are applicable to any information about alcohol and other drug abuse patients obtained by a "program" (42 CFR 2.11), if the program is federally assisted in any manner (42 CFR 2.12(b)). Accordingly, all project patient records are confidential and may be disclosed and used only in accordance with 42 CFR Part 2. The recipient and/or subrecipient is responsible for assuring compliance with these regulations and principles, including responsibility for assuring the security and confidentiality of all electronically transmitted patient material.

25. Drug-Free Workplace: During the performance of this agreement, the Subrecipient agrees to 1) provide a drug-free workplace for the Subrecipient's employees; 2) post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Subrecipient's workplace and specifying the actions that will be taken against employees for violations of such prohibition; 3) state in all solicitations or advertisements for employees placed by or on behalf of the Suprecipient that the Subrecipient maintains a drug-free workplace; and 4) include the provisions of the foregoing clauses in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

26. Promotional Items: Pursuant to 2 CFR 200.421(e), Federal funding awarded under Coronavirus State and Local Recovery Funds may not be used for Promotional Items. Promotional items

include but are not limited to clothing and commemorative items such as pens, mugs/cups, folders/folios, lanyards, and conference bags.

27. SAM and DUNS Requirements: This award is subject to requirements as set forth in 2 CFR 25 - Universal Identifier And System For Award Management. This includes the following:

    A. Requirement for SAM: Unless exempted from this requirement under 2 CFR 25.110, the Subrecipient must maintain its information in SAM, until the final financial report required under this agreement or receive the final payment, whichever is later. The information must be reviewed and updated at least annually after the initial registration, and more frequently if required by changes in the information or the addition of another award term.

    B. Requirement for Unique Entity Identifier (UEI) if you are authorized to make subawards under this award, you: Must notify potential subrecipients that no governmental organization, foreign public entity, domestic or foreign nonprofit organization, or Federal agency serving as a subrecipient may receive a subaward unless the entity has provided its unique entity identifier; and

28. May not make a subaward to a governmental organization, foreign public entity, domestic or foreign nonprofit organization, or Federal agency serving as a subrecipient, unless the entity has provided its unique entity identifier.

29. Mandatory Disclosures: Consistent with 2 CFR 200.113, the Subrecipient must disclose in a timely manner, in writing to the US Department of Treasury and the primary recipient, all information related to violations, or suspected violations, of Federal criminal law involving fraud, bribery, waste, abuse, or gratuity violations potentially affecting the Federal award. Subrecipients must disclose, in a timely manner, in writing to the prime recipient (pass through entity) and the US Department of Treasury, all information related to violations, or suspected violations, of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award.

    Failure to make required disclosures can result in any of the remedies described in 45 CFR 200.339 -Remedies for Noncompliance, including suspension or debarment (see 2 CFR parts 180 & 376 and 31 U.S.C. 3321). The Subrecipient will notify DBHDS when violations are reported to the federal government within three business days.

30. Lobbying Restrictions: Pursuant to 2 CFR 200.450, no portion of these funds may be used to engage in activities that are intended to support or defeat the enactment of legislation before the Congress or Virginia General Assembly, or any local legislative body, or to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any federal, state or local government, except in presentation to the executive branch of any State or local government itself. No portion of these funds can be used to support any personnel engaged in these activities. These prohibitions include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

31. Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(G)) amended by 2 C.F.R. Part 175: The Trafficking Victims Protection Act of 2000 authorizes termination of financial assistance provided to a private entity, without penalty to the Federal government, if the recipient or subrecipient engages in certain activities related to trafficking in persons. SAMHSA may unilaterally terminate this award, without penalty, if a private entity recipient, or a private entity subrecipient, or their employees:
    a) Engage in severe forms of trafficking in persons during the period of time that the award is

in effect;
b) Procure a commercial sex act during the period of time that the award is in effect; or,
c) Use forced labor in the performance of the award or subawards under the award.
d) The text of the full award term is available at 2 C.F.R. 175.15(b).

32. Accessibility Provisions: Recipients and subrecipients of Federal Financial Assistance (FFA) from the Coronavirus State and Local Recovery Fund are required to administer their programs in compliance with Federal civil rights law implemented by US Department of Treasury as codified in 31 CFR part 22 and 31 CFR part 23.

    These requirements include ensuring that entities receiving Federal financial assistance from the Treasury do not deny benefits or services, or otherwise discriminate on the basis of race, color, national origin (including limited English proficiency), disability, age, or sex (including sexual orientation and gender identity), in accordance with the following authorities: Title VI of the Civil Rights Act of 1964 (Title VI) Public Law 88-352, 42 U.S.C. 2000d-1 et seq., and the Department's implementing regulations, 31 CFR part 22; Section 504 of the Rehabilitation Act of 1973 (Section 504), Public Law 93-112, as amended by Public Law 93-516, 29 U.S.C. 794; Title IX of the Education Amendments of 1972 (Title IX), 20 U.S.C. 1681 et seq., and the Department's implementing regulations, 31 CFR part 28; Age Discrimination Act of 1975, Public Law 94-135, 42 U.S.C. 6101 et seq., and the Department implementing regulations at 31 CFR part 23.

33. Executive Order 13410: Promoting Quality and Efficient Health Care: This Executive Order promotes efficient delivery of quality health care through the use of health information technology, transparency regarding health care quality and price, and incentives to promote the widespread adoption of health information technology and quality of care. Accordingly, all recipients and subrecipients that electronically exchange patient level health information to external entities where national standards exist must:
    a) Use recognized health information interoperability standards at the time of any HIT system update, acquisition, or implementation, in all relevant information technology systems supported, in whole or in part, through this agreement/contract. Please consult www.healthit.gov for more information, and
    b) Use Electronic Health Record systems (EHRs) that are certified by agencies authorized by the Office of the National Coordinator for Health Information Technology (ONC), or that will be certified during the life of the grant. For additional information contact: Jim Kretz, at 240-276-1755 or Jim.Kretz@samhsa.hhs.gov.

34. Travel: Funds used to attend meetings, conferences or implement the activities of this grant must not exceed the lodging rates and per diem for Federal travel and Meal/Incidental expenses provided by the General Services Administration. These rates vary by jurisdiction.

35. English Language: All communication between the Pass-Through Agency and the Subrecipient must be in the English language and must utilize the terms of U.S. dollars. Information may be translated into other languages. Where there is inconsistency in meaning between the English language and other languages, the English language meaning shall prevail.

36. Intangible Property Rights Pursuant to 2 CFR 200.315:
    A. Title to intangible property (as defined in the Definitions Section of this Agreement) acquired under a Federal award vests upon acquisition in the non-Federal entity. The non-Federal entity must use that property for the originally authorized purpose, and must not encumber the property without approval of the Federal awarding agency (SAMHSA). When no longer needed for the originally authorized purpose, disposition of the intangible property must occur in accordance with the provisions in 2 CFR 200.313(e).
    B. The non-Federal entity may copyright any work that is subject to copyright and was developed,

or for which ownership was acquired, under a Federal award. The awarding agency reserves a royalty-free, nonexclusive and irrevocable right to reproduce, publish, or otherwise use the work for Federal purposes and to authorize others to do so.
C. The non-Federal entity is subject to applicable regulations governing patents and inventions, including government-wide regulations issued by the Department of Commerce at 37 CFR Part 401.
D. The Federal Government has the right to: 1) Obtain, reproduce, publish, or otherwise use the data produced under a Federal Award; and 2) Authorize others to receive, reproduce, publish, or otherwise use such data for Federal purposes.

37. Freedom of Information Act:
1) In response to a Freedom of Information Act (FOIA) request for research data relating to published research findings produced under a Federal award that were used by the Federal Government in developing an agency action that has the force and effect of law, the HHS awarding agency must request, and the non-Federal entity must provide, within a reasonable time, the research data so that they can be made available to the public through the procedures established under the FOIA. If the HHS awarding agency obtains the research data solely in response to a FOIA request, the HHS awarding agency may charge the requester a reasonable fee equaling the full incremental cost of obtaining the research data. This fee should reflect costs incurred by the Federal agency and the non-Federal entity. This fee is in addition to any fees the HHS awarding agency may assess under the FOIA (5 U.S.C. 552(a)(4)(A)).

2) Published research findings means when: (i) Research findings are published in a peer-reviewed scientific or technical journal; or(ii) A Federal agency publicly and officially cites the research findings in support of an agency action that has the force and effect of law. “Used by the Federal Government in developing an agency action that has the force and effect of law” is defined as when an agency publicly and officially cites the research findings in support of an agency action that has the force and effect of law.

3) Research data means the recorded factual material commonly accepted in the scientific community as necessary to validate research findings, but not any of the following: Preliminary analyses, drafts of scientific papers, plans for future research, peer reviews, or communications with colleagues. This “recorded” material excludes physical objects (e.g., laboratory samples). Research data also do not include:(i) Trade secrets, commercial information, materials necessary to be held confidential by a researcher until they are published, or similar information which is protected under law; and(ii) Personnel and medical information and similar information the disclosure of which would constitute a clearly unwarranted invasion of personal privacy, such as information that could be used to identify a particular person in a research study.

38. The requirements set forth in paragraph (E)(1) of this part do not apply to commercial organizations. The Pass-Through Agency reserves the irrevocable right to utilize any Intangible Property described above, royalty-free, for the completion of the terms of this Grant and Agreement.

39. National Historical Preservation Act and Executive Order 13287, Preserve America: The Subrecipient must comply with this federal legislation and executive order.

40. Welfare-to-Work: The Subrecipient is encouraged to hire welfare recipients and to provide additional needed training and mentoring as needed.

41. Applicable Laws and Courts: This agreement shall be governed in all respects by the laws of the Commonwealth of Virginia and any litigation with respect thereto shall be brought in the courts of

the Commonwealth. The Subrecipient shall comply with all applicable federal, state and local laws, rules and regulations.

42. Immigration Reform and Control Act of 1986: By entering into a written agreement with the Commonwealth of Virginia, the Subrecipient certifies that the Subrecipient does not, and shall not during the performance of the agreement for goods and/or services in the Commonwealth, knowingly employ an unauthorized alien as defined in the federal Immigration Reform and Control Act of 1986.

43. Construction Purchases: Coronavirus State and Local Recovery Funds may not be used for the purchase or construction of any building or structure to house any part of the program (Applicants may request up to $5,000 for renovations and alterations of existing facilities, if necessary and appropriate to the project).

44. Meals: Meals are allowable so long as they are part of conferences or allowable non-local travel and do not exceed the per diem reimbursement rate allowed for the jurisdiction by the General Services Administration. Grant funds may be used for light snacks, not to exceed $3.00 per person per day.

45. Sterile Needles or Syringes: Funds may not be used to provide sterile needles or syringes for the hypodermic injection of any illegal drug. Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with state and local law.

46. Compliance with Federal Regulations/Statute/Policy: The Subrecipient agrees to enforce, administer, and comply with any applicable federal regulations, statutes, or policies that are not otherwise mentioned in this agreement including 2 C.F.R. § 200, or any other source.

V. Federal Grant Specific Requirements

There are additional requirements to the grants included in Section IV of this Exhibit that are not universal to all grants that DBHDS administers. Included below, by grant name, is a list of the grant specific requirements as required by federal statute, regulation, and policy.

A. SAMHSA GRANTS

1. State Opioid Response Grant (SUD Federal Opioid Response)

Pursuant to the Notice of Award received by DBHDS and the Funding Opportunity Announcement (TI-20-012) associated with the State Opioid Response Grant, the following are requirements of the funding distributed to the Subrecipient from this grant.

a. Restrictions on Expenditures: State Opioid Response Grant funds may not be used to:

i. Pay for services that can be supported through other accessible sources of funding such as other federal discretionary and formula grant funds, e.g. HHS (CDC, CMS, HRSA, and SAMHSA), DOJ (OJP/BJA) and non-federal funds, 3rd party insurance, and sliding scale self-pay among others.

ii. Pay for a grant or subaward to any agency which would deny any eligible client, patient, or individual access to their program because of their use of Food and Drug Administration (FDA)-approved medications for the treatment of substance use disorders.

iii. Provide incentives to any health care professional for receipt of data waiver or any type of professional training development.

iv. Procure DATA waiver training. This training is offered free of charge by SAMHSA at pcssnow.org.

b. Expenditure Guidelines:

i. Grant funds:
   a) Shall be used to fund services and practices that have a demonstrated evidence-base, and that are appropriate for the population(s) of focus.
   b) For treatment and recovery support services grant funds shall only be utilized to provide services to individuals with a diagnosis of an opioid use disorder or to individuals with a demonstrated history of opioid overdose problems.
   c) May only fund FDA approved products.
   d) May only be used for HIV and viral hepatitis testing that is performed as clinically indicated and referral to appropriate treatment must be provided to those testing positive. Vaccination for hepatitis A and B should be provided or referral made for same as clinically indicated.

c. Limitations on Reimbursements: Subrecipient shall not be reimbursed or otherwise compensated for any expenditures incurred or services provided prior to or more than 40 days after the appropriate Award Period included in section IV.

DBHDS shall only reimburse or otherwise compensate the Subrecipient for documented expenditures incurred during this period that are: 1) reasonable and necessary to carry out the agreed upon scope of service outlined in Exhibit D, Exhibit G, or Notice of Award 2) documented by contracts or other evidence of liability consistent with established DBHDS and Subrecipient procedures; and 3) incurred in accordance with all applicable requirements for the expenditure of funds payable under any associated agreement.

d. Closeout: Final payment request(s) must be received by DBHDS no later than thirty (30) days after the end of the Period of Performance referenced in the Exhibit D, Exhibit G, or Notice of Award. No payment request will be accepted by DBHDS after this date without authorization from DBHDS. The Subrecipient may continue to expend retained funds until 40 days after the end of the Period of Performance to pay for unliquidated obligations.

Any funds remaining unexpended and unobligated at the end of the Period of Performance shall be returned to DBHDS within 30 days of the end of the Period of Performance. Any funds distributed to the Subrecipient by the pass-through entity that remain unexpended by 40 days after the end of the Period of Performance shall be returned to DBHDS. The Subrecipient will send these funds to DBHDS by no later than the end of the 75th day after the end of the Performance Period. Unexpended funds should be returned in the form of a check made payable to the Treasurer of Virginia and sent to:

DBHDS
PO Box 1797
Richmond, VA 23218-1797
C/O Eric Billings

Funds for this grant may also be returned via an electronic ACH payment to DBHDS' Truist Bank account. The account information and DBHDS' EIN is as follows:

Account Number: 201141795720002
Routing Number: 061000104
EIN: 546001731

Name and Address of Bank:
Truist Bank
214 North Tryon Street
Charlotte, NC 28202

If the ACH method is utilized, the Subrecipient shall provide email notification of their intention to provide payment electronically to:

Eric.Billings@dbhds.virginia.gov
Ramona.Howell@dbhds.virginia.gov
Dillon.Gannon@dbhds.virginia.gov
Christine.Kemp@dbhds.virginia.gov
Kim.Barton@dbhds.virginia.gov

Failure to return unexpended funds in a prompt manner may result in a denial of future federal Subrecipient awards from DBHDS.

The Subrecipient agrees that acceptance of final payment from DBHDS will constitute an agreement by the Subrecipient to release and forever discharge DBHDS, its agents, employees, representatives, affiliates, successors and assigns from any and all claims, demands, damages, liabilities, actions, causes of action or suits of any nature whatsoever, which Subrecipient has at the time of acceptance of final payment or may thereafter have, arising out of or in any way relating to any and all injuries and damages of any kind as a result of or in any way relating to a program funded by this grant. Subrecipient's obligations to DBHDS under this Exhibit shall not terminate until all closeout requirements are completed to the satisfaction of DBHDS. Such requirements shall include, without limitation, submitting final reports to DBHDS and providing any closeout-related information requested by DBHDS by the deadlines specified by DBHDS. This provision shall survive the expiration or termination of any associated agreement.

2. Substance Abuse Prevention and Treatment Block Grant (SUD FBG)

Pursuant to the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) Funding Agreement and relevant federal statutes, the following are requirements of the funding distributed to the Subrecipient.

a. **Restrictions on Expenditures:** No SAPTBG funds may not be used for any of the following purposes:
   i. To provide inpatient hospital services unless it has been determined, in accordance with the guidelines issued by the Secretary of Health and Human Services, that such treatment is a medical necessity for the individual involved and that the individual cannot be effectively treated in a community-based, non-hospital, residential program of treatment;
   ii. To make cash payments to intended recipients of health services;
   iii. To purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling with DBHDS, Federal Grants Manager approval) any building or other facility, or purchase major medical equipment as defined in the Defined Terms section of this Exhibit.
   iv. To satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds; or
   v. To provide financial assistance to any entity other than a public or non-profit entity.
   vi. To carry out any program that provides individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for acquired immune deficiency syndrome. (42 US Code § 300x-31(a))

b. **Grant Guidelines:**
   i. In the case of an individual for whom grant funds are expended to provide inpatient hospital services, as outlined above (A.a.), the Subrecipient shall not incur costs that are in excess of the

comparable daily rate provided for community-based, non-hospital, residential programs of treatment for substance abuse (42 US Code § 300x-31(b)(2)).

ii. No entity receiving SAPTBG funding may participate in any form of discrimination on the basis of age as defined under the Age Discrimination Act of 1975 (42 US Code § 6101), on the basis of handicap as defined under section 504 of the Rehabilitation Act of 1973 (29 US Code § 794), on the basis of sex as defined under Title IX of the Education Amendments of 1972 (20 US Code § 1681) or on the basis of race, color, or national origin as defined under Title VI of the Civil Rights Act of 1964 (42 US Code § 2000) (42 US Code § 300x-57(a)(1)).

iii. No person shall on the ground of sex, or on the ground of religion, be excluded from participation in, be denied the benefits of, or be subject to discrimination under, any program or activity funded in whole or in part with funds made available under section 300x or 300x-21 of title 42 US Code (42 US Code § 300x-57(a)(2)).

iv. The Subrecipient agrees to comply with the provisions of the Hatch Act (5 US Code § 1501-1508 and 7324-7328) which limits the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.

v. The Subrecipient will comply, as applicable with the provisions of the Davis-Bacon Act (40 US Code § 276(a) – 276(a)-7), the Copeland Act (40 US Code § 276(c) and 18 US Code § 874), and the Contract Work Hours and Safety Standards Act (40 US Code § 327-333), regarding labor standards for federally assisted construction subagreements.

vi. This funding source is designated to plan, implement, and evaluate activities that prevent or treat substance use disorder, including to fund priority substance use disorder treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time. Further these funds can be utilized to fund those priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery that are not covered by Medicaid, Medicare, or private insurance, fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment, and collecting performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services. To the extent possible, other funding sources must be utilized first except where prohibited by law or regulation. Substance Abuse Block Grant funding must, however, be the payor of last resort when providing treatment services to pregnant women, women with children, children, and individuals with Tuberculosis or HIV pursuant to 45 CFR 96.124, 127, and 128.

vii. Target and priority populations are pregnant and parenting women and intravenous (IV) drug users. In providing treatment services to these target and priority populations, providers must offer treatment in order of population preference as outlined in 45 CFR 96.131 (a) which is as follows:
   a) Pregnant injecting drug users;
   b) Pregnant substance abusers;
   c) Injecting drug users;
   d) All others

viii. Allowable SAPTBG services include: Healthcare Home/Physical Health (General and specialized outpatient medical services, Acute Primary care, General Health Screens, Tests and Immunizations, Comprehensive Care Management, Care coordination and Health Promotion, Comprehensive Transitional Care, Individual and Family Support, Referral to Community Services), Prevention and Promotion (Including Promotion, such as Screening, Brief Intervention and Referral to Treatment, Brief Motivational Interviews, Screening and Brief Intervention for Tobacco Cessation, Parent Training, Facilitated Referrals, Relapse Prevention/Wellness Recovery Support, Warm Line); Engagement Services (including Assessment, Specialized Evaluations (Psychological and Neurological), Service Planning (including crisis planning), Consumer/Family Education, Outreach); Outpatient Services (including Individual evidenced based therapies, Group therapy, Family therapy, Multi-family therapy, Consultation to Caregivers); Medication Services (including Medication management, Pharmacotherapy including MAT; Laboratory services); Community Rehabilitative Support (including Parent/Caregiver Support, Skill building (social,

daily living, cognitive), Case management, Behavior management, Supported employment, Permanent supported housing, Recovery housing, Therapeutic mentoring, Traditional healing services); Recovery Supports (including Peer Support, Recovery Support Coaching, Recovery Support Center Services, Supports for Self Directed Care); and Other Habilitative Supports (including Respite; Supported Education; Transportation; Assisted living services; Recreational services; Trained behavioral health interpreters; Interactive communication technology devices); Intensive Support Services (including Substance abuse intensive outpatient; Partial hospital; Assertive Community Treatment; Intensive home based services; Multi-systemic therapy; Intensive Case Management); Out of Home Residential Services (including Crisis residential/stabilization, Clinically Managed 24 Hour Care (SA), Clinically Managed Medium Intensity Care (SA), Adult Substance Abuse Residential, Adult Mental Health Residential, Youth Substance Abuse Residential Services, Children's Residential Mental Health Services, Therapeutic foster care); and Acute Intensive Services (including Mobile crisis, Peer based crisis services, Urgent care, 23 hr. observation bed, Medically Monitored Intensive Inpatient (SA), 24/7 crisis hotline services).

c. **Limitations on Reimbursements**: Subrecipient shall not be reimbursed or otherwise compensated for any expenditures incurred or services provided prior to or more than 40 days after the appropriate Award Period included in its Exhibit D, Exhibit G, or Notice of Award.

   DBHDS shall only reimburse or otherwise compensate the Subrecipient for documented expenditures incurred during this period that are: 1) reasonable and necessary to carry out the agreed upon scope of service outlined in Exhibit D, Exhibit G, or Notice of Award, 2) documented by contracts or other evidence of liability consistent with established DBHDS and Subrecipient procedures; and 3) incurred in accordance with all applicable requirements for the expenditure of funds payable under any associated agreement.

d. **Closeout**: Final payment request(s) must be received by DBHDS no later than thirty (30) days after the end of the Period of Performance referenced in the Exhibit D, Exhibit G, or Notice of Award. No payment request will be accepted by DBHDS after this date without authorization from DBHDS. The Subrecipient may continue to expend retained funds until 40 days after the end of the Period of Performance to pay for unliquidated obligations.
   DBHDS
   PO Box 1797
   Richmond, VA 23218-1797
   C/O Eric Billings

   Funds for this grant may also be returned via an electronic ACH payment to DBHDS' Truist Bank account. The account information and DBHDS' EIN is as follows:

   Account Number: 201141795720002
   Routing Number: 061000104
   EIN: 546001731

   Name and Address of Bank:
   Truist Bank
   214 North Tryon Street
   Charlotte, NC 28202

   If the ACH method is utilized, the Subrecipient shall provide email notification of their intention to provide payment electronically to:

   Eric.Billings@dbhds.virginia.gov
   Ramona.Howell@dbhds.virginia.gov

Dillon.Gannon@dbhds.virginia.gov
Christine.Kemp@dbhds.virginia.gov
Kim.Barton@dbhds.virginia.gov

Failure to return unexpended funds in a prompt manner may result in a denial of future federal Subrecipient awards from DBHDS.

The Subrecipient agrees that acceptance of final payment from DBHDS will constitute an agreement by the Subrecipient to release and forever discharge DBHDS, its agents, employees, representatives, affiliates, successors and assigns from any and all claims, demands, damages, liabilities, actions, causes of action or suits of any nature whatsoever, which Subrecipient has at the time of acceptance of final payment or may thereafter have, arising out of or in any way relating to any and all injuries and damages of any kind as a result of or in any way relating to a program funded by this grant. Subrecipient's obligations to DBHDS under this Exhibit shall not terminate until all closeout requirements are completed to the satisfaction of DBHDS. Such requirements shall include, without limitation, submitting final reports to DBHDS and providing any closeout-related information requested by DBHDS by the deadlines specified by DBHDS. This provision shall survive the expiration or termination of any associated agreement.

3. **Community Mental Health Services Block Grant (MH FBG)**
Pursuant to the Community Mental Health Services Block Grant (CMHSBG) Funding Agreement and relevant federal statutes, the following are requirements of the funding distributed to the Subrecipient.
   a. **Restrictions on Expenditures:** CMHSBG funds may not be used for any of the following purposes:
      1. To provide inpatient services;
      2. To make cash payments to intended recipients of health services;
      3. To purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling with DBHDS, Federal Grants Manager approval) any building or other facility, or purchase major medical equipment (as defined in the Definitions section of this Exhibit);
      4. To satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds; or
      5. To provide financial assistance to any entity other than a public or non-profit entity. (42 US Code § 300x-5(a))

   b. **Grant Guidelines:**
      1. No entity receiving CMHSBG funding may participate in any form of discrimination on the basis of age as defined under the Age Discrimination Act of 1975 (42 US Code § 6101), on the basis of handicap as defined under section 504 of the Rehabilitation Act of 1973 (29 US Code § 794), on the basis of sex as defined under Title IX of the Education Amendments of 1972 (20 US Code § 1681) or on the basis of race, color, or national origin as defined under Title VI of the Civil Rights Act of 1964 (42 US Code § 2000) (42 US Code § 300x-57(a)(1)).
      2. No person shall on the ground of sex, or on the ground of religion, be excluded from participation in, be denied the benefits of, or be subject to discrimination under, any program or activity funded in whole or in part with funds made available under section 300x or 300x-21 of title 42 US Code (42 US Code § 300x-57(a)(2)).
      3. The Subrecipient must provide the services through appropriate, qualified community programs, which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs. Services may be provided through community mental health centers only if the centers provide: 1) Services principally to individuals residing in a defined geographic area (hereafter referred to as a "service area"); 2) Outpatient services, including specialized outpatient services for children with a Serious Emotional Disturbance (SED), the elderly, individuals with a Serious Mental Illness (SMI), and residents of the service areas of the center who have been discharged from inpatient treatment at a mental health

facility; 3) 24-hour-a-day emergency care services; 4) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services; 5) Screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; 6) Services within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay; and 7) Services that are accessible promptly, as appropriate, and in a manner which preserves human dignity and assures continuity of high quality care (42 US Code § 300x-2(c)).

4. The Subrecipient agrees to comply with the provisions of the Hatch Act (5 US Code § 1501-1508 and 7324-7328) which limits the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.
5. The Subrecipient will comply, as applicable with the provisions of the Davis-Bacon Act (40 US Code § 276(a) – 276(a)-7), the Copeland Act (40 US Code § 276(c) and 18 US Code § 874), and the Contract Work Hours and Safety Standards Act (40 US Code § 327-333), regarding labor standards for federally assisted construction subagreements.
6. Treatment and competency restoration services may be provided to individuals with a serious mental illness or serious emotional disturbance who are involved with the criminal justice system or during incarceration.
7. Medicaid and private insurance, if available, must be used first.

c. **Limitations on Reimbursements**: Subrecipient shall not be reimbursed or otherwise compensated for any expenditures incurred or services provided prior to or more than 40 days after the appropriate Award Period included in section IV.

DBHDS shall only reimburse or otherwise compensate the Subrecipient for documented expenditures incurred during this period that are: 1) reasonable and necessary to carry out the agreed upon scope of service outlined in Exhibit D, Exhibit G, or Notice of Award 2) documented by contracts or other evidence of liability consistent with established DBHDS and Subrecipient procedures; and 3) incurred in accordance with all applicable requirements for the expenditure of funds payable under any associated agreement.

d. **Closeout**: Final payment request(s) must be received by DBHDS no later than thirty (30) days after the end of the Period of Performance referenced in the Exhibit D, Exhibit G, or Notice of Award. No payment request will be accepted by DBHDS after this date without authorization from DBHDS. The Subrecipient may continue to expend retained funds until 40 days after the end of the Period of Performance to pay for unliquidated obligations.

Any funds remaining unexpended and unobligated at the end of the Period of Performance shall be returned to DBHDS within 30 days of the end of the Period of Performance. Any funds distributed to the Subrecipient by the pass-through entity that remain unexpended by 40 days after the end of the Period of Performance shall be returned to DBHDS. The Subrecipient will send these funds to DBHDS by no later than the end of the 75th day after the end of the Performance Period. Unexpended funds should be returned in the form of a check made payable to the Treasurer of Virginia and sent to:

DBHDS
PO Box 1797
Richmond, VA 23218-1797
C/O Eric Billings

Funds for this grant may also be returned via an electronic ACH payment to DBHDS' Truist Bank account. The account information and DBHDS' EIN is as follows:

Account Number: 201141795720002
Routing Number: 061000104
EIN: 546001731

Name and Address of Bank:
Truist Bank
214 North Tryon Street
Charlotte, NC 28202

If the ACH method is utilized, the Subrecipient shall provide email notification of their intention to provide payment electronically to:

Eric.Billings@dbhds.virginia.gov
Ramona.Howell@dbhds.virginia.gov
Dillon.Gannon@dbhds.virginia.gov
Christine.Kemp@dbhds.virginia.gov
Kim.Barton@dbhds.virginia.gov

Failure to return unexpended funds in a prompt manner may result in a denial of future federal Subrecipient awards from DBHDS.

The Subrecipient agrees that acceptance of final payment from DBHDS will constitute an agreement by the Subrecipient to release and forever discharge DBHDS, its agents, employees, representatives, affiliates, successors and assigns from any and all claims, demands, damages, liabilities, actions, causes of action or suits of any nature whatsoever, which Subrecipient has at the time of acceptance of final payment or may thereafter have, arising out of or in any way relating to any and all injuries and damages of any kind as a result of or in any way relating to a program funded by this grant. Subrecipient's obligations to DBHDS under this Exhibit shall not terminate until all closeout requirements are completed to the satisfaction of DBHDS. Such requirements shall include, without limitation, submitting final reports to DBHDS and providing any closeout-related information requested by DBHDS by the deadlines specified by DBHDS. This provision shall survive the expiration or termination of any associated agreement.

4. **Projects for Assistance in Transition from Homelessness (PATH)**
Pursuant to the Notice of Award received by DBHDS, Funding Opportunity Announcement (SM-20-F2), and relevant statutes associated with the Project for Assistance in Transition from Homelessness (PATH) Grant, the following are requirements of the funding distributed to the Subrecipient.

   a. **Restrictions on Expenditures:** PATH funds may not be used for any of the following purposes:
      1. To support emergency shelters or construction of housing facilities;
      2. For inpatient psychiatric treatment costs or inpatient substance use disorder treatment costs; or
      3. To make cash payments to intended recipients of mental health or substance use disorder services (42 U.S. Code § 290cc-22(g)).
      4. For lease arrangements in association with the proposed project utilizing PATH funds beyond the project period nor may the portion of the space leased with PATH funds be used for purposes not supported by the grant.

   b. **Grant Guidelines:**
      1. All funds shall be used for the purpose of providing the following:
         a) Outreach services;
         b) Screening and diagnostic treatment services;
         c) Habilitation and rehabilitation services;
         d) Community mental health services;

e) Alcohol or drug treatment services;
f) Staff training including the training of individuals who work in shelters, mental health clinics, substance use disorder programs, and other sites where homeless individuals require services;
g) Case management services including:
   i. Preparing a plan for the provision of community mental health services to the eligible homeless individual involved and reviewing such plan not less than once every three months;
   ii. Providing assistance in obtaining and coordinating social and maintenance services for the eligible homeless individuals, including services relating to daily living activities, personal financial planning, transportation services, and habilitation and rehabilitation services, prevocational and vocational services, and housing services;
   iii. Providing assistance to the eligible homeless individual in obtaining income support services, including housing assistance, supplemental nutrition assistance program benefits, and supplemental security income benefits;
   iv. Referring the eligible homeless individual for such other services as may be appropriate; and
   v. Providing representative payee services in accordance with section 1631(a)(2) of the Social Security Act (42 U.S. Code § 1383(a)(2)) if the eligible homeless individual is receiving aid under Title XVI of such act (42 U.S. Code § 1381 et seq.) and if the applicant is designated by the Secretary to provide such services;
   vi. Supportive and supervisory services in residential settings;
   vii. Referrals for primary health services, job training, educational services, and relevant housing services;
   viii. Minor renovation, expansion, and repair of housing (as defined in the Definitions section of this Exhibit);
   ix. Planning of housing;
   x. Technical assistance in applying for housing assistance;
   xi. Improving the coordination of housing services;
   xii. Security deposits;
   xiii. The costs associated with matching eligible homeless individuals with appropriate housing situations;
   xiv. One-time rental payments to prevent eviction;
   xv. Other appropriate services as determined by the Secretary of Health and Human Services (42 U.S. Code § 290cc-22(b)).

2. All funds shall only be utilized for providing the services outlined above to individuals who:
   a) Are suffering from a serious mental illness; or
   b) Are suffering from a serious mental illness and from a substance use disorder; and
   c) Are homeless or at imminent risk of becoming homeless (42 U.S. Code § 290cc-22(a)).
3. Funding may not be allocated to an entity that:
   a) Has a policy of excluding individuals from mental health services due to the existence or suspicion of a substance use disorder; or
   b) Has a policy of excluding individuals from substance use disorder services due to the existence or suspicion of mental illness (42 U.S. Code § 290cc-22(e)).
4. Match amounts agreed to with DBHDS may be:
   i. Cash;
   ii. In-kind contributions, that are fairly evaluated, including plant, equipment, or services.
   iii. Amounts provided by the federal government or services assisted or subsidized to any significant extent by the Federal Government, shall not be included in determining the amount of match (42 U.S. Code § 290cc-23(b)).
5. Subrecipient may not discriminate on the basis of age under the Age Discrimination Act of 1975 (42 U.S. Code § 6101 et seq.), on the basis of handicap under section 504 of the

Rehabilitation Act of 1973 (29 U.S. Code § 794), on the basis of sex under Title IX of the Education Amendments of 1972 (20 U.S. Code § 1681 et seq.), or on the basis of race, color, or national origin under Title VI of the Civil Rights Act of 1964 (42 U.S. Code § 2000d et seq.)(42 U.S. Code § 290cc-33(a)(1)).

6. The Subrecipient shall not exclude from participation in, deny benefits to, or discriminate against any individuals that are otherwise eligible to participate in any program or activity funded from the PATH grant (42 U.S. Code § 290cc-33(a)(2)).

c. **Limitations on Reimbursements**: Subrecipient shall not be reimbursed or otherwise compensated for any expenditures incurred or services provided prior to or following one year after the end of the appropriate Award Period provided in section IV.

DBHDS shall only reimburse or otherwise compensate the Subrecipient for documented expenditures incurred during this period that are: 1) reasonable and necessary to carry out the agreed upon scope of service outlined in Exhibit D, Exhibit G, or Notice of Award 2) documented by contracts or other evidence of liability consistent with established DBHDS and Subrecipient procedures; and 3) incurred in accordance with all applicable requirements for the expenditure of funds payable under any associated agreement.

d. **Closeout**: Final payment request(s) must be received by DBHDS no later than thirty (30) days after the end of the Period of Performance referenced in the Exhibit D, Exhibit G, or Notice of Award. No payment request will be accepted by DBHDS after this date without authorization from DBHDS. The Subrecipient may continue to expend retained funds until 365 days after the end of the Period of Performance to pay for remaining allowable costs.

Any funds remaining unexpended and unobligated at the end of the Period of Performance shall be returned to DBHDS within 30 days of the end of the Period of Performance. Any funds distributed to the Subrecipient by the pass-through entity that remain unexpended by 365 days after the end of the Period of Performance shall be returned to DBHDS. The Subrecipient will send these funds to DBHDS by no later than the end of the 395th day after the end of the Performance Period. Unexpended funds should be returned in the form of a check made payable to the Treasurer of Virginia and sent to:

DBHDS
PO Box 1797
Richmond, VA 23218-1797
C/O Eric Billings

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Account Number: 201141795720002
Routing Number: 061000104
EIN: 546001731

Name and Address of Bank:
Truist Bank
214 North Tryon Street
Charlotte, NC 28202

If the ACH method is utilized, the Subrecipient shall provide email notification of their intention to provide payment electronically to:

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Dillon.Gannon@dbhds.virginia.gov
Christine.Kemp@dbhds.virginia.gov
Kim.Barton@dbhds.virginia.gov

Failure to return unexpended funds in a prompt manner may result in a denial of future federal Subrecipient awards from DBHDS.

The Subrecipient agrees that acceptance of final payment from DBHDS will constitute an agreement by the Subrecipient to release and forever discharge DBHDS, its agents, employees, representatives, affiliates, successors and assigns from any and all claims, demands, damages, liabilities, actions, causes of action or suits of any nature whatsoever, which Subrecipient has at the time of acceptance of final payment or may thereafter have, arising out of or in any way relating to any and all injuries and damages of any kind as a result of or in any way relating to a program funded by this grant. Subrecipient's obligations to DBHDS under this Exhibit shall not terminate until all closeout requirements are completed to the satisfaction of DBHDS. Such requirements shall include, without limitation, submitting final reports to DBHDS and providing any closeout-related information requested by DBHDS by the deadlines specified by DBHDS. This provision shall survive the expiration or termination of any associated agreement.

5. Screening Brief Intervention and Referral to Treatment Grant

Pursuant to the Notice of Award #1H79TI084066-01 (NOA) received by DBHDS and the Funding Opportunity Announcement (FOA) (TI-21-008) associated with the FY 2021 Screening, Brief Intervention and Referral to Treatment Grant, the following are requirements of the funding distributed to the Subrecipient as a result of this agreement.

a. **Restrictions on Expenditures: Screening Brief Intervention and Referral to Treatment** Grant funds may not be used for any of the following purposes: None for this grant.

b. **Grant Guidelines:**
   1. Funds shall be used to fund services and practices that have a demonstrated evidence-base, and that are appropriate for the population(s) of focus. An evidence-based practice refers to approaches to prevention or treatment that are validated by some form of documented research evidence.
   2. All patients must be screened for substance use. Such screening will be conducted by the Subrecipient or subcontractors of Subrecipient ("Subcontractors"). The Subrecipient or Subcontractors are also encouraged to screen for risk of suicide as well. If a patient screens positive for drug misuse, the Subrecipient or Subcontractors' staff will conduct a brief assessment to ascertain specific type(s) of drug(s) used, consumption level, and impact on functions of daily living to best determine level of severity and refer patients to specialty providers who can determine which specific type of treatment is needed. Subrecipients and Subcontractors with robust mental health services available must screen and assess clients for the presence of co-occurring serious mental illness and SUD and use the information obtained from the screening and assessment to develop appropriate treatment approaches for the persons identified as having such co-occurring disorders. In their interventions with children, Subrecipients or Subcontractors must also incorporate education for parents about the dangers of use of, and methods of, discouraging substance use.
   3. Subrecipients or Subcontractors, as applicable, must utilize third party reimbursements and other revenue realized from the provision of services to the extent possible and use SAMHSA grant funds only for services to individuals who are not covered by public or commercial health

insurance programs, individuals for whom coverage has been formally determined to be unaffordable, or for services that are not sufficiently covered by an individual's health insurance plan. Subrecipients or Subcontractors, as applicable, are also expected to facilitate the health insurance application and enrollment process for eligible uninsured clients. Subrecipients or Subcontractors, as applicable, should also consider other systems from which a potential service recipient may be eligible for services (for example, the Veterans Health Administration or senior services), if appropriate for and desired by that individual to meet his/her needs. In addition, Subrecipients or Subcontractors, as applicable, are required to implement policies and procedures that ensure other sources of funding are utilized first when available for the individual.

4. All SAMHSA recipients are required to collect and report certain data so that SAMHSA can meet its obligations under the Government Performance and Results (GPRA) Modernization Act of 2010. Recipients are required to submit data via SAMHSA's Performance Accountability and Reporting System (SPARS); and access will be provided upon notification of award.

c. **Limitations on Reimbursements**: Subrecipient shall not be reimbursed or otherwise compensated for any expenditures incurred or services provided prior to or following 40 days after the end of the Award Period included in section IV.

DBHDS shall only reimburse or otherwise compensate the Subrecipient for documented expenditures incurred during this period that are: 1) reasonable and necessary to carry out the agreed upon scope of service outlined in Exhibit D, Exhibit G, or Notice of Award 2) documented by contracts or other evidence of liability consistent with established DBHDS and Subrecipient procedures; and 3) incurred in accordance with all applicable requirements for the expenditure of funds payable.

d. **Closeout**: Final payment request(s) must be received by DBHDS no later than thirty (30) days after the end of the Period of Performance referenced in the Exhibit D, Exhibit G, or Notice of Award. No payment request will be accepted by DBHDS after this date without authorization from DBHDS. The Subrecipient may continue to expend retained funds until 40 days after the end of the Period of Performance to pay for unliquidated obligations.

Any funds remaining unexpended and unobligated at the end of the Period of Performance shall be returned to DBHDS within 30 days of the end of the Period of Performance. Any funds distributed to the Subrecipient by the pass-through entity that remain unexpended by 40 days after the end of the Period of Performance shall be returned to DBHDS. The Subrecipient will send these funds to DBHDS by no later than the end of the 75th day after the end of the Performance Period. Unexpended funds should be returned in the form of a check made payable to the Treasurer of Virginia and sent to:

DBHDS
PO Box 1797
Richmond, VA 23218-1797
C/O Eric Billings

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Charlotte, NC 28202

If the ACH method is utilized, the Subrecipient shall provide email notification of their intention to provide payment electronically to:

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Failure to return unexpended funds in a prompt manner may result in a denial of future federal Subrecipient awards from DBHDS.

The Subrecipient agrees that acceptance of final payment from DBHDS will constitute an agreement by the Subrecipient to release and forever discharge DBHDS, its agents, employees, representatives, affiliates, successors and assigns from any and all claims, demands, damages, liabilities, actions, causes of action or suits of any nature whatsoever, which Subrecipient has at the time of acceptance of final payment or may thereafter have, arising out of or in any way relating to any and all injuries and damages of any kind as a result of or in any way relating to a program funded by this grant. Subrecipient's obligations to DBHDS under this Exhibit shall not terminate until all closeout requirements are completed to the satisfaction of DBHDS. Such requirements shall include, without limitation, submitting final reports to DBHDS and providing any closeout-related information requested by DBHDS by the deadlines specified by DBHDS. This provision shall survive the expiration or termination of any associated agreement.

6. Emergency Grants to Address Mental and Substance Use Disorders during COVID-19 (MH & SUD Federal COVID Emergency Grant)

Pursuant to the Notice of Award received by DBHDS and the Funding Opportunity Announcement (FG-20-006) associated with the MH and SUD Emergency COVID-19 Grant, the following are requirements of the funding distributed to the Subrecipient as a result of this agreement.

a. **Restrictions on Expenditures:** MH and SUD Emergency COVID-19 Grant funds may not be used for any of the following purposes:
   1. Construction or major alterations and renovations.
      Subrecipient

b. **Grant Guidelines:**
   1. Subrecipient funds are to be used primarily to support direct treatment services for individuals impacted by COVID-19.
   2. The purchase of PPE is an allowable cost and can only be provided for staff working directly on the grant. The purchase of PPE for clients is not an allowable cost.
   3. The purchase of equipment or supplies (e.g., pre-paid minutes, cell phones, Hot spots, iPad tablets, etc.) for clients is not an allowable cost.

c. **Limitations on Reimbursements**: Subrecipient shall not be reimbursed or otherwise compensated for any expenditures incurred or services provided prior to or following 40 days after the end of the appropriate Award Period included in section IV.

DBHDS shall only reimburse or otherwise compensate the Subrecipient for documented expenditures incurred during this period that are: 1) reasonable and necessary to carry out the agreed upon scope of service outlined in Exhibit D, Exhibit G, or Notice of Award 2) documented by contracts or other evidence of liability consistent with established DBHDS and Subrecipient procedures; and 3) incurred in accordance with all applicable requirements for the expenditure of funds payable.

d. **Closeout**: Final payment request(s) must be received by DBHDS no later than thirty (30) days after the end of the Period of Performance referenced in the Exhibit D, Exhibit G, or Notice of Award. No payment request will be accepted by DBHDS after this date without authorization from DBHDS. The Subrecipient may continue to expend retained funds until 40 days after the end of the Period of Performance to pay for unliquidated obligations.

Any funds remaining unexpended and unobligated at the end of the Period of Performance shall be returned to DBHDS within 30 days of the end of the Period of Performance. Any funds distributed to the Subrecipient by the pass-through entity that remain unexpended by 40 days after the end of the Period of Performance shall be returned to DBHDS. The Subrecipient will send these funds to DBHDS by no later than the end of the 75th day after the end of the Performance Period. Unexpended funds should be returned in the form of a check made payable to the Treasurer of Virginia and sent to:

DBHDS
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The Subrecipient agrees that acceptance of final payment from DBHDS will constitute an agreement by the Subrecipient to release and forever discharge DBHDS, its agents, employees,

representatives, affiliates, successors and assigns from any and all claims, demands, damages, liabilities, actions, causes of action or suits of any nature whatsoever, which Subrecipient has at the time of acceptance of final payment or may thereafter have, arising out of or in any way relating to any and all injuries and damages of any kind as a result of or in any way relating to a program funded by this grant. Subrecipient's obligations to DBHDS under this Exhibit shall not terminate until all closeout requirements are completed to the satisfaction of DBHDS. Such requirements shall include, without limitation, submitting final reports to DBHDS and providing any closeout-related information requested by DBHDS by the deadlines specified by DBHDS. This provision shall survive the expiration or termination of any associated agreement.

A. Treasury Grants

1. **State and Local Fiscal Recover Fund Grant:** Pursuant to the Interim Final Rule issued by US Department of Treasury pertaining to Coronavirus State and Local Recovery Funds, SLFRF Compliance and Reporting Guidance Ver 2.1 dated November 15, 2021, and 31 CFR 35(A), the following are requirements of the funding distributed to the Subrecipient:
   - **a. Restrictions on Expenditures:** State and Local Fiscal Recovery Fund Grant funds may not be used to:
   - **b.** Pay Funds shall not be used to make a deposit to a pension fund. Treasury's Interim Final Rule defines a "deposit" as an extraordinary contribution to a pension fund for the purpose of reducing an accrued, unfunded liability. While pension deposits are prohibited, recipients may use funds for routine payroll contributions for employees whose wages and salaries are an eligible use of funds.
     Funds shall not be used towards funding debt service, legal settlements or judgments, and / or deposits to rainy day funds or financial reserves.
   - **c. Expenditure Guidelines:**
     Grant funds: Shall be used to pay for services and practices that have a demonstrated evidence-base, which are inclusive of: mental health treatment, substance misuse treatment, other behavioral health services, hotlines or warmlines, crisis intervention, overdose prevention, infectious disease prevention, and services or outreach to promote access to physical or behavioral health primary care and preventative medicine.
   - **d. Limitations on Reimbursements**: Subrecipient shall not be reimbursed or otherwise compensated for any expenditures incurred or services provided prior to or after the appropriate Award Period included in section IV.

     DBHDS shall only reimburse or otherwise compensate the Subrecipient for documented expenditures incurred during this period that are: 1) reasonable and necessary to carry out the agreed upon scope of service outlined in Exhibit D, Exhibit G, or Notice of Award 2) documented by contracts or other evidence of liability consistent with established DBHDS and Subrecipient procedures; and 3) incurred in accordance with all applicable requirements for the expenditure of funds payable under this agreement.

   - **e. Closeout**: Final payment request(s) under any associated Agreement must be received by DBHDS no later than thirty (30) days after the end of the Period of Performance referenced in the Exhibit D, Exhibit G, or Notice of Award. No payment request will be accepted by DBHDS after this date without authorization from DBHDS. The Subrecipient may continue to expend retained funds until the end of the Period of Performance to pay for remaining allowable costs.

     Any funds remaining unexpended at the end of the Period of Performance shall be returned to DBHDS within 30 days of the end of the Period of Performance. Unexpended funds should be returned in the form of a check made payable to the Treasurer of Virginia and sent to:

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The Subrecipient agrees that acceptance of final payment from DBHDS will constitute an agreement by the Subrecipient to release and forever discharge DBHDS, its agents, employees, representatives, affiliates, successors and assigns from any and all claims, demands, damages, liabilities, actions, causes of action or suits of any nature whatsoever, which Subrecipient has at the time of acceptance of final payment or may thereafter have, arising out of or in any way relating to any and all injuries and damages of any kind as a result of or in any way relating to a program funded by this grant. Subrecipient's obligations to DBHDS under this Exhibit shall not terminate until all closeout requirements are completed to the satisfaction of DBHDS. Such requirements shall include, without limitation, submitting final reports to DBHDS and providing any closeout-related information requested by DBHDS by the deadlines specified by DBHDS. This provision shall survive the expiration or termination of any associated agreement.

VI. List of Federal Grants

Provided in the chart below is a current list of the federal grants that DBHDS passes-through to CSB and the required identifying information that should be used to categorize and track these funds.

GRANT NAME: Substance Abuse Prevention and Treatment Block Grant (SUD FBG)
GRANT NAME: Substance Abuse Prevention and Treatment Block Grant (SUD FBG) **FEDERAL AWARD IDENTIFICATION NUMBER (FAIN):** B08TI084612 **FEDERAL AWARD DATE**: 8/10/2021 **FEDERAL AWARDING AGENCY**: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) **FEDERAL AWARD PASS-THROUGH ENTITY**: **Virginia Department of Behavioral Health and Developmental Services** **CFDA NUMBER**: 93.959 **RESEARCH AND DEVELOPMENT AWARD**: ____YES OR __X__NO **FEDERAL GRANT AWARD YEAR**: FFY 2022 **AWARD PERIOD**: 9/1/2021 – 9/30/2025
GRANT NAME: Community Mental Health Services Block Grant (MH FBG)
GRANT NAME: Community Mental Health Services Block Grant (MH FBG) **FEDERAL AWARD IDENTIFICATION NUMBER (FAIN):** B09SM085998 **FEDERAL AWARD DATE**: 11/28/2021 **FEDERAL AWARDING AGENCY**: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) **FEDERAL AWARD PASS-THROUGH ENTITY**: **Virginia Department of Behavioral Health and Developmental Services** **CFDA NUMBER**: 93.958 **RESEARCH AND DEVELOPMENT AWARD**: ____YES OR __X__NO **FEDERAL GRANT AWARD YEAR**: FFY 2022 **AWARD PERIOD**: 10/1/2021 – 9/30/2023
GRANT NAME: Substance Abuse Prevention and Treatment Block Grant (SUD FBG)
GRANT NAME: Substance Abuse Prevention and Treatment Block Grant (SUD FBG) **FEDERAL AWARD IDENTIFICATION NUMBER (FAIN):** B08TI084676 **FEDERAL AWARD DATE**: 2/10/2022 **FEDERAL AWARDING AGENCY**: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) **FEDERAL AWARD PASS-THROUGH ENTITY**: **Virginia Department of Behavioral Health and Developmental Services** **CFDA NUMBER**: 93.959 **RESEARCH AND DEVELOPMENT AWARD**: ____YES OR __X__NO **FEDERAL GRANT AWARD YEAR**: FFY 2022 **AWARD PERIOD**: 10/1/2022 – 9/30/2023
GRANT NAME: Community Mental Health Services Block Grant (MH FBG)

GRANT NAME: Community Mental Health Services Block Grant (MH FBG)
FEDERAL AWARD IDENTIFICATION NUMBER (FAIN): B09SM085877
FEDERAL AWARD DATE: 8/10/2021
FEDERAL AWARDING AGENCY: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA)
FEDERAL AWARD PASS-THROUGH ENTITY: **Virginia Department of Behavioral Health and Developmental Services**
CFDA NUMBER: 93.958
RESEARCH AND DEVELOPMENT AWARD: ____YES OR __X__NO
FEDERAL GRANT AWARD YEAR: FFY 2022
AWARD PERIOD: 9/1/2021 – 9/30/2025

GRANT NAME: State and Local Fiscal Recovery Fund (SLFRF)

GRANT NAME: State and Local Fiscal Recovery Fund (SLFRF)
FEDERAL AWARD IDENTIFICATION NUMBER (FAIN): NA
FEDERAL AWARD DATE: NA
FEDERAL AWARDING AGENCY: U.S. Department of Treasury
FEDERAL AWARD PASS-THROUGH ENTITY: **Virginia Department of Behavioral Health and Developmental Services**
CFDA NUMBER: 21.027
RESEARCH AND DEVELOPMENT AWARD: ____YES OR __X__NO
FEDERAL GRANT AWARD YEAR: FFY 2022
AWARD PERIOD: 3/3/2021 – 12/31/2024

TABLE OF CONTENTS

1. PURPOSE

The Community Services Board or Behavioral Health Authority (the "CSB") shall comply with certain program service requirements for those community services it provides and that the Department funds under this Exhibit G (the "Exhibit"). All terms, provisions and agreements set forth in the most current version of the Community Services Performance Contract remain in effect, except to the extent expressly modified herein. If the terms set forth in this Exhibit are inconsistent with the most current version of the Community Services Performance Contract, the terms set forth in this Exhibit shall apply.

2. NOTIFICATION OF AWARD

Department's Fiscal Services and Grants Management Office (the "FSGMO") and program offices will provide notification of federal grant award(s) to the CSB prior to initial payment disbursement. The notice will provide applicable federal grant specific information, award amounts, period of performance, and close out.

3. BILLING AND PAYMENT TERMS AND CONDITIONS

CSB shall comply with Section 9 of the performance contract.

4. USE OF FUNDS

Funds provided under this agreement shall not be used for any purpose other than as described herein and/or outlined in Exhibit F: Federal Grant Requirements, and other federal and state laws or regulations.

CSB agrees that if it does not fully implement, maintain, or meet established terms and conditions as established herein or as subsequently modified by agreement of the Parties, the Department shall be able to recover part or all of the disbursed funds as allowable under the terms and conditions of the performance contract.

5. LIMITATIONS ON REIMBURSEMENTS

CSB shall not be reimbursed or otherwise compensated for any expenditures incurred or services provided following the end of the period of performance.

6. PERFORMANCE OUTCOME MEASURES

CSB shall meet the standard performance outcome measures as set forth in collaboration with the Department.

7. REPORTING REQUIREMENTS

CSB shall comply with all standard and additional reporting requirements pursuant to, but not limited to the Reporting and Data Quality Requirements of the performance contract, Exhibit E: Performance Contract Schedule and Process, this Exhibit, and by the Department as required its funding authorities.

8. MONITORING, REVIEW, AND AUDIT

The Department may monitor and review use of the funds, performance of the Program or Service, and compliance with this agreement, which may include onsite visits to assess the CSB's governance, management and operations, and review relevant financial and other records and materials. In addition, the Department may conduct audits, including onsite audits, at any time during the term of this agreement with advance notification to the CSB.

9. TECHNICAL ASSISTANCE

The CSB and the Department shall work in partnership to address technical assistance needs to provide the program services herein.

10. OTHER TERMS AND CONDITIONS

CSB shall comply with established Continuous Quality Improvement (CQI) Process and CSB Performance Measures set forth in Exhibit B and any other requirements that may be established in an Exhibit D that may be associated with the program services as described herein.

This Exhibit may be amended pursuant to Section 5 of the performance contract.

11. FEDERAL FUNDED PROGRAM SERVICES

This section describes certain program services that have a primary funding source of federal funds but there may also be other sources of funding provided by the Department for these services.

11.1. Children's Mental Health Block Grant

Scope of Services and Deliverables
Children's Mental Health Block Grant funds are to be used to reduce states' reliance on hospitalization and develop effective community-based mental health services for children with Serious Emotional Disturbance (SED). Children with SED includes persons up to age 18 who have a diagnosable behavioral, mental, or emotional issue (as defined by the DSM). The state MHBG allotments are used to support community programs, expanded children's services, home-based crisis intervention, school-based support services, family and parenting support/education, and outreach to special populations

The purpose of these funds is to provide community-based services to youth (up to age 18), who have serious emotional disturbance with the goal of keeping youth in the community and reducing reliance on out-of-home placements. Services may include assessments and evaluations, outpatient or office-based treatment, case management, community-based crisis services, intensive community-based supports, community-based home services, and special populations of youth with SED such as juvenile justice, child welfare, and/other under-served populations. Services cannot be used for residential or inpatient care.

A. The CSB Responsibilities: The CSB agrees to comply with the following requirements.

1. The CSB shall use the funds Children's Mental Health Block Grant funds to reduce states' reliance on hospitalization and develop effective community-based mental health services for children with Serious Emotional Disturbance (SED). Children with SED includes persons up to age 18 who have a diagnosable behavioral, mental, or emotional issue (as defined by the DSM). This condition results in a functional impairment that substantially interferes with, or limits, a child's role or functioning in family, school, or community activities.
2. The CSB shall comply with the additional uses or restrictions for this grant pursuant to Exhibit F of the performance contract.

B. The Department Responsibilities: The Department agrees to comply with the following requirements.
The Department will periodically review case files through regional consultant block grant reviews to ensure funds are being spent accordingly.

11.2. Assertive Community Treatment (ACT) Program Services

Scope of Services and Deliverables

Assertive Community Treatment (ACT) provides long term needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illness especially those who have severe symptoms that are not effectively remedied by available treatments or who because of reasons related to their mental illness resist or avoid involvement with mental health services in the community. ACT services are offered to outpatients outside of clinic, hospital, or program office settings for individuals who are best served in the community.

ACT is a highly coordinated set of services offered by group of medical, behavioral health, peer recovery support providers and rehabilitation professionals in the community who work as a team to meet the complex needs of individuals with severe and persistent mental illness. An individual who is appropriate for ACT requires this comprehensive, coordinated approach as opposed to participating in services across multiple, disconnected providers, to minimize risk of hospitalization, homelessness, substance use, victimization, and incarceration. An ACT team provides person-centered services addressing the breadth of individuals' needs, and is oriented around individuals' personal goals. A fundamental charge of ACT is to be the first-line (and generally sole provider) of all the services that an individual receiving ACT needs. Being the single point of responsibility necessitates a higher frequency and intensity of community-based contacts between the team and individual, and a very low individual-to-staff ratio. ACT services are flexible; teams offer personalized levels of care for all individuals participating in ACT, adjusting service levels to reflect needs as they change over time.

An ACT team assists individuals in advancing toward personal goals with a focus on enhancing community integration and regaining valued roles (e.g. worker, daughter, resident, spouse, tenant, or friend). Because an ACT team often works with individuals who may demonstrate passive or active resistance to participation in services, an ACT team must carry out thoughtfully planned assertive engagement techniques including rapport-building strategies, facilitating the individual in meeting basic needs, and motivational interviewing interventions. The team uses these techniques to identify and focus on individuals' life goals and motivations to change. Likewise, it is the team's responsibility to monitor individuals' mental status and provide needed supports in a manner consistent with their level of need and functioning. The ACT team delivers all services according to a recovery-based philosophy of care. Individuals receiving ACT should also be engaged in a shared decision-making model, assistance with accessing medication, medication education, and assistance in medication to support skills in taking medication with greater independence. The team promotes self-determination, respects the person participating in ACT as an individual in their own right, and engages registered peer recovery specialists to promote hope that recovery from mental illness and regaining meaningful roles and relationships in the community are possible.

A. The CSB Responsibilities: The CSB agrees to comply with the following requirements.

1. The CSB shall design and implement its ACT program in accordance with requirements in the Department's Licensing Regulations for ACT in *12 VAC 35-105-1360 through 1410*, *Department of Medical Assistance Services Regulations and Provider Manual Appendix E*, and in accordance with best practice as outlined in the Tool Measurement of Assertive Community Treatment (TMACT).
2. CSB shall comply with ACT teams shall be available to individuals 24 hours per day and shall operate a minimum of 12 hours each weekday and eight hours each weekend day and each holiday;
3. ACT team shall make crisis services directly available 24 hours a day but may arrange coverage through another crisis services provider if the team coordinates with the crisis services provider daily.

4. The ACT team shall operate an after-hours on-call system and shall be available to individuals by telephone, or and in person when needed as determined by the team.
5. The CSB shall reserve any restricted state mental health funds earmarked for ACT that remain unspent only for ACT program services unless otherwise authorized by the Department in writing.
6. The CSB shall prioritize admission to ACT for adults with serious mental illnesses who are currently residing in state hospitals, have histories of frequent use of state or local psychiatric inpatient services, or are homeless.
7. The CSB shall assist Department staff as requested with any case-level utilization review activities, making records of individuals receiving ACT services available and providing access to individuals receiving ACT services for interviews.
8. CSB ACT staff shall participate in ACT network meetings with other ACT teams as requested by the Department.
9. ACT staff shall participate in technical assistance provided through the Department and shall obtain individual team-level training and technical assistance at least quarterly for the first two years of operation from recognized experts approved by the Department.
10. ACT Team are required to:
    a. Undergo the standardized rating process using the TMACT as specified in their DBHDS license.
    b. A new ACT team may obtain a conditional DBHDS license for ACT if their initial TMACT fidelity scores are in the low fidelity range of 2.7-3.3, but the team must rate at 3.4 or higher on the subsequent review to avoid losing this provisional license.
    c. ACT teams may reach full ACT certification status and a one-year DBHDS license if they obtain a TMACT score in the base fidelity range of 3.4-3.9.
    d. ACT providers scoring 4.0-5.0 are considered high fidelity (this category has two tiers: 4.0-4.3 are high fidelity and 4.4-5.0 are exemplary fidelity).
    e. Team is to be the first line (and generally sole provider) of all the services that individuals may need by providing individualized, intensive treatment/rehabilitation and support services in the community;
    f. Team develops and has access to each individual's individualized crisis plan and the team has the capacity to directly engage with each individual to help directly address emerging crisis incidents and to support stabilization;
    g. Team provides a higher frequency and intensity of community-based contacts with a staff-to-individual ratio no greater than 1:9; and
    h. Team provides services that are community based, flexible and appropriately adjusted based on the individuals evolving needs.
    i. ACT teams must offer and have the capacity to provide the following covered service components to address the treatment needs identified in the initial comprehensive needs assessment:
    j. Assessment and treatment planning
    k. Integrated dual disorders treatment for co-occurring substance use
    l. Crisis assessment and treatment/intervention
    m. Health literacy counseling
        1. Medication management
        2. Skills restoration/development
            a. Social Skills
            b. Wellness self-management and prevention
            c. Symptom management
            d. Skills required for activities of daily and community living
        3. Peer recovery support services;
        4. Empirically supported therapeutic interventions & therapies;

n. ACT service coordination (care coordination) consisting of facilitating access to:
    1. Employment and vocational services
    2. Housing access & support
    3. Other services based on client needs as identified in the Individualized Service Plan (ISP)
o. As clinically indicated and supported by staff capacity and client engagement, these services components can be provided in an individual and/or group setting.

11. The following required activities apply to ACT:
    i. At the start of services, a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner or Physician Assistant shall conduct an initial assessment consistent with the components required in the Comprehensive Needs Assessment (see Chapter IV for requirements), documenting the individual's diagnosis/es and describing how service needs match the level of care criteria. If a nurse practitioner who is not a psychiatric/mental health nurse practitioner or a physician assistant conducts the initial assessment it can only be used as the assessment for ACT and cannot be used as a comprehensive needs assessment by the provider for other mental health services (see Chapter IV for details).
    ii. Individual Service Plans (ISPs see Chapter IV for requirements) shall be required during the entire duration of services and must be current. The initial treatment plan (ISP) shall be completed on the day of admission to the service. The treatment planning process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP, LMHP-S, nurse practitioner or physician assistant.
    iii. ISPs must be reviewed as necessary at a minimum of every 30 calendar days or more frequently depending on the youth's needs. Refer to Chapter IV for additional guidance and documentation requirements for the 30-calendar day review as well as additional quarterly review requirements.
    iv. Medication prescription monitoring must be provided by a psychiatrist or psychiatric nurse practitioner who completes a psychiatric evaluation on the day of admission and has contact with individuals on a quarterly basis.
    v. For individuals with a co-occurring substance use diagnosis, the ACT team will provide individual and group modalities for dual disorders treatment based on the principles of Integrated Dual Disorder Treatment and aligned with the individual's readiness/stage of change. In addition, the ACT team will provide active substance use counseling and relapse prevention, as well as substance use education.
    vi. Registered peer recovery support specialists shall be a part of the ACT team with services to include coaching, consulting, wellness management and recovery strategies to promote recovery and self-direction. Registered peer recovery support specialists may also model and provide education on recovery principles and strategies to fellow team members.
    vii. If the individual consistently deviates from the required services in the ISP, the provider should work with the Managed Care Organization (MCO) or the fee for service (FFS) contractor to reassess for another level of care or model to better meet the individual's needs.
    viii. Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).
12. CSB shall be licensed by DBHDS as a provider of Assertive Community Treatment and credentialed with the individual's Medicaid MCO for individuals enrolled in Medicaid managed care or the Fee for Service (FFS) contractor for individuals in FFS. ACT service providers must follow all general Medicaid provider requirements specified in Chapter II of this manual.
13. ACT service providers shall meet the staff requirements as follows:
    i. ACT Team Sizes

a) ACT team sizes and definitions as defined herein are consistent with the national standards for the practice. In accordance with ACT fidelity standards, providers in urban locations should implement mid-size to large teams. Providers in more rural locations will likely implement small or mid-size teams as large teams may be impractical in a sparsely populated area. ACT teams should operate from a single home office as opposed to a collection of satellite locations to promote team coordination and collaboration.
   i. Small teams serve a maximum of 50 individuals, with one team member per eight or fewer individuals;
   ii. Mid-size teams serve 51-74 individuals, with one team member per nine or fewer individuals; and
   iii. Large teams serve 75-120 individuals, with one team member per nine or fewer individuals.

b) To ensure appropriate ACT team development, each new ACT team is recommended to titrate ACT intakes (no more than 4 total per month) * to gradually build up capacity to serve no more than 100–120 individuals (with a 1:9 ratio) and no more than 42–50 individuals (a 1:8 ratio) for smaller teams. Movement of individuals onto (admissions) and off of (discharges) the team caseload may temporarily result in breaches of the maximum caseload; thus, teams shall be expected to maintain an annual average not to exceed 50, 74, and 120 individuals, respectively.

ii. ACT Team Composition and Roles

a) ACT teams should be composed of individuals who have the strong clinical skills, professional qualifications, experience, and competency to provide a full breadth of biopsychosocial rehabilitation services. While all staff shall have some level of competency across disciplines, the team should emphasize areas of individual staff expertise and specialization to fully benefit ACT service participants. The service components must be delivered within professional scope for those services.

b) As required by DBHDS Regulations, a multidisciplinary ACT treatment team is comprised of the following professionals:
   i. Team Leader
   ii. Psychiatric Care Provider
   iii. Nurse
   iv. SUD/Co-Occurring Disorder Specialist
   v. Registered Peer Recovery Specialist
   vi. Vocational Specialist (must be QMHP)
   vii. Dedicated Office-Based Program Assistant
   viii. Generalist Clinical Staff Member

c) Medication prescription monitoring must be provided by a Psychiatrist or Psychiatric Nurse Practitioner who completes an initial assessment and has contact with individuals on a quarterly basis.

d) Medication administration must be provided by a Psychiatrist, Psychiatric Nurse Practitioner or appropriate licensed nursing professional based on ACT team size.

e) Individual, group, and family therapy must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S or CATP.

f) Health literacy counseling /psychoeducational interventions must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant, CATP, CSAC*, CSAC Supervisee* or a RN or LPN with at least one year of clinical experience involving medication management.

g) Crisis intervention must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, CATP, QMHP-A, QMHP-E, CSAC*, CSAC Supervisee* or CSAC-A*.

h) Skills restoration / development must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, and QMHP-A, QMHP-E or a QPPMH under the supervision of at least a QMHP-A.

i) Care coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, CATP, QMHP-A, QMHP-E, CSAC*, CSAC Supervisee* CSAC-A* or a QPPMH under the supervision of at least a QMHP-A.

j) Peer recovery support services must be provided by a Registered Peer Recovery Specialist.

k) **CSACs, CSAC Supervisees and CSAC-As may only provide services related to substance use disorder treatment per § 54.1-3507.1 and § 54.1-3507.2*

l) RNs, LPNs, and Nurse Practitioners shall hold an active license issued by the Virginia Board of Nursing. Physicians and Physician Assistants shall hold an active license issued by the Virginia Board of Medicine.

14. ACT Service Limitation:

i. In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply:

ii. An individual can participate in ACT services with only one ACT team at a time.

iii. Group therapy by LMHPs, LMHP-Rs, LMHP-RPs, LMHP-Ss and CATPs shall have a recommended maximum limit of 10 individuals in the group. Group size may exceed this limit based on the determination of the professional providing the service.

iv. ACT may not be authorized concurrently with Individual, Group or Family Therapy, Addiction and Recovery Treatment Services (ARTS) and Mental Health (MH) Intensive Outpatient, Outpatient Medication Management, Therapeutic Day Treatment, Intensive In Home Services, Community Stabilization, Mental Health Skill Building, Applied Behavior Analysis, Multisystemic Therapy, Functional Family Therapy, Psychiatric Residential Treatment Facility (PRTF), Therapeutic Group Home (TGH), ARTS Level 3.1-3.7 or Peer Recovery Support Services, as the activities of these services are included in the per diem. Up to a fourteen-calendar day service authorization overlap with these services is allowed as individuals are being transitioned to ACT from other behavioral health services. Up to a 31-calendar day service authorization overlap with these services is allowed as individuals are being transitioned from ACT to other behavioral health services (see service authorization section). Office based opioid treatment services (OBOT) and Office Based Addiction Treatment (OBAT) services are allowed simultaneously with ACT.

v. If an individual is participating in ACT and has a concurrent admission to a Partial Hospitalization Program, the team should conduct close care coordination with those providers to assure alignment of the treatment plan (ISP) and avoid any duplication of services.

vi. Activities that are not authorized for reimbursement include:

a) Contacts that are not medically necessary.

b) Time spent doing, attending, or participating in recreational activities.

c) Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
d) Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
e) Respite care.
f) Transportation for the individual or family. Additional medical transportation for service needs which are not considered part of ACT program services may be covered by the transportation service through the FFS Non-Emergency Medical Transportation Broker or MCO. Medical transportation to ACT providers may be billed to the transportation broker.
g) Covered services that have not been rendered.
h) Services rendered that are not in accordance with an approved authorization.
i) Services not identified on the individual's authorized ACT Treatment Plan.
j) Services provided without service authorization by the department or its designee.
k) Services not in compliance with the ACT National Provider Standards and not in compliance with fidelity standards.
l) Services provided to the individual's family or others involved in the individual's life that are not to the direct benefit of the individual in accordance with the individual's needs and treatment goals identified in the individual's plan of care.
m) Services provided that are not within the provider's scope of practice.
n) Anything not included in the approved ACT service description.
o) Changes made to ACT that do not follow the requirements outlined in the provider contract, this appendix, or ACT fidelity standards.
p) Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services.
q) Time spent when the individual is employed and performing the tasks of their job.
r) Note: ACT does include non-job specific vocational training, employment assessments, and ongoing support to maintain employment. ACT may provide the necessary medical services that enable the individual to function in the workplace, including ACT services such as a psychiatrist's or psychologist's treatment, rehabilitation planning, therapy, and counseling or crisis management that enable the individual to remain in and/or function in the workplace.

B. The Department Responsibilities: The Department agrees to comply with the following requirements.

a. The Department shall monitor ACT implementation progress through monthly reports submitted to the Department's Office of Adult Community Behavioral Health by the CSB.
b. The Department shall monitor through ACT fidelity monitoring using the Tool for Measurement of Assertive Community Treatment (TMACT).
c. The Department shall track adherence to the ACT model and determine annual ACT performance outcomes from teams through their participation in the administration of the most current ACT fidelity assessment.
d. The Department shall provide the data collection and additional reporting database, submission due dates, and reporting protocols to the CSB.

C. Reporting Requirements: To provide a standardized mechanism for ACT teams to track each individual's outcomes, which can then guide their own performance initiatives; teams will be required to regularly submit data through the ACT Monitoring Application. The data submitted will include:

a. Individual's receiving ACT services satisfaction.
b. Increased adherence to treatment/service plan;
c. Vocational/educational gains;
d. Increased length of stay in community residence;
e. Increased use of natural supports;
f. Reduced utilization of inpatient level of support;
g. Improved physical health;
h. Increased use of wellness self-management and recovery tools; and
i. Increased use of community living settings and supports

11.3. Project Link Program

Scope of Services and Deliverables

Project LINK has proven to be an asset to the community it serves by connecting women with substance use to targeted services and treatment, specific to women. Each Project LINK program is responsible for advisory meetings with agencies in their catchment, to integrate and coordinate additional service needs, and provide education to providers in the community around substance use disorders and women. The program is a catapult to an array of service and providers that include, but not limited to, behavioral health, physical health, medication assisted treatment and coordination of treatment options for children.

A. The CSB Responsibilities: The CSB agrees to comply with the following requirements.

1. The CSB shall work collaboratively with the DBHDS Office of Adult Community Behavioral Health Services (specifically with the Women's Services Coordinator, Amanda Stehura) to fulfill the Substance Abuse Block Grant (SABG) set aside requirement.
2. Submit reports by established deadlines.

B. The Department Responsibilities: The Department agrees to comply with the following requirements.

1. Provide oversight and monitor the Project LINK program to ensure the scope and deliverables are met
2. Communicate in a timely manner about changes to the program and funding allocations
3. Quarterly meetings with each site and Women's Services Coordinator(s)

C. Reporting Requirements: Reporting will follow the current reporting mechanism and timeframe of Project LINK as set forth in the Project LINK quarterly Survey Monkey reporting provided by the Department.

Submission of a programmatic quarterly report are due by the following dates:

1st Report	January 30th
2nd Report	April 30th
3rd Report	July 31st
4th Report	October 31st

11.4. State Opioid Response Program Services (SOR)

1. **SOR Prevention Program - Adverse Childhood Experiences (ACEs) Project**

Scope of Services and Deliverables
The SOR II grant was awarded to Virginia to combat the opioid epidemic and build upon programs started with STR/OPT-R and SOR Year 1 and 2. SOR II also supports evidence-based prevention to address stimulant misuse. SOR II prevention grant awards support the implementation of effective strategies identified by the Virginia Evidence-Based Outcomes Workgroup. The categories of approved strategies include: coalition development, heightening community awareness/education, supply reduction/environmental, tracking and monitoring, and harm reduction. A portion of SORII Prevention funds are approved for the ACEs Project.

SOR II Prevention grant funds for the Adverse Childhood Experiences (ACEs) Project must be used to fund prevention strategies that have a demonstrated evidence-base, and that are appropriate for the population(s) of focus.

A. The CSB Responsibilities: The CSB agrees to comply with the following requirements.
1. The CSB shall work collaboratively with the DBHDS Office of Behavioral Health Wellness (OBHW) team (particularly Behavioral Health Wellness Consultant/ACEs Coordinator Keith Cartwright) and OMNI Institute technical assistance team to fulfill requirements of the grant. This collaboration includes responding to information requests in a timely fashion, entering data in the Performance Based Prevention System (PBPS), submitting reports by established deadlines.
2. CSB understands that SOR prevention funds are restricted and shall be used only for approved SOR prevention strategies (from the CSB's approved SOR Logic Model).
3. CSB understands that changes to the budget (greater than a variance of 25 percent among approved budget items) and/or requests for additional funding must be sent via an email to the SOR Prevention Coordinator.

B. The Department Responsibilities: The Department agrees to comply with the following requirements.
1. The Department shall adhere to SOR II grant guidelines established by the Substance Abuse and Mental Health Services Administration (SAMHSA), including reporting on statewide and CSB-specific data, accomplishments and challenges.
2. The Department's Behavioral Health Wellness Consultant/ACEs Lead shall maintain regular monthly communication with the CSB and monitor SOR ACEs Project performance.
3. The Department, particularly the SOR Prevention Coordinator and ACEs Lead, will respond to inquiries in a timely manner, fulfill requests for training and share regular updates regarding the grant. Every effort will be made to provide at least two weeks lead time prior to report deadlines.
4. The Department will provide a budget template for annual budget submission.

2. **SOR Prevention Program - Behavioral Health Equity (BHE) Mini-Grant Project**

Scope of Services and Deliverables
The SOR II grant was awarded to Virginia to combat the opioid epidemic and build upon programs started with STR/OPT-R and SOR Year 1 and 2. SOR II also supports evidence-based prevention to address stimulant misuse. SOR II prevention grant awards support the implementation of effective strategies identified by the Virginia Evidence- Based Outcomes Workgroup. The categories of approved strategies include: coalition development, heightening community awareness/education, supply reduction/environmental, tracking and monitoring, and harm reduction.

A portion of SOR II Prevention funds were approved for the BHE Mini-Grant Project. BHE Mini-Grants provide CSB an award of funds to perform equity-oriented activities and programing throughout their agency and community. Funds can be used in innovative ways to meet the professional development and community needs of the populations being served. Grants recognize that minority communities may require interventions tailored to their unique needs. Grants should explicitly work to address the needs of marginalized populations.

A. The CSB Responsibilities: The CSB agrees to comply with the following requirements.
1. The CSB shall use the SOR II Prevention grant funds for the Behavioral Health Equity (BHE) Mini-Grant Project to fund strategies that have a demonstrated evidence-base and are appropriate for the population(s) of focus.
2. The CSB shall work collaboratively with the DBHDS Office of Behavioral Health Wellness (OBHW) team and Behavioral Health Equity Consultant, to complete all approved objectives from the BHE Mini-Grant application. This collaboration includes participating in a mid-grant check-in, completing a final grant report.

B. The Department Responsibilities: The Department agrees to comply with the following requirements.
1. The Department shall adhere to SOR II grant guidelines established by the Substance Abuse and Mental Health Services Administration (SAMHSA), including reporting on statewide and CSB-specific data, accomplishments and challenges.
2. The Department's Behavioral Health Equity Consultant will perform a mid-grant check-in, and will provide the format and collect the final grant report.

3. SOR - Treatment and Recovery Services

Scope of Services and Deliverables
Develop and provide opioid misuse prevention, treatment, and recovery support services for the purposes of addressing the opioid and stimulant misuse and overdose crisis. Implement service delivery models that enable the full spectrum of treatment and recovery support services facilitating positive treatment outcomes. Implement community recovery support services such as peer supports, recovery coaches, and recovery housing. Grantees must ensure that recovery housing is supported in an appropriate and legitimate facility. Implement prevention and education services including; training of healthcare professionals on the assessment and treatment of Opioid Use Disorder (OUD), peers and first responders on recognition of opioid overdose and appropriate use of the opioid overdose antidote, naloxone, develop evidence-based community prevention efforts including evidence-based strategic messaging on the consequence of opioid misuse, purchase and distribute naloxone and train on its use. Provide assistance with treatment costs and develop other strategies to eliminate or reduce treatment costs for uninsured or underinsured individuals. Provide treatment transition and coverage for individuals reentering communities from criminal justice settings or other rehabilitative settings. Address barriers to receiving medication assisted treatment (MAT) Support innovative telehealth strategies in rural and underserved areas to increase the capacity of communities to support OUD prevention, treatment, and recovery.

A. The CSB Responsibilities: The CSB agrees to comply with the following requirements.
1. The CSB shall comply with the Department's approved budget plan for services.
2. The CSB may employ SA MAT treatment personnel and recovery personnel
3. The CSB may provide treatment services to include: drug/medical supplies, drug screens, lab work, medical services, residential treatment, childcare services, client transportation, contingency management, recruitment services and treatment materials
4. The CSB shall provide recovery services to include: WRAP training and staff phones supplies

5. The CSB shall provide temporary housing supports in VARR certified houses, when necessary
6. The CSB shall collect GPRA data for each person receiving services at intake, discharge, and 6-month time points. This data must be submitted to OMNI Institute within five business days of survey completion.
7. All of the aforementioned GPRA reporting must be submitted to OMNI Institute within five business days of survey completion.
8. CSB receiving treatment or recovery funding under the SOR grant must complete a treatment or recovery Quarterly Survey every quarter of the grant.
9. The aforementioned Quarterly Survey must be submitted to OMNI Institute within two weeks of request by OMNI Institute.

B. The Department Responsibilities: The Department agrees to comply with the following requirements.

1. The Department shall be responsible for submitting required reporting to SAMHSA in accordance with the SOR Notice of Award.
2. The Department shall conduct physical and/or virtual site visits on an annual basis, or more frequently, if necessary. Each site visit will be documented in a written report submitted to the Director of Adult Community Behavioral Health.
3. The SOR team will provide quarterly reports to internal and external stakeholders.

C. Reporting Requirements: The CSB shall submit the Quarterly Treatment and Recovery Reporting Surveys through the online survey link that will be provided by OMNI Institute each quarter. All surveys must be submitted no later than the following dates:

Quarter 1	January 20
Quarter 2	April 15
Quarter 3	July 15
Quarter 4	October 14

The CSB shall collect GPRA data for each person receiving services at intake, discharge, and 6-month time points. This data must be submitted to OMNI Institute within five business days of survey completion.

11.5. Regional Suicide Prevention Initiative

Scope of Services and Deliverables
In an effort to increase capacity to address suicide prevention and promote mental health wellness, the Department funding for regional suicide prevention plans that implement evidenced based initiatives and strategies that promote a comprehensive approach to suicide prevention across the lifespan in the Commonwealth.

The regional or sub regional initiatives are intended to extend the reach and impact of suicide prevention efforts, afford greater access to suicide prevention resources by affected communities, and leverage and reduce costs for individual localities related to training or other suicide prevention action strategies.

A. The CSB Responsibilities: The CSB agrees to comply with the following requirements.

1. The CSB shall provide an action plan that includes (but not limited to) the following strategies and activities:

a. mental health wellness and suicide prevention trainings based on community need and capacity to provide;
b. activities for September Suicide Prevention Awareness Month and May Mental Health Awareness Month;
c. identification of anticipated measurable outcomes;
d. a logic model; and
e. a budget and budget narrative

2. These funds shall be used only for the implementation of the Regional Suicide Prevention Initiative described in the Regional Suicide Prevention plan (and or supplement plan) approved by the Department.
3. Any restricted state funds that remain unexpended or unencumbered at the end of the fiscal year may be carried over to the following year to be used only for Regional Suicide Prevention Initiative expenses authorized by the Department in consultation with the participating regional CSB.
4. Any federal funds that remain unexpended or unencumbered by the end of the Performance Period the CSB must contact the Department at least 30 days prior to the end of the Performance Period to discuss permissible purposes to expend or encumber those funds.

B. The Department Responsibilities: The Department agrees to comply with the following requirement.

1. The Department shall monitor Regional Suicide Prevention Initiative program implementation progress through a semi-annual report and annual report submitted by the Regional Suicide Prevention Initiative Lead CSB, other data gathering and analysis, periodic visits to the region to meet with Regional Suicide Prevention Initiative partners, and other written and oral communications with Regional Suicide Prevention Initiative team members.
2. The Department may adjust the CSB's allocation of continued state funds for the Regional Suicide Prevention Initiative based on the CSB's compliance with its responsibilities, including the requirements for maximizing resources from other sources.
3. The Department will provide guidelines for the annual plan and a template for the semi-annual and annual report for the CSB to use.

C. Reporting Requirements:

1. Mental Health First Aid and Suicide Prevention activities shall be included in each CSB's Prevention data system.
2. The Regional Suicide Prevention Initiative CSB shall submit its semi-annual report to the Department by **April 15th** and its annual report on **September 30th**.
3. Each region shall provide semi-annual report and annual report submitted by the Regional Suicide Prevention Initiative Lead CSB to the Suicide Prevention Coordinator.

11.6. Supplemental Substance Abuse Block Grant Funded Program Services - (Prevention And Treatment)

Scope of Services and Deliverables
This allocation provides supplemental funding to support additional allowable uses of Substance Abuse Prevention and Treatment (SAPT) Block Grant funding.

This funding source is designated to plan, implement, and evaluate activities that prevent or treat substance use disorder, including to fund priority substance use disorder treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time, fund those priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery that are not covered by Medicaid, Medicare, or private insurance, fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment, and collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and

recovery support services. SABG funds are to be the funds of last resort. Medicaid and private insurance, if available, must be used first. Target and priority populations are pregnant and parenting women and intravenous (IV) drug users. Any treatment services provided with SABG funds must follow treatment preferences established in 45 CFR 96.131(a):

1. Pregnant injecting drug users
2. Pregnant substance abusers
3. Injecting drug users
4. All others

Complete details of allowable services can be found in Exhibit F of the performance contract.

A. The CSB Responsibilities: The CSB agrees to comply with the following requirements

1. The CSB shall prioritize SAPT priority populations including individuals who do not have insurance, pregnant women and women with dependent children, and people who inject drugs
2. The CSB shall follow all other federal requirements pursuant to Exhibit F.

B. The Department Responsibilities: The CSB agrees to comply with the following requirements. The Department shall monitor uses of these supplemental funds in the same manner it monitors uses of SAPT treatment and recovery base funding, including SAMHSA measures and on-site or virtual reviews. These funds will be monitored as part of existing review processes.

11.7. Substance Abuse Block Grant (SABG) Prevention Set Aside Services, CAA Supplemental

Scope of Services and Deliverables

The SABG Prevention Set Aside CAA Supplemental is intended to prevent Substance Use Disorders (SUD) by implementing an array of strategies including information dissemination, education, alternatives, problem ID and referral, community capacity building and environmental approaches that target individuals, communities and the environment and guided by the Strategic Prevention Framework (SPF) planning model.

The SABG Prevention Set Aside CAA Supplemental funds may be used to implement and expand the CSB logic models which support both local and state priorities as identified below and through the CSB approved logic model and already submitted plan.

A. The CSB Responsibilities: The CSB agrees to comply with the following requirements.

1. General Capacity Requirements

a. Each CSB must complete an evaluation plan which is revised and approved annually and includes:
   i. A logic model which includes all of the required priority strategies all CSB must implement and any discretionary strategies the CSB has elected to implement.
   ii. A measurement plan documenting how all required metrics will be tracked and reported.

b. All prevention programs, practices, and strategies must be evidence-based and approved by the DBHDS OBHW team. Only strategies that align with the state-identified priorities and/or the CSB's logic model outcomes will be approved.

c. Each CSB must maintain a license for the Performance-Based Prevention System (PBPS) and record all implemented strategies in the PBPS. The resources to support this have been added to the CSB base allocation.

d. Each CSB must maintain a minimum of 1 FTE Prevention Lead position. This position leads and ensures compliance and implementation of all Prevention priority strategies.
e. Prevention funding should be used for prevention staff to attend at least one national prevention-related conference per year. Any national conferences outside of the NPN Prevention Research Conference, NATCON, CADCA National or Mid-Year Conferences must have prior DBHDS approval. Each CSB receives $3000 in their base allocation to help support this capacity building effort.
f. Submit an annual budget for SABG Prevention Set Aside utilizing DBHDS' template.
g. Within that budget, allocate specific resources for Marijuana prevention capacity building, planning and implementation in the amount of $45,000.

2. **Counter Tools**

a. The CSB shall conduct store audits of and merchant education with 100 percent of tobacco/nicotine retailers in its service area over a two-year period. Any retailer to be found in violation in the previous year is to be given priority for merchant education.

b. The CSB also must maintain and update a list of tobacco/nicotine retailers in its catchment area over the two-year period.

c. Data must be entered into the Counter Tools and PBPS systems.

d. The CSB base allocation includes $10,000 for these strategies.

e. Tobacco education programs for youth with the goal of reducing prevalence of use are not to be identified as SYNAR activities.

3. **ACEs Trainings**
   a. All CSB should ensure there are at least 2 ACEs master trainers in their catchment area at all times.
   b. All CSB must conduct at least 12 ACEs trainings annually.
   c. All ACEs training data (including number of trainings held and number of people trained) must be reported in PBPS.
   d. CSB which are designated as Self-Healing Communities and are receiving additional funding to address ACEs must complete all items noted above and the following:
      i. Maintain an ACEs self-healing community advisory committee made up of a cross-section of community partners, meets at least quarterly, reviews the Self-Healing Communities logic model and provides ongoing feedback and recommendations on how to best achieve the logic model goals. Create a logic model specific to the ACEs work that is planned and implemented in the community.
      ii. Submit a quarterly report on all ACEs strategies and measures.
      iii. Engage in a local Trauma-Informed Community Network (TICN) or other trauma-centered coalition

4. **Community Coalition Development**
   a. The CSB shall be involved in a minimum of 6-10 coalition meetings a year.
   b. The CSB should maintain membership in CADCA and/or CCoVA each year.
   c. The CSB and its associated coalition should ensure youth engagement in the coalition either as a sub-group of the coalition or a separate youth coalition.
   d. The CSB should maintain a social media presence to publicize prevention activities and messaging (Facebook page, Instagram, website, etc.) Websites should be updated monthly at a minimum and social media bi-weekly to ensure information and resources remain relevant and engages the community.
   e. Every 2 years, each CSB must complete a coalition readiness assessment and an assessment of representation in the coalition of the following 12 sectors: youth; parents; businesses; media; school; youth-serving organizations; law enforcement; religious/fraternal

organizations; civic and volunteer organizations; healthcare professionals; state, local and tribal governments; and other organizations involved in reducing illicit substance use.

5. **MH/Suicide Prevention Trainings**
   a. The CSB shall work with the regional MH/suicide prevention team to provide a regionally developed suicide prevention plan using the Strategic Prevention Framework model.
   b. The plan developed by the team shall identify suicide prevention policies and strategies. Strategies should be determined using the most current data and there should be strategies in the plan that are for the community as a whole as well as strategies that target subpopulations with the highest rates of suicide. The plan should also identify the CSB's marketing plan to ensure community groups (schools, faith groups, businesses, etc.) and community members are aware of the mental health and suicide prevention trainings the CSB is providing.
   c. Each MHFA trainer must provide a minimum of 3 Youth and/or Adult MHFA trainings annually.
   d. The CSB should ensure a minimum of 45 community participants are trained annually in MHFA (across all MHFA trainers at the CSB; there is no minimum number of trainees for each certified trainer).
   e. In addition to the required MHFA trainings, a minimum of 3 suicide prevention trainings per trainer must be provided annually. These 3 trainings may be a combination of any of the approved trainings below:
      i. ASIST
      ii. safeTALK
      iii. suicideTALK
      iv. QPR
   f. Every year, each CSB will be required to submit a mid-year (April) and end-of-year (September) report which should contain details on trainings implemented, including the number of different groups and community members participating in the trainings.

6. **Lock & Talk**
   a. CSB participating in the Lock and Talk Initiative shall develop an implementation plan that best meets the needs of their respective communities (including strategies to address target populations.)
   b. At a minimum the CSB is expected to implement components 1 & 2 below, and strongly encouraged to
   implement the Gun Shop Project and/or partner with their medical community (pharmacies, medical
   practices) if the Gun Shop Project is not an appropriate fit for their community.
   Lock and Talk Components:
   1) Media Campaign Materials (bus ads, posters, billboards, PSA, etc.)
   2) Medication Lock Box/Cable Lock/Trigger Lock Distribution at Events 3) Gun Shop Project

B. The Department Responsibilities: The Department agrees to comply with the following requirements.

1. The Department shall adhere to SABG Prevention Set Aside, grant guidelines established by the Substance Abuse and Mental Health Services Administration (SAMHSA), including reporting on statewide and CSB-specific data, accomplishments and challenges.
2. The Department's SABG Prevention Set Aside Behavioral Health Wellness Consultants shall maintain regular communication with the CSB, monitor performance through reporting, and provide technical assistance to the CSB upon request.
3. The Department will work with the CSB to mutually agree on annual site visit dates.
4. The Department, particularly the SABG Prevention Set Aside Behavioral Health Wellness Consultants will respond to inquiries in a timely fashion, fulfill requests for training and share regular updates regarding the grant.

5. Every effort will be made to provide at least two weeks lead time prior to report deadlines by DBHDS in partnership with OMNI Institute federal reporting contractor.
6. The Department will provide a budget template for annual budget submission

C. Reporting Requirements: All data is reported into the Prevention data system and must be submitted within 2 weeks of service delivery**.**

12. STATE FUNDED PROGRAM SERVICES

This section describes certain program services with a primary funding source of state general funds but there may also be other sources of funding provided by the Department for the services provided.

12.1. Auxiliary Grant In Supportive Housing Program (AGSH)

Scope of Services and Deliverables
Section 37.2-421.1 of the Code of Virginia provides that DBHDS may enter into an agreement for the provision of supportive housing for individuals receiving auxiliary grants pursuant to §51.5-160 with any provider licensed to provide mental health community support services, intensive community treatment, programs of assertive community treatment, supportive in-home services, or supervised living residential services. The Auxiliary Grant (AG) funds shall not be disbursed directly to the CSB or DBHDS. The Department for Aging and Rehabilitative Services (DARS) shall maintain administrative oversight of the Auxiliary Grant program, including the payment of AG funds from DSS to individuals in the program.

A. The CSB Responsibilities: The CSB shall comply with the following requirements pursuant.

1. For each individual served by the provider under this agreement, the provider shall ensure the following basic services:
   a. the development of an individualized supportive housing service plan ("ISP");
   b. access to skills training;
   c. assistance with accessing available community-based services and supports;
   d. initial identification and ongoing review of the level of care needs; and
   e. ongoing monitoring of services described in the individual's ISP.
2. Assist AGSH recipients with securing and maintaining lease-based rental housing. This residential setting shall be the least restrictive and most integrated setting practicable for the individual that:
   a. complies with federal habitability standards;
   b. provides cooking and bathroom facilities in each unit;
   c. affords dignity and privacy to the individual; and
   d. includes rights of tenancy pursuant to the Virginia Residential Landlord and Tenant Act (§55-248.2 et seq.).
   e. provides rental levels that leave sufficient funds for other necessary living expenses, and
   f. the provider shall not admit or retain recipients who require ongoing, onsite, 24-hour supervision and care or recipients who have any of the conditions or care needs described in subsection D of §63.2-1805.
3. Maintain an AGSH census of at least 45 individuals. The provider is expected to be full census within 12 months of operation and to maintain census of no less than 90% thereafter.
4. Request approval, in writing, of DBHDS for an AGSH recipient to live with a roommate freely chosen by the individual.
5. Adhere to all components of the AGSH Provider Operating Guidance.
6. Licensing/Certification Requirements:

a. The CSB shall maintain all relevant DBHDS licenses in good standing. Provide documentation of licensure status for relevant services to the Department for Aging and Rehabilitative Services (DARS) at initial certification and annually thereafter.
b. The CBS shall maintain annual certification with DARS in accordance with §51.5-160 Section D.

B. The Department Responsibilities:

1. DBHDS or its designee shall conduct annual inspections to determine whether the provider is in compliance with the requirements of this agreement. DBHDS will provide 30 days written notice for routine annual inspections. DBHDS may also conduct inspections at any time without notice.
2. DBHDS will work with the Provider to develop and implement AGSH data reporting requirements including data elements, formats, timelines and reporting deadlines.
3. Pursuant to §37.2-421.1 Section C., DBHDS may revoke this agreement if it determines that the provider has violated the terms of the agreement or any federal or state law or regulation.

C. Reporting Requirements: The CSB shall collect and report recipient level identifying information and outcome data at least quarterly no later than the 10th day following the end of the month (i.e., October 15th, January 15th, April 15th, and July 15th) and provide to DBHDS as requested**.**

12.2. Children's Mental Health Initiative (MHI) Funds

Scope of Services and Deliverables

The Mental Health Initiative (MHI) Fund was established by the General Assembly in FY 2000 to create a dedicated source of funding for mental health and substance abuse services for children and adolescents with serious emotional disturbances (SED) who are not mandated for the Children's Services Act (CSA). The Appropriation Act provides certain funds for the priority placed on those children who, absent services, are at-risk for custody relinquishment, as determined by the Family and Assessment Planning Team of the locality. These services have the purpose of keeping children in their homes and communities and preserving families whenever possible.

A. The CSB Responsibilities: The CSB agrees to comply with the following requirements.

1. MHI funds must be used exclusively to serve currently unserved children and adolescents or provide additional services to underserved children and adolescents with serious emotional disturbances, at risk for serious emotional disturbance, and/or with co-occurring disorders with priority placed on those children who, absent services, are at-risk for removal from the home due to placement by a local department of social services, admission to a congregate care facility or acute care psychiatric hospital or crisis stabilization facility, commitment to the Department of Juvenile Justice, or parental custody relinquishment. These funds shall be used exclusively for children and adolescents, not mandated for services under the Children's Services Act. Underserved refers to populations which are disadvantaged because of their ability to pay, ability to access care, or other disparities for reasons of race, religion, language group, sexual orientation or social status.
2. Children and adolescents must be under 18 years of age at the time services are initiated. MHI funds can be used to bridge the gap between the child and adolescent and adult service systems, if the service was initiated before the adolescent's 18th birthday. Services used to bridge the gap can only be used for up to one (1) year. MHI funds cannot be used to initiate new services once an adolescent turns 18 years of age.
3. MHI funds must be used to purchase services which will be used to keep the child or adolescent in the least restrictive environment and living in the community.
4. CSBs may use MHI funds to support personnel used to provide services to children and families. Each service provided shall should be linked to an individualized service plan for an

individual child and reported through the CCC3 by using Consumer Designation Code 915 code.

5. MHI funds should not be used when another payer source is available.
6. Services must be based on the individual needs of the child or adolescent and must be included in an individualized services plan. Services must be child-centered, family focused, and community-based. The participation of families is integral in the planning of these services.
7. CSBs must develop policies and procedures for accessing MHI funds for appropriate children and adolescents
8. The CSBs shall develop a Mental Health Initiative funding plan in collaboration with the local Family and Assessment Planning Teams and/or Community Policy and Management Team. The funding plan shall be approved by the Community Policy and Management Teams of the localities. The CSB should seek input and guidance in the formulation of the protocol from other FAPT and CPMT member agencies. A copy of the plan shall be kept on file at the CSB.

    a. The MHI Fund Protocol shall at minimum:
        i. Clearly articulate the target population to be served within the serious emotional disturbance, at risk for serious emotional disturbance, and/or with co-occurring disorders, non-CSA mandated population;
        ii. Establish defined protocols and procedures for accessing services, ensuring that all key stakeholder agencies have a method to link into services;
        iii. Clearly articulate the kinds or types of services to be provided; and
        iv. Provide for a mechanism for regular review and reporting of MHI expenditures.
9. **Appropriate Services to be supported by Mental Health Initiative (MHI) Funds -** CSBs must follow the DBHDS Core Services Taxonomy categories and subcategories in providing, contracting for, and reporting these services.
    a. Types of services that these funds may be used for include, but are not limited to: crisis intervention and stabilization, outpatient, intensive in-home, intensive care coordination, case management, Family Support Partners, evidence-based practices, therapeutic day treatment, alternative day support (including specialized after school and summer camp, behavior aide, or other wrap-around services), and, supervised family support services.
    b. All expenditures shall be linked to an individualized service plan for an individual child. Expenditures may be for something that is needed by more than one child, providing it can be linked to the individualized service plan of each child.
    c. CSBs may use MHI funds to support personnel used to provide services to children and families. For example, the funds may be used to create a position dedicated to serving the non-CSA mandated population of children in the community; however, as stated above, each service provided should be linked to an individualized service plan for an individual child.
    d. CSBs may use up to 10% of the total MHI fund allocation for administrative costs associated with the overall MHI fund management and administration. Administrative costs include non-direct service personnel and supplies.
    e. MHI funds may not be used for residential care services, partial or full hospitalizations, or for CSA sum sufficient populations. MHI funding may not be used to purchase vehicles, furniture, computers, or to provide training.

B. The Department Responsibilities: The Department agrees to comply with the following requirements.

The Department shall establish a mechanism for regular review and reporting of MHI Fund expenditures including monitoring unspent balances.

C. Reporting Requirements:

1. All expenditures shall be linked to an individualized service plan for an individual child and reported through the CCC3 by using Consumer Designation Code 915 code. Expenditures may be for something that is needed by more than one child, providing it can be linked to the individualized service plan of each child.
2. The CSB shall provide data reports as required in CCS 3 and finance reports on the funds provided by the Department. This information will be reported through the CCS3 by using Consumer Designation Code 915 code.
3. The CSB may carry-forward a balance in the MHI fund during the biennium in which the funds were distributed. If the CSB has a balance of 10% or greater, of the current allocation, at the end of the biennium, the CSB shall work with the OCFS to develop a plan to spend the end of the biennium balance.

12.3. Permanent Supportive Housing (PSH)

Scope of Services and Deliverables
If the CSB receives state mental health funds for PSH for adults with serious mental illness, it shall fulfill these requirements:

a. Comply with requirements in the PSH Initiative Operating Guidelines and any subsequent additions or revisions to the requirements agreed to by the participating parties. If the implementation of the program is not meeting its projected implementation schedule, the CSB shall provide a written explanation to and seek technical assistance from the Office of Adult Community Behavioral Health Services in the Department.

b. Ensure that individuals receiving PSH have access to an array of clinical and rehabilitative services and supports based on the individual's choice, needs, and preferences and that these services and supports are closely coordinated with the housing-related resources and services funded through the PSH initiative.

c. Assist Department staff as requested with any case-level utilization review activities, making records of individuals receiving PSH available and providing access to individuals receiving PSH for interviews.

d. Track and report the expenditure of restricted state mental health PSH funds separately in the implementation status reports required in subsection f below. Based on these reports, the Department may adjust the amount of state funds on a quarterly basis up to the amount of the total allocation to the CSB. The CSB shall include applicable information about individuals receiving PSH services and the services they receive in its information system and CCS Extract monthly extracts.

e. Reserve any current restricted state mental health funds for PSH that remain unspent at the end of the fiscal year to be used only for PSH activities in subsequent fiscal years as authorized by the Department.

f. Submit implementation status reports for PSH within 45 days after the end of the quarter for the first three quarters and within 60 days of the end of the fiscal year to the Department. Submit data about individuals following guidance provided by the Office of Adult Community Behavioral Health and using the tools, platforms, and data transmission requirements provided by the Department. Establish mechanisms to ensure the timely and accurate collection and transmission of data. The Department shall provide the data collection and reporting database, submission due dates, and reporting protocols to the CSB in sufficient time to allow it to comply with them.

g. Participate in PSH training and technical assistance in coordination with the Office of Adult Community Behavioral Health Services and any designated training and technical assistance

providers.

12.4. Forensic Services

Scope Services and Deliverables

A. **The CSB Responsibilities**: the CSB shall comply with the following requirements.

1. The CSB shall designate appropriate staff to the roles of Forensic Admissions Coordinator, Adult Outpatient Restoration Coordinator, and NGRI Coordinator to collaborate with the local courts, the forensic staff of state facilities, and the Department. The CSB shall notify the Department's Office of Forensic Services of the name, title, and contact information of these designees and shall inform the Director of any changes in these designations. The CSB shall ensure that designated staff completes all recommended training identified by the Department.

2. Forensic evaluations and treatment shall be performed on an outpatient basis unless the results of an outpatient evaluation indicate that hospitalization is necessary. The CSB shall consult with their local courts and the Forensic Coordinator at the designated DBHDS hospital as needed in placement decisions for individuals with a forensic status, based upon evaluation of the individual's clinical condition, need for a secure environment, and other relevant factors.

3. If an individual with a forensic status does not meet the criteria for admission to a state hospital, his psychiatric needs should be addressed in the local jail, prison, detention center, or other correctional facility, by the CSB in collaboration with local treatment providers.

4. Upon receipt of a court order for forensic evaluation, the CSB shall provide or arrange for the provision of forensic evaluations required by local courts in the community in accordance with State Board Policy 1041.

5. Upon receipt of a court order pursuant to § 16.1-356 of the Code of Virginia, the CSB shall provide or arrange for the provision of a juvenile competency evaluation.

6. Upon receipt of a court order pursuant to § 16.1-357, the CSB shall provide or arrange for the provision of services to restore a juvenile to competency to stand trial through the Department's statewide contract.

7. Upon receipt of a court order for the provision of adult outpatient competency restoration services pursuant to § 19.2-169.2 of the Code of Virginia, the CSB shall provide or arrange for the provision of services to restore the individual to competency to stand trial. These services shall be delivered in the local or regional jail, juvenile detention center (when a juvenile is being tried as an adult), other location in the community where the individual is currently located, or in another location suitable for the delivery of the restoration services when determined to be appropriate. These services shall include treatment and restoration services, emergency services, assessment services, the provision of medications and medication management services, and other services that may be needed by the individual in order to restore him to competency and to prevent his admission to a state hospital for these services.

8. Upon written notification from a DBHDS facility that an individual hospitalized for restoration to competency pursuant to § 19.2-169.2 of the Code of Virginia has been restored to competency and is being discharged, the CSB shall to the greatest extent possible provide or arrange for the provision of services to the individual to prevent his readmission to a state hospital for these services.

9. The CSB shall provide discharge planning for persons found not guilty by reason of insanity who are being treated in DBHDS facilities pursuant to § 19.2-182.2 through § 19.2 -182.7, and § 19.2-182.11 of the Code of Virginia, and in accordance with the provisions of the C*ollaborative Discharge Requirements for Community Services Boards and State Hospitals: Adult & Geriatric.*

10. The CSB will implement and monitor compliance with court-ordered Conditional Release Plans (CRPs) for persons found not guilty by reason of insanity and released with conditions pursuant to § 19.2-182.2 through § 19.2 -182.7, and § 19.2-182.11 of the Code of Virginia. This includes submission of written reports to the court on the person's progress and adjustment in the community, to be submitted no less frequently than every six months from the date of release to a locality served by the CSB. The CSB will also provide to the Department's Office of Forensic Services written monthly reports on the person's progress and adjustment in the community for their first 12 continuous months in the community. The CSB is responsible for providing the Office of Forensic Services copies of any written correspondence and court orders issued for NGRI acquittees in the community.

B. Reporting Requirements: The CSB shall supply information to the Department's Forensics Information Management System for individuals adjudicated not guilty by reason of insanity (NGRI), as required under § 37.2-508 or § 37.2-608 of the Code and as permitted under 45 CFR §§ 164.506 (c) (1) and (3), 164.512 (d), and 164.512 (k) (6) (ii)

12.5. Gambling Prevention

Scope of Service and Deliverable
The Problem Gambling and Support Fund (9039) via the Office of Behavioral Health Wellness, Problem Gambling Prevention Program intends to prevent and minimize harm from the expansion of legalized gambling by implementing the Strategic Prevention Framework (SPF) planning model. We will begin this work by conducting a needs assessment and building community capacity across the state to make data driven decisions to determine priorities and select evidence-based strategies based upon the priorities identified.

In an effort to increase capacity to address problem gambling prevention the Department provides funding for CSB level problem gambling prevention needs assessments, data collection, and capacity building to then implement evidenced based initiatives and strategies that promote a comprehensive approach to problem gambling prevention in the Commonwealth.

A. The CSB Responsibilities: The CSB agrees to comply with the following requirements.

1. The CSB shall provide a proposed budget.
2. These funds shall be used only for the implementation of the Problem Gambling Prevention Services described herein.
3. The CSB shall participate in assessing regional needs by collecting data for their catchment area on gambling and gaming behaviors, pervasiveness of gambling through an environmental scan, and community readiness to address problem gambling prevention.
4. The CSB shall build capacity in their CSB by assigning at least one person to oversee the problem gambling prevention needs assessment work who may then continue on to incorporate findings into the CSB's strategic plan and strategy implementation in the CSB's region as additional years of funding become available. This includes attending and participating in all trainings and webinars offered for this work.
5. The CSB may either hire at least a part time staff person, add hours on to a current part time position in the organization, or adjust a current employees workload to allow for time to lead and ensure compliance and implementation of all problem gambling prevention activities.

6. Any restricted state Problem Gambling and Support funds that remain unexpended or unencumbered at the end of the fiscal year may be carried over to the following year to be used only for Problem Gambling Prevention strategy expenses authorized by the Department.

B. The Department Responsibilities: The Department agrees to comply with the following requirements.

1. The Department shall monitor Problem Gambling Prevention Services program implementation progress through a quarterly report submitted by the CSB Problem Gambling Prevention Services Lead, other data gathering and analysis, periodic on-site or virtual visits to meet with the CSB Problem Gambling Prevention Services staff, and other written and oral communications with CSB Problem Gambling Prevention Services team members.
2. The Department may adjust the CSB's allocation of continued state funds for the Problem Gambling Prevention Services based on the CSB's compliance with its responsibilities, including the requirements for maximizing resources from other sources
3. The Department will respond to inquiries in a timely fashion, fulfill requests for training and share regular updates regarding the grant.
4. Every effort will be made to provide at least two weeks lead time prior to report deadlines by DBHDS in partnership with OMNI Institute federal reporting contractor.
5. The Department will provide a template for the plan and quarterly report for the CSB to use.

C. Reporting Requirements: The CSB shall track and account for its state Problem Gambling and Support Fund as restricted problem gambling prevention State funds, reporting expenditures of those funds separately in its quarterly reports.

12.6. Mental Health Services In Juvenile Detention Centers

Scope of Services and Deliverables

The Mental Health in Juvenile Detention Fund was established to create a dedicated source of funding for mental health services for youth detained in juvenile detention centers.

A CSB's primary role in a juvenile detention center is providing short-term mental health and substance use disorder services to youth detained in the center with mental illnesses or mental illnesses and co-occurring substance use disorders. As part of this role, a CSB also consults with juvenile detention center staff on the needs and treatment of youth. This may include case consultation with detention center staff. Since the youth have been court ordered to the center, they are under the jurisdiction of the center for care. A CSB provides consultation and behavioral health services in support of the centers care of youth and should establish and maintain positive, open, and professional communication with center staff in the interest of providing the best care to the youth.

A. The CSB Responsibilities: The CSB agrees to comply with the following requirements.

1. The CSB shall provide mental health and substance use services to youth detained in the juvenile detention center, this may include youth who are pre-adjudicated, youth who are post-adjudicated, youth who are post-dispositional, and youth who are in a community placement program. Since most youth have short lengths of stay, clinical services in juvenile detention should be designed to provide short term mental health and substance use services. At times, a youth may have a long length of stay and the CSB should be prepared to provide services as needed. Below are examples of core services a CSB typically provides with this funding to most of the youth it serves in juvenile detention centers:
    a. Case management,
    b. Consumer Monitoring,
    c. Assessment and Evaluation,
    d. Medical Services, or
    e. Individual or group therapy when appropriate (coded as outpatient services)
2. The CSB shall provide discharge planning for community based services for youth with identified behavioral health and/or substance use issues who return to the community.

3. The CSB shall have a Memorandum of Understanding (MOU), a Memorandum of Agreement (MOA), or contract with the juvenile detention center in which the CSB provides services. The MOU, MOA, or contract shall outline the roles and responsibilities of each entity as well as outline a plan for regular communication between the CSB and Juvenile Detention Center.
4. The CSB shall notify the Office of Child and Family Services of any significant staffing changes or vacancies that cannot be filled within 90 days.

B. The Department Responsibilities: The Department agrees to comply with the following requirements. The Department shall establish a mechanism for regular review of reporting Mental Health in Juvenile Detention fund expenditures, data, and MOUs/MOAs or contracts to include a process by the Office of Child and Family Services.

C. Reporting Requirements:

1. The CSB shall account for and report the receipt and expenditure of these restricted funds separately.
2. The CSB shall adhere to the current Core Services Taxonomy descriptions and classifications of services. This information will be reported through the CCS by using Consumer Designation Code 916 code assigned each youth receiving services. When the youth is no longer receiving services in the juvenile detention center, the 916 Consumer Designation Code will be closed out.
3. The CSB biennially, shall provide a copy of a signed MOU/MOA or contract to the Department.

13. OTHER PROGRAM SERVICES

This section includes certain program services initiatives CSB may engage in with the Department such as, but not limited to regional programs, pilot and other projects,

13.1. Mental Health Crisis Response And Child Psychiatry Funding –Regional Program Services

Scope of Services and Deliverables
Children's Residential Crisis Stabilization Units (CRCSU) are a crucial part of the community-based continuum of care in Virginia. The expectations outlined in this document support the strategic vision of DBHDS to provide access to quality, person-centered services and supports in the least restrictive setting, and that exemplify clinical and management best practices for CRCSUs. CRCSUs should demonstrate consistent utilization, evidence-based clinical programming, and efficient operations. CRCSUs provide treatment for individuals requiring less restrictive environments than inpatient care for managing their behavioral health crises.

The funds are provided to the CSB as the regional fiscal agent to fund other CSBs in the designated region or regional programs to provide Child Psychiatry and Children's Crisis Response services.

A. The CSB Responsibilities: The CSB agrees to comply with the following CRSCU requirements.

1. **Child Psychiatry and Crisis Response:** The regional fiscal agent shall require a Memorandum of Understanding (MOU), a Memorandum of Agreement (MOA), or a contract with all CSBs in their region if Child Psychiatry and Crisis Clinician Services are to be provided by individual boards. The MOU or MOA shall outline the roles, responsibilities of the regional fiscal agent and each board receiving funding, funding amounts, data and outcomes to be shared with the regional fiscal agent, and how children can access child psychiatry and crisis clinician services. The MOU, MOA, or contract shall be developed by the CSB providing the services, reviewed by the regional fiscal agent, and executed once agreed upon.

   If the CSB fiscal agent is providing regional Child Psychiatry and Crisis Clinician Services, then the regional fiscal agent shall develop the MOU, MOA, or contract to be reviewed by each CSB in the region and executed once agreed upon.

a. Each CSB shall have access to a board-certified Child and Adolescent Psychiatrist who can provide assessment, diagnosis, treatment and dispensing and monitoring of medications to youth and adolescents involved with the community services board. The CSB may hire a psychiatric nurse practitioner due to the workforce shortage of child and adolescent psychiatrists or contract within the region to have access.
b. The psychiatrist's role may also include consultation with other children's health care providers in the health planning region such as general practitioners, pediatricians, nurse practitioners, and community service boards' staff, to increase their expertise in the prevention, diagnosis, and treatment of children with mental health disorders.
c. CSBs must include, in the MOA/MOU, a description on how the CSB creates new or enhances existing community-based crisis response services in their health planning region, including, but not limited to mobile crisis response and community stabilization services, with the goal of diverting children from inpatient psychiatric hospitalization to less restrictive services in or near their communities.
d. Funds cannot be used to fund emergency services pre-screener positions if their role is to function as an emergency services clinician.

2. **Scope of Services for Children's Residential Crisis Stabilization Unit.**
   a. Staffing:
      1. The CRCSU staffing plan will be reviewed by the CSB clinical director at least quarterly to determine staffing needs and to ensure that staffing patterns meet the needs of the individuals served.
      2. Reviews are to ensure that staffing plans maximize the unit's ability to take admissions 24 hours a day seven (7) days a week. The CRCSU will follow the Service Description and Staffing as defined in Article 1 of Part IV in Chapter 105 Rules and Regulations for Licensing Providers by The Department of Behavioral Health and Developmental Services.
      3. The CRCSU will include family members, relatives and/or fictive kin in the therapeutic process and/or family support partners, unless it is not deemed clinically appropriate.
      4. The CRCSU will have a well-defined written plan for psychiatric coverage. The plan must address contingency planning for vacations, illnesses, and other extended absences of the primary psychiatric providers. Plans will be reviewed and updated as needed. Plans will be consistent with licensing and DMAS regulations.
      5. The CRCSU will have a well-defined written plan for nursing and/or clinical staff coverage. The plan must address contingency planning for vacations, vacancies, illnesses, and other extended staff absences. Plans will be reviewed and updated as needed. Plans will be consistent with licensing and DMAS regulations.
      6. The CRCSU will have a well-defined written plan for staffing all provider coverage during weather related events and other natural and man-made disasters or public health emergencies. Plans will be reviewed and updated as needed.
      7. CRCSU will have access to a Licensed Mental Health Professional (LMHP) or Licensed Mental Health Professional Eligible (LMHP-E) on-site during business hours and after hours, as needed, for 24/7 assessments.
   b. Admission and Discharge Process:
      1. Individuals considered for admission should not have reached their 18th birthday prior to admission.
      2. The CRCSU shall review and streamline their current admission process to allow for admissions 24 hours a day seven (7) days a week.
      3. The CRCSU shall develop well-defined written policies and procedures for reviewing requests for admission. The CRCSU will maintain written documentation of all requests and denials that include clinical information that could be used for inclusion or exclusion criteria. Admission denials must be reviewed by the LMHP or CSU Director within 72 hours of the denial decision.
      4. The CSU shall agree to the following exclusionary criteria:

i. The individual's psychiatric condition is of such severity that it can only be safely treated in an inpatient setting due to violent aggression or other anticipated need for physical restraint, seclusion or other involuntary control
   a. This may include: Individuals demonstrating evidence of active suicidal behavior. Individuals with current violent felony charges pending. Individuals demonstrating evidence of current assaultive or violent behavior that poses a risk to peers in the program or CRCSU staff. Individuals demonstrating sexually inappropriate behavior, such as sexually touching another child who is significantly older or younger that is not considered developmentally normal, within the last 12 months. Individuals with repetitive fire starter within the last 12 months.

ii. The individual's medical condition is such that it can only be safely treated in a medical hospital as deemed by a physician

iii. This may include individuals deemed to have medical needs that exceed the capacity of the program.

iv. The individual does not voluntarily consent to admission with the exception of temporary detention orders pursuant to §37.2-800 et. seq. and §16.1-335 et seq. of the Code of Virginia

v. This may include individuals that are unable or unwilling to participate in the programmatic requirements to ensure safety of staff and residents of the program. Individuals unable or unwilling to participate with the goals set out in individualized service plan (ISP). Individuals who demonstrate or report inability to function in a group setting without causing significant disruption to others and are not able to participate in alternative programming

vi. The individual can be safely maintained and effectively participate in a less intensive level of care

vii. This may include individuals whose needs can be better met through other services such as; individuals with a primary diagnosis of substance use disorder with current active use, individuals with ID/DD diagnosis better served by REACH programming.

viii. The request for service authorization is being pursued to address a primary issue of housing need, including individuals who were in some form of housing placement prior to admission to the RCSU and are not currently allowed to return and do not meet medical necessity criteria

ix. Admission does not meet medical necessity criteria and is being used solely as an alternative to incarceration.

x. Individuals admitted to the CRCSU should be at risk of serious emotional disturbance or seriously emotionally disturbed. The criteria for determining this is included in the current taxonomy.

5. The CRCSU shall accept and admit at least 55% of referrals made.
6. The CRCSU shall develop well-defined written policies and procedures for accepting step-downs from the Commonwealth Center for Children and Adolescents.
7. The CRCSU will follow discharge planning requirements as cited in the DBHDS licensing regulations (12VAC35-105-693).
8. CRCSUs will assess the integrated care needs of individuals upon admission and establish a plan for care coordination and discharge that addresses the individual's specialized care needs consistent with licensing and DMAS medical necessity

c. Programming
   1. The CRCSU will have a well-defined written schedule of clinical programming that covers at least eight (8) hours of services per day (exclusive of meals and breaks), seven (7) days a week. Programming will be trauma informed, appropriate for

individuals receiving crisis services, and whenever possible will incorporate evidence-based and best practices.
2. Programming must be flexible in content and in mode of delivery in order to meet the needs of individuals in the unit at any point in time.
3. The CRCSU will maintain appropriate program coverage at all times. The unit will have a written transition staffing plan(s) for changes in capacity.
4. The CRCSU manager, director, or designee shall implement a review process to evaluate both current and closed records for completeness, accuracy, and timeliness of entries. (12VAC35-105- 920)
5. Programming will contain a mix of services to include but not limited to: clinical, psycho educational, psychosocial, relaxation, and physical health.
6. Alternate programming must be available for individuals unable to participate in the scheduled programming due to their emotional or behavioral dysregulation.
7. The CRCSU manager, director, or designee shall outline how each service offers a structured program of individualized interventions and care designed to meet the individuals' physical and emotional needs; provide protection, guidance and supervision; and meets the objectives of any required individualized services plan. The CRCSU will provide scheduled recreational to include but not limited to: art, music, pet therapy, exercise, and yoga, acupuncture, etc.

d. Resources:
1. The CRCSU will develop a well-defined written process for building collaborative relationships with private and state facilities, emergency services staff, CSB clinical staff, schools, Family and Assessment Planning Teams (FAPT) and local emergency departments in their catchment area. Ideally, these collaborative relationships will facilitate the flow of referrals to the CRCSU for diversion and step down from a hospital setting and to transition an individual from a CRCSU to a higher level of care. This process will be documented in the CRCSUs policies and procedures.
2. The CRCSU will participate in meetings in collaboration with DBHDS and other CRCSUs at least quarterly

2. The CRCSU will comply with all DBHDS licensing requirements.
3. The CRCSU will provide data as per the provided DBHDS standardized spreadsheet for the CRCSU on a quarterly basis until such time this request is discontinued upon full operation of the retrieval of data from the Crisis Data Platform
4. The CRCSU will be responsible for the uploading of bed registry data metrics into the Crisis Data Platform as per the DBHDS Bed Registry Standards.
5. CRCSUs shall be considered regional programs and is not specific to the physical location of the program. The CSBs in the Region will revise the Memorandum of Understanding (MOU) governing the Regional CRCSU and provide this to the Department upon request.
6. The CRCSU will offer evidence based and best practices as part of their programming and have an implementation/ongoing quality improvement for these in the context of the applicable regulations. The CRCSU shall develop a written plan to maintain utilization at 65% averaged over a year and submit to DBHDS annually, Crisis Services Coordinator with ongoing revisions as needed. DBHDS will review utilization data annually and make adjustments to utilization targets up to 75% required capacity.
7. The CRCSU will develop a written plan to ensure the CRCSUs remain open, accessible, and available at all times as an integral part of DBHDSs community-based crisis services.
8. The CRCSU will develop a written plan to accept individuals accepting step-downs from Commonwealth Center for Children and Adolescents.
9. The CSB shall meet the reporting requirements required in Section 7. Reporting Requirements and Data Quality of the FY 2022 and FY 2023 Community Services Performance Contract. This includes reporting requirements for both CARS and CCS.

B. The Department Responsibilities: In order to implement the **Children's Residential Crisis Stabilization Unit** the Department agrees to comply with the following requirements.

1. The Department shall provide Technical Assistance (TA), to include but not limited to: networking meetings, training, and site visits to the CSB upon request or if the staff determines based on yearly monitoring visits that the project is not accomplishing its mission or meeting its goals as described above.
2. The Department will initiate Quality Improvement Plans (QIP) after Technical Assistance has been provided and a CRCSU continues to not meet established benchmarks and goals. The purpose of the QIP is to have a period of collaborative improvement.
3. The Department will initiate Corrective Action Plans (CAP) if benchmarks and goals continue to not be met after TA and QIPs. There may be times where an issue is so severe that a CAP would be necessary where there was not a QIP in place, but this would be under extenuating circumstances.
4. The Department shall conduct annual monitoring reviews on the procedures outlined above.
5. The Department shall determine need for site visits based on monitoring that the CRCSU is not accomplishing its mission or meeting its goals as described in this document. The CRCSU will construct a corrective action plan for units not meeting their goals and collaborate with the CRCSU to implement the plan.
6. The Department shall monitor data to ensure data submitted through reports meets the expectations as outlined in this document and in the CRCSU written plans
7. The Department shall schedule quarterly meetings with the CCRU points of contact

C. Reporting Requirements for Children's Residential Crisis Stabilization Unit.

1. Annually submit as part of the yearly programmatic monitoring a plan to DBHDS to streamline the admission process to allow for 24 hours a day, 7 day a week admissions.
2. The CRCSU will document in EHR all required elements for service and CCS.
3. Monthly CRCSU will provide additional data points as requested to DBHDS Office of Child and Family Services, no later than the 15th of the month following the reporting month.
4. Providing data, as per the provided DBHDS standardized spreadsheet, for the CRCSU on a quarterly basis until such time this request is discontinued upon full operation of the retrieval of data from the Crisis Data Platform;
5. Uploading of bed registry data metrics into the Crisis Data Platform as per the DBHDS Bed Registry Standards per Code of Virginia (Chapter 3, Article 1, 37.2-308.1)

13.2. Child Psychiatry And Children's Crisis Response Funding

A. The CSB Responsibilities: In order to implement the CSB Fiscal Agent agrees to comply with the following requirements.

1. The Regional Fiscal Agent shall notify the department of any staffing issues for these services such as a reduction in staffing or an extended vacancy.
2. The Regional Fiscal Agent shall consult with the Office of Child and Family Services about any changes to the services allocation.
3. The CSB may charge an administrative cost in accordance with the role the CSB is serving for the region. The amount of funding that may be retained by the Regional Fiscal Agent for Administrative Costs is as follows:

    a. If the Regional Fiscal Agent is only passing the funding through to another CSB or service entity and is not entering into a contract or managing the program for which the funds are intended, the Regional
    b. Fiscal Agent may retain up to 2.5% of the allocation amount for Administrative Costs.
    c. If the Regional Fiscal Agent is entering into a subcontract with another entity which will allow the third party to administer the service or program, the Regional Fiscal Agent may retain up to 5% of the allocation for Administrative Costs.

d. If the Regional Fiscal Agent is directly administering the program or service for which the funds are intended, the Regional Fiscal Agent may retain up to 10% of the allocation for Administrative Costs.

4. The Regional Fiscal Agent shall receive monthly Child Psychiatry reports from each CSB which include: the hours of service provided by the child psychiatrist, the number of children served, and consultation hours with other health providers. This shall occur when the Regional Fiscal Agent is passing the funding to another CSB within the region to manage the responsibility of providing psychiatric services.
5. The Regional Fiscal Agent shall provide the executed MOU, MOA, or contract with each CSB to the Department's Office of Child and Family Services for its review.

B. The Department Responsibilities: In order to implement the **Child Psychiatry and Children's Crisis Response Funding** the Department agrees to comply with the following requirements.

1. The Department shall distribute the funds in the regular semi-monthly electronic funds transfers, beginning with the July 1 payment of each state fiscal year.
2. The Department shall establish a mechanism for regular review of reporting Child Psychiatry Services through the Child Psychiatry and Children's Crisis Response Funding expenditures, data, and MOUs/MOAs to include a process by the Office of Child and Family Services and will regularly share this data with the CSB's for proactive programming.
3. The Department will annually review Child Psychiatry and Children's crisis response spending.
4. The Department will provide technical assistance as needed.
5. The Department shall provide Technical Assistance (TA) as needed to the CSB's.

C. Reporting Requirements: For **Regional Fiscal Agent for Child Psychiatry and Crisis Response Responsibilities**.

1. The CSB shall account for and report the receipt and expenditure of these performance contract restricted funds separately.
3. The CSB shall adhere to the current Core Services Taxonomy descriptions and classifications of services.
4. The CSB shall provide a copy of a signed MOU/MOA to the Department.
5. The CSB should notify the department of staffing issues for these programs, such as a reduction in staffing or an extended vacancy.
7. The CSB may carry-forward a balance in the Child Psychiatry and Children's Crisis Response Fund during the biennium in which the funds were distributed. If the CSB has a balance of 10% or greater, of the current allocation, at the end of the biennium, the CSB shall work with the OCFS to develop a plan to spend the end of the biennium balance.

13.3. System Transformation of Excellence and Performance (STEP – VA)

STEP-VA is an initiative designed to improve the community behavioral health services available to all Virginians. All CSB in Virginia are statutorily required to provide all STEP-VA services. These services include: Same Day Access, Primary Care Screening, Outpatient Services, Crisis Services, Peer and Family Support Services, Psychiatric Rehabilitation, Veterans Services, and Case Management and Care Coordination. Over time, after full implementation of STEP-VA, the Department anticipates fewer admissions to state and private hospitals, decreased emergency room visits, and reduced involvement of individuals with behavioral health disorders in the criminal justice system.

1. Outpatient Services

Scope of Services and Deliverables

Outpatient services are considered to be foundational services for any behavioral health system. The Core Services Taxonomy 7.3 states that outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychiatry, psychological testing and assessment, laboratory and ancillary services. As one of the required services for STEP-VA, the purpose of the Outpatient Services step is to ensure the provision of high quality, evidence-based, trauma-informed, culturally-competent, accessible behavioral health services that addresses a broad range of diagnoses and considers an individual's course of illness across the lifespan from childhood to adulthood.

A. The CSB Responsibilities: The CSB agrees to comply with the following requirements.

1. The CSB will offer evidence based and best practices as part of their programming and implementation of Outpatient Services to the adults, children and families in the community.
2. The CSB/BHA shall increase capacity and community access to Children's Outpatient services.
3. CSB shall provide an appointment to a high quality CSB outpatient provider or a referral to a non-CSB outpatient behavioral health service within 10 business days of the completed SDA intake assessment, if clinically indicated. The quality of outpatient behavioral health services is the key component of this step.
4. All CSB will establish a quality management program and continuous quality improvement plan to assess the access, quality, efficiency of resources, behavioral healthcare provider training, and patient outcomes of those individuals receiving outpatient services through the CSB. This may include improvement or expansion of existing services, the development of new services, or enhanced coordination and referral process to outpatient services not directly provided by the CSB.
5. CSB shall establish expertise in the treatment of trauma related conditions.
6. CSB should provide a minimum for outpatient behavioral healthcare providers of 8 hours of trauma focused training in treatment modalities to serve adults, children/adolescents and their families within the first year of employment and 4 hours in each subsequent years or until 40 hours of trauma-focused treatment can be demonstrated.
7. The CSB shall complete and submit to the Department quarterly DLA-20 composite scores through CCS as well as provide training data regarding required trauma training yearly in July when completing federal Block Grant reporting.

B. The Department Responsibilities: The Department agrees to comply with the following requirements.

1. Conduct in-person or virtual visits/check-ins at least 2 times a year with the CSB program leadership to ensure compliance with the scope and requirements of the regional services; and to review outcomes, which include challenges and successes of the programs.
2. Determine the need for site visits based on monitoring, particularly if the Programs are not accomplishing its missions, and/or meeting its goals as described in this document.

2. Primary Care Screening and Monitoring

Any child diagnosed with a serious emotional disturbance and receiving ongoing CSB behavioral health service or any adult diagnosed with a serious mental illness and receiving ongoing CSB behavioral health service will be provided or referred for a primary care screening on a yearly basis.

A. For the implementation of "ongoing behavioral health service" is defined as "child with SED receiving Mental Health Targeted Case Management or adult with SMI receiving Mental Health Targeted Case Management". These clients are required to be provided with a yearly primary care screening to include, at minimum, height, weight, blood pressure, and BMI. This

screening may be done by the CSB or the individual may be referred to a primary care provider to have this screening completed.

B. If the screening is done by a primary care provider, the CSB is responsible for the screening results to be entered in the patient's CSB electronic health record. The CSB will actively support this connection and coordinate care with physical health care providers for all service recipients.

C. CSB shall screen and monitor any individual over age 3 being prescribed an antipsychotic medication by a CSB prescriber for metabolic syndrome following the American Diabetes Association guidelines.

D. Individuals with serious mental illness (SMI), a population primarily served by the CSB, are known to be at higher risk for poor physical health outcomes largely due to unidentified chronic conditions. Therefore it is important for behavioral health staff to provide primary care screening to identify and provide related care coordination to ensure access to needed physical health care.

E. For the population includes all individuals over age 3 who receive psychiatric medical services by the CSB. CSB must report the screen completion and monitoring completion in CCS monthly submission**.**

3. Same Day Access (SDA)

SDA means an individual may walk into or contact a CSB to
Request mental health or substance use disorder services and receive a comprehensive clinical behavioral health assessment, not just a screening, from a licensed or license-eligible clinician the same day. Based on the results of the comprehensive assessment, if the individual is determined to need services, the goal of SDA is that he or she receives an appointment for face-to-face or other direct services in the program clinical circumstances.

A. SDA emphasizes engagement of the individual, uses concurrent EHR documentation during the delivery of services, implements techniques to reduce appointment no shows, and uses centralized scheduling. If it has received state mental health funds to implement SDA, the CSB shall report SDA outcomes through the CCS Extract outcomes file. The CSB shall report the date of each SDA comprehensive assessment, whether the assessment determined that the individual needed services offered by the CSB, and the date of the first service offered at the CSB for all individuals seeking mental health or substance use disorder services from the CSB.

B. The Department shall measure SDA by comparing the date of the comprehensive assessment that determined the individual needed services and the date of the first CSB face-to-face or other direct service offered to the individual. SDA benchmarks can be found in Exhibit B of the performance contract.

4. Service Members, Veterans, and Families (SMVF)

As one of the nine required services for System Transformation Excellence and Performance (STEP-VA), the purpose of the Service Members Veterans and Families (SMVF) step is to ensure SMVF receive needed mental health, substance abuse, and supportive services in the most efficient and effective manner available. Services shall be high quality, evidence-based, trauma-informed, culturally-competent, and accessible. Per the Code of Virginia, CSB core services, as of July 1, 2021 shall include mental health services for members of the armed forces located 50 miles or more from a military treatment facility and veterans located 40 miles or more from a Veterans Health Administration medical facility.

A. All CSB shall ensure they have clinician(s) who specialize in treatment for post-traumatic stress disorder and other forms of trauma including from military and/or combat service including military sexual trauma and substance use disorders.

B. CSB shall ensure behavioral health services including but not limited to SMI, SUD, Co-Occurring and Youth/Adolescents. Clinical services for this population shall align with federal

clinical guidelines from Veterans Affairs and Department of Defense can be found at https://www.healthquality.va.gov.

C. CSB shall identify and refer SMVF seeking services to internal providers that have been trained in military cultural competency (MCC); collaborate with Military Treatment Facilities (MTFs), Veterans Health Administration (VHA) facilities, Virginia Department of Veterans Services (DVS) programs and other external providers to determine SMVF eligibility for services, and assist SMVF with services navigation.

D. The CSB shall submit information on SMVF receiving services in CCS monthly submission**.**

13.3. Case Management Services Training

The CSB shall ensure that all direct and contract staff that provide case management services have completed the case management curriculum developed by the Department and that all new staff complete it within 30 days of employment. The CSB shall ensure that developmental disability case managers or support coordinators complete the ISP training modules developed by the Department within 60 days of their availability on the Department's web site or within 30 days of employment for new staff.

13.4. Developmental Case Management Services Organization

The CSB shall structure its developmental case management or support coordination services so that a case manager or support coordinator does not provide a DD Waiver service other than services facilitation and a case management or support coordination service to the same individual. This will ensure the independence of services from case management or service coordination and avoid perceptions of undue case management or support coordination influence on service choices by an individual.

13.5. Access To Substance Abuse Treatment For Opioid Abuse

The CSB shall ensure that individuals requesting treatment for opioid drug abuse, including prescription pain medications, regardless of the route of administration, receive rapid access to appropriate treatment services within 14 days of making the request for treatment or 120 days after making the request if the CSB has no capacity to admit the individual on the date of the request and within 48 hours of the request it makes interim services, as defined in 45 CFR § 96.126, available until the individual is admitted.

13.6. Regional Programs

The CSB shall manage or participate in the management of, account for, and report on regional programs in accordance with the Regional Program Operating Principles and the Regional Program Procedures in the Core Services Taxonomy 7.3. The CSB agrees to participate in any utilization review or management activities conducted by the Department involving services provided through a regional program.

14. CSB CODE MANDATED SERVICES		
Services	**Mandated**	**Description**
Certification of Preadmission Screening Clinicians	VA Code Mandated	The CSB and Department prioritize having emergency custody order or preadmission screening evaluations performed pursuant to Article 16 of Chapter 11 of Title 16.1, Chapters 11 and 11.1 of Title 19.2, and Chapter 8 of Title 37.2 in the Code provided by the most qualified, knowledgeable, and experienced CSB staff.
Department of Justice Settlement Agreement (DOJ SA)	Compliance with DOJ SA	See Exhibit M of the performance contract.
Discharge Planning	VA Code Mandated	Section 37.2-500 of the Code of Virginia requires that CSB must provide emergency services.
Emergency Services Availability	VA Code Mandated	Section 32.2-500 of the code requires the CSB shall have at least one local telephone number, and where appropriate one toll-free number, for emergency services telephone calls that is available to the public 24 hours per day and seven days per week throughout its service area.
Preadmission Screening	VA Code Mandated	The CSB shall provide preadmission screening services pursuant to § 37.2-505 or § 37.2-606, § 37.2-805, § 37.2-809 through § 37.2-813, § 37.2-814, and § 16.1-335 et seq. of the Code and in accordance with the Continuity of Care Procedures in Appendix A of the CSB Administrative Requirements for any person who is located in the CSB's service area and may need admission for involuntary psychiatric treatment. The CSB shall ensure that persons it designates as preadmission screening clinicians meet the qualifications established by the Department per section 4.h and have received required training provided by the Department.
Preadmission Screening Evaluations	VA Code Mandated	1.) The purpose of preadmission screening evaluations is to determine whether the person meets the criteria for temporary detention pursuant to Article 16 of Chapter 11 of Title 16.1, Chapters 11 and 11.1 of Title 19.2, and Chapter 8 of Title 37.2 in the Code and to assess the need for hospitalization or treatment. Preadmission screening reports required by § 37.2-816 of the Code shall comply with requirements in that section.
STEP-VA	VA Code Mandated and Appropriations Act MM.1	Pursuant to 37.2-500 and 37.2-601 of the Code, all CSB shall provide the following services as described in the Taxonomy and report data through CCS 3 and CARS as required by the Department. Same Day Mental Health Assessment Services (SDA or Same Day Access) Outpatient Primary Care Screening Services

		Outpatient Behavioral Health and Substance Use Disorder Services Peer Support and Family Support Services Mental Health Services for Military Service Members, Veterans, and Families (SMVF)
Virginia Psychiatric Bed Registry	VA Code Mandated	The CSB shall participate in and utilize the Virginia Psychiatric Bed Registry required by § 37.2-308.1 of the Code to access local or state hospital psychiatric beds or residential crisis stabilization beds whenever necessary to comply with requirements in § 37.2-809 of the Code that govern the temporary detention process.

Exhibit H FY22-23: Regional Local Inpatient Purchase of Services (LIPOS) Requirements

Effective July 1, 2021, The Department and the CSB agree to implement the following requirements for management and utilization of all regional state mental health acute care (LIPOS) funds to enhance monitoring of and financial accountability for LIPOS funding, divert individuals from admission to state hospitals when clinically appropriate, and expand the availability of local inpatient psychiatric hospital services for state facility diversions.

HB1800 P. Out of this appropriation, $8,774,784 from the general fund the second year is provided from a transfer from Item 322 for Community Services Boards and a Behavioral Health Authority to divert admissions from state hospitals by purchasing acute inpatient or community-based psychiatric services at private facilities. This funding shall continue to be allocated to Community Services Boards and a Behavioral Health Authority for such purpose in an efficient and effective manner so as not to disrupt local service contracts and to allow for expeditious reallocation of unspent funding between Community Services Boards and a Behavioral Health Authority.

A. The CSB Responsibilities

1. All regional state mental health LIPOS funds allocated within the region shall be managed by the regional management group (RMG) and the regional utilization management and consultation team (RUMCT) on which the CSB participates in accordance with Core Services Taxonomy 7.3.

2. The CSB, through the RMG and RUMCT on which it participates, shall ensure that other funds or resources such as pro bono bed days offered by contracting local hospitals and Medicaid or other insurance payments are used to offset the costs of local inpatient psychiatric bed days or beds purchased with state mental health LIPOS funds so that regional state mental health LIPOS funds can be used to obtain additional local inpatient psychiatric bed days or beds.

3. If an individual's primary diagnosis is SA (Substance Abuse) and a TDO (Temporary Detention Order) is issued to a private psychiatric facility LIPOS may be used by the CSB.

4. CSBs and/or regions are expected to maintain contracts or memorandum of agreement with local facilities that at minimum specifies funding is to be utilized as funding of last resort, authorization procedures, timeliness of invoicing, the rate and any other limitations. These contracts or MOU's shall be available to DBHDS upon request for review.

5. Annually regions will provide DBHDS with contracted rates for facilities. This will be due with the first quarter report.

B. The Department Responsibilities

1. The Department, may conduct utilization reviews of the CSB or region at any time to confirm the effective utilization of regional state mental health LIPOS funds.

2. The Department shall provide technical assistance when requested by the CSB.

C. Payment Terms

1. LIPOS allocations are distributed to the regional fiscal agent. The RMG/ RUMCT and Regional fiscal agent retain responsibility to ensure equitable access to the regional allocation by CSB and report to DBHDS any funding deficits or re allocation by CSB. Funding for regions will be

determined by DBHDS in collaboration with the region based on regional spending from previous year.

a) For initial allocation to be distributed within 15 day of the beginning of the fiscal year DBHDS will allocated the higher of: either Average spending for previous fiscal year quarters 1, 2 and 3 **OR** the highest quarter spent.

b) For the quarters 2, 3 and 4 of the fiscal year determination of the allocation will be based on the previous quarter amount spent. *For example: Quarter 2 funding is a reimbursed amount of quarter 1 LIPOS spending.*

c) At any time during the year should expenses exceed funding regions may request assistance from DBHDS. Additionally DBHDS will monitor expenses and encumbrance to ensure regions have adequate funding for invoices received after the end of the fiscal year per contract/MOA agreements.

2. Administration fees for LIPOS are based on the following:

a) The Regional Fiscal Agent is entering into a subcontract with another entity which will allow the third party to administer the service or program, the Regional Fiscal Agent may retain up to 5% of the allocation/expenditures for Administrative Costs.

OR

The annualized cost of the employed Regional manager.

b) The determination of which administration fee methodology utilized will be discussed and documented by regional leadership and DAP specialist with DBDHS. Should the region choose the 5% this 5% will be determined based on the amount spent the previous fiscal year.

c) The administration fee that is agreed upon will be sent in full to the region at the beginning of the fiscal year.

3. Any balance of LIPOS funds at the end of quarter 4 may be accounted for in the following fiscal year allocation. Unspent balances are not to be utilized without approval from DBHDS.

D. Reporting

1. The region will provide quarterly data on an agreed upon LIPOS data collection tool each quarter no later than 30 Days after the end of the quarter. Regions will maintain documentation of invoices from providers. These invoices and documentation shall be available to DBHDS upon request.

2. Any changes to the LIPOS reporting tool will be reviewed and discussed with CSB Regional Managers and they will be given a 30-day time frame to implement changes.

3. CSBs are responsible for maintaining reporting in the electronic health record for individuals receiving LIPOS contracted services. Bed days used should be recorded under Inpatient services (250).

Amendment 1
FY22-23 Community Services Performance Contract
Exhibit I: Behavioral Health Wellness/Prevention Services

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A. Required SABG Prevention Set-Aside Frameworks

1. **Strategic Prevention Framework (SPF):** The CSB, in partnership with local community coalitions, shall use the data driven Strategic Prevention Framework (SPF) planning model to: complete a needs assessment using community, regional, and state data; build capacity to successfully implement prevention services; develop logic models, inclusive of CSB only programs and coalition partnership efforts, and a strategic plan with measurable goals, objectives, and strategies; implement evidenced-based programs, practices, and strategies that are linked to data and target populations; evaluate program management and decision making for enabling the ability to reach outcomes; plan for the sustainability of prevention outcomes; and utilize culturally appropriate strategies throughout all aspects of the SPF process.

   The CSB shall work with OMNI Institute, the Department's evaluation contractor, to develop an evaluation plan for its SABG prevention set aside-funded prevention services, Suicide Prevention, Mental Health First Aid and Problem Gambling Prevention strategies.

2. **Institute of Medicine (IOM) and Center for Substance Abuse Prevention (CSAP) Six (6) Strategies**: The CSB shall use the IOM model to identify target populations based on levels of risk: universal, selective, and indicated. The CSB shall utilize the CSAPs evidenced- based strategies: information dissemination, education and skill building, alternatives, problem identification and referral, community-based process, and environmental approaches.
   Community-based process/coalitions and environmental approaches that impact the population as a whole are keys to achieving successful outcomes and are Department priorities.

3. **Evidence Based Prevention Practice:** The Department prioritizes programs, practices, and strategies that target the prevention of substance use disorders, gambling use disorders and suicide and promotes mental health wellness across the lifespan using data to identify specific targets. The current prevention model best practice and a Department priority is environmental strategies complemented by programs that target the highest risk populations: selective and indicated (refer to subsection 5.b).

   All programs, practices, and strategies must link to a current local needs assessment and align with priorities set forth by the Department. Remaining Departmental resources may be utilized to meet additional locally identified needs in the CSB catchment area. Programs, practices, and strategies can be selected from the following resources: Office of Juvenile Justice and Delinquency Prevention Effective, Blueprints Model Programs, Blueprints Promising Programs, Suicide Prevention Resource Center Section 1, Centers for Disease Control and Prevention Evidence-Based Practices and other sources of evidenced based prevention practice.

   The CSB must select them based on evidence and effectiveness for the community and target population. All programs, practices, and strategies must be approved by the Department prior to implementation.

   Substance abuse prevention services may not be delivered to persons who have substance use disorders in an effort to prevent continued substance use as mandated by the federal Substance Abuse Block grant.

B. DBHDS Behavioral Health Wellness Priorities

1. **SYNAR Strategies- Merchant Education and Counter Tools**
   In July 1992, Congress enacted P.L. 102-321 section 1926, the SYNAR Amendment, to decrease youth retail access to tobacco.

Beginning in FY 2003, the Department allocated $10,000 annually to the CSB to complete SYNAR-related tasks. To stay in compliance with the SABG, states must meet and sustain the merchant retail violation rate (RVR) under 20 percent or face penalties to the entire SABG, including funds for treatment. Merchant education involves educating local merchants about the consequences of selling tobacco products to youth. This strategy has been effective in keeping state RVR rates under the required 20 percent. The CSB shall conduct merchant education activities with all merchants deemed by the Alcoholic Beverage Control Board to be in violation of selling tobacco products to youth in the CSB's service area. Other merchants shall be added if deemed to be at higher risk due to factors such as being in proximity to schools.

The CSB, itself or in collaboration with the local coalition, shall continuously update the verified list of tobacco retailers, including all retailers selling vapor products, by conducting store audits and recording the data into the Countertools system.

The CSB shall conduct store audits of and merchant education with 100 percent of tobacco retailers in its service area over a two year period. All store audit and merchant education activities shall be documented in the Counter Tools system and recorded in the prevention data system. Tobacco education programs for youth with the goal of reducing prevalence or use are not to be identified as SYNAR activities.

2. Adverse Childhood Experiences (ACEs) Self-Healing Communities

ACEs have been connected to physical, emotional and behavioral health consequences in youth and adults to include substance use disorder, depression, anxiety and suicide. The self-healing communities' model builds the capacity of communities to define and solve problems most relevant to their localities to address ACEs and prevent and reduce the impact.

This model starts with training and then expanding leadership in each community. Research shows there is a significant connection between ACEs and suicides and drug overdoses. Helping communities understand the impact of ACEs will expand the leadership capacity necessary to do just that.

3. Mental Health First Aid (MHFA) and Regional Suicide Prevention Initiatives

In the FY 2014 budget, an ongoing appropriation was made to expand and support Suicide Prevention and Mental Health First Aid initiatives across the Commonwealth of Virginia in an effort to prevent suicide and reduce the stigma of mental illness and encourage seeking help**.**

The CSB shall work with the regional MH/Suicide prevention team to provide a regionally developed suicide prevention plan using the Strategic Prevention Framework model.

The plan developed by the team shall identify suicide prevention policies and strategies using the most current data to target populations with the highest rates of suicide. If selected by the region, the CSB shall act as the fiscal agent for the state funds supporting the suicide prevention services. MHFA may be offered by individual CSBs and/or as a part of the regional effort.

4. Problem Gambling Use Prevention

Problem Gambling Prevention has been identified through the JLARC November 2019 reports as follows: Additional gambling options in Virginia would increase the number of Virginians at risk of harm from problem gambling. These harms include financial instability and negative impacts on mental health and relationships. The percentage of adult Virginians who experience gambling disorder—a clinical addiction—would be small, but a larger number of gamblers would suffer

negative effects, as well as their friends and family. Virginia's current problem gambling prevention and treatment efforts are minimal and need to be enhanced, even if gaming is not expanded. States with casinos and other forms of gaming typically use a portion of their gaming tax revenue to fund problem gambling prevention and treatment efforts. An effective problem gambling prevention and treatment program in Virginia could cost $2 million to $6 million annually. An effective program would also require collaboration among gaming operators and the state, with the Department of Behavioral Health and Developmental Services leading the state's efforts. DBHDS OBHW partners with local CSBs to implement prevention efforts.

C. SABG Prevention Proposed Performance Contract Measures

To reflect the performance in the above-named categories, we will use the following measures as a minimum requirement:

Priority	Performance Contract Measures Strategy
General Capacity Requirements	**1.** Each CSB must complete an evaluation plan which is revised and approved annually and includes: a. A logic model which includes all of the required priority strategies all CSBs must implement and any discretionary strategies the CSB has elected to implement. b. A measurement plan documenting how all required metrics will be tracked and reported. **2.** All prevention programs, practices, and strategies must be evidence-based and approved by the DBHDS OBHW team. Only strategies that align with the state-identified priorities and/or the CSB's logic model outcomes will be approved. **3.** Each CSB must maintain a license for the Performance-Based Prevention System (PBPS) and record all implemented strategies in the PBPS. **4.** Each CSB must maintain a minimum of 1 FTE Prevention Lead position. This position leads and ensures compliance and implementation of all Prevention priority strategies. **5.** Prevention funding should be used for prevention staff to attend at least one national prevention-related conference per year. Any national conferences outside of the NPN **6.** Prevention Research Conference, NATCON, CADCA National or Mid-Year Conferences must have prior DBHDS approval. Each CSB receives $3000 in their base allocation to help support this capacity building effort.
Community Coalition Development	**1.** The CSB shall be involved in a minimum of 6-10 coalition meetings a year. **2.** The CSB should maintain membership in CADCA and/or CCoVA each year. **3.** The CSB and its associated coalition should ensure youth engagement in the coalition either as a sub-group of the coalition or a separate youth coalition. **4.** The CSB should maintain a social media presence to publicize prevention activities and messaging (Facebook page, Instagram, website, etc.) Websites should be updated monthly at a minimum and social media bi-weekly to ensure information and resources remain relevant and engages the community. **5.** Every 2 years, each CSB must complete a coalition readiness assessment and an assessment of representation in the coalition of the following 12 sectors: youth; parents; businesses; media; school; youth-serving organizations; law enforcement; religious/fraternal organizations; civic and volunteer organizations; healthcare professionals; state, local and tribal governments; and other organizations involved in reducing illicit substance use.

SYNAR: Merchant Education and Counter Tools	**1.** The CSB shall conduct store audits of and merchant education with 100 percent of **2.** tobacco/nicotine retailers in its service area over a two-year period. Any retailer to be found in violation in the previous year is to be given priority for merchant education. The CSB also must maintain and update a list of tobacco/nicotine retailers in its catchment area over the two-year period. **3.** Data must be entered into the Counter Tools and PBPS systems. **4.** Tobacco education programs for youth with the goal of reducing prevalence of use are not to be identified as SYNAR activities.
ACEs Self-Healing Communities	**1.** All CSBs should ensure there are at least 2 ACEs master trainers in their catchment area at all **2.** times. All CSBs must conduct at least 12 ACEs trainings annually. **3.** All ACEs training data (including number of trainings held and number of people trained) must be reported in PBPS. **4.** CSBs which are designated as Self-Healing Communities and are receiving additional funding to address ACEs must complete all items noted above *and* the following: **5.** Maintain an ACEs self-healing community advisory committee made up of a cross-section of community partners, meets at least quarterly, reviews the Self-Healing Communities logic model and provides ongoing feedback and recommendations on how to best achieve the logic model goals.
	6. Create a logic model specific to the ACEs work that is planned and implemented in the community. **7.** Submit a quarterly report on all ACEs strategies and measures. **8.** Engage in a local Trauma-Informed Community Network (TICN) or other trauma-centered coalition.
MHFA/Suicide Prevention Planning and Trainings	**1.** The CSB shall work with the regional MH/suicide prevention team to provide a regionally **2.** developed suicide prevention plan using the Strategic Prevention Framework model. The plan developed by the team shall identify suicide prevention policies and strategies. Strategies should be determined using the most current data and there should be strategies in the plan that are for the community as a whole as well as strategies that target subpopulations with the highest rates of suicide. The plan should also identify the CSB's marketing plan to ensure community groups (schools, faith groups, businesses, etc.) and community members are aware of the mental health and suicide prevention trainings the CSB is providing. **3.** Each MHFA trainer must provide a minimum of 3 Youth and/or Adult MHFA trainings annually. **4.** The CSB should ensure a minimum of 45 community participants are trained annually in MHFA (across all MHFA trainers at the CSB; there is no minimum number of trainees for each certified trainer). **5.** In addition to the required MHFA trainings, a minimum of 3 suicide prevention trainings *per trainer* must be provided annually. These 3 trainings may be a combination of any of the approved trainings below: a. ASIST b. safeTALK c. suicideTALK d. QPR **6.** Every year, each CSB will be required to submit a mid-year (April) and end-of-year (September) report which should contain details on trainings implemented, including the number of different groups and community members participating in the trainings.

Lock & Talk	**1.** CSBs participating in the Lock and Talk Initiative shall develop an implementation plan that best meets the needs of their respective communities (including strategies to address target populations.) At a minimum CSBs are expected to implement components 1 & 2 below, and strongly encouraged to implement the Gun Shop Project and/or partner with their medical community (pharmacies, medical practices) if the Gun Shop Project is not an appropriate fit for their community. **2.** Lock and Talk Components: a) Media Campaign Materials (bus ads, posters, billboards, PSA, etc.) b) Medication Lock Box/Cable Lock/Trigger Lock Distribution at Event c) Gun Shop Project
Problem Gambling Prevention	Each CSB will complete the Problem Gambling strategies as identified by the Problem Gambling Coordinator which includes completion of the initial needs assessment. Additional capacity building and information dissemination will be determined by the results of the needs assessment

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MEMORANDUM

Re: Guidance Regarding Individual Choice and Discharge Options

As referenced in a memo that was distributed by Daniel Herr, Deputy Commissioner for Facility Services on September 25, 2019, below is guidance that was developed in consultation with the DBHDS Office of Human Rights. This guidance concerns an individuals' choice as it relates to community based discharge options and continuing inpatient hospitalization.

This guidance is based upon the following primary considerations.

- Human Rights:
  - It is a violation of an individual's right to remain in the state's most restrictive setting, i.e., state hospital, when a more integrated and less restrictive level of care is available and addresses the individual's risks and treatment needs;
  - An individual does not have a right for the state to provide multiple alternatives when there is an existing clinically appropriate option currently available ; and
  - The individual does not have a right to remain in the hospital once a community based option is made available.

- Patient Care and Safety: Given the state hospital census crisis, the impact of over-crowding and high case-loads for patient and staff safety, quality of care, and potential for delayed admissions for individuals in the community, state hospitals have an affirmative obligation to provide treatment focused on rapid discharge. An individual in a state hospital does not have the choice of waiting for a "more ideal" community alternative when another clinically appropriate option is available.

Guidance

Once an individual is clinically ready for discharge, and services and a placement are available to meet their community needs, DBHDS expects that the individual will be discharged to that placement as expeditiously as possible.

If an individual requires funding support through DAP, the CSB and state hospital must first refer the individual to any appropriate DBHDS contracted placement, such as a group home or

assisted living facility. DAP funds for alternative placements will not be available to the individual if existing funded resources are available and appropriate.

When appropriate services and housing have been identified, the individual should promptly be scheduled for discharge. If the individual wishes to make alternative arrangements, the individual must make those arrangements prior to discharge, or make their preferred arrangements from the community setting post discharge. The individual may not delay their discharge for the purpose of putting preferred arrangements into place.

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Department of Behavioral Health and Developmental Services

This document is designed to provide consistent direction and coordination of activities required of state hospitals and community services boards (CSBs) in the development and implementation of discharge planning. The activities delineated in these protocols are based on or referenced in the Code of Virginia or the community services performance contract. In these protocols, the term CSB includes local government departments with a policy-advisory CSBs, established pursuant to § 37.2-100 of the Code of Virginia, and the behavioral health authority, established pursuant to § 37.2-601 et seq. of the Code of Virginia.

Shared Values:

Both CSBs and state hospitals recognize the importance of timely discharge planning and implementation of discharge plans to ensure the ongoing availability of state hospital beds for individuals presenting with acute psychiatric needs in the community. The recognition that discharge planning begins at admission is an important aspect of efficient discharge planning.

The Code of Virginia assigns the primary responsibility for discharge planning to CSBs; however, discharge planning is a collaborative process that must include state hospitals.

Joint participation in treatment planning and frequent communication between CSBs and state hospitals are the most advantageous method of developing comprehensive treatment goals and implementing successful discharge plans. The treatment team, in consultation with the CSB, shall ascertain, document, and address the preferences of the individual and their surrogate decision maker (if one has been designated) in the assessment and discharge planning process that will promote elements of recovery, resiliency, self-determination, empowerment, and community integration.

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Attachments:
Appendix A: Out of Catchment Notification/Referral Form
Appendix B: Memo Regarding Patient Choice at Discharge
Appendix C: DAP Memory Care Justification Form

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General Requirements

Regional Responsibility	Responsible Entity	Timeframe
The CSB emergency services clinicians shall complete a tracking form documenting all private hospital contacts prior to seeking a bed of last resort at a state hospital, and transmit the form to the receiving state hospital, along with the preadmission screening form.	CSB emergency services	*Upon admission request to state hospital*
Each CSB shall provide the DBHDS Director of Community Integration (or designee) with the names of CSB personnel who are serving as the CSB's state hospital discharge liaisons. The DBHDS Office of Community Integration will update and distribute listings of all CSB discharge planning and state hospital social work contacts to CSB regional managers and state hospital social work directors, with the expectation that these will be distributed to individual CSBs and state hospital social workers.	CSBs DBHDS Office of Community Integration	*At least quarterly, or whenever changes occur* *At least quarterly*
Each region shall develop a process for developing, updating, and distributing a list of available CSB and regional housing resources funded by DBHDS for individuals being discharged from state hospitals. The resource listing should include willing private providers. Regions shall review and update the list and ensure that it is available to CSB state hospital liaisons, state hospital social work staff, and Central Office Community Transition Specialists to ensure that all resource options are explored for individuals in state hospitals.	CSB regions	*Updated at least quarterly*
In order to facilitate communication and timely problem solving, each region shall establish, regularly review, and update a regional bidirectional process, with time frames, and clearly defined steps for notification, discussion, and resolution of issues surrounding discharge planning for both adult and geriatric hospitals, to include CSBs, state hospitals, and Central Office levels. A copy of this process shall be submitted to each region's Community Transition Specialist.	CSB regions	*Updated as needed*

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Collaborative Responsibilities Following Admission to State Hospitals

CSB Responsibilities	Timeframe	State Hospital Responsibilities	Timeframe
The CSB emergency services clinician shall notify the CSB discharge planner of every admission to a state hospital	*Within 24 hours of the issuance of the TDO*		
CSB staff shall participate in discussions to determine whether the state hospital is the most appropriate treatment site	*Immediately upon admission and ongoing*	State hospital staff shall assess each individual to determine whether the state hospital is the most appropriate treatment site	*Immediately upon admission and ongoing*
CSB staff shall begin the discharge planning process for both civil and forensic admissions. If the CSB disputes case management CSB/discharge planning responsibility for the individual, the CSB shall notify the state hospital social work director immediately upon notification of the admission (for reference, please see the definition of "case management CSB/CSB responsible for discharge planning" contained in the glossary of this document). 1. For every admission to a state hospital from the CSB's catchment area that is not currently open to services at that CSB, the CSB shall open the individual to consumer monitoring and assign case management/discharge planning responsibilities to the appropriate staff. 2. The individual assigned to take the lead in discharge planning will ensure that other relevant parties (CSB program staff, private providers, etc.) are engaged with state hospital social work staff.	*Upon admission*	State hospital staff shall contact the CSB to notify them of the new admission State hospital staff shall also provide a copy of the admissions information/face sheet to the CSB, as well as the name and phone number of the social worker assigned and the name of the admitting unit For individuals admitted with a primary developmental disability (DD) diagnosis, or a co-occurring mental health and DD diagnosis, the hospital social work director (or designee) shall communicate with the CSB discharge liaison to determine who the CSB has identified to take the lead in discharge planning (CSB liaison or DD staff). At a minimum, the CSB staff is who assigned lead discharge planning responsibilities shall participate in all treatment team meetings and discharge planning meetings; however, it is most advantageous if both staff can participate in treatment teams as much as possible.	*Within one business day* *Within one business day*

3. CSB staff shall establish a personal contact (preferably in person) with the hospitalized individual in order to initiate collaborative discharge planning.	*Within seven calendar days of admission*		
CSB staff will make arrangements to attend CTP and TPR meetings in person. If CSB staff are unable to physically attend the CTP or TPR meeting, the CSB may request arrangements for telephone or video conference. For NGRI patients with approval for unescorted community not overnight privileges and higher, the CSB NGRI Coordinator shall also make arrangements to attend any CTP and TPR meetings in person, or, if unable to attend in person, may request alternative accommodations. In the event that the arrangements above are not possible, the CSB shall make efforts to discuss the individual's progress towards discharge with the state hospital social worker within two business days of the CTP or TPR meeting.	*Ongoing* *Ongoing*	State hospital staff shall make every effort to inform the CSB by email of the date and time of CTP meetings. For NGRI patients with approval for unescorted community not overnight privileges and higher, state hospital staff will include the CSB NGRI Coordinator in these notifications. If CTP and TPR meetings must be changed from the originally scheduled time, the state hospital shall make every effort to ensure that the CSB is made aware of this change The CTP meeting shall be held within seven calendar days of admission. Note: It is expected that the state hospital will make every effort to include CSBs in CTP and	*At least two business days prior to the scheduled meeting* *Within seven calendar days of admission*

Note: While it may not be possible for the CSB to attend every treatment planning meeting, participation in person or via phone or video conference is expected. This is the most effective method of developing comprehensive treatment goals and implementing efficient and successful discharge plans.	*Within two business days of the missed meeting*	TPRs, including providing alternative accommodations (such as phone or video) and scheduling meetings so that liaisons can participate in as many treatment team meetings as possible	

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Needs Assessment

CSB Responsibilities	Timeframe	State Hospital Responsibilities	Timeframe
Discharge planning begins on the initial prescreening evaluation and continues throughout hospitalization. In completing the discharge plan, the CSB shall consult with the individual, members of the treatment team, the surrogate decision maker, and (with consent) family members or other parties, to determine the preferences of the individual upon discharge. The CSB shall obtain required releases of information. The discharge plan shall include: • The anticipated date of discharge from the state hospital • The identified services needed for successful community placement and the frequency of those services • The specific public and/or private providers that have agreed to provide these services	*At admission and ongoing thereafter* *As soon as possible upon admission*	The state hospital social worker shall complete the comprehensive social work assessment. This assessment shall provide information to help determine the individual's needs upon discharge. The treatment team shall document the individual's preferences in assessing their unique needs upon discharge.	*Prior to the CTP or within seven calendar days of admission* *Ongoing*
CSB shall assist with any required forms of identification, or obtaining required documents that an individual may already have.	*As needed*	The state hospital shall assess if any form of identification will be required for discharge planning purposes, what forms of identification the individual may already have available, and begin the process of obtaining identification if needed	*Within one week of admission*

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If the individual's needs change or as more specific information about the discharge plan becomes available, the CSB staff shall update the discharge plan accordingly	*Ongoing*	As an individual's needs change, the hospital social worker shall document changes in their progress notes and through communications/meetings with the CSB.	*Ongoing*

The CSB and the state hospital treatment team shall ascertain, document, and address the preferences of the individual and the surrogate decision maker as to the placement upon discharge. These preferences shall be addressed to the greatest degree possible in determining the optimal and appropriate discharge placement (please see attached memo regarding patient choice in state hospital discharges)	*Ongoing*

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Pre-Discharge Planning

Note: please see glossary for information regarding state and federal regulations concerning release of information for discharge planning purposes

CSB Responsibilities	Timeframe	State Hospital Responsibilities	Timeframe
For the following services, the CSB shall confirm the availability of serves, as well as the individual's appropriateness for services; or refer to a private provider for services • Case management • Psychosocial rehabilitation • Mental health skill building • Permanent supportive housing • PACT/ICT • Other residential services operated by the CSB or region The CSB shall share the outcome of the assessment and the date when the services will be available with the hospital treatment team.	*Within 10 business days of receiving the referral* *Immediately upon completion of the assessment*	The state hospital treatment team shall review discharge needs on an ongoing basis. If referrals for the following services are needed for the individual, the hospital social worker shall refer the individual to the CSB responsible for discharge planning for assessment for eligibility • Case management • Psychosocial rehabilitation • Mental health skill building • Permanent supportive housing • PACT/ICT • Other residential services operated by the CSB or region	*Within two business days of the treatment team identifying the need for the services*

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NGRI Acquittees		NGRI Acquittees	
The CSB Executive Director shall appoint an individual with the appropriate knowledge, skills, and abilities to serve as NGRI Coordinator for their agency (please see glossary for specific requirements)	*Ongoing. Changes in assigned NGRI Coordinator should be communicated to DBHDS Central Office Forensics staff*	State hospital staff shall provide notice to the NGRI Coordinator of any meetings scheduled to review an acquittee's appropriateness for a privilege increase or release	*At least two business days prior to the scheduled meeting*
The CSB NGRI Coordinator or designee (with decision-making and signatory authority) shall attend in person or via telephone any meetings scheduled to discuss an acquittee's appropriateness for privilege level increases at the unescorted community not overnight privilege level or higher.	*Ongoing*	The state hospital shall provide notice to CSB staff, including the CSB NGRI Coordinator, of the need for a risk management plan (RMP), a Conditional Release Plan (CRP), or an Unconditional Release Plan (UCRP) once the determination has been made that a packet must be completed	*Within one business day of the treatment team identifying the individual as being eligible for a privilege increase or release*
The CSB NGRI Coordinator shall review, edit, sign, and return the risk management plan (RMP) for individuals adjudicated as NGRI		The state hospital shall complete the packet requesting an increase in privilege level or release	*Within 10 business days of the treatment team identifying the individual as being eligible for a privilege increase*
The CSB NGRI Coordinator shall develop and transmit to the state hospital a fully developed conditional release plan (CRP) or unconditional release plan (UCRP) with all required signatures	*Within 10 business days of receiving notice from the state hospital*		
Please note: For some NGRI patients, the RMP or CRP may involve more than one CSB. It is			

essential that the CSB responsible for the development of these plans communicates efficiently with other involved CSBs, and ensures that these plans are signed as soon as possible according to the time frames above.	*Within 10 business day of being notified that the individual has been recommended for release*		

Guardianship Upon being notified of the need for a guardian, the CSB shall explore potential individuals/agencies to serve in that capacity. If the CSB cannot locate a suitable candidate who agrees to serve as guardian, they shall notify the state hospital to begin the process of referral for a DBHDS guardianship slot.	*Within two business days of notification* *Within 10 business days of notification of need for a guardian*	**Guardianship** Evaluation for the need for a guardian shall start upon admission. Activities related to securing a guardian (if needed) start and continue regardless of a patient's discharge readiness level. The hospital social worker shall notify the CSB discharge planner that the treatment team has determined that the individual is in need of a guardian in order to be safely discharged. If notified by the CSB that a suitable candidate for guardianship cannot be located, the state hospital shall begin the process of referring the individual to DBHDS Central Office for a DBHDS guardianship slot. This referral shall include a comprehensive assessment of the individual's lack of capacity, and potential for regaining capacity. This assessment shall be shared with the CSB upon completion by the evaluating clinician.	*Within two business days of determination* *Immediately upon notification by the CSB of the need for a DBHDS guardianship slot*

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Assisted Living (ALF) Referrals		**Assisted Living Referrals**	
The CSB shall obtain verbal consent and releases from the individual or the surrogate decision maker to begin initial contacts to facilities regarding bed availability and willingness to consider the individual for placement.	*As soon as an ALF is being considered, and prior to the individual being determined to be RFD*	The state hospital shall complete the UAI.	*Within five business days of the individual being found discharge ready level 2*
The CSB shall obtain required documentation and send referral packets to multiple potential placements. The referrals are to be sent simultaneously.	*Within one business day after the individual is rated as RFD*	The state hospital shall transmit the UAI to the CSB	*Immediately upon completion of the UAI*
If the CSB does not receive a response from a potential placement, the CSB shall be follow up with providers regarding potential placements. It is expected that the CSB will continue to communicate with the provider about potential placement until a disposition decision is reached or the patient discharges to a different placement.	*Within five business days of sending the referral*	The state hospital shall assist in the facilitation of interviews/assessments required by potential ALF providers	*As requested*
If it is determined that a secure Memory Care unit is recommended and that DAP will be required to fund this placement, the CSB shall completed the Memory Care Justification form, submit to the Community Transition Specialist for their hospital, and receive approval prior to referring to secure memory care units.			

	Prior to referring to private pay Memory Care units		

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Nursing Home (NH) Referrals The CSB shall obtain verbal consent and releases from the individual or the surrogate decision maker to begin initial contacts regarding bed availability and willingness to consider the individual for placement. The CSB shall obtain required documentation and send referral packets to multiple potential placements. The referrals are to be sent simultaneously. If the CSB does not receive a response from a potential placement, the CSB shall follow up with providers regarding potential placements. It is expected that the CSB will continued to communicate with the provider about potential placement until a disposition decision is reached or the patient discharges to a different placement.	*As soon as an NH is being considered, and prior to the individual being determined to be RFD* *Within one business day after the individual is rated as RFD* *Within five business days of sending the referral*	**Nursing Home Referrals** The state hospital shall complete the UAI For individuals who require PASRR screening, the state hospital shall send the referral packet to Ascend The results of the level 2 PASRR screening shall be transmitted to the CSB The state hospital shall assist in the facilitation of interviews/assessments required by potential nursing home providers	*Within five business days of the individual being found discharge ready level 2* *Within one business day of the individual being found clinically ready for discharge* *Immediately upon receipt of the screening results* *As requested*

Shelter Placements Both the CSB responsible for discharge planning, and the CSB that serves the catchment area where the shelter is located shall follow the same procedures as outlined in the CSB transfers section for out of catchment placements.		**Shelter Placements** If discharge to a shelter is clinically recommended and the individual or their surrogate decision maker agrees with this placement, the hospital social worker shall document this recommendation in the medical record. The hospital social worker shall notify the director of social work when CSB consultation has occurred. The director of social work shall review the plan for discharge to a shelter with the medical director (or their designee). Following this review, the medical director (or designee) shall document endorsement of the plan for discharge to a shelter in the individual's medical record. In the case of out of catchment shelter placements, hospital staff shall notify both the CSB responsible for discharge planning, as well as the CSB that serves the catchment area of the shelter.	*Prior to discharge*

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Individuals with a Developmental Disability (DD) Diagnosis		**Individuals With A Developmental Disability (DD) Diagnosis**	
The CSB shall determine and report to the hospital if the individual is currently receiving DD services, has a waiver, is on the waiver waiting list, or should be screened for waiver	*Within two business days of admission*	Upon identification than an individual admitted to the state hospital has a DD diagnosis, the hospital social work director shall notify the CSB liaison/case manager and the CSB DD director (or designee).	*Immediately upon notification of diagnosis*
When indicated based on the information above, the VIDES shall be completed		The state hospital shall notify the designated CSB lead for discharge planning of all relevant meetings, as well as the REACH hospital liaison (if REACH is involved) so attendance can be arranged.	*Ongoing*
The CSB shall initiate a referral to REACH for any individual who is not already being followed by REACH	*Within ten business days of admission*		
If applicable, the CSB shall ensure that the individual has been added to the DD Waiver waitlist.	*Within three calendar days of admission*	The state hospital shall assist the CSB in compiling all necessary documentation to implement the process for obtaining a DD waiver and/or bridge funding. This may including conducting psychological testing and assessments as needed.	*As needed. Required psychological testing and assessment shall be completed within 21 calendar days of referral*
The CSB liaison and support coordinator shall participate in the development and updating of the discharge plan, including attending and participating in treatment team meetings, discharge planning meetings, and other related meetings.	*Immediately upon notification of need*	The state hospital shall serve as a consultant to the DD case manager as needed.	
The CSB shall contact and send referrals to potential providers, and assist in coordinating assessments with these providers.	*At admission and ongoing*	The state hospital shall assist with coordinating assessments with potential providers.	
The CSB shall assist in scheduling tours/visits with potential providers for the individual		The state hospital shall facilitate tours/visits with potential providers for the individual and/or the individual's surrogate decision maker.	*At the time that the individual is rated a discharge ready level 2*

and/or the individual's surrogate decision maker. The CSB shall locate and secure needed specialists who will support the individual in the community at discharge. If required, the CSB shall facilitate the transfer of case management responsibilities to the receiving CSB according to the *Transferring Support Coordination/DD Waiver Slots* policy. The CSB shall request an emergency DD waiver slot if the individual is determined to be eligible for waiver, prior to requesting DAP funding. If it is anticipated that an individual with a DD diagnosis is going to require transitional funding, the CSB shall completed an application for DD crisis funds.	*At the time that an individual is rated a discharge ready level 2* *Ongoing* *Prior to discharge* *According to timelines set forth in the transfer procedure* *Immediately upon notification of need*	Note: When requested referrals or assessments are not completed in a timely manner, the state hospital director shall contact the CSB Executive Director to resolve delays in the referral and assessment process.	*Ongoing*

	Immediately upon notification of need		

Readiness for Discharge

CSB Responsibilities	Timeframe	State Hospital Responsibilities	Timeframe
Once the CSB has received notification of an individuals' readiness for discharge, they shall take immediate steps to implement the discharge plan	*Immediately upon notification*	The treatment team shall assess and rate the clinical readiness for discharge for all individuals The state hospital social worker shall notify the CSB through the use of email when the treatment team has made a change to an individual's discharge readiness rating. This includes when an individual is determined to be ready for discharge and no longer requires inpatient level of care. Or, for voluntary admissions, when consent has been withdrawn.	*A minimum of weekly* *Within one business day*
In response to the state hospital's weekly email including all patients who are RFD, the CSB	*Within two business days*	On weeks in which CSB and state hospital census/barriers meetings do not occur, the state	*Weekly*

shall "reply all" with discharge planning updates. Note: These email correspondences are not required to occur on weeks when CSBs and state hospitals collaboratively review patients who are ready for discharge. These notifications and responses shall occur for all individuals, including individuals who were diverted from other state hospitals.		hospital shall use encrypted email to provide notification to each CSB's liaison, the liaison's supervisor, the CSB behavioral health director or equivalent, the CSB executive director, the state hospital social work director, the state hospital director, the appropriate Regional Manager, and the Central Office Community Transition Specialist (and others as appropriate) of every individual who is ready for discharge, including the date that the individual was determined to be clinically ready for discharge. Note: These notifications and responses shall occur for all individuals, including individuals who were diverted from other state hospitals.	

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Clinical Readiness for Discharge Rating Scale

1. **Clinically Ready for Discharge**
   - Has met treatment goals and no longer requires inpatient hospitalization
   - Is exhibiting baseline behavior that is not anticipated to improve with continued inpatient treatment
   - No longer requires inpatient hospitalization, but individual/family/surrogate decision maker is reluctant to participate in discharge planning
   - NGRI patients with 48 hour passes and utilizing passes for 6 months with clinical stability
   - NGRI patients with 48 hour passes and have FRP approval for conditional or unconditional release -
   - NGRI patients with 48 hour passes and have FRP approval for conditional or unconditional release and court has denied release*
   - URIST with court oversight: clinically stable, evaluations completed and ready to be discharged*
   - Any civil patient for which the barrier to discharge is not clinical stability
2. **Almost Clinically Ready for Discharge**
   - Has made significant progress towards meetings treatment goals, but needs additional inpatient care to fully address clinical issues and/or there is a concern about adjustment difficulties
   - Can take community trial visits to assess readiness for discharge; may have the civil privilege level to go on temporary overnight visits
   - NGRI with unescorted community visits, including 48 hour passes for up to six months prior to FRP approval.
   - Other forensic legal status: significant clinical improvement, evaluations not yet completed
3. **Not Clinically Ready for Discharge**
   - Has not made significant progress towards treatment goals and requires treatment and further stabilization in an acute psychiatric inpatient setting
   - NGRI and does not have unescorted community visits privilege
   - Other forensic legal status: may present with symptoms, willing to engage in treatment, evaluations not yet completed
4. **Significant Clinical Instability Limiting Privileges and Engagement in Treatment**
   - Not nearing psychiatric stability
   - Requires constant 24 hour a day supervision in an acute inpatient psychiatric setting
   - Presents significant risk and/or behavioral management issues that requires psychiatric hospitalization to treat
   - Unable to actively engage in treatment and discharge planning, due to psychiatric or behavioral instability
   - Other forensic legal status: not psychiatrically stable or nearing psychiatric stability, evaluations not completed

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**For any patient in which the legal system (e.g. court system, probation, etc.) is required to approve their discharge plan, their designation on the discharge ready list should be notated with a double asterisk(**)*

Note: Discharge planning begins at admission and is continuously active throughout hospitalization, independent of an individual's clinically readiness for discharge rating.

Discharge Readiness Dispute Process for State Hospitals, CSBs, and DBHDS Central Office

1. The CSB shall notify the state hospital social work director (or designee), in writing, of their disagreement with the treatment team's designation of the individual's clinical readiness for discharge within three calendar days (72 hours) of receiving the discharge readiness notification.
2. The state hospital social work director (or designee) shall initiate a resolution effort to include a meeting with the state hospital and CSB staff at a higher level than the treatment team (including notification to the CSB executive director and state hospital director), as well as a representative from the Central Office Community Integration Team. This meeting shall occur within one business day of receipt of the CSB's written disagreement.
3. If the disagreement remains unresolved, the Central Office Community Integration Team will immediately give a recommendation regarding the patient's discharge readiness to the DBHDS Commissioner. The Commissioner shall provide written notice of their decision regarding discharge to the CSB executive director and state hospital director.
4. During the dispute process outlined above, the CSB shall formulate a discharge plan that can be implemented within three business days if the decision is in support of clinical readiness for discharge.
5. Should the Commissioner determine that the individual is clinically ready for discharge and the CSB has not developed a discharge plan to implement immediately, then the discharge plan shall be developed by the Department and the Commissioner may take action in accordance with Virginia Code § 37.2-505(A)(3).

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Finalizing Discharge

Joint Responsibility of the State Hospital, CSB, and DBHDS Central Office

At a minimum, twice per month the state hospital and CSB staff shall review individuals rated a 1 on the clinical readiness for discharge scale. Individuals rated a 2 on the clinical readiness for discharge scale shall be jointly reviewed at least once per month. To ensure that discharge planning is occurring at an efficient pace, the CSB shall provide updated discharge planning progress that shall be documented in these reviews. The regional utilization structures shall review at least monthly the placement status of those individuals who are on the Extraordinary Barriers List (EBL).

The Office of Community Integration shall monitor the progress of those individuals who are identified as being ready for discharge, with a specific focus on individuals who are on the EBL.

When a disagreement between the state hospital and the CSB occurs regarding the discharge plan for an individual, both parties shall attempt to revolve the disagreement and will include the individual and their surrogate decision maker, if appropriate. If these parties are unable to reach a resolution, the state hospital will notify their Central Office Community Transition Specialist within three business days to request assistance in resolving the dispute.

CSB Responsibilities	Timeframe	State Hospital Responsibilities	Timeframe
In the event that the CSB experiences extraordinary barriers to discharge and is unable to complete the discharge within seven (7) calendar days of the determination that the individual is clinically ready for discharge, the CSB shall document in the CSB medical record the reason(s) why the discharge cannot occur within seven (7) days of determination. The documentation shall describe the barriers to discharge (i.e. reason for placement on the Extraordinary Barriers List (EBL) and the specific steps being taken by the CSB to address these barriers.	*Within seven (7) calendar days of determination that individual is clinically ready for discharge*		

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The reduce readmissions to state hospitals, CSBs, in conjunction with the treatment team, shall develop and complete (when clinically indicated) a safety and support plan as part of the individual's discharge plan Note: Safety and support plans are generally not required for court-ordered evaluations, restoration to competency cases, and jail transfers; however, at the clinical discretion of the CSB and/or treatment team, the development of a safety and support plan may be advantageous when the individuals presents significant risk factors, and for those individuals who will be returning to the community following a brief incarceration period. Exception: Due to having a risk management plan as part of the conditional release plan, NGRI acquittees do not require a safety and support plan	*Prior to discharge*	The state hospital shall collaborate and provide assistance in the development of safety and support plans Note: Safety and support plans are generally not required for court-ordered evaluations, restoration to competency cases, and jail transfers; however, at the clinical discretion of the CSB and/or treatment team, the development of a safety and support plan may be advantageous when the individuals presents significant risk factors, and for those individuals who will be returning to the community following a brief incarceration period. Exception: Due to having a risk management plan as part of the conditional release plan, NGRI acquittees do not require a safety and support plan	*Prior to discharge*

CSB staff shall ensure that all arrangements for psychiatric services and medical follow up appointments are in place. CSB staff shall ensure the coordination of any other intra-agency services (e.g. employment, outpatient services, residential, etc.) and follow up on applications for entitlements and other resources submitted by the state hospital. The CSB case manager, primary therapist, or other designated clinical staff shall schedule an appointment to see individuals who have been discharged from a state hospital. The CSB case manager, discharge liaison, or other designated clinical staff shall ensure that an appointment with the CSB (or private) psychiatrist is scheduled when the individual is being discharged on psychiatric medications	*Prior to discharge* *Prior to and following discharge* *Within seven calendar days, or sooner if the individual's condition warrants* *Within seven days of discharge*		

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Benefit applications For any patient who is committed to a state facility (or CMA), and whose hospital stay is less than 30 days, the CSB shall initiate applications for Social Security benefits. The CSB shall contact the entity responsible for processing entitlement applications (SSA, DSS, etc.) to ensure that the benefits application has been received and that these entities have all required documentation. If benefits are not active with 30 days of the patient's discharge, the CSB shall again contact the entity responsible for processing the entitlement application in order to expedite benefit approval.	*As soon as a discharge date is finalized* *30 days post-discharge, and every 15 days thereafter until benefits are active*	**Benefit applications** State hospital staff shall initiate applications for Medicare, Medicaid, Social Security benefits, Auxiliary Grant, and other financial entitlements as necessary. Applications shall be initiated in a timely manner per federal and state regulations **Note: For patients whose hospital stay is less than 30 days, the CSB will be responsible for Social Security applications* To facilitate follow-up, if benefits are not active at the time of discharge, the state hospital shall notify the CSB of the type of entitlement application, as well as the date it was submitted, and include a copy of entitlement applications with the discharge documentation that is provided to the CSB	*Prior to discharge and per federal and state regulations*
Discharge Transportation The CSB shall ensure that discharge transportation is arranged for individuals discharging from state hospitals. Note: When transportation is the only remaining barrier to discharge, the state hospital and CSB will implement a resolution process for resolving transportation issues when these are anticipated to result in discharges being delayed by 24 hours or more.	*Prior to scheduled discharge date*	Note: When transportation is the only remaining barrier to discharge, the state hospital and CSB will implement a resolution process for resolving transportation issues when these are anticipated to result in discharges being delayed by 24 hours or more.	

		Discharge Instructions: The treatment team shall complete the discharge information and instructions form (DIIF). State hospital staff shall review the DIIF with the individual and/or their surrogate decision maker and request their signature. Distribution of the DIIF shall be provided to all next level of care providers, including the CSB. The state hospital medical director shall be responsible for ensuring that the physician's discharge summary is provided to the CSB responsible for discharge planning (and prison or jails, when appropriate)	*Prior to discharge* *No later than one calendar day post-discharge* *As soon as possible post-discharge*

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Transfers between CSBs

CSB Responsibilities	Timeframe	State Hospital Responsibilities	Timeframe
Transfers shall occur when an individual is being discharged to a different CSB catchment area than the CSB responsible for discharge planning. If a determination is made that an individual will be relocating post-discharge, the CSB responsible for discharge planning shall immediately notify the CSB affected. The CSB shall complete and forward a copy of the Out of Catchment Notification/Referral form to the receiving CSB. Note: Coordination of the possible transfer shall, when possible, allow for discussion of resource availability and resource allocation between the two CSBs prior to the transfer. Exception to above may occur when the CSB, individual served, and/or their surrogate decision maker wish to keep services at the original CSB, while living in a different CSB catchment area. For NGRI patients, CSB NGRI coordinators will consult regarding any possible transfers between CSBs. Transfers of NGRI patients shall be accepted by the receiving CSB unless the	*Prior to discharge* *Prior to discharge*	The state hospital social worker shall indicate in the medical record any possibility of a transfer out of the original CSB catchment area.	*Ongoing*

necessary services in the release plan are permanently unavailable, resulting in increased risk to the community or to the NGRI acquittee. For individuals who are enrolled in CSB DD services, please follow the *Transferring Support Coordination/DD Waiver Slots* policy.			
At a minimum, the CSB responsible for discharge and the CSB that serves the discharge catchment area shall collaborate prior to the actual discharge date. The CSB responsible for discharge planning is responsible for completing the discharge plan, conditional release plan, and safety and support plan (if indicated), and for the scheduling of follow up appointments. While not responsible for the development of the discharge plan and the safety and support plan, the CSB that serves the catchment area where the patient will be discharged should be actively involved in the development of these plans. The arrangements for and logistics of this	*Prior to discharge*		

involvement are to be documented in the discharge plan and the individual's medical record. The CSB responsible for discharge planning shall provide the CSB that serves the catchment area where the patient will be discharging with copies of all relevant documentation related to the treatment of the individual.	*Prior to discharge*		
If the two CSBs cannot agree on the transfer, they shall seek resolution from the Director of Community Integration (or designee). The CSB responsible for discharge planning shall initiate this contact	*Within three calendar days of notification of intent to transfer*		

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Glossary

Acute Admissions or Acute Care Services: Services that provide intensive short-term psychiatric treatment in state mental health hospitals.

Case Management CSB/CSB Responsible for Discharge Planning: The public body established pursuant to § 37.2-501 of the *Code of Virginia* that provides mental health, developmental, and substance abuse services within each city and county that established it and in which an adult resides or in which surrogate decision maker resides. The case management CSB is responsible for case management and liaising with the hospital when an individual is admitted to a state hospital, and for discharge planning. If the individual or surrogate decision maker chooses for the individual to reside in a different locality after discharge from the state hospital, the CSB serving that locality becomes the receiving CSB and works with the CSB responsible for discharge planning/referring CSB, the individual, and the state hospital to effect a smooth transition and discharge. The CSB responsible for discharge planning is ultimately responsible for the completion of the discharge plan. Reference in these protocols to CSB means CSB responsible for discharge planning, unless the context clearly indicates otherwise.

Case management/ CSB responsible for discharge planning designations may vary from the definition above under the following circumstances:

- When the individual's living situation is unknown or cannot be determined, or the individual lives outside of Virginia, the CSB responsible for discharge planning is the CSB which completed the pre-screening admission form.
- For individuals who are transient or homeless, the CSB serving the catchment area in which the individual is living or sheltered at the time of pre-screening is the CSB responsible for discharge planning.
- When a CSB other than the pre-screening CSB is continuing to provide services and supports to the individual, then the CSB responsible for discharge planning is the CSB providing those services and supports.
- For individuals in correctional facilities, in local hospitals, or Veteran's Administration facilities, or in regional treatment/detox programs, the CSB responsible for discharge planning is the CSB serving the catchment area in which the individual resided prior to incarceration, or admission to local hospitals, Veterans Administration facilities, or regional detox programs
- In instances in which there is a dispute related to which CSB is responsible for discharge planning, the state hospital will work collaboratively with the CSBs involved to determine which CSB is responsible within two business days. If resolution cannot be reached, the state hospital will contact their Community Transition Specialist who will make a determination based on the available information.

Comprehensive Treatment Planning Meeting: The meeting, which follows the initial treatment meeting and occurs within seven days of admission to a state hospital. At this meeting, the individual's comprehensive treatment plan (CTP) is developed by the treatment team in consultation with the

individual, the surrogate decision maker, the CSB and, with the individual's consent, family members and private providers. The purpose of the meeting is to guide, direct, and support all treatment aspects for the individual.

Co-occurring Disorders: Individuals are diagnosed with more than one, and often several, of the following disorders: mental health disorders, developmental disability, or substance use disorders. Individuals may have more than one substance use disorder and more than one mental health disorder. At an individual level, co-occurring disorders exist when at least one disorder of each type (for example: a mental health and substance use disorder or developmental disability and mental health disorder) can be identified independently of the other and are not simply a cluster of symptoms resulting from a single disorder.

Discharge Plan or Pre-Discharge Plan: Hereafter referred to as the discharge plan, means an individualized plan for post-hospital services that is developed by the case management CSB in accordance with § 37.2-505 and § 16.1-346.1 of the Code of Virginia in consultation with the individual, surrogate decision maker, and the state hospital treatment team. This plan must include the mental health, developmental, substance abuse, social, educational, medical, employment, housing, legal, advocacy, transportation, and other services and supports needed by the individual, consistent with subdivision A.3 of § 37.2-505, following an episode of hospitalization and must identify the public or private providers that have agreed to provide these services and supports. The discharge plan is required by § 37.2-505, § 16.1-346.1, and § 37.2-508 of the Code of Virginia.

Level 2 PASRR Screening: Federal law requires that all individuals (regardless of payer source) who apply as a new admission to a Medicaid-certified nursing facility (NF) be evaluated for evidence of possible mental illness or intellectual disability. This evaluation and determination is conducted to ensure that individuals are placed appropriately, in the least restrictive setting possible, and that individuals receive needed services, wherever they are living. The process involves two steps, known as Level 1(UAI) and Level 2 screening. The use of a Level 1 and Level 2 screening and evaluation is known as the Preadmission Screening and Resident Review (PASRR) process. In Virginia, level 2 PASRR screenings are conducted by Ascend. Individuals with a sole or primary diagnosis of dementia are exempt from Level 2 screenings.

NGRI Coordinator (CSB): Required knowledge:

- Understanding of the basic criminal justice process and the Virginia Code related to insanity acquittees
- Understanding of risk assessment and risk management in the community as well as the knowledge of what community resources are needed for risk management
- Ability to work with an interdisciplinary team
- Ability to communicate well, particularly knowledge of how to write to the court and how to verbally present information in a courtroom setting
- Knowledge of person-centered planning practices that emphasizes recovery principals.

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Responsibilities:

1. Serving as the central point of accountability for CSB-assigned acquittees in DBHDS state hospitals
   a. Ensuring adequate and prompt communication with state hospital staff, Central Office staff, and their own agency staff related to NGRI patients
   b. Working with state hospital staff to resolve any barriers to treatment or release planning for NGRI patients
   c. Participating in all meetings where their presence is necessary in order to make decisions related to NGRI privilege increases or release
   d. Jointly preparing Risk Management Plans, Conditional Release Plans, or Unconditional Release Plans; Promptly responding to requests for modifications, reconciling differences, and returning signed documents to prevent delays to NGRI patient progress towards discharge
2. Serving as the central point for accountability and overseeing compliance of the CSB and the NGRI acquittee when court ordered for Conditional Release:
   a. Oversee compliance of the CSB with the acquittee's court-ordered Conditional Release Plan (CRP).
   b. Monitor the provision of CSB and non-CSB services in the CRP through agreed-upon means, including written reports, observation of services, satisfaction of the acquittee, etc.
   c. Assess risk on a continuous basis and make recommendations to the court
   d. Be the primary point of contact for judges, attorneys, and DBHDS staff.
   e. Coordinate the provision of reports to the courts & DBHDS in a timely fashion
   f. Assure that reports are written professionally and address the general and special conditions of the CRP with appropriate recommendations
   g. Prepare correspondence to the courts and DBHDS regarding acquittee non-compliance to include appropriate recommendations for the court to consider
   h. Provide adequate communication and coordinate the re-admission of NGRI acquittees to the state hospital when necessary
   i. Represent the CSB in court hearings regarding insanity acquittees
3. Maintain training and expertise needed for this role.
   a. Agree to participate in any and all DBHDS-developed training developed specifically for this role
   b. Agree to seek out consultation with DBHDS as needed
   c. Train other CSB staff and other provider staff (as appropriate) regarding the responsibilities of working with insanity acquittees, including the monthly and 6 month court reports

Primary Substance Use Disorder: An individual who is clinically assessed as having one or more substance use disorder per the current Diagnostic and Statistical Manual of Mental Disorders (DSM) with the substance use disorder being the "principle diagnosis" (i.e. the condition established after evaluation to be chiefly responsible for the admission). The individual may not have a mental health disorder per the current DSM or the mental health disorder is not the principle diagnosis.

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Releases of Information: The practice of authorizing a healthcare entity to release protected health information to other healthcare providers, non-healthcare organizations, or individuals. Obtained a signed release of information is best practice and should occur if at all possible; however, collaboration and information sharing for the purposes of discharge planning does not require a release of information, with the exception of SUD information protected by 42 CFR Part 2. While releases of information are best practice, they should not be a barrier to discharge. These activities are explained in the Code of Virginia § 37.2-839. Additionally please see HIPAA requirements on Treatment, Payment, & Health Care Operations. Lastly this provision is covered in the Human Right Regulations 12VAC35-115-80- B.8.g.

State Hospital: A hospital or psychiatric institute, or other institution operated by DBHDS that provides acute psychiatric care and treatment for persons with mental illness

Surrogate Decision Maker: A person permitted by law or regulations to authorize the disclosure of information or give consent for treatment and services, including medical treatment, or participation in human research, on behalf of an individual who lacks the mental capacity to make these decisions. A surrogate decision maker may include an attorney-in-fact, health care agent, legal guardian, or, if these are not available, the individual's family member (spouse, adult child, parent, adult brother or sister, or any other relative of the individual) or a next friend of the individual (defined in 12VAC35-115-146).

Treatment Team: The group of individuals responsible for the care and treatment of the individual during the period of hospitalization. Team members shall include, at a minimum, the individual receiving services, psychiatrist, a psychologist, a social worker, and a nurse. CSB staff shall actively participate, collaborate, and consult with the treatment team during the individual's period of hospitalization. The treatment team is responsible for providing all necessary and appropriate supports to assist the CSB in completing and implementing the individual's discharge plan.

Treatment Plan: A written plan that identifies the individual's treatment, educational/vocational and service needs, and states the goals, objectives, and interventions designed to address those needs. There are two sequential levels of treatment plans:

1. The "initial treatment plan," which directs the course of care during the first hours and days after admission; and
2. The "comprehensive treatment plan (CTP)," developed by the treatment team with CSB consultation, which guides, directs, and supports all treatment of the individual.

Treatment Plan Review (TPR): Treatment planning meetings or conferences held subsequent to the CTP meeting.

CSB State Hospital Discharge Planning Performance Measures

1. Eligible patients will be seen by CSB staff (outpatient therapist, case manager, psychiatrist, etc.) within seven calendar days of discharge from a state hospital (assessments by emergency services are not considered follow-up appointments). 80% of eligible patients will be seen by a CSB clinical staff member within seven calendar days of the discharge date.
2. CSBs will have a state hospital 30 day readmission rate of 7% or below
3. Patients followed by CSBs will have an average length of stay on the extraordinary barriers list (EBL) of 60 days or less. *Please note this measure will exclude NGRI patients.
4. CSBs that serve a population of 100,000 or more will have an average daily census of ten (10) beds or less per 100,000 adult and geriatric population. DBHDS shall calculate the CSBs' average daily census per 100,000 for the adult and geriatric population for patients with the following legal statuses: civil temporary detention order, civil commitment, court mandated voluntary, voluntary, and NGRI patients with 48 hours unescorted community visit privileges.

All data performance measure outcomes will be distributed to CSBs by DBHDS on a monthly basis.

Virginia Department of Behavioral Health & Developmental Services

DAP SECURE MEMORY CARE JUSTIFICATION

Instructions:

With the assistance of the state hospital social worker, complete to determine patient's need for secure memory care.

Patient Name: Click or tap here to enter text.

SECURE MEMORY CARE NEEDS	
Has this individual been diagnosed with Major Neurocognitive Disorder (dementia)? If yes, please list specific diagnosis: Click or tap here to enter text.	**Choose an item.**
What is this individual's level of mobility? Does this individual require equipment in order to ambulate? If yes, explain_Click or tap here to enter text.	**Choose an item.**
Has this individual engaged in exit-seeking behaviors on a consistent basis while hospitalized? If yes, explain_Click or tap here to enter text.	**Choose an item.**
Can the individual be supported safely to a less restrictive setting with a monitoring device such as project lifesaver or wander guard? Click or tap here to enter text.	**Choose an item.**
Is this individual currently formally identified by the state hospital as an elopement risk?Click or tap here to enter text.	**Choose an item.**
Please provide a justification as to why a secure (locked) facility is the least restrictive setting appropriate for this individual's discharge from the state hospital:_Click or tap here to enter text.	**Choose an item.**

CSB DAP Coordinator Signature_____

Date _____

Revised 3/2020

OUT OF CATCHMENT REFERRAL INSTRUCTIONS

The out of catchment referral is to be used when individuals are being discharged from the state hospital to a catchment area that is outside of the originating CSB's area. The form is utilized to provide information about the individual, as a referral for needed services, and notification for emergency services.

The form has two parts: notification and referral.

For individuals residing short term in another catchment area, or individuals not engaged in CSB services:

- **Please complete page 1- Notification-** This page provides necessary information for CSBs to be aware of individuals discharging from state facilities who are temporarily in another catchment area, or individuals discharging to a catchment area that will not be referred to CSB services.

For individuals being placed in another catchment who will require CSB services AND/OR have a DAP plan for services in another catchment area:

- **Please complete the entire referral form**
- **Please provide documentation including any EHR face sheet and most recent assessments. Additionally, at discharge, please provide the hospital discharge information to the accepting CSB.**

If the individual has a DAP plan, please be sure to submit the narrative and IDAPP to the accepting CSB and the regional manager.

OUT OF CATCHMENT NOTIFICATION/REFERRAL FORM

☐Notification Only *(Page 1)* ☐Full Referral **(***Pages 1-3; for individuals who will be referred for services)*

Patient Name:

Last 4 of SS#: DOB: Click or tap to enter a date.

State Hospital: Choose an item.

Admission Date: Click or tap to enter a date.

Primary Diagnosis:

Anticipated Discharge Date: Click or tap to enter a date. Next Treatment Team Date: Click or tap to enter a date.

Social Worker: Phone Number: Click or tap here to enter text.

Current CSB: Choose an item.

Name of Contact:

Phone: Email:

CSB of Discharge Residence: Choose an item.

Name of Contact:

Phone: Email:

Discharge Address:

Type of Residence:

Phone Number:

Contact at Residence (if applicable):

Does this individual have a legal guardian or POA? Choose an item.

(If yes, please list below under "Emergency Contact")

Emergency contact:

Address:

Phone:

Does this individual have a conservator or payee? Choose an item.

Name:

Address:

Phone:

Will this individual be referred for any services at CSB of discharge residence? Choose an item.

(If yes, please complete the remaining pages of this form.)

I. **Previous Housing** – Please list the individual's housing prior to admission to the state hospital:

Type of Housing:

Name of Residence (if applicable):

Reason Not Returning:

II. **Entitlements and Funding Sources**

☐SSI/SSA Amount:

☐SSDI Amount:

☐Medicaid List # and Type:

☐Medicare List # and Type:

☐DD Waiver Choose an item.

☐Auxiliary Grant Local DSS office where application sent:

☐SNAP

☐VA Benefits Click or tap here to enter text.

☐Private Insurance List Type and #:

☐Other:

III. **DAP**

Type: Choose an item.

Reason Needed:

IV. **Community Support** – What type of community-based services will be required?

☐Case Management

☐PACT/ICT

☐Mental Health Skill Building

☐Psychosocial Rehabilitation

☐Employment Services:

☐Substance Use Services:

☐Outpatient Services:

☐Other:

☐DAP Monitoring

V. **Legal Status**

Does individual have a valid ID? Choose an item.

Does the patient have any existing/pending criminal charges or court dates?Choose an item.

List Charges:

Court:

Court Date(s):

Is the individual NGRI? Choose an item. If yes please follow NGRI protocols.

VI. **Safety and Support Plan/Crisis Plan Initiated?** - Choose an item.

(If Yes, please attach)

VII. **Electronic Signature**

Notifying/Referring CSB: _____ Date: _____

Referral Sent to: Click or tap here to enter text.

Date: Click or tap to enter a date.

Referral Communication Method:Choose an item.

Amendment 1
FY22 –23 Community Services Performance Contract
Exhibit M: Department of Justice Settlement Agreement Requirements

The CSB and the Department agrees to comply with the following requirements in the Settlement Agreement for Civil Action No: 3:12cv00059-JAG between the U.S. Department of Justice (DOJ) and the Commonwealth of Virginia, entered in the U. S. District Court for the Eastern District of Virginia on August 23, 2012 [section IX.A, p. 36], and in compliance indicators agreed to by the parties and filed with the Court on January 14, 2020.

Sections identified in text or brackets refer to sections in the agreement requirements that apply to the target population defined in section III.B of the Agreement: individuals with developmental disabilities who currently reside in training centers, (ii) meet criteria for the DD Waiver waiting list, including those currently receiving DD Waiver services, or (iii) reside in a nursing home or an intermediate care facility (ICF).

1.) Case Managers or Support Coordinators shall provide anyone interested in accessing DD Waiver Services with a DBHDS provided resource guide that contains information including but not limited to case management eligibility and services, family supports- including the IFSP Funding Program, family and peer supports, and information on the My Life, My Community Website, information on how to access REACH services, and information on where to access general information. [section III.C.2. a-f, p. 1].

2.) Case management services, defined in section III.C.5.b, shall be provided to all individuals receiving Medicaid Home and Community-Based Waiver services under the Agreement by case managers or support coordinators who are not directly providing or supervising the provision of Waiver services to those individuals [section III.C.5.c, p. 8].

3.) For individuals receiving case management services pursuant to the Agreement, the individual's case manager or support coordinator shall meet with the individual face-to-face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs [section V.F.1, page 26].
   a. At these face-to-face meetings, the case manager or support coordinator shall: observe the individual and the individual's environment to assess for previously unidentified risks, injuries, needs, or other changes in status; assess the status of previously identified risks, injuries, needs, or other changes in status; assess whether the individual's individual support plan (ISP) is being implemented appropriately and remains appropriate for the individual; and ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs.
   b. The case manager or support coordinator shall document in the ISP the performance of these observations and assessments and any findings, including any changes in status or significant events that have occurred since the last face-to-face meeting.
   c. If any of these observations or assessments identifies an unidentified or inadequately addressed risk, injury, need, or change in status, a deficiency in the individual's support plan or its implementation, or a discrepancy between the implementation of supports and services and the individual's strengths and preferences, then the case manager or support coordinator shall report and document the issue in accordance with Department policies and regulations, convene the individual's service planning team to address it, and document its resolution.

4.) DBHDS shall develop and make available training for CSB case managers and leadership staff on how to assess change in status and that ISPs are implemented appropriately. DBHDS shall provide a tool with elements for the case managers to utilize during face-to-face visits to assure that changes in status as well as ISP are implemented appropriately and documented.
   a. CSB shall ensure that all case managers and case management leadership complete the training that helps to explain how to identify change in status and that elements of the ISP are implemented appropriately. The CSB shall deliver the contents of the DBHDS training through support coordinator supervisors or designated trainers to ensure case managers understand the definitions of a change in

status or needs and the elements of appropriately implemented services, as well as how to apply and document observations and needed actions.

b. CSB shall ensure that all case managers use the DBHDS On-Site Visit Tool during one face-to-face visit each quarter for individuals with Targeted Case Management and at one face-to-face visit per month for individuals with Enhanced Case Management to assess at whether or not each person receiving services under the waiver experienced a change in status and to assess whether or not the ISP was implemented appropriately.

5.) Using the process developed jointly by the Department and Virginia Association of Community Services Boards (VACSB) Data Management Committee (DMC), the CSB shall report the number, type, and frequency of case manager or support coordinator contacts with individuals receiving case management services [section V.F.4, p. 27].

6.) The CSB shall report key indicators, selected from relevant domains in section V.D.3 on page 24, from the case manager's or support coordinator's face-to-face visits and observations and assessments [section V.F.5, p 27]. Reporting in WaMS shall include the provision of data and actions related to DBHDS defined elements regarding a change in status or needs and the elements of appropriately implemented services in a format, frequency, and method determined by DBHDS [section III.C.5.b.i.].

7.) The individual's case manager or support coordinator shall meet with the individual face-to-face at least every 30 days (including a 10 day grace period but no more than 40 days between visits), and at least one such visit every two month must be in the individual's place of residence, for any individuals who [section V.F.3, pages 26 and 27]:

a. Receive services from providers having conditional or provisional licenses;
b. Have more intensive behavioral or medical needs as defined by the Supports Intensity Scale category representing the highest level of risk to individuals
c. Have an interruption of service greater than 30 days;
d. Encounter the crisis system for a serious crisis or for multiple less serious crises within a three-month period;
e. Have transitioned from a training center within the previous 12 months; or
f. Reside in congregate settings of five or more individuals. Refer to Enhanced Case Management Criteria Instructions and Guidance issued by the Department.

8.) Case managers or support coordinators shall give individuals a choice of service providers from which they may receive approved DD Waiver services, present all options of service providers based on the preferences of the individuals, including CSB and non-CSB providers, and document this using the Virginia Informed Choice Form in the waiver management system (WaMS) application. [section III.C.5.c, p. 8]. The CSB SC will complete the Virginia Informed Choice form to document provider and SC choice for Regional Support Team referrals, when changes in any provider, service, or service setting occurs, a new service is requested, the individual is dissatisfied with a service or provider, and no less than annually.

9.) The CSB shall complete the Support Coordinator Quality Review process for a statistically significant sample size as outlined in the Support Coordinator Quality Review Process.

a. DBHDS shall annually pull a statistically significant stratified sample of individuals receiving HCBS waiver and send this to the CSB to be utilized to complete the review.
b. Each quarter, the CSB shall complete the number of Support Coordinator Quality Reviews and provide data to DBHDS as outlined by the process.
c. DBHDS shall analyze the data submitted to determine the following elements are met:
    i. The CSB offered each person the choice of case manager/provider
    ii. The case manager assesses risk, and risk mitigation plans are in place

iii. The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed.
iv. The case manager assists in developing the person's ISP that addresses all of the individual's risks, identified needs and preferences.
v. The ISP includes specific and measurable outcomes, including evidence that employment goals have been discussed and developed, when applicable.
vi. The ISP was developed with professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served.
vii. The ISP includes the necessary services and supports to achieve the outcomes such as medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services necessary.
viii. Individuals have been offered choice of providers for each service.
ix. The case manager completes face-to-face assessments that the individual's ISP is being implemented appropriately and remains appropriate to the individual by meeting their health and safety needs and integration preferences.
x. The CSB has in place and the case manager has utilized where necessary, established strategies for solving conflict or disagreement within the process of developing or revising ISPs, and addressing changes in the individual's needs, including, but not limited to, reconvening the planning team as necessary to meet the individuals' needs.

d. DBHDS shall review the data submitted and complete a semi-annual report that includes a review of data from the Support Coordinator Quality Reviews and provide this information to the CSB. To assure consistency between reviewers, DBHDS shall complete an inter-rater reliability process.
e. If 2 or more records do not meet 86% compliance for two consecutive quarters, the CSB shall receive technical assistance provided by DBHDS.
f. The CSB shall cooperate with DBHDS and facilitate its completion of on-site annual retrospective reviews at the CSB to validate findings of the CSB Support Coordinator Quality Review to provide technical assistance for any areas needing improvement.

10.) Case managers or support coordinators shall offer education about integrated community options to any individuals living outside of their own or their families' homes and, if relevant, to their authorized representatives or guardians [section III.D.7, p. 14]. Case managers shall offer this education at least annually and at the following times:
a. At enrollment in a DD Waiver
b. When there is a request for a change in Waiver service provider(s)
c. When an individual is dissatisfied with a current Waiver service provider,
d. When a new service is requested
e. When an individual wants to move to a new location, or
f. When a regional support team referral is made as required by the Virginia Informed Choice Form

11.) For individuals receiving case management services identified to have co-occurring mental health conditions or engaging in challenging behaviors, the individual's case manager or support coordinator shall assure that effective community based behavioral health and/or behavioral supports and services are identified and accessed where appropriate and available.
a. If the case manager or support coordinator incurs capacity issues related to accessing needed behavioral support services in their designated Region, every attempt to secure supports should be made to include adding the individual to several provider waitlists (e.g., based upon individualized needs, this may be inclusive of psychotherapy, psychiatry, counseling, applied behavior analysis/positive behavior support providers, etc.) and following up with these providers quarterly to determine waitlist status. [SA. Provision: III.C.6.a.i-iii Filing reference: 7.14, 7.18]
b. DBHDS will provide the practice guidelines and a training program for case managers regarding the minimum elements that constitute an adequately designed behavioral program, as provided under

Therapeutic Consultation waiver services, and what can be observed to determine whether the plan is appropriately implemented. The CSB shall ensure that all case managers and case management leadership complete the training such that case managers are aware of the practice guidelines for behavior support plans and of key elements that can be observed to determine whether the plan is appropriately implemented. [SA. Provision: III.C.6.a.i-iii Filing reference: 7.16, 7.20]

12.) The CSB shall identify children and adults who are at risk for crisis through the standardized crisis screening tool or through the utilization of the elements contained in the tool at intake, and if the individual is identified as at risk for crisis or hospitalization, shall refer the individual to REACH. [SA. Provision: III.C.6.a.i-iii Filing reference: 7.2]

13.) For individuals that receive enhanced case management, the case manager or support coordinator shall utilize the standardized crisis screening tool during monthly visits; for individuals that receive targeted case management, the case manager or support coordinator shall use the standardized crisis screening tool during quarterly visits. Any individual that is identified as at risk for crisis shall be referred to REACH. [S.A. Provision: III.C.6.a.i-iii Filing reference: 7.3]

14.) The CSB shall ensure that CSB Executive Directors, Developmental Disability Directors, case management or support coordination supervisors, case managers or support coordinators, and intake workers participate in training on how to identify children and adults who are at risk for going into crisis.
   a. CSBs shall ensure that training on identifying risk of crisis for intake workers and case managers (or support coordinators) shall occur within 6 months of hire. [S.A. Provision: III.C.6.a.i-iii Filing reference: 7.5]

15.) The CSB shall provide data on implementation of the crisis screening tool as requested by DBHDS when it is determined that an individual with a developmental disability has been hospitalized and has not been referred to the REACH program.
   a. The CSB shall provide to DBHDS upon request copies of the crisis risk assessment tool, or documentation of utilization of the elements contained within the tool during a crisis screening, for quality review purposes to ensure the tool is being implemented as designed and is appropriately identifying people at risk of crisis. [S.A. Provision: III.C.6.a.i-iii Filing reference: 7.6]
   b. DBHDS shall develop a training for the CSB to utilize when training staff on assessing an individuals risk of crisis/hospitalization.
   c. DBHDS shall initiate a quality review process to include requesting documentation for anyone psychiatrically hospitalized who was not referred to the REACH program and either actively receiving case management during the time frame or for whom an intake was completed prior to hospitalization. The CSB shall promptly, but within no more than 5 business days, provide the information requested.
   d. DBHDS shall request information to verify presence of DD diagnosis for persons that are psychiatrically hospitalized that are not known to the REACH program. The CSB shall promptly, but within no more than 5 business days, provide the information requested. [S.A. Provision: III.C.6.b.ii.A Filing references 8.6, 8.7]
   e.

16.) CSB Case manager shall work with the REACH program to identify a community residence within 30 days of admission to the program including making a referral to RST when the system has been challenged to find an appropriate provider within this timeframe.
   a. a. If a waiver eligible individual is psychiatrically hospitalized, is a guest at a REACH CTH, or is residing at an Adult Transition Home and requires a waiver to obtain a community residence, the CSB shall submit an emergency waiver slot request. [S.A. Provision III.C.6.b.ii.A Filing reference 10.2]

17.) CSB emergency services shall be available 24 hours per day and seven days per week, staffed with clinical professionals who shall be able to assess crises by phone, assist callers in identifying and connecting with local services, and, where necessary, dispatch at least one mobile crisis team member adequately trained to address the crisis for individuals with developmental disabilities [section III.C.6.b.i.A, p. 9].

a. The mobile crisis team shall be dispatched from the Regional Education Assessment Crisis Services Habilitation (REACH) program that is staffed 24 hours per day and seven days per week by qualified persons able to assess and assist individuals and their families during crisis situations and that has mobile crisis teams to address crisis situations and offer services and support on site to individuals and their families within one hour in urban areas and two hours in rural areas as measured by the average annual response time [section III.C.6.b.ii, pages 9 and 10].
b. All Emergency services staff and their supervisors shall complete the REACH training, created and made available by DBHDS, that is part of the emergency services training curriculum.
c. DBHDS shall create and update a REACH training for emergency staff and make it available through the agency training website.
d. CSB emergency services shall notify the REACH program of any individual suspected of having a developmental disability who is experiencing a crisis and seeking emergency services as soon as possible, preferably prior to the initiation of a preadmission screening evaluation in order to allow REACH and emergency services to appropriately divert the individual from admission to psychiatric inpatient services when possible.
e.
f. If the CSB has an individual receiving services in the REACH Crisis Therapeutic Home (CTH) program with no plan for discharge to a community residence and a length of stay that shall soon exceed 30 concurrent days, the CSB Executive Director or his or her designee shall provide a weekly update describing efforts to achieve an appropriate discharge for the individual to the Director of Community Support Services in the Department's Division of Developmental Services or his/her designee.
g. DBHDS shall notify the CSB Executive Director or designee when it is aware of a person at the REACH CTH who is nearing a 30-day concurrent stay.

18.) Comply with State Board Policy 1044 (SYS) 12-1 Employment First [section III.C.7.b, p. 11]. This policy supports identifying community-based employment in integrated work settings as the first and priority service option offered by case managers or support coordinators to individuals receiving day support or employment services.

a. CSB case managers shall take the on-line case management training modules and review the case management manual.
b. CSB case managers shall initiate meaningful employment conversations with individuals starting at the age of 14 until the age of retirement (65).
c. CSB case managers shall discuss employment with all individuals, including those with intense medical or behavioral support needs, as part of their ISP planning processes.
d. CSB case managers shall document goals for or toward employment for all individuals 18-64 or the specific reasons that employment is not being pursued or considered.
e. DBHDS shall create training and tools for case managers regarding meaningful conversation about employment, including for people with complex medical and behavioral support needs. The CSB shall utilize this training with its staff and document its completion.

19.) CSB case managers or support coordinators shall liaise with the Department's regional community resource consultants regarding responsibilities as detailed in the Performance Contract [section III.E.1, p. 14].

20.) Case managers or support coordinators shall participate in discharge planning with individuals'

personal support teams (PSTs) for individuals in training centers and children in ICF/IIDs for whom the CSB is the case
management CSB, pursuant to § 37.2-505 and § 37.2-837 of the Code that requires the CSB to develop discharge plans in collaboration with training centers [section IV.B.6, p. 16].

21.) In developing discharge plans, CSB case managers or support coordinators, in collaboration with facility PSTs, shall provide to individuals and, where applicable, their authorized representatives, specific options for types of community residences , services, and supports based on the discharge plan and the opportunity to discuss and meaningfully consider these options [section IV.B.9, p. 17].

22.) CSB case managers or support coordinators and PSTs shall coordinate with specific types of community providers identified in discharge to provide individuals, their families, and, where applicable, their authorized representatives with opportunities to speak with those providers, visit community residences (including, where feasible, for overnight visits) and programs, and facilitate conversations and meetings with individuals currently living in the community and their families before being asked to make choices regarding options [section IV.B.9.b, p. 17].

23.) CSB case managers or support coordinators and PSTs shall assist individuals and, where applicable, their authorized representatives in choosing providers after providing the opportunities described in subsection 13 above and ensure that providers are timely identified and engaged in preparing for individuals' transitions [section IV.B.9.c, p.17]. Case managers or support coordinators shall provide information to the Department about barriers to discharge for aggregation and analysis by the Department for ongoing quality improvement, discharge planning, and development of community-based services [IV.B.14, p. 19].

24.) In coordination with the Department's Post Move Monitor, the CSB shall conduct post- move monitoring visits within 30, 60, and 90 days following an individual's movement from a training center to a community setting [section IV.C.3, p.19]. The CSB shall provide information obtained in these post move monitoring visits to the Department within seven business days after the visit.

25.) If a CSB provides day support or residential services to individuals in the target population, the CSB shall implement risk management and quality improvement processes, including establishment of uniform risk triggers and thresholds that enable it to adequately address harms and risks of harms, including any physical injury, whether caused by abuse, neglect, or accidental causes [section V.C.1, p. 22].

26.) Using the protocol and the real-time, web-based incident reporting system implemented by the Department, the CSB shall report any suspected or alleged incidents of abuse or neglect as defined in § 37.2-100 of the Code, serious injuries as defined in 12 VAC 35- 115-30 of the *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services* or deaths to the Department within 24 hours of becoming aware of them [section V.C.2, p. 22].

27.) CSBs shall participate with the Department to collect and analyze reliable data about individuals receiving
services under this Agreement from each of the following areas:

a. safety and freedom from harm
b. physical, mental, and behavioral
c. avoiding crises
d. choice and self-determination
e. community inclusion, health and well-being
f. access to services
g. provider capacity
h. stability [section V.D.3, pgs. 24 & 25]

28.) CSBs shall participate in the regional quality council established by the Department that is responsible for

assessing relevant data, identifying trends, and recommending responsive actions in its region [section V.D.5.a, p. 25].

29.) CSB's shall review and provide annual feedback on the Quality Review Team (QRT) End of Year Report.

30.) CSBs shall participate in DBHDS initiatives that ensure the reliability and validity of data submitted to the Department. Participation may include reviews of sampled data, the comparison of data across DBHDS and CSB systems, and the involvement of operational staff to include information technology. Meeting frequency shall be semi-annually, but not more than monthly depending on the support needed.

31.) CSBs shall provide access to the Independent Reviewer to assess compliance with this Agreement. The Independent Reviewer shall exercise his access in a manner that is reasonable and not unduly burdensome to the operation of the CSB and that has minimal impact on programs or services to individuals receiving services under the Agreement [section VI.H, p. 30 and 31]

32.) CSBs shall participate with the Department and any third party vendors in the implementation of the National Core Indicators (NCI) Surveys and Quality Service Reviews (QSRs) for selected individuals receiving services under the Agreement. This includes informing individuals and authorized representatives about their selection for participation in the NCI individual surveys or QSRs; providing the access and information requested by the vendor, including health records, in a timely manner; assisting with any individual specific follow up activities; and completing NCI surveys [section V.I, p. 28].
   a. During FY22 the QSR process will be accelerated and will require the CSB to fully participate in the completion of QSR implementation twice during a nine-month period. This will ensure that the Commonwealth can show a complete improvement cycle intended by the QSR process by June 30, 2022. The attached GANTT details the schedule for the QSR reviews of 100% of providers, including support coordinators, for two review cycles.

33.) The CSB shall notify the community resource consultant (CRC) and regional support team (RST) in the following circumstances to enable the RST to monitor, track, and trend community integration and challenges that require further system development:
   a. within five calendar days of an individual being presented with any of the following residential options: an ICF, a nursing facility, a training center, or a group home/congregate setting with a licensed capacity of five beds or more;
   b. if the CSB is having difficulty finding services within 30 calendar days after the individual's enrollment in the waiver; or
   c. immediately when an individual is displaced from his or her residential placement for a second time [sections III.D.6 and III.E, p. 14].

34.) DBHDS shall provide data to CSBs on their compliance with the RST referral and implementation process.
   a. DBHDS shall provide information quarterly to the CSB on individuals who chose less integrated options due to the absence of something more integrated at the time of the RST review and semi-annually
   b. DBHDS shall notify CSBs of new providers of more integrated services so that individuals who had to choose less integrated options can be made aware of these new services and supports.
   c. CSBs shall offer more integrated options when identified by the CSB or provided by DBHDS.
   d. CSBs shall accept technical assistance from DBHDS if the CSB is not meeting expectations.

35.) Case managers or support coordinators shall collaborate with the CRC to ensure that person-centered planning and placement in the most integrated setting appropriate to the individual's needs and consistent with his or her informed choice occur [section III.E.1- 3, p. 14].
   a. CSBs shall collaborate with DBHDS CRCs to explore community integrated options including working with providers to create innovative solutions for people.The Department encourages the CSB to provide the Independent Reviewer with access to its services and records and to individuals

receiving services from the CSB; however, access shall be given at the sole discretion of the CSB [section VI.G, p. 31].

36.) Developmental Case Management Services

a. Case managers or support coordinators employed or contracted by the CSB shall meet the knowledge, skills, and abilities qualifications in the Case Management Licensing Regulations, 12 VAC 35-105-1250. During its inspections, the Department's Licensing Office may verify compliance as it reviews personnel records.
b. Reviews of the individual support plan (ISP), including necessary assessment updates, shall be conducted with the individual quarterly or every 90 days and include modifications in the ISP when the individual's status or needs and desires change.
c. During its inspections, the Department's Licensing Office may verify this as it reviews the ISPs including those from a sample identified by the CSB of individuals who discontinued case management services.
d. The CSB shall ensure that all information about each individual, including the ISP and VIDES, is imported from the CSB's electronic health record (EHR) to the Department within five (5) business days through an electronic exchange mechanism mutually agreed upon by the CSB and the Department into the electronic waiver management system (WaMS).
e. If the CSB is unable to submit via the data exchange process, it shall enter this data directly through WaMS, when the individual is entered the first time for services, or when his or her living situation changes, her or his ISP is reviewed annually, or whenever changes occur, including the individual's Race and the following information:

i.	full name	viii.	level of care information
ii.	social security number	ix.	change in status
iii.	Medicaid number	x.	terminations
iv.	CSB unique identifier	xi.	transfers
v.	current physical residence address	xii.	waiting list information
vi.	living situation (e.g., group home	xiii.	bed capacity of the group home if that is chosen
vii.	family home, or own home)	xiv.	Current support coordinator's name

f. Case managers or support coordinators and other CSB staff shall comply with the SIS® Administration Process and any changes in the process within 30 calendar days of notification of the changes.
g. Case managers or support coordinators shall notify the Department's service authorization staff that an individual has been terminated from all DD waiver services within 10 business days of termination.
h. Case managers or support coordinators shall assist with initiating services within 30 calendar days of waiver enrollment and shall submit Request to Retain Slot forms as required by the Department. All written denial notifications to the individual, and family/caregiver, as appropriate, shall be accompanied by the standard appeal rights (12VAC30-110).
i. Case managers or support coordinators shall complete the level of care tool for individuals requesting DD Waiver services within 60 calendar days of application for individuals expected to present for services within one year.
j. Case managers or support coordinators shall comply with the DD waitlist process and slot assignment process and implement any changes in the processes within 30 calendar days of written notice from the Department.

37.) Targeted Technical Assistance

a. The CSB shall participate in technical assistance as determined by the Case Management Steering Committee. Technical assistance may be comprised of virtual or on-site meetings, trainings, and record reviews related to underperformance in any of the following areas monitored by the committee: Regional Support Team referrals, Support Coordination Quality Review results, Individual Support Plan entry completion, and case management contact data.

b. DBHDS shall provide a written request that contains specific steps and timeframes necessary to complete the targeted technical assistance process.
c. The CSB shall accommodate technical assistance when recommended within 45 days of the written request.
d. CSB failure to participate in technical assistance as recommended or demonstrate improvement within 12 months may result in further actions under Exhibit I of this contract.

38.) CSB Quality Improvement Committees will review annually the DMAS-DBHDS Quality Review Team's

End of Year report on the status of the performance measures included in the DD HCBS Waivers' Quality Improvement Strategy with accompanying recommendations to the DBHDS Quality Improvement Committee. CSB documentation of these reviews and resultant CSB-specific quality improvement activities will be reported to DBHDS within 30 days of receiving the report.

Amendment 1
FY22-23 Community Services Performance Contract
Addendum I
Administrative Requirements and Processes and Procedures

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Amendment 1
FY22-23 Community Services Performance Contract
Addendum I
Administrative Requirements and Processes and Procedures

I. Purpose

The Administrative Requirements and Processes and Procedures include statutory, regulatory, policy, process and procedures and other requirements that are not expected to change frequently. The CSB and the Department shall comply with these requirements and processes and procedures. This document is incorporated into and made a part of the Community Services Performance Contract (PC) by reference. The Department will work with the CSBs regarding any substantive changes to this document, with the exception of changes in statutory, regulatory, policy, or other requirements.

II. CSB Requirements

A. Financial Management Requirements, Policies, and Procedures

Generally Accepted Accounting Principles: The CSB's financial management and accounting system shall operate and produce financial statements and reports in accordance with Generally Accepted Accounting Principles. It shall include necessary personnel and financial records and a fixed assets system. It shall provide for the practice of fund accounting and adhere to cost accounting guidelines issued by the Department.

If it is an administrative policy CSB that is a city or county department or agency or is required to adhere to local government financial management requirements, policies, and procedures or it is the local government department with a policy-advisory CSB, the CSB shall comply with local government financial management requirements, policies, and procedures.

If the Department receives any complaints about the CSB's financial management operations, the Department will forward these complaints to the local government and any other appropriate authorities. In response to those complaints, the Department may conduct a review of that CSB's financial management activities.

1. **Accounting:** CSBs shall account for all service and administrative expenses accurately and submit timely reports to the Department to document these expenses.

2. **Annual Independent Audit:** If it is an operating CSB, the behavioral health authority, or an administrative policy CSB that is not a city or county department or agency or is not required to adhere to local government financial management requirements, policies, and procedures, the CSB shall obtain an independent annual audit conducted by certified public accountants.

    a. Audited financial statements shall be prepared in accordance with generally accepted accounting principles (GAAP). The appropriate GAAP basis financial reporting model is the Enterprise Fund in accordance with the requirements of Governmental Accounting Standards Board (GASB) Statement Number 34, *Basic Financial Statements- and Management's Discussion and Analysis- for State and Local Governments*. GASB 34 replaces the previous financial reporting model *Health Care Organizations Guide*, produced by the American Institute of Certified Public Accountants.

    b. Copies of the audit and the accompanying management letter shall be provided to the Office of Budget and Financial Reporting in the Department and to each local government that established the CSB.

    c. CSBs shall, to the extent practicable, obtain unqualified audit opinions. Deficiencies and exceptions noted in an audit or management letter shall be resolved or corrected within a reasonable period of time, mutually agreed upon by the CSB and the Department.

    d. If it is an administrative policy CSB that is a city or county department or agency or is required to adhere to local government financial management requirements, policies, and procedures or it is the local government department with a policy-advisory CSB, the CSB shall be included in the annual audit of its local government.

        i. Copies of the applicable portions of the accompanying management letter shall be provided to the Office of Budget and Financial Reporting in the Department.

ii. Deficiencies and exceptions noted in a management letter shall be resolved or corrected within a reasonable period of time, mutually agreed upon by the CSB, its local government(s), and the Department.

e. If an administrative policy CSB that is a city or county department or agency or is required to adhere to local government financial management requirements, policies, and procedures or the local government department with a policy-advisory CSB obtains a separate independent annual audit conducted by certified public accountants, audited financial statements shall be prepared in accordance with generally accepted accounting principles.

i. The appropriate GAAP basis financial reporting model is the Enterprise Fund in accordance with the requirements of Governmental Accounting Standards Board (GASB) Statement Number 34, *Basic Financial Statements- and Management's Discussion and Analysis- for State and Local Governments*. The local government will determine the appropriate fund classification in consultation with its certified public accountant.

ii. Copies of the audit and the accompanying management letter shall be provided to the Office of Budget and Financial Reporting and to each local government that established the CSB.

iii. CSBs shall, to the extent practicable, obtain unqualified audit opinions.

iv. Deficiencies and exceptions noted in an audit or management letter shall be resolved or corrected within a reasonable period of time, mutually agreed upon by the CSB and the Department.

3. **Federal Audit Requirements:** When the Department subgrants federal grants to a CSB, the CSB shall satisfy all federal government audit requirements.

4. **Subcontractor Audits:** Every CSB shall obtain, review, and take any necessary actions on audits of any subcontractors that provide services that are procured under the Virginia Public Procurement Act and included in a CSB's performance contract. The CSB shall provide copies of these audits to the Office of Budget and Financial Reporting in the Department.

5. **Bonding:** If it is an operating CSB, the behavioral health authority, or an administrative policy CSB that is not a city or county department or agency or is not required to adhere to local government financial management requirements, policies, and procedures, CSB employees with financial responsibilities shall be bonded in accordance with local financial management policies.

6. **Fiscal Policies and Procedures:** If it is an operating CSB, the behavioral health authority, or an administrative policy CSB that is not a city or county department or agency or is not required to adhere to local government financial management requirements, policies, and procedures, a CSB's written fiscal policies and procedures shall conform to applicable State Board policies and Departmental policies and procedures.

7. **Financial Management Manual:** If it is an operating CSB, the behavioral health authority, or an administrative policy CSB that is not a city or county department or agency or is not required to adhere to local government financial management requirements, policies, and procedures, a CSB shall be in material compliance with the requirements in the current Financial Management Standards for Community Services Boards issued by the Department.

8. **Local Government Approval:** CSBs shall submit their performance contracts to the local governments in their service areas for review and approval, pursuant to § 37.2-508 or § 37.2-608 of the Code of Virginia, which requires approval of the contracts by September 30.
   a. CSBs shall submit their contracts to the local governing bodies of the cities and counties that established them in accordance with the schedules determined by those governing bodies or at least 15 days before meetings at which the governing bodies are scheduled to consider approval of their contracts.
   b. Unless prohibited from doing so by its local government(s), a CSB may submit its contract to the Department before it is approved by its local government(s).

9. **Department Review:** If a CSB is an operating CSB, the behavioral health authority, or an administrative policy CSB that is not a city or county department or agency or is not required to adhere to local government financial management requirements, policies, and procedures, the Department may conduct a review of the CSB's financial management activities at any time.

    a. While it does not conduct routine reviews of the CSB's financial management activities, the Department may conduct a review in response to significant deficiencies, irregularities, or problems identified in the CSB's audit or management letter or in response to complaints or information that it receives.

        i. Such reviews shall be limited to sub-recipient monitoring responsibilities in 2 CFR Part 200.331 associated with receipt of federal funds by the CSB.

        ii. CSBs shall submit formal plans of correction to the Office of Budget and Financial Reporting in the Department within 45 days of receipt of official reports of reviews.

        iii. Minor compliance issues shall be corrected within 45 days of submitting a plan. Action to correct major compliance issues shall be initiated within 45 days and completed within 180 days of submitting a plan, unless the Department grants an extension.

    b. If it is an administrative policy CSB that is a city or county department or agency or is required to adhere to local government financial management requirements, policies, and procedures or it is the local government department with a policy-advisory CSB, the Department may conduct a review of a CSB's financial management activities at any time in order to fulfill its responsibilities for federal sub-recipient (CSB) monitoring requirements under the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards 2 CFR Part 200.331.

B. Procurement Requirements, Policies, and Procedures

1. **Procurement Policies and Procedures:** If it is an operating CSB, the behavioral health authority, or an administrative policy CSB that is not a city or county department or agency or is not required to adhere to local government procurement requirements, policies, and procedures, a CSB shall have written procurement policies and procedures in effect that address internal procurement responsibilities, small purchases and dollar thresholds, ethics, and disposal of surplus property. Written procurement policies and procedures relating to vendors shall be in effect that address how to sell to the CSB, procurement, default, and protests and appeals. All written policies and procedures shall conform to the Virginia Public Procurement Act.

   If it is an administrative policy CSB that is a city or county department or agency or is required to adhere to local government procurement requirements, policies, and procedures or it is the local government department with a policy-advisory CSB, a CSB shall comply with its local government's procurement requirements, policies, and procedures, which shall conform to the Virginia Public Procurement Act. If the Department receives any complaints about the CSB's procurement operations, the Department will forward these complaints to the local government and any other appropriate authorities. In response to those complaints, the Department may conduct a review of that CSB's procurement activities.

2. **Department Review:** If a CSB is an operating CSB, the behavioral health authority, or an administrative policy CSB that is not a city or county department or agency or is not required to adhere to local government procurement requirements, policies, and procedures, the Department may conduct a review of the CSB's procurement activities at any time. While it does not conduct routine reviews of the CSB's procurement activities, the Department may conduct a review in response to significant deficiencies, irregularities, or problems identified in the CSB's independent annual audit or management letter or in response to complaints or information that it receives. The review will include a sampling of CSB subcontracts. CSBs shall submit formal plans of correction to the Office of Administrative Services in the Department within 45 days of receipt of official reports of reviews. Minor compliance issues shall be corrected within 45 days of submitting a plan. Action to correct major compliance issues shall be initiated within 45 days and completed within 180 days of submitting a plan, unless the Department grants an extension.

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C. Reimbursement Requirements, Policies, and Procedures

1. **Reimbursement System:** Each CSB's reimbursement system shall comply with § 37.2-504 and § 37.2-511 or § 37.2-605 and § 37.2-612 and with § 20-61 of the Code of Virginia and State Board Policy 6002 (FIN) 86-14. Its operation shall be described in organizational charts identifying all staff members, flow charts, and specific job descriptions for all personnel involved in the reimbursement system.

2. **Policies and Procedures:** Written fee collection policies and procedures shall be adequate to maximize fees from individuals and responsible third party payers.

3. **Schedule of Charges:** A schedule of charges shall exist for all services that are included in the CSB's performance contract, shall be related reasonably to the cost of the services, and shall be applicable to all recipients of the services.

4. **Ability to Pay:** A method, approved by a CSB's board of directors that complies with applicable state and federal regulations shall be used to evaluate the ability of each individual to pay fees for the services he or she receives.
5. **Department Review:** While it does not conduct routine reviews of the CSB's reimbursement activities, the Department may conduct a review at any time in response to significant deficiencies, irregularities, or problems identified in the CSB's independent annual audit or management letter or in response to complaints or information that it receives.

    a. CSBs shall submit formal plans of correction to the Office of Cost Accounting and Reimbursement in the Department within 45 days of receipt of official reports of reviews.

    b. Minor compliance issues shall be corrected within 45 days of submitting a plan. Action to correct major compliance issues shall be initiated within 45 days and completed within 180 days of submitting a plan, unless the Department grants an extension.

6. **Medicaid and Medicare Regulations:** CSBs shall comply with applicable federal and state Medicaid and Medicare regulations, policies, procedures, and provider agreements. Medicaid non-compliance issues identified by Department staff will be communicated to the Department of Medical Assistance Services.

D. Human Resource Management Requirements, Policies, and Procedures

1. **Statutory Requirements:** If it is an operating CSB, the behavioral health authority, or an administrative policy CSB that is not a city or county department or agency or is not required to adhere to local government human resource management requirements, policies, and procedures, a CSB shall operate a human resource management program that complies with state and federal statutes, regulations, and policies.

   If it is an administrative policy CSB that is a city or county department or agency or is required to adhere to local government human resource management requirements, policies, and procedures or it is the local government department with a policy-advisory CSB, a CSB shall be part of a human resource management program that complies with state and federal statutes, regulations, and policies.

2. **Policies and Procedures:** If it is an operating CSB, the behavioral health authority, or an administrative policy CSB that is not a city or county department or agency or is not required to adhere to local government human resource management requirements, policies, and procedures, a CSB's written human resource management policies and procedures shall include a classification plan and uniform employee pay plan and, at a minimum, shall address:
    a) nature of employment;
    b) equal employment opportunity;
    c) recruitment and selection;
    d) criminal background and reference check requirements;

e) classification and compensation, including a uniform employee pay plan;
f) employment medical examinations (e.g., TB);
g) nepotism (employment of relatives);
h) probationary period;
i) initial employee orientation;
j) transfer and promotion;
k) termination, layoff, and resignation;
l) benefits, including types and amounts of leave, holidays, and health, disability, and other insurances;
m) hours of work;
n) outside employment;
o) professional conduct;
p) employee ethics;
q) compliance with state Human Rights Regulations and the CSB's local human rights policies and procedures;
r) HIPAA compliance and privacy protection;
s) compliance with the Americans with Disabilities Act;
t) compliance with Immigration Reform and Control Act of 1986;
u) conflicts of interests and compliance with the Conflict of Interests Act;
v) compliance with Fair Labor Standards Act, including exempt status, overtime, and compensatory leave;
w) drug-free workplace and drug testing;
x) maintenance of a positive and respectful workplace environment;
y) prevention of sexual harassment;
z) prevention of workplace violence;
aa) whistleblower protections;
bb) smoking;
cc) computer, internet, email, and other electronic equipment usage;
dd) progressive discipline (standards of conduct);
ee) employee performance evaluation;
ff) employee grievances;
gg) travel reimbursement and on-the-job expenses;
hh) employee to executive director and board of directors contact protocol; and
ii) communication with stakeholders, media, and government officials.

If it is an administrative policy CSB that is a city or county department or agency or is required to adhere to local government human resource management requirements, policies, and procedures or it is the local government department with a policy-advisory CSB, a CSB shall adhere to its local government's human resource management policies and procedures.

3. **Job Descriptions:** If it is an operating CSB, the behavioral health authority, or an administrative policy CSB that is not a city or county department or agency or is not required to adhere to local government human resource management requirements, policies, and procedures, a CSB shall have written, up-to-date job descriptions for all positions.

   Job descriptions shall include identified essential functions, explicit responsibilities, and qualification statements, expressed in terms of knowledge, skills, and abilities as well as business necessity and bona fide occupational qualifications or requirements.

4. **Grievance Procedure:** If it is an operating CSB, the behavioral health authority, or an administrative policy CSB that is not a city or county department or agency or is not required to adhere to local government human resource management, policies, procedures, and requirements, a CSB's grievance procedure shall satisfy § 15.2-1507 of the Code of Virginia.

5. **Uniform Pay Plan:** If it is an operating CSB, a behavioral health authority, or an administrative policy CSB that is not a city or county department or agency or is not required to adhere to local government human resource management requirements, policies, and procedures, a CSB shall adopt a uniform pay plan in accordance with § 15.2-1506 of the Code of Virginia and the Equal Pay Act of 1963.

6. **Department Review:** If it is an operating CSB, the behavioral health authority, or an administrative policy CSB that is not a city or county department or agency or is not required to adhere to local government human resource management requirements, policies, and procedures, employee complaints regarding a CSB's human resource management practices will be referred back to the CSB for appropriate local remedies.
   a) The Department may conduct a human resource management review to ascertain a CSB's compliance with performance contract requirements and assurances, based on complaints or other information received about a CSB's human resource management practices. If a review is done and deficiencies are identified, a CSB shall submit a formal plan of correction to the Office of Human Resource Management and Development in the Department within 45 days of receipt of an official report of a review.
   b) Minor compliance issues shall be corrected within 45 days of submitting the plan. Action to correct major compliance issues shall be initiated within 45 days and completed within 180 days of submitting the plan, unless the Department grants an extension.
   c) If it is an administrative policy CSB that is a city or county department or agency or is required to adhere to local government human resource management requirements, policies, and procedures or it is the local government department with a policy-advisory CSB, employee complaints regarding a CSB's human resource management practices will be referred back to the local government for appropriate local remedies. In response to complaints that it receives, the Department may conduct a review of the local government's human resource management practices at any time.

E. Comprehensive State Planning

1. **General Planning:** The CSB shall participate in collaborative local and regional service and management information systems planning with state facilities, other-CSBs, other public and private human services agencies, and the Department, as appropriate. In accordance with § 37.2-504 or § 37.2-605 of the Code of Virginia, the CSB shall provide input into long-range planning activities that are conducted by the Department.

2. **Participation in State Facility Planning Activities**
   The CSB shall participate in collaborative planning activities with the Department to the greatest extent possible regarding the future role and structure of the state facilities.

F. Interagency Relationships

Pursuant to the case management requirements of § 37.2-500 or § 37.2-601 of the Code of Virginia, the CSB shall, to the extent practicable, develop and maintain linkages with other community and state agencies and facilities that are needed to assure that individuals it serves are able to access treatment, training, rehabilitative, and habilitative mental health, developmental, or substance abuse services and supports identified in their individualized services plans. The CSB shall comply with § 37.2-504 or § 37.2-605 of the Code of Virginia regarding interagency agreements.

The CSB also shall develop and maintain, in conjunction with the courts having jurisdiction in the cities or counties served by the CSB, cooperative linkages that are needed to carry out the provisions of § 37.2-805 through § 37.2-821 and related sections of the Code of Virginia pertaining to the involuntary admission process.

The CSB shall develop and maintain the necessary linkages, protocols, and interagency agreements to effect the provisions of the Comprehensive Services Act for At-Risk Youth and Families (§ 2.2-5200 through § 2.2-5214 of the Code of Virginia) that relate to services that it provides. Nothing in this provision shall be construed as requiring the CSB to provide services related to this act in the absence of sufficient funds and interagency agreements.

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III. The Department Requirements

A. Comprehensive State Planning

The Department shall conduct long-range planning activities related to state facility and community services, including the preparation and dissemination of the Comprehensive State Plan required by § 37.2-315 of the Code of Virginia.

B. Administrative Fee

The Department shall partner with the CSBs to establish administrative fee policies and procedures.

C. Information Technology

The Department shall operate and provide technical assistance and support, to the extent practicable, to the CSB about the Community Automated Reporting System (CARS), the Community Consumer Submission (CCS) software, the FIMS, and the prevention data system referenced in the performance contract and comply with State Board Policies 1030 and 1037.

1. Pursuant to § 37.2-504 and § 37.2-605 of the Code of Virginia, the Department shall implement procedures to protect the confidentiality of data accessed or received in accordance with the performance contract.

2. The Department shall ensure that any software application that it issues to the CSB for reporting purposes associated with the performance contract has been field tested in accordance with Appendix D by a reasonable number of CSBs to assure compatibility and functionality with the major IT systems used by CSBs, is operational, and is provided to the CSB sufficiently in advance of reporting deadlines to allow the it to install and run the software application.

3. The Department shall collaborate with the VACSB DMC in the implementation of any new data management or data warehousing systems to ensure appropriate interoperability and workflow management.

Amendment 1
FY22-23 Community Services Performance Contract
Addendum I
Administrative Requirements and Processes and Procedures

Appendix A: CSB and Board of Directors Organization and Operations

These requirements apply to the CSB board of directors or staff and the services included in this agreement.

A. CSB Organization
The CSB's organization chart shall be consistent with the current board of directors and staff organization. The organization chart shall include the local governing body or bodies that established the CSB and the board's committee structure.

B. Board Bylaws
Board of directors (BOD) bylaws shall be consistent with local government resolutions or ordinances establishing the CSB, board policies, and the CSB's organization chart and shall have been reviewed and revised in the last two years.

C. CSB Name Change
If the name of an operating CSB changes, the CSB shall attach to this contract copies of the resolutions or ordinances approving the CSB's new name that were adopted by the boards of supervisors or city councils (local governing bodies) that established the CSB. If the number of appointments made to the CSB by its local governing bodies changes, the CSB shall attach to this contract copies of the resolutions or ordinances adopted by the local governing bodies that changed the number of appointments.

If the name of an administrative policy CSB that is not a local government department or that serves more than one city or county changes, the CSB shall attach to this contract copies of the resolutions or ordinances approving the CSB's new name that were adopted by the boards of supervisors or city councils (local governing bodies) that established the CSB. If the number of appointments made to the CSB by its local governing bodies changes, the CSB shall attach to this contract copies of the resolutions or ordinances adopted by the local governing bodies that changed the number of appointments.

D. BOD Member Job Description
The BOD and executive director shall develop a board member position description, including qualifications, duties and responsibilities, and time requirements that the CSB shall provide to its local governing bodies to assist them in board appointments.

E. BOD Member Training
The executive director shall provide new board members with training on their legal, fiduciary, regulatory, policy, and programmatic powers and responsibilities and an overview of the performance contract within one month of their appointment. New board members shall receive a board manual before their first board meeting with the information needed to be an effective board member.

F. BOD Policies
The BOD shall adopt policies governing its operations, including board- staff relationships and communications, local and state government relationships and communications, committee operations, attendance at board meetings, oversight and monitoring of CSB operations, quality improvement, conflict of interests, freedom of information, board member training, privacy, security, and employment and evaluation of and relationship with the executive director.

G. FOIA Compliance
The BOD shall comply with the Virginia Freedom of Information Act (FOIA) in the conduct of its meetings, including provisions governing executive sessions or closed meetings, electronic communications, and notice of meetings.

H. BOD Meeting Schedule

The BOD shall adopt an annual meeting schedule to assist board member attendance.

I. Meeting Frequency

The BOD shall meet frequently enough (at least six times per year) and receive sufficient information from the staff to discharge its duties and fulfill its responsibilities. This information shall include quarterly reports on service provision, funds and expenditures, and staffing in sufficient detail and performance on the behavioral health and developmental performance measures and other performance measures in Exhibit B. Board members shall receive this information at least one week before a scheduled board meeting.

J. Reporting Fraud

1. Fraud is an intentional wrongful act committed with the purpose of deceiving or causing harm to another party. Upon discovery of circumstances suggesting a reasonable possibility that a fraudulent transaction has occurred, the CSB's executive director shall report this information immediately to any applicable local law enforcement authorities and the Department's Internal Audit Director.

2. All CSB financial transactions that are the result of fraud or mismanagement shall become the sole liability of the CSB, and the CSB shall refund any state or federal funds disbursed by the Department to it that were involved in those financial transactions.

3. The CSB shall ensure that new CSB board members receive training on their fiduciary responsibilities under applicable provisions of the Code and this contract and that all board members receive annual refresher training on their fiduciary responsibilities.

K. Financial Management

The CSB shall comply with the following requirements, as applicable.

1. To avoid any appearance of conflict or impropriety, the CSB shall provide complete annual financial statements to its Certified Public Accountant (CPA) for audit. If the CSB does not produce its annual financial statements internally, it should not contract production of the statements to the same CPA that conducts its annual independent audit.
2. Operating CSBs and the BHA shall rebid their CPA audit contracts at least every five (5) years once the current CPA contracts expire. If the firm performing the audit is more than 60 days late for two consecutive years, the CSB reserves the right to rebid for the services of an annual audit.
   If the Department determines in its review of the CPA audit provided to it or during its financial review of the CSB that the CSB's CPA audit contains material omissions or errors and informs the CSB of this situation, this could be grounds for the CSB to cancel its audit contract with the CPA.
3. A designated staff person shall review all financial reports prepared by the CSB for the reliance of third parties before the reports are presented or submitted and the reviews shall be documented.
4. All checks issued by the CSB that remain outstanding after one year shall be voided.
5. All CSB bank accounts shall be reconciled regularly, and a designated staff person not involved in preparing the reconciliation shall approve it.
6. A contract administrator shall be identified for each contract for the purchase of services entered into by the CSB, and every contract shall be signed by a designated staff person and each other party to the contract, where applicable.
7. A designated staff person shall approve and document each write-off of account receivables for services to individuals. The CSB shall maintain an accounts receivable aging schedule, and debt that is deemed to be uncollectable shall be written off periodically. The CSB shall maintain a system of internal controls including separation of duties to safeguard accounts receivable assets. A designated staff person who does not enter or process the CSB's payroll shall certify each payroll.
8. The CSB shall maintain documentation and reports for all expenditures related to the federal Mental Health Block Grant and federal Substance Abuse Prevention and Treatment Block Grant funds contained in Exhibit

A sufficient to substantiate compliance with the restrictions, conditions, and prohibitions related to those funds.

9. The CSB shall maintain an accurate list of fixed assets as defined by the CSB. Assets that are no longer working or repairable or are not retained shall be excluded from the list of assets and written off against accumulated depreciation, and a designated staff person who does not have physical control over the assets shall document their disposition. The current location of or responsibility for each asset shall be indicated on the list of fixed assets.
10. Access to the CSB's information system shall be controlled and properly documented. Access shall be terminated in a timely manner when a staff member is no longer employed by the CSB to ensure security of confidential information about individuals receiving services and compliance with the Health Insurance Portability and Accountability Act of 1996 and associated federal or state regulations.
11. If it is an operating CSB or the BHA, the CSB shall maintain an operating reserve of funds sufficient to cover at least two months of personnel and operating expenses and ensure that the CSB's financial position is sound. An operating reserve consists of available cash, investments, and prepaid assets.
12. At any point during the term of this contract, if it determines that its operating reserve is less than two months, the CSB shall notify the Department within 10 calendar days of the determination and develop and submit a plan to the Department within 30 business days that includes specific actions and timeframes to increase the reserve to at least two months in a reasonable time.
13. Once it approves the plan, the Department shall incorporate it as an Exhibit
    i. D of this contract and monitor the CSB's implementation of it.
14. The CSB's annual independent audit, required of the CSB Administrative Requirements, presents the CSB's financial position, the relationship between the CSB's assets and liabilities.
15. If its annual independent audit indicates that the CSB's operating reserve is less than two months, the CSB shall develop a plan that includes specific actions and timeframes to increase the reserve to at least two months in a reasonable time and submit the plan to the Department within 30 calendar days of its receipt of the audit for the Department's review and approval.
16. Once it approves the plan, the Department shall incorporate it as an Exhibit D of this contract and monitor the CSB's implementation of it.

L. Employment of a CSB Executive Director or Behavioral Health Authority (BHA) Chief Executive Officer (CEO) Position

1. When an operating CSB executive director or behavioral health authority (BHA) chief executive officer (CEO) position becomes vacant, the CSB or BHA board of directors (BOD) shall conduct a broad and thorough public recruitment process that may include internal candidates and acting or interim executive directors.
2. CSB or BHA may choose to work with the Department's Human Resources Department (HR) in its recruitment and selection process in order to implement applicable provisions of § 37.2-504 or § 37.2- 605 of the Code and to ensure selection of the most qualified candidate.
3. The CSB or BHA shall provide a current position description and salary and the advertisement for the position to the HR for review and approval prior to advertising the position.
4. The CSB or BHA BOD may choose to invite HR staff to meet with it to review the board's responsibilities and to review and comment on the board's screening criteria for applicants and its interview and selection procedures.
5. The CSB or BHA BOD shall follow the steps outlined in the current CSB Executive Director Recruitment Process Guidance issued by the Department, adapting the steps to reflect its unique operating environment and circumstances where necessary, to have a legally and professionally defensible recruitment and selection process. Department staff shall work with the BOD search committee to help it use the Guidance document in its process.
6. The CSB or BHA BOD may choose to include an HR staff as a voting member of its search committee to provide the Department's perspective and feedback directly to the committee.
7. Prior to employing a new executive director or CEO, the CSB or BHA shall provide a copy of the application and resume of the successful applicant and the proposed salary to the HR for review and approval for

adherence to minimum qualifications and the salary range established by the Department pursuant to § 37.2-504 or § 37.2-605 and contained in the current CSB Executive Director Recruitment Process Guidance.

8. If the CSB or BHA proposes employing the executive director or CEO above the middle of the salary range, the successful applicant shall meet the preferred qualifications in addition to the minimum qualifications in the Guidance. This review does not include Department approval of the selection or employment of a particular candidate for the position.
9. Section 37.2-504 or § 37.2-605 of the Code requires the CSB or BHA to employ its executive director or CEO under an annually renewable contract that contains performance objectives and evaluation criteria. The CSB or BHA shall provide a copy of this employment contract to the HR for review and approval prior to employment of the new executive director or CEO or before the contract is executed.

M. Administrative Policy CSB Executive Director Position

1. The CSB may choose to involve staff in the Department's HR in its recruitment and selection process in order to implement applicable provisions of § 37.2-504 or § 37.2-605 of the Code. The CSB shall provide a current position description and the advertisement for the position to the HR for review prior to the position being advertised pursuant to § 37.2- 504 of the Code.
2. Prior to employing the new executive director, the CSB shall provide a copy of the application and resume of the successful applicant to the HR for review for adherence to minimum qualifications established by the Department pursuant to § 37.2-504. This review does not include Department approval of the selection or employment of a particular candidate for the position.
3. While § 37.2-504 of the Code does not require an administrative policy CSB to employ its executive director under an annually renewable contract that contains performance objectives and evaluation criteria, the CSB should follow this accepted human resource management practice.

Appendix B: Disaster Response and Emergency Service Preparedness Requirements

A. The CSB agrees to comply with section 416 of Public Law 93-288 (the Stafford Act) and § 44-146.13 through § 44-146.28 of the Code regarding disaster response and emergency service preparedness. These Code sections authorize the Virginia Department of Emergency Management, with assistance from the Department, to execute the *Commonwealth of Virginia Emergency Operations Plan*, as promulgated through Executive Order 50 (2012).

B. Disaster behavioral health assists with mitigation of the emotional, psychological, and physical effects of a natural or man-made disaster affecting survivors and responders. Disaster behavioral health support is most often required by Emergency Support Function No. 6: Mass Care, Emergency Assistance, Temporary Housing, and Human Services; Emergency Support Function No. 8: Health and Medical Services; and Emergency Support Function No. 15: External Affairs. The CSB shall:

1. Provide the Department with and keep current 24/7/365 contact information for disaster response points of contact at least three persons deep
2. Report to the Department all disaster behavioral health recovery and response activities related to a disaster
3. Comply with all Department directives coordinating disaster planning, preparedness, response, and recovery to disasters.

C. The Disaster Behavioral Health Annex template shall address: listing behavioral health services and supports, internal to CSB and at other organizations in the community, available to localities during the preparedness, response, and recovery phases of a disaster or emergency event and designating staff to provide disaster behavioral health services and supports during emergency operations. To implement this plan, the CSB shall:

1. Develop protocols and procedures for providing behavioral health services and supports during emergency operations;
2. Seek to participate in local, regional, and statewide planning, preparedness, response, and recovery training and exercises;
3. Negotiate disaster response agreements with local governments and state facilities; and
4. Coordinate with state facilities and local health departments or other responsible local agencies, departments, or units in preparing all hazards disaster plans.

Appendix C: Unspent Balances Principles and Procedures

1. Unspent Balances Principles and Procedures

a. **Unspent balances:** Means any funds received from the Department to include federal funds, restricted and unrestricted state general funds, and other state special funds that remain unexpended at the end of the fiscal year in which they were disbursed by the Department. These funds will hereafter be referred to as state funds unless clarity requires more specificity.

These principles and procedures apply to all CSBs. These principles and procedures shall apply to all unspent balances of state funds present in a CSB's accounts.

b. **CSB Unspent Federal Funds**
Any unspent federal funds shall be returned to the Department at the end of the funding period in which they were allocated pursuant to the timeline and closeout process outlined in section III of Exhibit F. The only exception is for the expenditure of federal funds for allowable unliquidated obligations within appropriate spend-down periods as outlined in Exhibit F.

Federal funds that are disbursed to CSBs on a reimbursement basis are not subject to return to DBHDS unless an issue with the reimbursement calculation is identified that would necessitate the return of funding.

c. **CSB Allocations of State Funds**: Given provisions in State Board Policy 6005 and § 37.2-509 or § 37.2-611 of the Code of Virginia, the Department shall allocate funds in Grants to Localities in the Appropriation Act without applying estimated year-end balances of unspent state funds to the next year's awards to CSBs.

d. **Calculation of Balances:** In order to identify the correct amounts of unspent state fund balances, the Department shall continue to calculate unspent balances for all types of funds sources, except for federal grants.
   i. The Department shall calculate balances for restricted and unrestricted state funds, local matching funds, and fees~~,~~ based on the end of the fiscal year Community Automated Reporting System (CARS) reports submitted by all CSBs no later than the deadline in Exhibit E of the performance contract. The Department shall continue to communicate information about individual balances to each CSB.

e. **Unspent Balances for Regional Programs**: While all unspent balances exist in CSB financial management systems, unspent balances for a regional program may be handled by the fiscal agent and CSBs participating in the regional program as they decide for purposes allowable for the regional program. All participating CSBs must review and approve how these balances are handled and the agreed upon uses must fall within the allowable uses for any restricted regional programs. Balances for regional programs may be prorated to each participating CSB for its own locally determined uses or allocated to a CSB or CSBs for regionally approved uses, or the CSB that functions as the regional program's fiscal agent may retain and expend the funds for purposes determined by all of the participating CSBs. Procedures for handling regional program balances of unspent funds should be included in the regional program memorandum of agreement for the program among the participating CSBs, and those procedures must be consistent with the principles and procedures in this Appendix and the applicable provisions of the current performance contract.

f. **Allowable Uses of Unspent State Fund Balances**: Consistent with the intent of the Grants to Localities item in the Appropriation Act and § 37.2-500 or § 37.2-601 of the Code of Virginia, CSBs may use unspent balances of state funds only for mental health, developmental, and substance use disorder services purposes. Any other uses of unspent state fund balances are not acceptable and are a violation of the CSB's performance contract with the Department.

g. **Collective Uses of Unspent Balances**: A group of CSBs may pool amounts of their unspent balances to address one-time issues or needs that are addressed more effectively or efficiently on a collective basis. Any pooled restricted funds must be used in accordance with the terms of the restriction. The use of these pooled unspent balances shall be consistent with the principles and procedures in this Appendix.

2. Reserve Funds: A CSB shall place all unspent balances of unrestricted and restricted state funds that it has accumulated from previous fiscal years in a separate reserve fund. CSBs shall identify and account separately for unspent balances of each type of restricted state funds from previous fiscal years in the reserve fund. The CSB shall use this reserve fund only for mental health, developmental, and substance use disorder services purposes, as specified in these principles and procedures or by the Department.

a. Reserve funds must not be established using current fiscal year funds, which are appropriated, granted, and disbursed for the provision of services in that fiscal year. This is particularly relevant for funds restricted by funding sources such as the General Assembly, since these funds cannot be used for another purpose. Transferring current fiscal year state funds into a reserve fund or otherwise intentionally not expending them solely for the purpose of accumulating unspent state funds to create or increase a reserve fund is a violation of the legislative intent of the Appropriation Act and is not acceptable.

b. **Size of Reserve Funds**: The maximum acceptable amount of unspent state fund balances that a CSB may accumulate in a reserve fund shall be equal to 50 percent of the amount of all state funds received from the Department during the current fiscal year up to a maximum of $7 million. If this amount of all state funds is less than 50 percent of the total amount of state funds received by the CSB during any one of the preceding five fiscal years, then 50 percent of that larger amount shall constitute the acceptable maximum amount of unspent state fund balances that may be accumulated in a reserve account.

i. If a CSB has accumulated more than this amount, it must expend enough of those reserve funds on allowable uses for mental health, developmental, or substance use disorder services purposes to reduce the amount of accumulated state fund balances to less than 50 percent of the amount of all state funds received from the Department during the current fiscal year.

ii. In calculating the amount of acceptable accumulated state fund balances, amounts of long term capital obligations incurred by a CSB shall be excluded from the calculation. If a CSB has a plan approved by its CSB board and reviewed and approved in advance by the Department to reserve a portion of accumulated balances toward an identified future capital expense such as the purchase, construction, renovation, or replacement of land or buildings used to provide mental health, developmental, or substance use disorder services; purchase or replacement of other capital equipment, including facility-related machinery or equipment; or purchase of information system equipment or software, the reserved amounts of state funds shall be excluded from the maximum acceptable amount of unspent state fund balances.

3. Effective Period of Restrictions on State General Funds

a. Allowable uses of state funds for identified purposes (restricted funds) remain restricted as originally appropriated. After the end of the biennium in which the restricted funds were disbursed to CSB, any unexpended balances of those state funds shall be identified and shall remain restricted for permissible purposes. CSB must obtain approval from the Department to use these funds for other purposes.

b. The Department may request an accounting of the total amount of accumulated unexpended restricted state funds per funding source. If necessary, the Department may direct the CSBs to

repurpose the use of those funds or the Department may re-allocate those funds amongst other CSBs based on need.

4. Performance Contract Exhibit A Documentation

a. All uses of unspent balances of state funds shall be documented in the CSB's performance contract for the year in which the unspent balances are expended. If the balances will be used to support operational costs, the funds shall be shown as state retained earnings in the performance contract and in the CARS mid-year report, if the expense occurs in the first two quarters, and in the end of the fiscal year CARS report.

b. If the balances will be used for major capital expenses, such as the purchase, construction, major renovation, or replacement of land or buildings used to provide mental health, developmental, or substance use disorder services or the CSB's management and administrative operations or the purchase or replacement of information system equipment, these costs shall be shown as state retained earnings and shall be described separately on the Financial Comments page (AF-2) of the performance contract and the CARS reports.

c. Balances used for major capital expenses shall be included in appropriate lines as applicable but shall not be included in the service costs shown in the performance contract or CARS reports because these expenses would distort the ongoing costs of the services in which the major capital expenses would be included. Differences between the financial and service costs related to the inclusion of unspent balances as retained earnings for major capital expenses shall be explained on the Reconciliation of Financial Report and Core Services Costs by Program Area page. However, depreciation of those capital assets can be included in service costs.

d. In either case, for each separate use of unspent balances of state funds, the amount expended and the category from those listed in the expenditure shall be shown on the Financial Comments page of the CARS report. The amount of unspent balances must be shown along with the specific sources of those balances, such as unrestricted state funds or particular restricted state funds. Uses of unspent balances of state funds shall be reviewed and approved by the Department in accordance with the principles and procedures in this document and the Performance Contract Process in Exhibit E of the performance contract.

e. CSBs may maintain their accounting records on a cash or accrual basis for day-to-day accounting and financial management purposes; however its CARS reporting must be in compliance with Generally Accepted Accounting Principles (GAAP). CSBs may submit CARS reports to the Department on a cash or modified accrual basis, but they must report on a consistent basis; and the CARS reports must include all funds contained in the performance contract that are received by the CSB during the reporting period.

5. Department Review of Unspent Balances

In exercising its stewardship responsibility to ensure the most effective, prudent, and accountable uses of state funds, the Department may require CSBs to report amounts of unexpended state funds from previous fiscal years. The Department also may withhold current fiscal year disbursements of state funds from a CSB if amounts of unexpended state funds for the same purposes in the CSB's reserve account exceed the limits in this document. This action would not affect the allocation of those state funds in the following fiscal year. The Department also may review available unspent balances of state funds with a CSB that exhibits a persistent pattern of providing lower levels of services while generating significant balances of unspent state funds, and the Department may take actions authorized by State Board Policy 6005 to address this situation. Finally, the Department may establish other requirements in collaboration with CSBs for the identification, use, reporting, or redistribution of unexpended balances of state funds.

Appendix D: User Acceptance Testing Process

1. User acceptance testing (UAT) is testing used to validate an application against the business requirements. It also provides the opportunity for the end user/client to determine if the application is acceptable or not. UAT is the last step in ensuring that the application is performing as expected and to minimize any future undue costs caused by unexpected errors and decreased data veracity.

2. By the time an application has reached the UAT process, the code is expected to work as determined in the business requirements. Unpredictability is one of the least desirable outcomes of using any application. Several factors make UAT necessary for any software development or modification project, especially for complex applications like CCS 3 or the Waiver Management System (WaMS) that interface with many IT vendor-supplied data files and are used by many different end users in different ways.

3. In the UAT process, end users test the business functionality of the application to determine if it can support day-to-day business practices and user case scenarios. The Community Service Boards (CSB) and Department of Behavioral Health and Developmental Services (DBHDS) will use the following UAT process for major new releases and/or upgrades of CCS 3, WaMS, or other applications that involve the addition of new data elements or reporting requirements or other functions that would require significant work by CSB IT staff and vendors.

4. Major changes in complex systems such as CCS or WaMS shall occur only once per year at the start of the fiscal year and in accordance with the testing process below. Critical and unexpected changes may occur outside of this annual process for business applications, under those circumstances DBHDS will follow the established UAT process to implement them. Smaller applications follow the process below at the discretion of the DBHDS and the VACSB DMC. (Virginia Community Service Board Data Management Committee).

5. Minor releases of CCS 3 or other applications will utilize shorter processes that will require a modification to the established UAT process. Minor releases can be described as small modifications of the application and that does not involve collecting new data elements. For example, bug fixes or correcting vendor or CSB names or adding values in existing look up tables may start at D-35.

Department and CSB User Acceptance Testing Process	
Time Frame	**Action**
D Day	Date data must be received by the Department (e.g., 8/31 for CCS 3 monthly submissions and 7/1 for WaMS).
D - 15	The Department issues the final version of the new release to CSBs for their use.
D - 20	UAT is completed and application release is completed.
D - 35	UAT CSBs receive the beta version of the new release and UAT begins.
D - 50	CSBs begin collecting new data elements that will be in the new release. Not all releases will involve new data elements, so for some releases, this date would not be applicable.
D - 140	The Department issues the final revised specifications that will apply to the new release. The revised specifications will be accompanied by agreed upon requirements specifications outlining all of the other changes in the new release. CSBs use the revised specifications to modify internal business practices and work with their IT vendors to modify their EHRs and extracts.
Unknown	The time prior to D-150 in which the Department and CSBs develop and negotiate the proposed application changes. The time needed for this step is unknown and will vary for each new release depending on the content of the release.

**Time Frame is based on calendar days*

Department and CSB User Acceptance Testing Process	
Time Frame	**Action**
Variable	The time prior to D-150 in which DBHDS and CSBs develop and negotiate the proposed application changes. The time needed for this step is unknown and will vary for each new release depending on the content of the release
D - 140	The Department issues the final revised specifications that will apply to the new release. The revised specifications will be accompanied by agreed upon requirements specifications outlining all changes in the new release.
D - 50	CSBs begin collecting new data elements that will be in the new release. Not all releases will involve new data elements, so for some releases, this date would not be applicable.
D - 35	UAT testers (DBHDS & CSB representatives) receive the beta version of the new release and UAT begins.
D – 20	UAT is completed. Test outcomes are validated and identified errors are mitigated. The application release is completed.
D - 15	The Department issues the final version of the new release to CSBs for their use.
D Day	Initial date data must be received by the Department (e.g., 8/31 for CCS 3 monthly submissions and 7/1 for WaMS).

Appendix E: INTENTIONALLY LEFT BLANK FOR FUTURE USE

Addendum II FY2022-23: Central Office, State Facility, and Community Services Board Partnership Agreement

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Addendum II FY2022-23: Central Office, State Facility, and Community Services Board Partnership Agreement

Section 1: Purpose

The Central Office of the Department of Behavioral Health and Developmental Services (Department), state hospitals and training centers (state facilities) operated by the Department, and community services boards (CSBs), which are entities of local governments, are the operational partners in Virginia's public system for providing mental health, developmental, and substance use disorder services. CSBs include operating CSBs, administrative policy CSBs, and policy-advisory CSBs to local government departments and the behavioral health authority that are established pursuant to Chapters 5 and 6, respectively, of Title 37.2 of the Code of Virginia.

Pursuant to State Board Policy 1034, the partners enter into this agreement to implement the vision statement articulated in State Board Policy 1036 and to improve the quality of care provided to individuals receiving services (individuals) and enhance the quality of their lives. The goal of this agreement is to establish a fully collaborative partnership process through which CSBs, the Central Office, and state facilities can reach agreements on operational and policy matters and issues. In areas where it has specific statutory accountability, responsibility, or authority, the Central Office will make decisions or determinations with the fullest possible participation and involvement by the other partners. In all other areas, the partners will make decisions or determinations jointly. The partners also agree to make decisions and resolve problems at the level closest to the issue or situation whenever possible. Nothing in this partnership agreement nullifies, abridges, or otherwise limits or affects the legal responsibilities or authorities of each partner, nor does this agreement create any new rights or benefits on behalf of any third parties.

The partners share a common desire for the system of care to excel in the delivery and seamless continuity of services for individuals and their families and seek similar collaborations or opportunities for partnerships with advocacy groups for individuals and their families and other system stakeholders. We believe that a collaborative strategic planning process helps to identify the needs of individuals and ensures effective resource allocation and operational decisions that contribute to the continuity and effectiveness of care provided across the public mental health, developmental, and substance use disorder services system. We agree to engage in such a collaborative planning process.

This partnership agreement also establishes a framework for covering other relationships that may exist among the partners. Examples of these relationships include regional initiatives such as the regional utilization management teams, regional crisis stabilization programs, regional discharge assistance programs, regional local inpatient purchases of services, and REACH programs.

Section 2: Roles and Responsibilities

Although this partnership philosophy helps to ensure positive working relationships, each partner has a unique role in providing public mental health, developmental, and substance use disorder services. These distinct roles promote varying levels of expertise and create opportunities for identifying the most effective mechanisms for planning, delivering, and evaluating services.

A. Central Office

1. Ensures through distribution of available state and federal funding that an individually focused and community-based system of care, supported by community and state facility resources, exists for the delivery of publicly funded services and supports to individuals with mental health or substance use disorders or developmental disabilities.

2. Promotes the public mental health, developmental, and substance use disorder service delivery system (including the Central Office) quality improvement efforts that focus on individual outcome and provider performance measures designed to enhance service quality, accessibility, and availability, and provides assistance to the greatest extent practicable with Department-initiated surveys and data requests.

3. Supports and encourages the maximum involvement to ensure that services are not imposed on individuals receiving services. The receiver of services should be an active participant in the planning, delivery, and documentation of services whenever practical participation of individuals receiving services and family members

of individuals receiving services in policy formulation and services planning, delivery, monitoring, and evaluation.

4. Ensures fiscal accountability that is required in applicable provisions of the Code, relevant state and federal regulations, and policies of the State Board.

5. Promotes identification of state-of-the-art, best or promising practice, or evidence-based programming and resources that exist as models for consideration by other partners.

6. Seeks opportunities to affect regulatory, policy, funding, and other decisions made by the Governor, the Secretary of Health and Human Resources, the General Assembly, the Department of Medical Assistance Services and other state agencies, and federal agencies that interact with or affect the other partners.

7. Encourages and facilitates state interagency collaboration and cooperation to meet the service needs of individuals and to identify and address statewide interagency issues that affect or support an effective system of care.

8. Serves as the single point of accountability to the Governor and the General Assembly for the public system of mental health, developmental, and substance use disorder services.

9. Problem solves and collaborates with a CSB and state facility together on a complex or difficult situation involving an individual who is receiving services when the CSB and state facility have not been able to resolve the situation successfully at their level.

B. Community Services Boards

1. Pursuant to § 37.2-500 and 37.2-600 of the Code and State Board Policy 1035, serve as the single points of entry into the publicly funded system of individually focused and community-based services and supports for individuals with mental health or substance use disorders or developmental disabilities, including individuals with co-occurring disorders in accordance with State Board Policy 1015.

2. Serve as the local points of accountability for the public mental health, developmental, and substance use disorder service delivery system.

3. To the fullest extent that resources allow, promote the delivery of community-based services that address the specific needs of individuals, particularly those with complex needs, with a focus on service quality, accessibility, integration, and availability and on self-determination, empowerment, and recovery.

4. Support and encourage the maximum involvement and participation of individuals receiving services and family members of individuals receiving services in policy formulation and services planning, delivery, monitoring, and evaluation.

5. Establish services and linkages that promote seamless and efficient transitions of individuals between state facility and community services.

6. Promote sharing of program knowledge and skills with other partners to identify models of service delivery that have demonstrated positive outcomes for individuals receiving services.

7. Problem-solve and collaborate with state facilities on complex or difficult situations involving individuals receiving services.

8. Encourage and facilitate local interagency collaboration and cooperation to meet the other services and supports needs, including employment and stable housing, of individuals receiving services.

C. State Facilities

1. Provide psychiatric hospitalization and other services to individuals identified by CSBs as meeting statutory requirements for admission in § 37.2-817 of the Code and criteria in the Continuity of Care Procedures in the

CSB Administrative Requirements, including the development of specific capabilities to meet the needs of individuals with co-occurring mental health and substance use disorders in accordance with State Board Policy 1015.

2. Within the resources available, provide residential, training, or habilitation services to individuals with developmental disabilities identified by CSBs as needing those services in a training center and who are certified for admission pursuant to § 37.2-806 of the Code.

3. To the fullest extent that resources allow, provide services that address the specific needs of individuals with a focus on service quality, accessibility, and availability and on self-determination, empowerment, and recovery.

4. Support and encourage the involvement and participation of individuals receiving services and family members of individuals receiving services in policy formulation and services planning, delivery, monitoring, and evaluation.

5. Establish services and linkages that promote seamless and efficient transitions of individuals

6. Promote sharing of program knowledge and skills with other partners to identify models of service delivery that have demonstrated positive outcomes for individuals.

7. Problem-solve and collaborate with CSBs on complex or difficult situations involving individuals receiving services.

Section 3: Vision and Core Values

The Central Office, state facilities, and CSBs share a common desire for the public system of care to excel in the delivery and seamless continuity of services to individuals receiving services and their families. While they are interdependent, each partner works independently with both shared and distinct points of accountability, such as state, local, or federal governments, other funding sources, individuals receiving services, and families. The partners embrace a common vision and core values that guide the Central Office, state facilities, and CSBs in developing and implementing policies, planning services, making decisions, providing services, and measuring the effectiveness of service delivery.

A. Vision Statement

The vision, as articulated in State Board Policy 1036, is of a system of quality recovery-oriented services and supports that respects the rights and values of individuals with mental illnesses, intellectual disability, other developmental disabilities who are eligible for or are receiving Medicaid developmental disability waiver services, or substance use disorders, is driven by individuals receiving services, and promotes self-determination, empowerment, recovery, resilience, health and overall wellness, and the highest possible level of participation by individuals receiving services in all aspects of community life, including work, school, family, and other meaningful relationships. This vision also includes the principles of inclusion, participation, and partnership.

B. Core Values

1. Underpinning the vision are the core values of accountability, responsiveness, accessibility and localized solution meaning:

2. The Central Office, state facilities, and CSBs are working in partnership; we hold each other accountable for adhering to our core values.

3. As partners, we will focus on fostering a culture of responsiveness and striving for continuous quality improvement.

4. All services should be designed to be welcoming, accessible, and capable of providing interventions properly matched to the needs of individuals with co-occurring disorders.

5. As partners, we will make decisions and resolve problems at the level closest to the issue or situation whenever possible.

Section 4: Indicators Reflecting Core Values

The public system of care in Virginia is guided by simple, cost-effective measures reflecting the core values and expectations identified by the Central Office, state facilities, and CSBs. Subsequently, any indicators or measures should reflect the core values listed in the preceding section. The partners agree to identify, prioritize, collect, and utilize these measures as part of the quality assurance systems mentioned in Section 6 of this agreement and in the quality improvement plan described in Section 6.b of the community services performance contract.

Section 5: Advancing the Vision

The partners agree to engage in activities to advance the achievement of the Vision Statement contained in State Board Policy 1036 and Section 3 of this agreement, including these activities.

1. **Recovery:** The partners agree, to the greatest extent possible, to:
   a. provide more opportunities for individuals receiving services to be involved in decision making,
   b. increase recovery-oriented, peer-provided, and consumer-run services,
   c. educate staff and individuals receiving services about recovery, and
   d. assess and increase the recovery orientation of CSBs, the Central Office, and state hospitals.
2. **Integrated Services:** The partners agree to advance the values and principles in the Charter Agreement signed by the CSB and the Central Office and to increase effective screening and assessment of individuals for co-occurring disorders to the greatest extent possible.
3. **Person-Centered Planning:** The partners agree to promote awareness of the principles of person-centered planning, disseminate and share information about person-centered planning, and participate on work groups focused on implementing person-centered planning.

Section 6: Critical Success Factors

The partners agree to engage in activities that will address the following seven critical success factors. These critical success factors are required to transform the current service system's crisis response orientation to one that provides incentives and rewards for implementing the vision of a recovery and resilience-oriented and person-centered system of services and supports. Successful achievement of these critical success factors will require the support and collective ownership of all system stakeholders.

1. Virginia successfully implements a recovery and resilience-oriented and person-centered system of services and supports.

2. Publicly funded services and supports that meet growing mental health, developmental, and substance use disorder services needs are available and accessible across the Commonwealth.

3. Funding incentives and practices support and sustain quality care focused on individuals receiving services and supports, promote innovation, and assure efficiency and cost effectiveness.

4. State facility and community infrastructure and technology efficiently and appropriately meet the needs of individuals receiving services and supports.

5. A competent and well-trained mental health, developmental, and substance use disorder services system workforce provides needed services and supports.

6. Effective service delivery and utilization management assures that individuals and their families receive services and supports that are appropriate to their needs.

7. Mental health, developmental, and substance use disorder services and supports meet the highest standards of quality and accountability.

Section 7: Accountability

The Central Office, state facilities, and CSBs agree that it is necessary and important to have a system of accountability. The partners also agree that any successful accountability system requires early detection with faithful, accurate, and complete reporting and review of agreed-upon accountability indicators. The partners further agree that early detection of problems and collaborative efforts to seek resolutions improve accountability. To that end, the partners commit themselves to a problem identification process defined by open sharing of performance concerns and a mutually supportive effort toward problem resolution. Technical assistance, provided in a non-punitive manner designed not to "catch" problems but to resolve them, is a key component in an effective system of accountability.

Where possible, joint work groups, representing CSBs, the Central Office, and state facilities, shall review all surveys, measures, or other requirements for relevance, cost benefit, validity, efficiency, and consistency with this statement prior to implementation and on an ongoing basis as requirements change. In areas where it has specific statutory accountability, responsibility, or authority, the Central Office will make decisions or determinations with the fullest possible participation and involvement by the other partners. In all other areas, the partners will make decisions or determinations jointly.

The partners agree that when accreditation or another publicly recognized independent review addresses an accountability issue or requirement, where possible, compliance with this outside review will constitute adherence to the accountability measure or reporting requirement. Where accountability and compliance rely on affirmations, the partners agree to make due diligence efforts to comply fully. The Central Office reserves the powers given to the department to review and audit operations for compliance and veracity and upon cause to take actions necessary to ensure accountability and compliance.

Section 8: Involvement and Participation of Individuals Receiving Services and Their Family Members

1. **Involvement and Participation of Individuals Receiving Services and Their Family Members:** CSBs, state facilities, and the Central Office agree to take all necessary and appropriate actions in accordance with State Board Policy 1040 to actively involve and support the maximum participation of individuals receiving services and their family members in policy formulation and services planning, delivery, monitoring, and evaluation.

2. **Involvement in Individualized Services Planning and Delivery by Individuals Receiving Services and Their Family Members:** CSBs and state facilities agree to involve individuals receiving services and, with the consent of individuals where applicable, family members, authorized representatives, and significant others in their care, including the maximum degree of participation in individualized services planning and treatment decisions and activities, unless their involvement is not clinically appropriate.

3. **Language:** CSBs and state facilities agree that they will endeavor to deliver services in a manner that is understood by individuals receiving services. This involves communicating orally and in writing in the preferred languages of individuals, including Braille and American Sign Language when applicable, and at appropriate reading comprehension levels.

4. **Culturally Competent Services:** CSBs and state facilities agree that in delivering services they will endeavor to address to a reasonable extent the cultural and linguistic characteristics of the geographic areas and populations that they serve.

Section 9: Communication

CSBs, state facilities, and the Central Office agree to communicate fully with each other to the greatest extent possible. Each partner agrees to respond in a timely manner to requests for information from other partners, considering the type, amount, and availability of the information requested.

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Section 10: Quality Improvement

On an ongoing basis, the partners agree to work together to identify and resolve barriers and policy and procedural issues that interfere with the most effective and efficient delivery of public mental health, developmental, and substance use disorder services.

Section 11: Reviews, Consultation, and Technical Assistance

CSBs, state facilities, and the Central Office agree, within the constraints of available resources, to participate in review, consultation, and technical assistance activities to improve the quality of services provided to individuals and to enhance the effectiveness and efficiency of their operations.

Section 12: Revision

This is a long-term agreement that should not need to be revised or amended annually. However, the partners agree that this agreement may be revised at any time with the mutual consent of the parties. When revisions become necessary, they will be developed and coordinated through the System Leadership Council. Finally, either party may terminate this agreement with six months written notice to the other party and to the System Leadership Council.

Section 13: Relationship to the Community Services Performance Contract

This partnership agreement by agreement of the parties is hereby incorporated into and made a part of the current community services performance contract by reference.

Core Services Taxonomy 7.3

Effective July 1, 2014 for FY 2015 and Subsequent Fiscal Years Until Superseded.

June 30, 2014

Core Services Taxonomy 7.3

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Core Services Taxonomy 7.3

Introduction

The idea of core services emerged from the General Assembly's Commission on Mental Health and Mental Retardation, chaired by Richard M. Bagley, in 1980. The first list of core services, developed in response to a Commission recommendation, contained five categories of services: emergency, inpatient, outpatient and day support, residential, and prevention and early intervention. The State Board of Behavioral Health and Developmental Services (State Board) approved the original core services definitions in 1981. The General Assembly accepted general definitions of these services and amended § 37.1-194 of the Code of Virginia in 1984 to list the services, requiring the provision of only emergency services. In 1998, the legislature required the provision of case management services, subject to the availability of funds appropriated for them.

The initial description of core services established a useful conceptual framework for Virginia's network of community services board (CSB) and state hospital and training center (state facility) services. However, this description was too general and not sufficiently quantifiable for meaningful data collection and analysis. The initiation of performance contracting in Fiscal Year (FY) 1985 revealed the need for detailed, consistent, and measurable information about services and individuals receiving services. Experience with the first round of contracts reinforced the need for core services definitions that were sufficiently differentiated to reflect the variety of programs and services and yet were general enough to encompass the broad diversity of service modalities and the need for basic, quantified data about services, collected and reported uniformly.

The Virginia Department of Behavioral Health and Developmental Services (Department) and the Virginia Association of Community Services Boards (VACSB) developed the first core services taxonomy, a classification and definition of services, in 1985 to address these needs. The original version of the taxonomy was used with the FY 1986 and 1987 community services performance contracts. State Board Policy 1021 (SYS) 87-9 on core services, adopted in 1987, states that the current version of the taxonomy shall be used to classify, describe, and measure the services delivered directly or through contracts with other providers by all CSBs and state facilities. The Department and the VACSB have revised the core services taxonomy seven times since 1985.

Core Services Taxonomy 7, used in FY 2006 and 2007, added a new core services category, limited services, separated outpatient and case management services into two categories to provide more visibility for case management services, and split day support services into day support services and employment services to reflect the clear differences between them. The limited services category allowed CSBs to capture less information about services that are typically low intensity, infrequent, or short-term (e.g., less than 30 days or four to eight sessions in duration) services. As a result, Taxonomy 7 had nine categories of core services: emergency, inpatient, outpatient, case management, day support, employment, residential, prevention and early intervention, and limited services.

Core Services Taxonomy 7.1, used in FY 2008 and 2009, incorporated changes in the Community Consumer Submission 3 (CCS 3), the new admission and discharge paradigm, and new system transformation initiative services. It reordered core services categories to reflect the new paradigm. Some services were grouped under services available outside of a program area (SAOPA), but most were under services available at admission to a program area. It added a tenth core services category, consumer-run services, and two subcategories, ambulatory crisis stabilization services and residential crisis stabilization services, and separated prevention and infant and toddler intervention into separate categories.

Core Services Taxonomy 7.3

Core Services Taxonomy 7.2, used in FY 2010 through FY 2014, incorporated two new concepts: service subtype, used only for emergency and case management services, and service location to provide more specific information about core services; these changes are reflected in the CCS. It replaced consumer with individual or individual receiving services unless the context requires the use of consumer (e.g., the CCS). It retained infant and toddler services for descriptive purposes only. Information about these services is collected through a separate information system instead of the CCS, and the services are funded through a separate contract. Taxonomy 7.2 added two appendices on regional programs that were previously in the performance contract. It replaced SAOPA with emergency services and ancillary services. Finally, mental health or substance use disorder or intellectual disability were used to refer to a condition experienced by an individual, while mental health, substance abuse, or developmental services referred respectively to the services that address these conditions.

Core Services Taxonomy 7.3, effective for FY 2015 and subsequent years, incorporates all revisions of Taxonomy 7.2 issued since July 1, 2009. It adds a new outpatient services subcategory for intensive outpatient and clarifies that consumer designation code 920 includes all individuals receiving intellectual disability home and community-based Medicaid waiver services.

Taxonomy categories and subcategories are inclusive rather than narrowly exclusive; they are not meant to capture every detail about everything a CSB or state facility does. Categories and subcategories allow meaningful and accurate descriptions and measurements of service delivery activities; this can help produce valid and informative analyses and comparisons of CSBs, state facilities, and regions. Given the diversity and variety of Virginia's localities and the mix and availability of resources and services from other public and private providers, each CSB may not need to provide every subcategory in the taxonomy. The categories and subcategories do not create additional mandates for CSBs; only emergency and case management services are now required.

The relationship of taxonomy core services categories and subcategories to the more traditional community services organizational structure is represented below.

Community Services Board or Behavioral Health Authority (CSB)
Program Area (all mental health, developmental, or substance abuse services)
Core Service Category (e.g., residential services)
Core Service Subcategory (e.g., intensive residential services)
Service Subtype (for emergency and case management services) and
Service Location (for all services)
Services in a Subcategory (e.g.in-home respite in supportive residential)
Individual Program (e.g., a particular group home)
Discrete Service Activity (e.g., meal preparation)

The numbers after some core services categories and all core service subcategories in the definitions section and the matrix are the Community Automated Reporting System (CARS) and CCS codes for those services. Core services categories with subcategories, such as inpatient services, do not have codes because they have subcategories with codes. However, core services categories with no subcategories, such as emergency services, do have codes. Services that have moved to different categories, such as individual supported employment moving from the day support services to the employment services category, retain the same code numbers that they had in Taxonomy 7 and the original CCS for historical data base continuity purposes. The CARS and CCS do not include details of the bottom three levels (*services in a subcategory*, individual program and discrete service activity) above.

Core Services Taxonomy 7.3

Types of Community Services Boards (CSBs)

A particularly meaningful classification of CSBs is the relationship between the CSB and its local government or governments. While CSBs are agents of the local governments that established them, most CSBs are not city or county government departments. Section 37.2-100 of the Code of Virginia defines three types of CSBs, and Chapter 6 of Title 37.2 authorizes behavioral health authorities (BHAs) to provide community services. Throughout the taxonomy, community services board or CSB refers to all of the following organizations.

Administrative policy CSB or administrative policy board means the public body organized in accordance with the provisions of Chapter 5 (§ 37.2-500 et seq.) that is appointed by and accountable to the governing body of each city and county that established it to set policy for and administer the provision of mental health, developmental, and substance abuse services. The administrative policy CSB or administrative board denotes the board, the members of which are appointed pursuant to § 37.2-501 with the powers and duties enumerated in subsection A of § 37.2-504 and § 37.2-505. An administrative policy CSB includes the organization that provides mental health, developmental, and substance abuse services through local government staff or contracts with other organizations and providers, unless the context indicates otherwise. An administrative policy CSB does not employ its staff. There are 11 administrative policy CSBs; nine are city or county government departments; two are not, but use local government staff to provide services.

Behavioral health authority (BHA) or authority means a public body and a body corporate organized in accordance with the provisions of Chapter 6 (§ 37.2-600 et seq.) that is appointed by and accountable to the governing body of the city or county that established it for the provision of mental health, developmental, and substance abuse services. BHA or authority also includes the organization that provides these services through its own staff or through contracts with other organizations and providers, unless the context indicates otherwise. Chapter 6 authorizes Chesterfield County and the cities of Richmond and Virginia Beach to establish a BHA; only Richmond has done so. In many ways, a BHA most closely resembles an operating CSB, but it has several powers or duties in § 37.2-605 of the Code of Virginia that are not given to CSBs.

Operating CSB or operating board means the public body organized in accordance with the provisions of Chapter 5 (§ 37.2-500 et seq.) that is appointed by and accountable to the governing body of each city and county that established it for the direct provision of mental health, developmental, and substance abuse services. The operating CSB or operating board denotes the board, the members of which are appointed pursuant to § 37.2-501 with the powers and duties enumerated in subsection A of § 37.2-504 and § 37.2-505. Operating CSB or operating board also includes the organization that provides such services, through its own staff or through contracts with other organizations and providers, unless the context indicates otherwise. The 27 operating CSBs employ their own staff and are not city or county government departments.

Policy-Advisory CSB or policy-advisory board means the public body organized in accordance with the provisions of Chapter 5 that is appointed by and accountable to the governing body of each city and county that established it to provide advice on policy matters to the local government department that provides mental health, developmental, and substance abuse services directly or through contracts with other organizations and providers pursuant to subsection A of § 37.2-504 and § 37.2-505. The policy-advisory CSB or policy-advisory board denotes the board, the members of which are appointed pursuant to § 37.2-501 with the powers and duties enumerated in subsection B of § 37.2-504. The CSB has no operational powers or duties; it is an advisory board to a local government department. There is one local government department with a policy-advisory CSB, the Portsmouth Department of Behavioral Healthcare Services.

Emergency and Ancillary Services (400)**:** If a CSB determines that it can serve a person who is seeking or has been referred for services, the CSB opens a case for the person. Persons needing these services may access them without being admitted to a program area (all mental health, developmental, or substance abuse services). However, individuals who have been admitted to a program area may still access the following services if they need them. These services do not require collecting as many CCS data elements or as much individual service record information as admission to a program area does. If a person receives any of the following services and is subsequently admitted to a program area, the additional CCS program area admission data elements must be collected. The 400 is a pseudo program area code for CCS service file purposes, since this group of services is not a program area. If individuals receive any of the following services after they are admitted to a program area, these services still must be coded with the 400 code, rather than the program area code (100, 200, or 300) to which they have been admitted.

1. **Emergency Services** (100) are unscheduled and sometimes scheduled crisis intervention, stabilization, and referral assistance provided over the telephone or face-to-face, if indicated, 24 hours per day and seven days per week to people seeking such services for themselves or others. Services also may include walk-ins, home visits, and jail interventions. Emergency services include preadmission screening activities associated with admission to a state hospital or training center or other activities associated with the judicial admission process. This category also includes Medicaid crisis intervention and short-term crisis counseling and intellectual disability home and community-based (ID HCB) waiver crisis stabilization and personal emergency response system services. Persons receiving critical incident stress debriefing services are not counted as individuals receiving services, and service units are identified and collected through the z-consumer function in the CCS.

   Service Subtype is a specific activity associated with a particular core service category or subcategory for which a service.txt file is submitted in the CCS. Currently, service subtypes are defined only for emergency services and case management services. The emergency services subtype is collected at every emergency services encounter and reported in the service file; every emergency service encounter is coded with one of these six subtypes in the CCS.

   a. **Crisis Intervention** is provided in response to an acute crisis episode. This includes counseling, short term crisis counseling, triage, or disposition determination and all emergency services not included in the following service subtypes.

   b. **Crisis Intervention Provided Under an Emergency Custody Order** is clinical intervention and evaluation provided by a certified preadmission screening evaluator in response to an emergency custody order (ECO) issued by a magistrate.

   c. **Crisis Intervention Provided Under Law Enforcement Custody (paperless ECO)** is clinical intervention and evaluation provided by a certified preadmission screening evaluator to an individual under the custody of a law enforcement officer without an ECO issued by a magistrate.

   d. **Independent Examination** is an examination provided by an independent examiner who satisfies the requirements in and who conducts the examination in accordance with § 37.2-815 of the Code of Virginia in preparation for a civil commitment hearing.

e. **Commitment Hearing** is attendance of a certified preadmission screening evaluator at a civil commitment or recommitment hearing conducted pursuant to § 37.2-817.

f. **MOT Review Hearing** is attendance at a review hearing conducted pursuant to §§ 37.2-817.1 through 37.2-817.4 for a person under a mandatory outpatient treatment (MOT) order.

2. **Ancillary Services** consist of the following activities that typically are short term (less than 30 days or four to eight sessions in duration), infrequent, or low-intensity services.

a. ***Motivational Treatment Services*** (318) are generally provided to individuals on an hourly basis, once per week, through individual or group counseling in a clinic. These services are structured to help individuals resolve their ambivalence about changing problematic behaviors by using a repertoire of data gathering and feedback techniques. Motivational treatment services are not a part of another service; they stand alone. Their singular focus on increasing the individual's motivation to change problematic behaviors, rather than on changing the behavior itself, distinguishes motivational treatment services from outpatient services. A course of motivational treatment may involve a single session, but more typically four to eight sessions; and it may be repeated, if necessary, as long as repetition is clinically indicated. Prior to placement in motivational treatment, the individual's level of readiness for change is usually assessed, based on clinical judgment, typically supported by standardized instruments. An assessment may follow a course of motivational treatment to ascertain any changes in the individual's readiness for change. Psycho-educational services are included in this subcategory.

b. ***Consumer Monitoring Services*** (390) are provided to individuals who have not been admitted to a program area but have had cases opened by the CSB. For example, this includes individuals with opened cases whom the CSB places on waiting lists for other services, for example, Medicaid ID wavier services. Individuals receive no interventions or face-to-face contact, but they receive consumer monitoring services that typically consist of service coordination or intermittent emergency contacts. Other examples of consumer monitoring services include individuals who receive only outreach services, such as outreach contacts through projects for assistance in transition from homelessness (PATH), individuals in waiting list groups, and outreach by peers to individuals who are in need of services or have been referred for services.

c. ***Assessment and Evaluation Services*** (720) include court-ordered or psychological evaluations; initial assessments for screening, triage, and referral for individuals who probably will not continue in services; and initial evaluations or assessments that result in placement on waiting lists without receiving other services. An abbreviated individualized services plan and services record may be required.

d. ***Early Intervention Services*** (620) are intended to improve functioning or change behavior in individuals who have been identified as beginning to experience problems, symptoms, or behaviors that, without intervention, are likely to result in the need for treatment. Outpatient service activities should not be included here merely to avoid record keeping or licensing requirements since this is not clinically appropriate and could expose the CSB to increased liability. Services are generally targeted to identified individuals or groups and include case consultation, groups for adolescents who have been suspended for use of alcohol or tobacco, and programs for children or adults exhibiting behavior changes following loss such as divorce, death of a loved one, and job loss. School-based interventions should be included in prevention, early intervention, or outpatient services, as appropriate.

3. ***Consumer-Run Services*** (730) are self-help programs designed, governed, and led by and for people in recovery. Consumer-run services employ peers as staff and volunteers and are often open on weekends and evenings beyond the usual hours traditional services operate. Services are usually open door or drop in, with no required applications, waiting times, or appointments. Services include networking, advocacy, and mutual support groups; drop-in centers; supported housing; hospital liaison; recreation and social activities; arts and crafts and exercise groups; peer counseling, mentorship, and one-on-one consultations; information and referrals; and knowledge and skill-building classes such as employment training, computer training, and other seminars and workshops. Consumer-run centers also may offer the use of washers and dryers, showers, telephones for business calls, mailboxes, and lending libraries. Because of their nature, no information is collected in the CCS about consumer-run services or the individuals participating in them. Instead, the number of persons participating in consumer-run services is reported in the CARS management report. However, core services provided by peers are included and reported where they are delivered, e.g., in outpatient, rehabilitation, or residential services, rather than in consumer-run services; see Appendix G for more information.

Services Available at Admission to a Program Area: If an individual needs other services beyond emergency or ancillary services, the CSB admits the individual to a program area: all mental health (100), developmental (200), or substance abuse (300) services. Depending on his or her needs, the individual may be admitted to two or even three program areas. An individual may be admitted directly to a program area, bypassing case opening, but CCS data elements collected at case opening must still be obtained. Even after admission to a program area, an individual may still receive emergency or ancillary services if he or she needs them.

4. **Inpatient Services** deliver services on a 24-hour-per-day basis in a hospital or training center.
   a. ***Medical/Surgical Care*** provides acute medical treatment or surgical services in state facilities. These services include medical detoxification, orthopedics, oral surgery, urology, care for pneumonia, post-operative care, ophthalmology, ear, nose and throat care, and other intensive medical services.
   b. ***Skilled Nursing Services*** deliver medical care, nursing services, and other ancillary care for individuals with mental disabilities who are in state facilities and require nursing as well as other care. Skilled nursing services are most often required by individuals who are acutely ill or have significant intellectual disability and by older adults with mental health disorders who suffer from chronic physical illnesses and loss of mobility. Services are provided by professional nurses, licensed practical nurses, and qualified paramedical personnel under the general direction and supervision of a physician.
   c. ***Intermediate Care Facility for Individuals with Intellectual Disability (ICF/ID) Services*** are provided in state training centers for individuals with intellectual disability who require active habilitative and training services, including respite and emergency care, but not the degree of care and treatment provided in a hospital or skilled nursing home.
   d. ***Intermediate Care Facility/Geriatric Services*** are provided in state geriatric facilities by interdisciplinary teams to individuals who are 65 years of age and older. Services include psychiatric treatment, medical treatment, personal care, and therapeutic programs appropriate to the facility and to the individual's needs.
   e. ***Acute Psychiatric or Substance Abuse Inpatient Services*** (250) provide intensive short-term psychiatric treatment in state hospitals or intensive short-term psychiatric treatment,

including services to individuals with intellectual disability, or substance abuse treatment, except medical detoxification, in local hospitals. Services include intensive stabilization, evaluation, psychotropic medications, psychiatric and psychological services, and other supportive therapies provided in a highly structured and supervised setting.

f. ***Community-Based Substance Abuse Medical Detoxification Inpatient Services*** (260) use medication under the supervision of medical personnel in local hospitals to systematically eliminate or reduce the effects of alcohol or other drugs in the body.

g. ***Extended Rehabilitation Services*** offer intermediate or long-term treatment in a state hospital for individuals with severe psychiatric impairments, emotional disturbances, or multiple disabilities (e.g., individuals with mental health disorders who also are deaf). Services include rehabilitation training, skills building, and behavioral management for people who are beyond the crisis stabilization and acute treatment stages.

5. **Outpatient Services** provide clinical treatment services, generally in sessions of less than three consecutive hours, to individuals and groups.

a. ***Outpatient Services*** (310) are generally provided to individuals on an hourly schedule, on an individual, group, or family basis, and usually in a clinic or similar facility or in another location, including a jail or juvenile detention center. Outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services. Medical services include the provision of psychiatric, medical, psychiatric nursing, and medical nursing services by licensed psychiatrists, physicians, and nurses and the cost of medications purchased by the CSB and provided to individuals. Medication services include prescribing and dispensing medications, medication management, and pharmacy services. Medication only visits are provided to individuals who receive only medication monitoring on a periodic (monthly or quarterly) basis from a psychiatrist, other physician, psychiatric nurse, or physician's assistant. These visits are included in outpatient services. The Department has identified a minimum set of information for licensing purposes that would be needed to constitute an individualized services plan (ISP) for individuals receiving only medication visits.

Outpatient services also include *intensive in-home services* that are time-limited, usually between two and six months, family preservation interventions for children and adolescents with or at risk of serious emotional disturbance, including such individuals who also have a diagnosis of intellectual disability. In-home services are provided typically but not solely in the residence of an individual who is at risk of being moved into or is being transitioned to home from an out-of-home placement. The services provide crisis treatment; individual and family counseling; life, parenting, and communication skills; case management activities and coordination with other required services; and 24 hour per day emergency response.

Outpatient services also include *jail-based habilitation services* that involve daily group counseling, individual therapy, psycho-educational services, 12 step meetings, discharge planning, and pre-employment and community preparation services.

Finally, outpatient services also include Medicaid ID HCB waiver skilled nursing services and therapeutic consultation services. Probation and parole and community corrections day reporting centers also are included in outpatient services, rather than in ancillary services.

b. ***Intensive Outpatient Services*** (313) provide substance abuse treatment in a concentrated manner for two or more consecutive hours per day to groups of individuals in nonresidential settings multiple times per week. This service is provided over a period of time for individuals requiring more intensive services than outpatient services can provide. Intensive substance abuse outpatient services include multiple group therapy sessions during the week, individual and family therapy, individual monitoring, and case management.

c. ***Medication Assisted Treatment*** (335) combines outpatient treatment with administering or dispensing synthetic narcotics, such as methadone or buprenorphine (suboxone), approved by the federal Food and Drug Administration for the purpose of replacing the use of and reducing the craving for opioid substances, such as heroin or other narcotic drugs.

d. ***Assertive Community Treatment*** (350) consists of two modalities: intensive community treatment (ICT) and program of assertive community treatment (PACT). Individuals served by either modality have severe symptoms and impairments that are not effectively remedied by available treatments or, because of reasons related to their mental health disorders, resist or avoid involvement with mental health services. This could include individuals with severe and persistent mental illnesses who also have co-occurring diagnoses of intellectual disability. Assertive community treatment provides an array of services on a 24-hour per day basis to these individuals in their natural environments to help them achieve and maintain effective levels of functioning and participation in their communities. Services may include case management, supportive counseling, symptom management, medication administration and compliance monitoring, crisis intervention, developing individualized community supports, psychiatric assessment and other services, and teaching daily living, life, social, and communication skills.

   ICT is provided by a self-contained, interdisciplinary team of at least five full-time equivalent clinical staff, a program assistant, and a psychiatrist. This team (1) assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illnesses, (2) minimally refers individuals to outside service providers, (3) provides services on a long-term care basis with continuity of caregivers over time, (4) delivers 75 percent or more of the services outside of the program's offices, and (5) emphasizes outreach, relationship building, and individualization of services. PACT is provided by a self-contained, inter-disciplinary team of at least 10 full-time equivalent clinical staff, a program assistant, and a psychiatrist, and this team meets the five criteria contained in the definition of ICT.

6. **Case Management Services** (320) assist individuals and their family members to access needed services that are responsive to the individual's needs. Services include: identifying and reaching out to individuals in need of services, assessing needs and planning services, linking the individual to services and supports, assisting the individual directly to locate, develop, or obtain needed services and resources, coordinating services with other providers, enhancing community integration, making collateral contacts, monitoring service delivery, and advocating for individuals in response to their changing needs.

   Service Subtype is a specific activity associated with a particular core service category or subcategory for which a service.txt file is submitted in the CCS. Currently, service subtypes are defined only for emergency and case management services. The case management services subtype is collected at every developmental case management services encounter and reported in the service file with one of the two subtypes in the CCS. CSBs may report these service subtypes for mental health or substance abuse case management services, but this is optional.

a. **Face-to-Face Case Management Services:** These are case management services received by an individual and provided by a case manager during a face-to-face encounter in a case management service licensed by the Department. Examples of service hour activities applicable to face-to-face case management services include case management, individual present and discharge planning, individual present. All other case management services must be reported using non-face-to-face case management.

b. **Non-Face-to-Face Case Management Services:** These are all other case management services provided to or on behalf of an individual by a case manager in a case management service licensed by the Department. This includes telephone contacts with the individual, any contacts (face-to-face or otherwise) with the individual's family members or authorized representative, or any contacts (face-to-face or otherwise) about the individual with other CSB staff or programs or other providers or agencies. Examples of service hour activities applicable to non-face-to-face case management services include:

- case management, individual not present;
- phone consultation with individual;
- report writing re: individual;
- individual-related staff travel; and
- discharge planning, individual not present.

7. **Day Support Services** provide structured programs of treatment, activity, or training services, generally in clusters of two or more continuous hours per day, to groups or individuals in non-residential settings.

a. ***Day Treatment or Partial Hospitalization*** (410) is a treatment program that includes the major diagnostic, medical, psychiatric, psychosocial, and prevocational and educational treatment modalities designed for adults with serious mental health, substance use, or co-occurring disorders who require coordinated, intensive, comprehensive, and multi-disciplinary treatment that is provided several hours per day for multiple days each week and is not provided in outpatient services.

This subcategory also includes *therapeutic day treatment for children and adolescents*, a treatment program that serves children and adolescents (birth through age 17) with serious emotional disturbances or substance use or co-occurring disorders or children (birth through age 7) at risk of serious emotional disturbance in order to combine psychotherapeutic interventions with education and mental health or substance abuse treatment. Services include: evaluation, medication education and management, opportunities to learn and use daily living skills and to enhance social and interpersonal skills, and individual, group, and family counseling.

b. ***Ambulatory Crisis Stabilization Services*** (420) provide direct care and treatment to non-hospitalized individuals experiencing an acute crisis related to mental health, substance use, or co-occurring disorders that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization, provide normative environments with a high assurance of safety and security for crisis intervention, stabilize individuals in crisis, and mobilize the resources of the community support system, family members, and others for ongoing rehabilitation and recovery. Ambulatory crisis stabilization services may be provided in an individual's home or in a community-based program licensed by the Department. These services are planned for and provide services for up to 23 hours per day. Services that are integral to and provided in ambulatory crisis stabilization programs, such as outpatient or case management services, should not be reported separately in those core services since they are included in the ambulatory crisis stabilization day support hours.

c. ***Rehabilitation or Habilitation*** (425) consists of training services in two modalities.

Psychosocial rehabilitation provides assessment, medication education, opportunities to learn and use independent living skills and to enhance social and interpersonal skills, family support and education, vocational and educational opportunities, and advocacy to individuals with mental health, substance use, or co-occurring disorders in a supportive community environment focusing on normalization. It emphasizes strengthening the individual's abilities to deal with everyday life rather than focusing on treating pathological conditions.

Habilitation provides planned combinations of individualized activities, supports, training, supervision, and transportation to individuals with intellectual disability to improve their condition or maintain an optimal level of functioning. Specific components of this service develop or enhance the following skills: self-care and hygiene, eating, toileting, task learning, community resource utilization, environmental and behavioral skills, medication management, and transportation. Habilitation also includes Medicaid ID HCB waiver day support (center-based and non-center- based) and prevocational services.

8. **Employment Services** provide work and support services to groups or individuals in non-residential settings.

   a. ***Sheltered Employment*** (430) programs provide work in a non-integrated setting that is compensated in accordance with the Fair Labor Standards Act for individuals with disabilities who are not ready, are unable, or choose not to enter into competitive employment in an integrated setting. This service includes the development of social, personal, and work-related skills based on an individualized services plan.

   b. ***Group Supported Employment*** (465) provides work to small groups of three to eight individuals at job sites in the community or at dispersed sites within an integrated setting. Integrated setting means opportunities exist for individuals receiving services in the immediate work setting to have regular contact with non-disabled persons who are not providing support services. The employer or the vendor of supported employment services employs the individuals. An employment specialist, who may be employed by the employer or the vendor, provides ongoing support services. Support services are provided in accordance with the individual's written rehabilitation plan. Models include mobile and stationary crews, enclaves, and small businesses. Group supported employment includes Medicaid ID HCB waiver supported employment - group model.

   c. ***Individual Supported Employment*** (460) provides paid employment to an individual placed in an integrated work setting in the community. The employer employs the individual. On-going support services that may include transportation, job-site training, counseling, advocacy, and any other supports needed to achieve and to maintain the individual in the supported placement are provided by an employment specialist, co-workers of the supported employee, or other qualified individuals. Support services are provided in accordance with the individual's written rehabilitation plan. Individual supported employment includes Medicaid ID HCB waiver supported employment - individual model.

9. **Residential Services** provide overnight care with an intensive treatment or training program in a setting other than a hospital or training center, overnight care with supervised living, or other supportive residential services.

a. ***Highly Intensive Residential Services*** (501) provide overnight care with intensive treatment or training services. These services include:

Mental Health Residential Treatment Centers such as short term intermediate care, residential alternatives to hospitalization such as community gero-psychiatric residential services[1], and residential services for individuals with co-occurring diagnoses (e.g., mental health and substance use disorders, intellectual disability and mental health disorders) where intensive treatment rather than just supervision occurs;

Community Intermediate Care Facilities for Individuals With Intellectual Disability (ICF/ID) that provide care to individuals who have intellectual disability and need more intensive training and supervision than may be available in an assisted living facility or group home, comply with Title XIX of the Social Security Act standards and federal certification requirements, provide health and habilitation services, and provide active treatment to individuals receiving services toward the achievement of a more independent level of functioning or an improved quality of life; and

Substance Abuse Medically Managed Withdrawal Services that provide detoxification services with physician services available when required to eliminate or reduce the effects of alcohol or other drugs in the individual's body and that normally last up to seven days, but this does not include medical detoxification services provided in community-based substance abuse medical detoxification inpatient services (260) or social detoxification services.

b. ***Residential Crisis Stabilization Services*** (510) provide direct care and treatment to non-hospitalized individuals experiencing an acute crisis related to mental health, substance use, or co-occurring disorders that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization, provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in crisis, and mobilize the resources of the community support system, family members, and others for ongoing rehabilitation and recovery. Residential crisis stabilization services are provided in a community-based program licensed by the Department. These services are planned for and provide overnight care; the service unit is a bed day. Services that are integral to and provided in residential crisis stabilization programs, such as outpatient and case management services, should not be reported separately in those core services since they are included in the bed day.

c. ***Intensive Residential Services*** (521) provide overnight care with treatment or training that is less intense than highly intensive residential services. It includes the following services and Medicaid ID HCB waiver congregate residential support services.

Group homes or *halfway houses* provide identified beds and 24 hour supervision for individuals who require training and assistance in basic daily living functions such as meal preparation, personal hygiene, transportation, recreation, laundry, and budgeting. The expected length of stay normally exceeds 30 days.

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[1] Community gero-psychiatric residential services that provide 24-hour non-acute care with treatment in a setting that offers less intensive services than a hospital, but more intensive mental health services than a nursing home or group home. Individuals with mental health disorders, behavioral problems, and concomitant health problems, usually age 65 and older, who are appropriately treated in a geriatric setting, receive intensive supervision, psychiatric care, behavioral treatment planning, nursing, and other health-related services.

Primary care offers substance abuse rehabilitation services that normally last no more than 30 days. Services include intensive stabilization, daily group therapy and psycho-educational services, consumer monitoring, case management, individual and family therapy, and discharge planning.

Intermediate rehabilitation is a substance abuse psychosocial therapeutic milieu with an expected length of stay up to 90 days. Services include supportive group therapy, psycho-education, consumer monitoring, case management, individual and family therapy, employment services, and community preparation services.

Long-term habilitation is a substance abuse psychosocial therapeutic milieu with an expected length of stay of 90 or more days that provides a highly structured environment where residents, under staff supervision, are responsible for daily operations of the facility. Services include intensive daily group and individual therapy, family counseling, and psycho-education. Daily living skills and employment opportunities are integral components of the treatment program. Jail-based habilitation services, previously reported here, should be reported in outpatient services (310).

d. ***Supervised Residential Services*** (551) offer overnight care with supervision and services. This subcategory includes the following services and Medicaid ID HCB waiver congregate residential support services.

Supervised apartments are directly-operated or contracted, licensed residential programs that place and provide services to individuals in apartments or other residential settings. The expected length of stay normally exceeds 30 days.

Domiciliary care provides food, shelter, and assistance in routine daily living but not treatment or training in facilities of five or more beds. This is primarily a long-term setting with an expected length of stay exceeding 30 days. Domiciliary care is less intensive than a group home or supervised apartment; an example would be a licensed assisted living facility (ALF) operated, funded, or contracted by a CSB.

Emergency shelter or *residential respite* programs provide identified beds, supported or controlled by a CSB, in a variety of settings reserved for short term stays, usually several days to no more than 21 consecutive days.

Sponsored placements place individuals in residential settings and provide substantial amounts of financial, programmatic, or service support. Examples include individualized therapeutic homes, specialized foster care, family sponsor homes, and residential services contracts for specified individuals. The focus is on individual residential placements with expected lengths of stay exceeding 30 days rather than on organizations with structured staff support and set numbers of beds.

e. ***Supportive Residential Services*** (581) are unstructured services that support individuals in their own housing arrangements. These services normally do not involve overnight care delivered by a program. However, due to the flexible nature of these services, overnight care may be provided on an hourly basis. It includes the following services and Medicaid ID HCB waiver supported living/in-home supports, respite (agency and consumer-directed) services, companion services (agency and consumer-directed), and personal assistance services (agency and consumer-directed).

In-Home respite provides care in the homes of individuals with mental disabilities or in a setting other than that described in residential respite services above. This care may last

from several hours to several days and allows the family member care giver to be absent from the home.

Supported living arrangements are residential alternatives that are not included in other types of residential services. These alternatives assist individuals to locate or maintain residential settings where access to beds is not controlled by a CSB and may provide program staff, follow along, or assistance to these individuals. The focus may be on assisting an individual to maintain an independent residential arrangement. Examples include homemaker services, public-private partnerships, and non-CSB subsidized apartments (e.g., HUD certificates).

Housing subsidies provide cash payments only, with no services or staff support, to enable individuals to live in housing that would otherwise not be accessible to them. These cash subsidies may be used for rent, utility payments, deposits, furniture, and other similar payments required to initiate or maintain housing arrangements for individuals. This is used only for specific allocations of funds from the Department earmarked for housing subsidies. Numbers of individuals receiving services and expense information should be included in supportive residential services in performance contract reports. Information associated with other housing subsidies should be included in the services of which they are a part.

10. **Prevention Services** (610) are designed to prevent mental health or substance use disorders. Activities that are really outpatient services should not be included in prevention services to avoid record keeping or licensing requirements, since this exposes the CSB to increased liability, is not clinically appropriate, and violates the regulatory requirements of the federal Substance Abuse Prevention and Treatment block grant. Prevention services promote mental health through individual, community, and population-level change strategies. Prevention services are identified through the implementation of the Strategic Prevention Framework, an evidenced-based and community-based needs assessment-focused planning model. This model involves data-driven needs assessment, planning and evaluation, capacity building, and implementation of evidenced-based programs, strategies, and practices. Overlaying all these components are cultural competence and sustainability of effective outcomes. To achieve community level strategies, CSBs must be a part of a community coalition. Emphasis is on enhancement of protective factors and reduction of risk factors in individuals and the community. Information on substance abuse prevention services is collected and reported separately through the Department's contracted prevention services information system, instead of being included in the CCS. The following six strategies comprise prevention services.

    Information Dissemination provides awareness and knowledge of the nature and extent of mental health and substance use disorders and intellectual disability. It also provides awareness and knowledge of available prevention programs and services. Examples of information dissemination include media campaigns, public service announcements, informational brochures and materials, community awareness events, and participation on radio or TV talk shows. Information dissemination is characterized by one-way communication from the source to the audience.

    Prevention Education aims to affect critical life and social skills, including general competency building, specific coping skills training, support system interventions, strengthening caregivers, and decision-making skills training. Prevention education is characterized by two-way communication with close interaction between the facilitator or educator and program

participants. Examples of prevention education include children of alcoholics groups and parenting classes.

Alternatives provide for the participation of specific populations in activities that are constructive, promote healthy choices, and provide opportunities for skill building. Examples of prevention alternatives include leadership development, community service projects, alcohol, tobacco, and other drug free activities, and youth centers.

Problem Identification and Referral aims at the identification of those individuals who are most at risk of developing problematic behaviors in order to assess if their behaviors can be changed though prevention education. Examples include student and employee assistance programs.

Community-Based Process aims at enhancing the ability of the community to provide prevention and treatment services more effectively. Activities include organizing, planning, enhancing efficiency and effectiveness of service implementation, interagency collaboration, coalition building, and networking. Examples include community and volunteer training, multi-agency coordination and collaboration, accessing services and funding, and community team-building.

Environmental Prevention Activities establish or change written and unwritten community standards, codes, and attitudes, thereby influencing the development of healthy living conditions. Examples include modifying advertising practices and promoting the establishment and review of alcohol, tobacco, and other drug use policies.

11. ***Infant and Toddler Intervention Services*** (625) provides family-centered, community-based early intervention services designed to meet the developmental needs of infants and toddlers and the needs of their families as these needs relate to enhancing the child's development. These services prevent or reduce the potential for developmental delays in infants and toddlers and increase the capacity of families to meet the needs of their at-risk infants and toddlers. Infant and toddler intervention is delivered through a comprehensive, coordinated, interagency, and multidisciplinary services system. Infant and toddler intervention includes:

    a. assistive technology,
    b. audiology,
    c. family training, counseling, and home visits,
    d. health services,
    e. nursing services,
    f. nutrition services,
    g. occupational therapy,
    h. physical therapy,
    i. medical services (for diagnostic or evaluation purposes only),
    j. special instruction,
    k. psychological services,
    l. service coordination,
    m. social work services,
    n. speech-language pathology,
    o. transportation services, and
    p. vision services.

    The identified individual receiving services is the infant or toddler. Information about infant and toddler intervention services, including funds, expenditures, costs, service units, and the individuals receiving them is collected and reported to the Department through a separate contract and automated information system, rather than through CARS reports and the CCS. Consequently, this service is not included in the Core Services Category and Subcategory Matrix in the taxonomy. This infant and toddler intervention services definition is included in the taxonomy for information and reference purposes.

Core Services Taxonomy 7.3

Community Consumer Submission (CCS) Consumer Designation Codes

The CCS consumer designation codes for specialized initiatives or projects (consumer designation codes for short) identify individuals who are served in certain specific initiatives or projects; these codes are not service codes *per se*, like 310 is the core services code for Outpatient Services, instead, these codes reflect a particular status of those individuals. Consumer designation codes may encompass more than special projects or initiatives.

The component services of these projects or initiatives are included in the appropriate core services and numbers of individuals in these initiatives are counted in the CCS in the following manner. When an individual receives services in any of the following initiatives, the consumer designation code for the initiative will be entered in the type of care file for the individual. Units of service for these initiatives will be recorded and accumulated in the applicable core services associated with the initiative, such as outpatient, case management, day treatment or partial hospitalization, rehabilitation or habilitation, or various residential services.

905 - Mental Health Mandatory Outpatient Treatment (MOT) Orders
910 - Discharge Assistance Program (DAP)
915 - Mental Health Child and Adolescent Services Initiative,
916 - Mental Health Services for Children and Adolescents in Juvenile Detention Centers
918 - Program of Assertive Community Treatment (PACT),
919 - Projects for Assistance in Transition from Homelessness (PATH), and
920 - Medicaid Intellectual Disability (ID) Home and Community-Based Waiver Services.
933 - Substance Abuse Medication Assisted Treatment
935 - Substance Abuse Recovery Support Services

Additional CCS consumer designation codes may be used to identify individuals involved in special projects and to gather information about those individuals and the services associated with those projects. The Department and the VACSB Data Management Committee will designate and approve additional consumer designation codes for such purposes.

Descriptions of Some Consumer Designation Codes

Consumer Designation Code 905 - Mental Health Mandatory Outpatient Treatment (MOT) Orders is used only for individuals for whom a judge or special justice has issued a mandatory outpatient treatment order pursuant to § 37.2-817.D of the Code of Virginia and for whom the CSB has developed an initial mandatory outpatient treatment plan pursuant to § 37.2-817.F and a comprehensive mandatory outpatient treatment plan pursuant to § 37.2-817.G. Individuals receiving services from the CSB as a result of any other court orders (e.g., court-ordered evaluations, forensic evaluations, or competency restoration services) shall not be assigned this consumer designation code. If an individual who is the subject of an MOT order will be receiving mental health services under that order from or through the CSB and has not been admitted to the mental health services program area (100) previously, the individual must be admitted to that program area, with two CCS TypeOfCare records submitted in the next monthly CCS extract file submission: first, one record for the admission, and second, one record for the 905 consumer designation code. The ServiceFromDate on the second record must be the date of the MOT order and must be the same or a later date than the ServiceFromDate on the TypeOfCare record for the admission to the mental health services program area. When the MOT order expires or is rescinded, the date of that expiration or rescission must be entered as the ServiceThroughDate on a TypeOfCare record to end the MOT consumer designation code.

If an individual who is the subject of an MOT order will not be receiving mental health services under that order from or through the CSB, for example, the individual will receive services from non-contracted private providers and the CSB will only be monitoring the individual's compliance with the comprehensive MOT plan, then admission to the mental health services program area (100) is not necessary. The CSB's monitoring of compliance with the MOT plan should be recorded as consumer monitoring services (390), an ancillary service, and, if the CSB did not perform the preadmission screening or provide emergency services to the individual, the CSB still must open a case on the individual, collecting the applicable CCS 3 data elements associated with case opening. A TypeOfCare record for the initiation of the MOT must still be submitted by the CSB to start the MOT consumer designation code. When the MOT order expires or is rescinded, the date of that expiration or rescission must be entered as the ServiceThroughDate on a TypeOfCare record to end the MOT consumer designation code.

The duration of the MOT order is specified in the order, per § 37.2-817.E of the Code of Virginia. The clerk of the court must provide a copy of the order, per § 37.2-817.I, to the person who is the subject of the order and to the CSB that is required to monitor the individual's compliance with the MOT plan pursuant to § 37.2-817.1. Sections 37.2-817.3 and 37.2-817.4 contain provisions for the rescission or continuation of MOT orders.

Consumer Designation Code 910 - Discharge Assistance Program (DAP) is used for individuals receiving services supported with mental health state DAP funds. Since the state hospital discharge date and related DAP TypeOfCareFromDate may precede the TypeOfCareFromDate for admission to the mental health services program area, the individual does not have to be admitted to the mental health services program area (100) before being given a 910 consumer designation code.

Consumer Designation Code 915 - Mental Health Child and Adolescent Services Initiative is used for children and adolescents with serious emotional disturbance (SED) or related disorders who are not mandated to receive services funded through the Comprehensive Services Act. Initiative services are funded with restricted mental health state funds that are used exclusively for this purpose. Related disorders are not defined in the Appropriations Act, but the term allows sufficient flexibility to serve children with mental health or co-occurring mental health and substance use disorders who may not fit the definition of SED but may need services that can only be provided with these Initiative funds.

Consumer Designation Code 916 - Mental Health Services for Children and Adolescents in Juvenile Detention Centers is used for children and adolescents in juvenile detention centers receiving CSB services that are funded with restricted mental health state funds identified for this purpose. The use of this consumer designation code will eliminate the separate paper reporting mechanism for these services by CSBs maintained by the Department's Office of Child and Family Services. A CSB's primary role in a juvenile detention center is providing short-term services to juveniles with mental health disorders or co-occurring mental health and substance use disorders who are incarcerated in the center. As part of this role, a CSB also consults with juvenile detention center staff on the needs and treatment of these juveniles. Since the juveniles have been court ordered to the center, they are under the jurisdiction of the center for care. A CSB provides consultation and behavioral health services in support of the center's care of these juveniles. If the CSB provides consultation to the center's staff about groups of children, rather than about specific individuals, the CSB should report the service hours using the z-consumer function in the CCS.

A CSB typically provides the following core services to most of the juveniles it serves in juvenile detention centers: emergency, consumer monitoring, assessment and evaluation, or early intervention services. Since these services are being provided in a consultative mode within the juvenile detention center and the CSB will not have an ongoing clinical relationship with most of these juveniles once they are released, CSB staff should enter information about these services in the juvenile's record at the detention center, rather than initiating an individualized services plan (ISP) or service record at the CSB. Less frequently, a CSB may provide outpatient services to juveniles whose needs and lengths of stay warrant them and case management services for juveniles who are near discharge to their home CSBs. These services are typically more intensive and of longer duration, and staff must initiate ISPs at the CSB for juveniles receiving them. Except for outpatient and case management services, the other services that can be provided are emergency or ancillary services and, therefore, require limited CCS 3 data to be collected. However, if it provides outpatient or case management services, a CSB must admit the juvenile to the mental health services program area with a Type Of Care record prior to assigning a 916 consumer designation code, according to instructions in the CCS 3 Extract Specifications. The CSB must collect a full data set consistent with the CCS 3 requirements, as well as conform to the licensing requirements for the provision of those services.

A CSB must assign a 916 consumer designation code to each juvenile served in a juvenile detention center when his or her case is opened for CCS 3 purposes, so the services that he or she receives while in the juvenile detention center and upon discharge from it can be identified with this initiative. Normally, an individual must be admitted to a program area in order to assign a consumer designation code. However, an exception exists in the CCS 3 Extract Specifications for juveniles who receive only emergency or ancillary services; the CSB can submit a TypeOfCare record to assign the 916 consumer designation code without an admission to a program area. Refer to the *Revised Guidance for CSB Services in Juvenile Detention Centers*, March 3, 2008, for further information about collecting and reporting information about these services.

Consumer Designation Code 920 - Medicaid ID Home and Community-Based (HCB) Waiver Services is used only for individuals who have been admitted to the developmental services program area (200) and are receiving any Medicaid ID HCB waiver services from a CSB, directly or through CSB contracts with other agencies or individuals where the CSB remains the provider for DMAS purposes, or from any other provider of Medicaid ID HCB waiver services. Admission to the developmental services program area (200) is a prerequisite for assigning this consumer designation code. Assigning the 920 consumer designation code to individuals who do not receive Medicaid ID HCB waiver services from the CSB should not be a problem since the CSB provides case management services, a non-waiver service, to all individuals receiving Medicaid ID HCB waiver services, even if the CSB does not provide those waiver services.

Consumer Designation Code 933 - Substance Abuse Medication Assisted Treatment is used only for individuals who have been admitted to the substance abuse services program area (300) and are receiving buprenorphine (suboxone) that is provided by the CSB or prescribed by a private physician who has a formal agreement with the CSB to provide medical oversight for medication assisted treatment to individuals for whom the CSB is providing support services, including counseling and case management. Medication assisted treatment is reported in outpatient services. Admission to the substance abuse services program area (300) is a prerequisite for assigning this consumer designation code.

Consumer Designation Code 935 – Substance Abuse Recovery Support Services is used only for individuals receiving recovery support at a program funded specifically for this purpose by the Department. Because of the mix of services (some emergency or ancillary services) that individuals will receive, admission to the substance abuse services program area (300) is not a prerequisite for assigning this consumer designation code.

Recovery support services are designed and delivered by peers in recovery and in coordination with clinical staff. However, recovery support services are designed and provided primarily by individuals in recovery; although supportive of formal treatment, recovery support services are not intended to replace treatment services in the commonly understood clinical sense of that term. Recovery support services include:

1. **emotional support** that offers demonstrations of empathy, caring, and concern that bolster one's self-esteem and confidence and include peer mentoring, peer coaching, and peer-led support groups;
2. **informational support** that involves assistance with knowledge, information, and skills and includes peer-led life skills training, job skills training, citizenship restoration, educational assistance, and health and wellness information;
3. **instrumental support** that provides concrete assistance in helping others do things or get things done, especially stressful or unpleasant tasks, and includes connecting people to treatment services, providing transportation to get to support groups, child care, clothing closets, and filling our applications or helping people obtain entitlements; and
4. **affiliational support** that offers the opportunity to establish positive social connections with other recovering people.

CSB services associated with recovery support include emergency, motivational treatment, and assessment and evaluation services in addition to needed substance abuse services.

Core Services Category and Subcategory Matrix

Emergency and Ancillary Services

	Unit of Service	Capacity
1. **Emergency Services** (100)	Service Hour	NA
2. **Ancillary Services**		
a. Motivational Treatment Services (318)	Service Hour	NA
b. Consumer Monitoring Services (390)	Service Hour	NA
c. Assessment and Evaluation Services (720)	Service Hour	NA
d. Early Intervention Services (620)	Service Hour	NA
3. **Consumer-Run Services** (730)	NA	NA

Core Services Category and Subcategory Matrix

Services Available at Admission to a Program Area

	MH	DV	SA	Unit of Service	Capacity
4. **Inpatient Services**					
a. Medical/Surgical Care (State Facility)	x	x	NA	Bed Day	Bed
b. Skilled Nursing Services (State Facility)	x	x	NA	Bed Day	Bed
c. ICF/ID Services (State Facility)	NA	x	NA	Bed Day	Bed
d. ICF/Geriatric Services (State Facility)	x	x	NA	Bed Day	Bed
e. Acute Psychiatric or Substance Abuse Inpatient Services (250)	x	NA	x	Bed Day	Bed
f. Community-Based Substance Abuse Medical Detoxification Inpatient Services (260)	NA	NA	x	Bed Day	Bed
g. Extended Rehabilitation Services (St. Facility)	x	NA	NA	Bed Day	Bed
5. **Outpatient Services**					
a. Outpatient Services (310)	x	x	x	Service Hour	NA
b. Intensive Outpatient (313)	NA	NA	x	Service Hour	NA
c. Medication Assisted Treatment (335)	NA	NA	x	Service Hour	NA
d. Assertive Community Treatment (350)	x	NA	NA	Service Hour	NA
6. **Case Management Services** (320)	x	x	x	Service Hour	NA
7. **Day Support Services**					
a. Day Treatment or Partial Hospitalization (410)	x	NA	x	Day Support Hour	Slot
b. Ambulatory Crisis Stabilization Services (420)	x	x	x	Day Support Hour	Slot
c. Rehabilitation (MH, SA) or Habilitation (425)	x	x	x	Day Support Hour	Slot
8. **Employment Services**					
a. Sheltered Employment (430)	x	x	x	Day of Service	Slot
b. Group Supported Employment (465)	x	x	x	Day of Service	Slot
c. Individual Supported Employment (460)	x	x	x	Service Hour	NA
9. **Residential Services**					
a. Highly Intensive Residential Services (501)	x	x	x	Bed Day	Bed
b. Residential Crisis Stabilization Services (510)	x	x	x	Bed Day	Bed
c. Intensive Residential Services (521)	x	x	x	Bed Day	Bed
d. Supervised Residential Services (551)	x	x	x	Bed Day	Bed
e. Supportive Residential Services (581)	x	x	x	Service Hour	NA
10. **Prevention Services** (610)	x	x	x	Service Hour	NA

Core Services Taxonomy 7.3

Core Services Definitions: Units of Service

There are four kinds of service units in this core services taxonomy: service hours, bed days, day support hours, and days of service. These units are related to different kinds of core services and are used to measure and report delivery of those services. The unit of service for each core service category or subcategory is shown in the Core Services Category and Subcategory Matrix on the preceding pages. Units of service are collected and reported in the Community Consumer Submission (CCS) for all services provided by CSBs directly or through contracts with other providers.

1. ***Service Hours***

   A service hour is a continuous period measured in fractions or multiples of an hour during which an individual or a family member, authorized representative, care giver, health care provider, or significant other through in-person or electronic (audio and video or telephonic) contact on behalf of the individual receiving services or a group of individuals participates in or benefits from the receipt of services. This definition also includes significant electronic contact with the individual receiving services and activities that are reimbursable by third party payers. The following table, developed by the Department and the VACSB Data Management Committee, contains examples of activities received during service hour services directly by or on behalf of individuals or groups of individuals.

Examples of Service Hour Activities	
Individual, group, family, or marital, counseling or therapy	Phone consultation with individual
Psychological testing and evaluations	Follow up and outreach
Medication visit or physician visit	Social security disability evaluation
Crisis intervention	Case management, individual present
Intake, psychiatric, forensic, court, and jail evaluations	Case management, individual not present
Emergency telephone contacts with individual	Peer self help or support
Preadmission screening evaluations	Individual or group training
Independent examinations	Job development for individuals
Commitment and MOT hearings	Report writing re: individual
Attending court with the individual	Individual-related staff travel
Discharge planning, individual present	Activity or recreation therapy
Discharge planning, individual not present	Education of individuals
	Early intervention activities

   Service hours measure the amounts of services received by or on behalf of individuals or groups of individuals. For example, if nine individuals received one hour of group therapy, one service hour of outpatient services would be reported for each individual in a service.txt record in the CCS. Service hours are reported in the CCS service file only for the following core services:

   - Emergency services,
   - Motivational treatment services,
   - Consumer monitoring services,
   - Assessment and evaluation services,
   - Early intervention services,
   - Outpatient services,
   - Intensive outpatient services,
   - Medication assisted treatment,
   - Assertive community treatment,
   - Case management services,
   - Individual supported employment, and
   - Supportive residential services.

   Mental health and developmental prevention services are discussed on the next page.

Z-Consumers: Service hours that are not received by or associated directly with individuals or groups of individuals also are collected and reported for the core services listed at the bottom of the previous page through the CCS using the z-consumer (unidentified individual receiving services) function (NC Service file). In addition, mental health and developmental prevention services are collected and reported using the z-consumer function, since individuals receiving services are not counted for prevention services. All information about Substance Abuse Prevention Services is collected and reported through the KIT Prevention System. Examples of z-consumer activities are listed below.

Examples of Z-Consumer Activities for Service Hours	
Case-specific clinical supervision	Employee, student, or peer assistance
Record charting	Staff preparation for individual, group, family, or marital counseling or therapy
Case consultation	
Treatment planning conference	Healthy pregnancies and fetal alcohol syndrome education
Phone Calls in emergency services	
Participation in FAPT	Child abuse and neglect prevention and positive parenting programs
Coordination of multidisciplinary teams	
Consultation to service providers	Neighborhood-based high risk youth programs
Application for admission to facility	Competency building programs
Preparing for workshops and training	Skill-building group training

Service hours received by groups of identifiable individuals (e.g., individuals participating in group outpatient services) must not be reported using the z-consumer function (NC service file); they must be reported in the service file as service hours received by each individual participating in the group. Similarly, service hours directly associated with individuals, such as case management without the individual present, discharge planning without the individual present, phone consultation with the individual, or report writing re: individual, must not be reported using the z-consumer function. Finally, units of service for core services measured with bed days, days of service, or day support hours must not be reported in the CCS using the z-consumer function (NC service file).

2. ***Bed Days***

A bed day involves an overnight stay by an individual in a residential or inpatient program, facility, or service. Given the unique nature of residential SA medically managed withdrawal services, CSBs may count partial bed days for this service. If an individual is in this program for up to six hours, this would equal ¼ bed day, six to 12 hours would equal ½ bed day, 12 to 18 hours would equal ¾ bed day, and 18 to 24 hours would equal one bed day.

3. ***Day Support Hours***

Many day support services provided to groups of individuals are offered in sessions of two or more consecutive hours. However, Medicaid billing units for State Plan Option and ID waiver services vary by service. Therefore, counting service units by the smallest reasonable unit, a day support hour, is desirable and useful. Medicaid service units, if different from taxonomy units of service, need to be converted to taxonomy units for Medicaid services included in the CCS. The day support hour is the unit of service for day treatment or partial hospitalization, ambulatory crisis stabilization, and rehabilitation or habilitation and measures hours received by individuals in those services.

This unit allows the collection of more accurate information about services and will facilitate billing various payors that measure service units differently. At a minimum, day support programs that deliver services on a group basis must provide at least two consecutive hours in a session to be considered a day support program.

4. ***Days of Service***

Two employment services provided to groups of individuals are offered in sessions of three or more consecutive hours. Day of service is the unit of service for sheltered employment and group supported employment. A day of service equals five or more hours of service received by an individual. If a session lasts three or more but less than five hours, it should be counted as a half day. Since the unit of service is a day, fractional units should be aggregated to whole days in the CCS. Also, Medicaid service units, if different from taxonomy units, need to be converted to taxonomy units for Medicaid services included in the CCS.

Core Services Definitions: Static Capacities

Static capacities are reported through performance contract reports in the Community Automated Reporting System (CARS) for those services shown in the Core Services Category and Subcategory Matrix with a static capacity that are provided by CSBs directly or through contracts with other providers.

1. ***Number of Beds***

The number of beds is the total number of beds for which the facility or program is licensed and staffed or the number of beds contracted for during the performance contract period. If the CSB contracts for bed days without specifying a number of beds, convert the bed days to a static capacity by dividing the bed days by the days in the term of the CSB's contract (e.g., 365 for an annual contract, 183 for a new, half-year contract). If the CSB contracts for the placement of a specified number of individuals, convert this to the number of beds by multiplying the number of individuals by their average length of stay in the program and then dividing the result by the number of days in the term of the CSB's contract.

2. ***Number of Slots***

Number of slots means the maximum number of individuals who could be served during a day or a half-day session in most day support programs. It is the number of slots for which the program or service is staffed. For example, in psychosocial rehabilitation programs, the number of slots is not the total number of members in the whole program; it is the number of members who can be served by the program at the same time during a session. If the CSB contracts for days of service without specifying a number of slots, convert the days of service to a static capacity by dividing the days of service by the days in the term of the CSB's contract (e.g., 248 for an annual contract based on 365 days minus 105 weekend and 12 holiday days). If the CSB contracts for the placement of a specified number of individuals, convert this to days of service by multiplying the number of individuals by the average units of service they receive and then convert the resulting days of service to slots, per the preceding example. If the CSB contracts for day support hours without specifying a number of slots, convert the hours to a static capacity by dividing the day support hours by the number of hours the program is open daily and dividing the result by the number of days the program is open during the CSB's contract period.

Core Services Taxonomy 7.3

Core Services Definitions: Individuals Receiving Services

Section 37.2-100 of the Code of Virginia defines an individual receiving services as a current direct recipient of public or private mental health, developmental, or substance abuse treatment or habilitation services. The term individual or individual receiving services will always be those individuals who have been admitted to a program area or for whom a CSB has opened a case and who have received valid services during a reporting period or the contract period. However, persons participating in prevention services are not counted as individuals receiving services.

If a CSB has opened a case for an individual or admitted an individual to a program area, but the individual has not received any valid services during the reporting period or the contract period, the CSB must not report that individual as a consumer in the CCS. Information about all individuals receiving valid services from CSBs through directly operated services or contracts with other providers must be collected and reported through the CCS.

Inpatient Core Service and State Facility Cost Centers Crosswalk

The following table crosswalks the inpatient services in the core services taxonomy (4.a through g) with the state facility cost centers and codes.

Core Service and State Facility Cost Accounting Crosswalk		
4.	**Inpatient Services** (Core Service)	
	State Facility Cost Center	**Code**
a.	**Medical/Surgical**	
	Acute Medical/Surgical (Certified)	411
b.	**Skilled Nursing**	
	Skilled Nursing - ID (Certified)	421
	Skilled Nursing - General (Certified)	423
c.	**Intermediate Care Facility/Intellectual Disability (ID)**	
	ICF/ID Certified (General)	529
d.	**Intermediate Care Facility/Geriatric**	
	ICF (Certified)	441
	Chronic Disease (Certified)	443
e.	**Acute Intensive Psychiatric**	
	Acute Admissions (Certified)	457
g.	**Extended Rehabilitation**	
	Community Preparation/Psychosocial	481
	Long Term Rehabilitation	482
	Child and Adolescent Services (General)	487
	Clinical Evaluation	488
	Forensic Medium Security	490
	Forensic Maximum Security	491
	Forensic Intermediate Security	493

Administrative Expenses means the expenses incurred by the CSB for its administrative functions. Administrative expenses are incurred for common or joint activities that cannot be identified readily with a particular organizational activity or cost objective. Expenses may include overall leadership and supervision of the CSB organization (e.g., expenses for the executive director, deputy director or director of administration, and support staff), financial management, accounting, reimbursement, procurement, human resources management, information technology services, policy development, strategic planning, resource development and acquisition, quality improvement, risk management, intergovernmental relations, board member support, and media relations.

Administrative functions and expenses may be centralized or included in programs and services, depending on the CSB's organizational structure. However, in either alternative, administrative and management expenses must be identified and allocated on a basis that is auditable and satisfies generally accepted accounting principles among service costs across the three program areas and emergency and ancillary services on financial and service forms in the performance contract and reports, and administrative costs must be displayed separately on the Consolidated Budget form (page AF-1) in the performance contract and reports. CSB administrative and management expenses shall be reasonable and subject to review by the Department.

Admission means the process by which a CSB accepts a person for services in one or more program areas (all mental health, developmental, or substance abuse services). If a person is only interviewed regarding services or triaged and referred to another provider or system of care, that activity does not constitute an admission. The staff time involved in that activity should be recorded in the core service category or subcategory (e.g., emergency or outpatient services) where the activity occurred as a z-consumer, a service with no associated individual receiving services, for Community Consumer Submission (CCS) purposes. Admission is to a program area, not to a specific program or service. A clinical record is opened on all persons seen face-to-face for an assessment. Individuals who will be receiving services through a CSB-contracted program or service are admitted to a program area, based upon a face-to-face clinical assessment. In order for a person to be admitted to a program area, all of the following actions are necessary:

1. an initial contact has been made,
2. a clinical screening or initial assessment was conducted,
3. a unique identifier for the individual was assigned or retrieved from the management information system if the person has been admitted for a previous episode of care, and
4. the person is scheduled to receive services in a directly-operated or contractual service in the program area.

Admission is to a program area. An individual is not admitted to a program area for emergency services or ancillary (motivational treatment, consumer monitoring, assessment and evaluation, or early intervention) services; the CSB opens a case for that individual. The CCS requires collection of an abbreviated set of data elements, rather than a full set, for these services. However, all of the CCS data elements that were not collected then must be collected if an individual subsequently is admitted to a program area. It is possible that an individual may be admitted to more than one program area concurrently. A case is not opened for an individual participating in consumer-run services. CSBs providing consumer-run services directly or contractually must report the number of individuals participating in those services separately in the CARS management report.

Case Management CSB means the CSB that serves the area in which the individual receiving services lives. The case management CSB is responsible for case management, liaison with the state facility when a person is admitted to it, and discharge planning. Any change in case management CSB for an individual shall be implemented in accordance with the current *Discharge Planning Protocols* to ensure a smooth transition for the individual and the CSB. Case management CSB also means the CSB to which bed day utilization is assigned, beginning on the day of admission, for an episode of care and treatment when an individual is admitted to a state facility.

Case Opening means the process by which the CSB opens a case for a person. The CSB has determined that it can serve the person who has sought or been referred to it for services. This does not constitute an admission to a program area. When the CSB opens a case for a person, he or she can access the following services without being admitted to a program area: emergency services or ancillary (motivational treatment, consumer monitoring, assessment and evaluation, and early intervention) services. The CSB collects only minimal CCS data elements at case opening. If the person needs other services, he or she is admitted to a program area. A person can be admitted directly to a program area without going through case opening; however, CCS data and other information collected at case opening must still be collected and reported.

Case Closing means the process by which the CSB closes a case for an individual who received services.

Cognitive Delay means a child is at least three but less than six years old and has a confirmed cognitive developmental delay. Documentation of a confirmed cognitive developmental delay must be from a multidisciplinary team of trained personnel, using a variety of valid assessment instruments. A confirmed delay will be noted on the test with a score that is at least 25 percent below the child's chronological age in one or more areas of cognitive development. A developmental delay is defined as a significant delay in one of the following developmental areas: cognitive ability, motor skills, social/adaptive behavior, perceptual skills, or communication skills. A multidisciplinary team of trained personnel will measure developmental delay (25 percent below the child's chronological age) by a using a variety of valid assessment instruments. The most frequently used instruments in Virginia's local school systems are the Battelle Developmental Inventory, Learning Accomplishments Profile - Diagnostic Edition (LAP-D), the Early Learning Accomplishment Profile (ELAP), and the Hawaiian Early Learning Profile (HELP). For infants and toddlers born prematurely (gestation period of less than 37 weeks), the child's actual adjusted age is used to determine his or her developmental status. Chronological age is used once the child is 18 months old.

Co-Occurring Disorders means individuals are diagnosed with more than one, and often several, of the following disorders: mental health or substance use disorders or intellectual disability. Individuals may have more than one substance use disorder and more than one mental health disorder. At an individual level, co-occurring disorders exist when at least one disorder of each type (e.g., mental health and substance use disorder or intellectual disability and mental health disorder) can be identified independently of the other and are not simply a cluster of symptoms resulting from a single disorder. The mental health and substance use disorders of some individuals may not, at a given point in time, fully meet the criteria for diagnoses in DSM IV categories. While conceptually ideal, diagnostic certainty cannot be the sole basis for system planning and program implementation.

A service definition of co-occurring disorders includes individuals who are pre-diagnosis in that an established diagnosis in one domain (mental health disorder, intellectual disability, or substance use disorder) is matched with signs or symptoms of an evolving disorder in another domain. Similarly, the service definition also includes individuals who are post-diagnosis in that one or both of their substance use disorder and their mental health disorder may have resolved for a substantial period of time, but who present for services with a unitary disorder and acute signs or symptoms of a co-occurring condition. For example, an individual with a substance use disorder who is now suicidal may not meet the formal criteria for a DSM IV diagnosis but is clearly in need of services that address both conditions. Refer to State Board Policy 1015 (SYS) 86-22 for more information about providing services to individuals with co-occurring mental health disorders, intellectual disability, or substance use disorders.

The definition of co-occurring disorders for the Community Consumer Submission data set is individuals shall be identified as having co-occurring mental health and substance use disorders if there is (1) an Axis I or Axis II mental health diagnosis and (a) an Axis I substance use disorder diagnosis or (b) admission to the substance abuse program area (denoted in a type of care record) or (2) an Axis I substance use disorder diagnosis and (a) an Axis I or Axis II mental health diagnosis or (b) admission to the mental health program area (denoted in a type of care record).

Discharge means the process by which a CSB documents the completion of a person's episode of care in a program area. Discharge occurs at the program area level, as opposed to a specific service. When an individual has completed receiving all services in the program area to which he or she was admitted, the person has completed the current episode of care and is discharged from that program area. A person is discharged from a program area if any of the following conditions exists; the individual has:

1. been determined to need no further services in that program area,
2. completed receiving services from all CSB and CSB-contracted services in that program area,
3. received no program area services in 90 days from the date of the last face-to-face service or service-related contact or indicated that he no longer desires to receive services, or
4. relocated or died.

Persons may be discharged in less than the maximum time since the last face-to-face contact (i.e., less than 90 days) at the CSB's discretion, but the person must be discharged if no face-to-face services have been received in the maximum allowable time period for that episode of care. Once discharged, should an individual return for services in a program area, that person would be readmitted to that program area; the subsequent admission would begin a new episode of care. If the person is discharged because he or she has received no services in 90 days, the discharge date must be the date of the last face-to-face or other contact with the person, not the 90th day.

In the rare circumstance in which services are provided for an individual after he or she has been discharged (e.g., completing a discharge summary), the units of service should be collected and reported in the core service category or subcategory (e.g., outpatient or case management services) where the activity occurred using the z-consumer function (NC service file), a service with no associated individual receiving services, for CCS purposes.

Episode of Care means all of the services provided to an individual to address an identified condition or support need over a continuous period of time between an admission and a discharge. An episode of care begins with admission to a program area, and it ends with the discharge from

that program area. An episode of care may consist of a single face-to-face encounter or multiple services provided through one or more programs. A person is not admitted to emergency services or ancillary services; those services are outside of an episode of care. If a person has received his or her last service but has not yet been discharged from a program area, and he or she returns for services in that program area within 90 days, the person is not readmitted, since he or she has not been discharged; the person is merely accepted into that program area for the needed services.

Intellectual Disability means a disability, originating before the age of 18 years, characterized concurrently by (i) significantly sub average intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at least two standard deviations below the mean and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills (§ 37.2-100 of the Code of Virginia).

Mental Illness means a disorder of thought, mood, emotion, perception, or orientation that significantly impairs judgment, behavior, capacity to recognize reality, or ability to address basic life necessities and requires care and treatment for the health, safety, or recovery of the individual or for the safety of others (§ 37.2-100 of the Code of Virginia).

Serious Mental Illness means a severe and persistent mental or emotional disorders that seriously impair the functioning of adults, 18 years of age or older, in such primary aspects of daily living as personal relations, self-care skills, living arrangements, or employment. Individuals with serious mental illness who have also been diagnosed as having a substance abuse disorder or developmental disability are included in this definition. Serious mental illness is defined along three dimensions: diagnosis, level of disability, and duration of illness. All three dimensions must be met to meet the criteria for serious mental illness.

a. Diagnosis: The person must have a major mental disorder diagnosed using the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). These disorders are: schizophrenia, major affective disorders, paranoia, organic or other psychotic disorders, personality disorders, or other disorders that may lead to chronic disability. A diagnosis of adjustment disorder or a V Code diagnosis cannot be used to satisfy these criteria.

b. Level of Disability: There must be evidence of severe and recurrent disability resulting from mental illness. The disability must result in functional limitations in major life activities. Individuals should meet at least two of the following criteria on a continuing or intermittent basis. The person:
   1.) Is unemployed; is employed in a sheltered setting or supportive work situation; has markedly limited or reduced employment skills; or has a poor employment history;
   2.) Requires public financial assistance to remain in the community and may be unable to procure such assistance without help;
   3.) Has difficulty establishing or maintaining a personal social support system;
   4.) Requires assistance in basic living skills such as personal hygiene, food preparation, or money management; or
   5.) Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.

c. Duration of Illness: The individual is expected to require services of an extended duration, or the individual's treatment history meets at least one of the following criteria.

1.) The individual has undergone psychiatric treatment more intensive than outpatient care more than once in his or her lifetime (e.g., crisis response services, alternative home care, partial hospitalization, and inpatient hospitalization), or

2.) The individual has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.

Serious Emotional Disturbance means a serious mental health problem that can be diagnosed under the DSM-IV in children ages birth through 17 (until the 18th birthday), or the child must exhibit all of the following:

a. Problems in personality development and social functioning that have been exhibited over at least one year's time, and

b. Problems that are significantly disabling based upon the social functioning of most children that age, and

c. Problems that have become more disabling over time, and

d. Service needs that require significant intervention by more than one agency.

At Risk of Serious Emotional Disturbance means children aged birth through seven are considered at risk of developing serious emotional disturbances if they meet at least one of the following criteria.

a. The child exhibits behavior or maturity that is significantly different from most children of that age and is not primarily the result of developmental disabilities; or

b. Parents or persons responsible for the child's care have predisposing factors themselves that could result in the child developing serious emotional or behavioral problems (e.g., inadequate parenting skills, substance abuse, mental illness, or other emotional difficulties, etc.); or

c. The child has experienced physical or psychological stressors that have put him or her at risk for serious emotional or behavioral problems (e.g., living in poverty, parental neglect, physical or emotional abuse, etc.).

Please refer to Appendix A that contains detailed criteria in checklists for serious mental illness, serious emotional disturbance, and at risk of serious emotional disturbance. Those criteria are congruent with these definitions and will ensure consistent screening for and assessment of these conditions.

Program Area means the general classification of service activities for one of the following defined conditions: a mental health disorder, intellectual disability, or a substance use disorder. The three program areas in the public services system are mental health, developmental, and substance abuse services. In the taxonomy, mental health or substance use disorder or intellectual disability refers to a condition experienced by an individual; and mental health, substance abuse, or developmental refers respectively to the services that address that condition.

Service Area means the city or county or any combination of cities and counties or counties or cities that established and is served by the CSB.

Service Location means the location in which the service for which a service.txt file is submitted in the Community Consumer Submission (CCS) was provided to an individual. Service location is reported in the service file for every service in all program areas (100, 200, and 300) and for

emergency and ancillary services (400). Service location is collected at every service encounter. Service locations are defined in CCS data element 65.

Service Subtype is a specific activity associated with a particular core service category or subcategory for which a service.txt file is submitted in the Community Consumer Submission. Service Subtypes now are defined only for emergency services and case management services. Service subtypes are defined in CCS data element 64.

Substance Abuse means the use of drugs, enumerated in the Virginia Drug Control Act (§ 54.01-3400 et seq.), without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior and (iii), because of such substance abuse, requires care and treatment for the health of the individual. This care and treatment may include counseling, rehabilitation, or medical or psychiatric care (§ 37.2-100 of the Code of Virginia). Substance abuse is now beginning to be defined and described as substance use disorder. There are two levels of substance use disorder: substance addiction (dependence) and substance abuse.

Substance Addiction (Dependence), as defined by ICD-9, means uncontrollable substance-seeking behavior involving compulsive use of high doses of one or more substances resulting in substantial impairment of functioning and health. Tolerance and withdrawal are characteristics associated with dependence. ICD-9 defines substance dependence as a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. tolerance, as defined by a need for markedly increased amounts of the substance to achieve intoxification or desired effect or markedly diminished effect with continued use of the same amount of the substance;
2. withdrawal, as manifested by the characteristic withdrawal syndrome for the substance or the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms;
3. the substance is often taken in larger amounts or over a longer period than was intended;
4. there is a persistent desire or unsuccessful efforts to cut down or control substance use;
5. a great deal of time is spent on activities necessary to obtain the substance, use the substance, or recover from its effects;
6. important social, occupational, or recreational activities are given up or reduced because of substance use; and
7. the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

Substance Abuse, as defined by ICD-9, means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. It leads to clinically significant impairment or distress, as manifested by one (or more) of the following occurring within a 12-month period:

1. recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household);

2. recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
3. recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); and
4. continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxification, physical fights).

Appendix A: Diagnostic Criteria Checklists

Serious Mental Illness Criteria Checklist		
Yes	**No**	**Criteria**
		1. Age: The individual is 18 years of age or older.
		2. DIAGNOSIS: The individual has a major mental disorder diagnosed using the DSM IV. **At least one of the following diagnoses must be present.** Adjustment disorder or V Code diagnoses do not meet this criterion.
		Schizophrenia, all types
		Major Affective Disorder
		Paranoid Disorder
		Organic Disorder
		Other Psychotic Disorder
		Personality Disorder
		Other mental health disorder that may lead to chronic disability
		3. Level Of Disability: There must be evidence of severe and recurrent disability resulting from mental illness. The disability must result in functional limitations in major life activities. **The individual must meet at least two of these criteria on a continuing or intermittent basis.** The individual:
		Is unemployed; employed in a sheltered setting or a supportive work situation; has markedly limited or reduced employment skills; or has a poor employment history.
		Requires public financial assistance to remain in the community and may be unable to procure such assistance without help.
		Has difficulty establishing or maintaining a personal social support system.
		Requires assistance in basic living skills such as personal hygiene, food preparation, or money management.
		Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.
		4. Duration Of Illness: The individual's treatment history must meet at least one of these criteria. The individual:
		Is expected to require services of an extended duration.
		Has undergone psychiatric treatment more intensive than outpatient care more than once in his or her lifetime (e.g., crisis response services, alternative home care, partial hospitalization, and inpatient hospitalization).
		Has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.
		If Yes is checked for criterion 1, and for at least one response in criterion 2, and for at least two responses in criterion 3, and for at least one response in criterion 4, then check Yes here to indicate that the individual has serious mental illness.
NOTE: Any diagnosis checked in 2 above must be documented in the individual's clinical record and in the CSB's information system, and the individual's clinical record also must contain documentation that he or she meets any criteria checked in 3 and 4 above.		

Serious Emotional Disturbance Criteria Checklist		
Yes	**No**	**Criteria**
		1. Age: The individual is a child, age birth through 17 (until the 18th birthday).
		2. Diagnosis: The child has a serious mental health problem that can be diagnosed under the DSM IV. Specify the diagnosis: _____
		3. Problems And Needs: The child must exhibit all of the following:
		Problems in personality development and social functioning that have been exhibited over at least one year's time, and
		Problems that are significantly disabling based upon the social functioning of most children that child's age, and
		Problems that have become more disabling over time, and
		Service needs that require significant intervention by more than one agency.
		If Yes is checked for criterion 1 and for criterion 2 **OR** for all four responses in criterion 3, then check Yes here to indicate that the child has serious emotional disturbance.
NOTE: Any diagnosis in criterion 2 above must be documented in the child's clinical record and in the CSB's information system, and the child's clinical record also must contain documentation of any of the problems or needs checked in criterion 3 above.		

At Risk Of Serious Emotional Disturbance Criteria Checklist		
Yes	**No**	**Criteria**
		1. Age: The person is a child, age birth through 7.
		2. Problems: The child must meet at least one of the following criteria.
		The child exhibits behavior or maturity that is significantly different from most children of that age and which is not primarily the result of developmental disabilities; or
		Parents or persons responsible for the child's care have predisposing factors themselves that could result in the child developing serious emotional or behavioral problems (e.g., inadequate parenting skills, substance use disorder, mental illness, or other emotional difficulties, etc.); or
		The child has experienced physical or psychological stressors that have put him or her at risk for serious emotional or behavioral problems (e.g., living in poverty, parental neglect, or physical or emotional abuse, etc,).
		If Yes is checked for criterion 1 and for any problem in criterion 2, then check Yes here to indicate that the child is at risk of serious emotional disturbance.
NOTES: These criteria should be used only if the child does not have serious emotional disturbance. The child's clinical record must contain documentation of any of the problems checked in criterion 2 above.		

Appendix B: Core Services Taxonomy and Medicaid Intellectual Disability Home and Community-Based Waiver (ID Waiver) Services Crosswalk

Core Services Taxonomy Service	ID Home and Community-Based Waiver Service
Emergency Services	Crisis Stabilization/Crisis Supervision Personal Emergency Response System [1]
Inpatient Services	None
Outpatient Services	Skilled Nursing Services [2] Therapeutic Consultation [3]
Case Management Services	None. Case Management is not a Waiver service.
Day Support: Habilitation	Day Support (Center-Based and Non-Center-Based) and Prevocational
Sheltered Employment	None
Group Supported Employment	Supported Employment - Group Model
Individual Supported Employment	Supported Employment - Individual Placement
Highly Intensive Residential Services	None, this is ICF/ID services in the taxonomy.
Intensive Residential Services	Congregate Residential Support Services [5]
Supervised Residential Services	Congregate Residential Support Services [5]
Supportive Residential Services	Supported Living/In-Home Residential Supports Agency and Consumer-Directed Respite Services, Personal Assistance Services [4], and Companion Services
Early Intervention, Ancillary Services	None

This crosswalk is included for information purposes. When there is an inconsistency between Medicaid service units and taxonomy units of service, taxonomy units of service will be used for uniform cost report and CCS purposes. Medicaid service definitions can be accessed at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManuals

[1] **Personal Emergency Response System** will be counted in the taxonomy and performance contract in terms of numbers of individuals served and expenses; there are no core services taxonomy units of service for this Medicaid service.

[2] **Skilled Nursing Services** are available to individuals with serious medical conditions and complex health care needs that require specific skilled nursing services that are long term and maintenance in nature ordered by a physician and which cannot be accessed under the Medicaid State Plan. Services are provided in the individual's home or a community setting on a regularly scheduled or intermittent need basis. The Medicaid service unit is one hour.

[3] **Therapeutic Consultation** provides expertise, training, and technical assistance in a specialty area (psychology, behavioral consultation, therapeutic recreation, rehabilitation engineering, speech therapy, occupational therapy, or physical therapy) to assist family members, care givers, and other service providers in supporting the individual receiving services. ID Waiver therapeutic consultation services may not include direct therapy provided to Waiver recipients or duplicate the activities of other services available to the person through the State Plan for Medical Assistance. This service may not be billed solely for monitoring purposes. The Medicaid service unit is one hour. Therapeutic consultation is included under outpatient services in the crosswalk, instead of

case management services, to preserve the unique nature of case management services and because it seemed to fit most easily in outpatient services. This also is the preference expressed by the VACSB Developmental Services Council.

[4] **Personal Assistance Services** are available to ID Waiver recipients who do not receive congregate residential support services or live in an assisted living facility and for whom training and skills development are not primary objectives or are received in another service or program. Personal assistance means direct assistance with personal care, activities of daily living, medication or other medical needs, and monitoring physical condition. It may be provided in residential or non-residential settings to enable an individual to maintain health status and functional skills necessary to live in the community or participate in community activities. Personal assistance services may not be provided during the same hours as Waiver supported employment or day support, although limited exceptions may be requested for individuals with severe physical disabilities who participate in supported employment. The Medicaid service unit is one hour. Personal Assistance Services and Companion Services are included under supportive residential services because they are more residentially based than day support based. The credentials for both include Department residential services licenses. This is the preference expressed by the VACSB Developmental Services Council. The Medicaid service unit and taxonomy unit are the same, a service hour.

[5] **Congregate Residential Support Services** have a Medicaid service unit measured in hours; this is inconsistent with the taxonomy bed day unit of service for intensive and supervised residential services. Therefore, congregate residential support services will be counted in the taxonomy and performance contract reports in terms of numbers of individuals served and expenses; there are no taxonomy units of service for these Medicaid services.

Environmental Modifications are available to individuals who are receiving at least one other ID Waiver service along with Medicaid targeted case management services. Modifications are provided as needed only for situations of direct medical or remedial benefit to the individual. These are provided primarily in an individual's home or other community residence. Modifications may not be used to bring a substandard dwelling up to minimum habitation standards. Environmental modifications include physical adaptations to a house or place of residence necessary to ensure an individual's health or safety or to enable the individual to live in a non-institutional setting, environmental modifications to a work site that exceed reasonable accommodation requirements of the Americans with Disabilities Act, and modifications to the primary vehicle being used by the individual. The Medicaid service unit is hourly for rehabilitation engineering, individually contracted for building contractors, and may include supplies. Environmental Modifications are included in the core service in which they are implemented (e.g., various residential services or case management services).

Assistive Technology is available to individuals who are receiving at least one other ID Waiver service along with Medicaid targeted case management services. It includes specialized medical equipment, supplies, devices, controls, and appliances not available under the State Plan for Medical Assistance that enable individuals to increase their abilities to perform activities of daily living or to perceive, control or communicate with the environment in which they live or that are necessary to their proper functioning. It may be provided in a residential or non-residential setting. The Medicaid service unit is hourly for rehabilitation engineering or the total cost of the item or the supplies. Assistive technology is included in the core service in which it is implemented (e.g., various residential services or case management services).

Appendix C: Retired Core Services Service Codes

The following core services service codes have been retired from use. The codes are listed in this appendix so that when core service categories or subcategories are added to the taxonomy in the future, none of these retired codes will be assigned to those new services.

Retired Core Services Service Codes		
Core Service Category	**Former Core Services Subcategory**	**Service Code**
Outpatient Services	Medical Services	311
Outpatient Services	Intensive In-Home Services	315
Outpatient Services	Opioid Detoxification Services	330
Outpatient Services	Opioid Treatment Services	340
Day Support	Therapeutic Day Treatment for Children and Adolescents	415
Day Support	Alternative Day Support Arrangements	475
Residential Services	Jail-Based Habilitation Services	531
Residential Services	Family Support Services	587
Limited Services	Substance Abuse Social Detoxification Services	710

Appendix D: Reserved for Future Use

Core Services Taxonomy 7.3

Appendix E: Regional Program Operating Principles

A regional program is funded by the Department through the community services board or behavioral health authority, hereafter referred to as the CSB, and operated explicitly to provide services to individuals who receive services from the CSBs participating in the program. A regional program may be managed by the participating CSBs or by one CSB, have single or multiple service sites, and provide one or more types of service. A regional program also may include self-contained, single purpose programs (e.g., providing one type of core service, usually residential) operated by one CSB for the benefit of other CSBs or programs contracted by one CSB that serve individuals from other CSBs.

A regional program can be a highly effective way to allocate and manage resources, coordinate the delivery and manage the utilization of high cost or low incidence services, and promote the development of services where economies of scale and effort could assist in the diversion of individuals from admission to state facilities. Each individual receiving services provided through a regional program must be identified as being served by a particular CSB. That CSB will be responsible for contracting for and reporting on the individuals that it serves and the services that it provides; and each individual will access services through and have his or her individualized services plan managed by that particular CSB. CSBs are the single points of entry into publicly funded mental health, developmental, and substance abuse services, the local points of accountability for coordination of those services, and the only entities identified in the Code of Virginia that the Department can fund for the delivery of community mental health, developmental, or substance abuse services.

The regional program operating principles provide guidance for CSBs to implement and manage identified regional programs and to account for services provided by the programs. The principles also provide guidance for the Department to monitor regional programs on a more consistent basis. Adherence to these principles will ensure that performance contracts and reports, including the Community Automated Reporting System (CARS) and the Community Consumer Submission (CCS) reports, contain complete and accurate information about individuals receiving services, services, funding, and expenses.

Regional Program Operating Principles

1. **Individual CSB Reporting:** The CCS, a secure and HIPAA-compliant individual data reporting system, is the basis for all statewide individual and service data. Therefore, every individual served in any manner must be included in some CSB's information system, so that necessary individual and service information can be extracted by CSBs and provided to the Department using the CCS. If a CSB does not collect information about all of the individuals it serves and services, including those served by regional programs, in its information system, it will not be able to report complete information about its operations to the Department.

    a. Unless subsection b. is applicable, each CSB participating in a regional program shall admit individuals that it serves through the regional program to the applicable program area(s) and maintain CCS data about them in its information system. For performance contract and report purposes (CARS and CCS), each participating CSB shall maintain and report funding, expense, cost, individual, and service information associated with the regional program for each individual that it serves through the regional program.

b. If one CSB operates a regional program on behalf of other CSBs in a region, it shall admit all individuals for services provided by the regional program, maintain CCS data about these individuals in its information system, and maintain and report funding, expense, cost, individual, and service information associated with those individuals, or, if the participating CSBs elect, each referring CSB may report on the individuals it serves.

2. **Regional Program Funding:** Depending on the design of a regional program, the Department may disburse state or federal funds for a regional program to each participating CSB or to one CSB that operates a regional program or agrees to serve as the fiscal agent for a regional program. Sections 37.2 -504 and 37.2-508 of the Code of Virginia establish the community services performance contract as the mechanism through which the Department provides state and federal funds to CSBs for community services and through which CSBs report on the use of those and other funds. All regional programs shall be included in the performance contract and reflected in CARS and CCS reports.

   a. If the Department disburses regional program funds to each participating CSB, each participating CSB shall follow existing performance contract and report requirements and procedures for that portion of the regional program funded by that CSB.

   b. If the Department disburses regional program funds to a CSB that operates a regional program on behalf of the other CSBs in a region, the operating CSB shall follow existing performance contract and report requirements and procedures, as if the regional program were its own program.

   c. If the Department disburses regional program funds to a CSB that has agreed to serve as the fiscal agent (fiscal agent CSB) for the regional program, disbursements will be based on, accomplished through, and documented by appropriate procedures, developed and implemented by the region.

   d. When funds are disbursed to a fiscal agent CSB, each participating CSB shall identify, track, and report regional program funds that it receives and spends as funds for that regional program. Each participating CSB, including the fiscal agent CSB, shall reflect in its CARS reports and CCS 3 extracts only its share of the regional program, in terms of individuals served, services provided, funds received, expenses made, and costs of the services. Any monitoring and reporting of and accountability for the fiscal agent CSB's handling of state or federal funds for a regional program shall be accomplished through the performance contract and reports. Alternately, if the participating CSBs elect, each CSB may perform these functions for its share of the regional program.

   e. When funds are disbursed to a fiscal agent CSB that pays a contract agency to deliver regional program services, the fiscal agent CSB and participating CSBs may elect to establish an arrangement in which the fiscal agent CSB reports all of the funds and expenditures in the fiscal pages of Exhibit A while the participating CSBs and the fiscal agent CSB report information about individuals served, units of services, and expenses for those units only for the individuals it serves on the program pages of Exhibit A, with a note on the Comments page of Exhibit A explaining the differences between the fiscal and program pages. Alternately, if the participating CSBs elect, the fiscal agent CSB may admit the individuals served by other participating CSBs and, for purposes of this regional program, treat those individuals as its own for documentation and reporting purposes.

3. **Financial Reporting:** All funds, expenses, and costs for a regional program shall be reported to the Department only once; they may be reported by individual CSBs, the CSB that serves as the fiscal agent, or both, depending on how the regional program is designed and operates. For example, the fiscal agent CSB might report the revenues and expenses for a regional program provided by a contract agency, and a CSB that refers individuals it serves to that regional program may report the service and cost information related to those individuals.

4. **Consumer Reporting:** Each individual who receives services through a regional program shall be reported to the Department only once for a particular service. However, an individual who receives services from more than one CSB should be reported by each CSB that provides a service to that individual. For example, if an individual receives outpatient mental health services from one CSB and residential crisis stabilization services from a second CSB operating that program on behalf of a region, the individual would be admitted to each CSB and each CSB would report information about the individual and the service it provided to the individual.

5. **Service Reporting:** Each service provided by a regional program shall be reported only once, either by the CSB providing or contracting for the service or the CSB that referred individuals it served to the regional program operated or contracted by another CSB or by the region.

6. **Contracted Regional Programs:** When the case management CSB refers an individual to a regional program that is operated by a contract agency and paid for by the regional program's fiscal agent CSB, the case management CSB shall report the service and cost information, but not the funding and expense information, even though it did not provide or pay for it, since there would be no other way for information about it to be extracted through the CCS. Alternately, if the participating CSBs elect, the fiscal agent CSB could admit the individual for this service and report information about the individual receiving services, services, costs, funds, and expenses itself; in this situation, the case management CSB would report nothing about this service.

7. **Transfers of Resources Among CSBs:** CSBs should be able to transfer state, local, and federal funds to each other to pay for services that they purchase from each other.

8. **Use of Existing Reporting Systems:** Existing reporting systems (the CCS and CARS) shall be used wherever possible, rather than developing new reporting systems, to avoid unnecessary or duplicative data collection and entry. Any new service or program shall be implemented as simply as possible regarding reporting requirements.

9. **Regional Administrative and Management Expenses:** CSBs and the Department have provider and local or state authority roles that involve non-direct services tasks such as utilization management and regional authorization committees. These roles incur additional administrative and management expenses for the programs. CSBs shall report these expenses as part of their costs of delivering regional services. The Department shall factor in and accept reasonable administrative and management expenses as allowable costs in regional programs.

10. **Local Supplements:** If a CSB participating in a regional program supplements the allocation of state or federal funds received by the CSB operating that program through transferring resources to the operating CSB, the participating CSB shall show the transfer as an expense on financial forms but not as a cost on service forms in its performance contract and reports. Then, the participating CSB will avoid displaying an unrealistically low service cost in its reports for the

regional program and double counting individuals served by and service units delivered in the regional program, since the operating CSB already reports this information.

11. **Balances:** Unexpended balances of current or previous fiscal year regional program funds should not be retained by the participating CSBs to which the regional fiscal agent CSB or the Department disbursed the funds, unless this is approved by the region for purposes that are consistent with the legislative intent of the Appropriation Act item that provided the funds. Otherwise, the balances should be available for redistribution during the fiscal year among participating CSBs to ensure maximum utilization of these funds. Each region should establish procedures for monitoring expenditures of regional program funds and redistributing those unexpended balances to ensure that uses of those funds are consistent with the legislative intent of the Appropriation Act item that provided the funds.

12. **Issue Resolution:** Regional program funding issues, such as the amount, sources, or adequacy of funding for the program, the distribution of state allocations for the regional program among participating CSBs, and financial participation of each CSB whose individuals receive services from the regional program, should be resolved at the regional level among CSBs participating in the program, with the Department providing information or assistance upon request.

13. **Local Participation:** Whenever possible, regional funding and reporting approaches should encourage or provide incentives for the contribution of local dollars to regional activities.

Four Regional Program Models

The following models have been developed for CSBs and the Department to use in designing, implementing, operating, monitoring, and evaluating regional programs. These models are paradigms that could be altered by mutual agreement among the CSBs and the Department as regional circumstances warrant. However, to the greatest extent possible, CSBs and the Department should adhere to these models to support and reinforce more consistent approaches to the operation, management, monitoring, and evaluation of regional programs. CSBs should review these models and, in consultation with the Department, implement the applicable provisions of the model or models best suited to their particular circumstances, so that the operations of any regional program will be congruent with one of these models.

1. Operating CSB-Funded Regional Program Model

1. The CSB that operates a regional program receives state and sometimes other funds from the Department for the program. The operating CSB provides the services, projects the total funding and cost for the regional program in its performance contract and contract revision(s), and reports total actual individuals served and units of service(s) delivered in its Community Consumer Submission 3 (CCS 3) extracts and reports funding, expenses, costs, and static capacities in its CARS. Other CSBs, which refer individuals to the regional program for services, project and report nothing for the regional program in their contracts, CARS reports, or CCS 3 extracts.
2. The operating CSB admits individuals receiving services from the regional program to the applicable program area (all MH, DV, or SA services) and develops individualized services plans (ISPs) for them for service(s) provided by the regional program. When individuals complete receiving all services from the regional program, they are discharged from the

applicable program area by the operating CSB, unless they are receiving other services in that program area from that operating CSB. If individuals also are receiving services from the operating CSB in another program area, the CSB admits them to that program area. The operating CSB provides appropriate information about the services provided and other clinical information to the CSB that referred the individual to the regional program for clinical record keeping purposes at the referring CSB.

3. The operating CSB ensures that the appropriate information about individuals and services in the regional program is entered into its information system, so that the information can be extracted by the CCS 3 and reported in the CCS 3 and applicable CARS reports. Thus, for performance contract and reporting purposes, individuals receiving services from a regional program operated by that CSB are reported by that operating CSB.
4. Each of the other CSBs with individuals receiving services from this regional program admits those individuals to the applicable program area and provides a service, such as case management, consumer monitoring, or another appropriate service, but not in service(s) provided by the regional program. Thus, individuals receiving services from a regional program will appear in the CCS 3 extracts for two CSBs, but not for the same services.
5. If the other CSBs with individuals receiving services from this regional program provide additional funds to the operating CSB to supplement the funds that the operating CSB receives from the Department for the regional program, these other CSBs show the revenues and expenses for this supplement on the financial forms in their performance contracts, contract revisions, and reports. However, these other CSBs do not show any services provided, individuals served, or costs for the regional program's services on the service forms in their contracts, revisions, or reports. These other CSBs include an explanation on the Financial Comments page of the difference between the expenses on the financial forms and the costs on the service forms. The operating CSB shows the services provided, individuals served, and total costs (including costs supported by supplements from the other CSBs) for the regional program's services on its service forms, but it does not show any revenues or expenses associated with the supplements on the financial pages in its contract, contract revision(s), and reports. The operating CSB includes an explanation of the difference between the expenses on the financial forms and the costs on the service forms on the Financial Comments page.
6. All of the CSBs, to the extent practicable, determine individual CSB allocations of the state and sometimes other funds received from the Department, based on service utilization or an agreed-upon formula.
7. Regional programs should receive the same state funding increases as regular CSB grant-funded activities, such as the salary increases for community services provided from time to time by the General Assembly in the Appropriation Act.

This model also could be adapted by a region to handle its LIPOS services, if one CSB receives all of the LIPOS funds, admits all of the individuals receiving LIPOS services, and pays all of the LIPOS providers. Participating CSBs should negotiate this adaptation with the Department.

2. All Participating CSBs-Funded Regional Program Model

1. Each CSB that participates in a regional program that is operated by one of those CSBs receives state and sometimes other funds from the Department for that program. Each participating CSB may supplement this amount with other funds available to it if the funds received from the Department are not sufficient to cover the regional program's expenses. Each participating CSB

uses those funds to purchase services from the regional program for the individuals it serves, projects the funding and cost for the regional program in its performance contract) and reports actual individuals served and units of service(s) delivered in its Community Consumer Submission 3 (CCS 3) extracts and reports funding, expenses, costs, and static capacities in its performance contract reports (CARS) only for the individuals it serves.

2. The regional program operated by one of the participating CSBs functions like a contract agency provider. All of the individual, service, static capacity, funding, expense, and cost information for the whole program is maintained separately and is not included in the contract, contract revision(s), reports (CARS), and CCS 3 extracts of the CSB operating the program. The participating CSBs, including the CSB operating the program, include only the parts of this information that apply to the individuals it serves in their contracts, contract revisions, reports, and extracts. The regional program is licensed by the Department, when applicable, and develops and maintains individualized services plans (ISPs) for individuals that it serves.
3. Each participating CSB admits individuals receiving services from the regional program to the applicable program area (all MH, DV, or SA services) for the services provided by the regional program. The services provided by the regional program are listed in the ISPs maintained by the participating CSBs for these individuals. When individuals complete receiving all services from the regional program, they are discharged from the applicable program area by the participating CSB, unless they continue to receive other services in that program area from that participating CSB. The regional program provides appropriate information about the services provided and other clinical information to the CSB that referred the individual to the program, as any contract agency would provide such information to the contracting CSB.
4. Each participating CSB, including the CSB operating the regional program, ensures that the appropriate information about the individuals it serves and their services is entered into its information system, so that the information can be extracted by the CCS 3 and reported in the CCS 3 submissions and applicable CARS reports for that participating CSB.
5. Regional programs should receive the same state funding increases as regular CSB grant-funded activities, such as the salary increases for community services provided from time to time by the General Assembly in the Appropriation Act.

3. Fiscal Agent CSB-Funded Regional Program Model

1. One CSB receives state and sometimes other funds from the Department and acts as the fiscal agent for a regional program. The Department disburses the regional allocation to the fiscal agent CSB on behalf of all CSBs participating in the regional program.
2. The fiscal agent CSB, in collaboration with the other participating CSBs, develops agreed-upon procedures that describe how the CSBs implement the regional program and jointly manage the use of these funds on a regional basis. The procedures also establish and describe how unused funds can be reallocated among the participating CSBs to ensure the greatest possible utilization of the funds. These procedures should be documented in a regional memorandum of agreement (MOA) that is available for review by the Department.
3. The fiscal agent CSB receives the semi-monthly payments of funds from the Department for the regional program. The fiscal agent CSB disburses the regional program funds to individual CSBs, including itself when applicable, in accordance with the procedures in paragraph 2. The fiscal agent CSB displays such disbursements on a Transfer In/Out line of the applicable resources page in its final performance contract revision and its reports. The other CSBs

receiving the transferred funds show the receipt of these funds on the same line. CSBs provide more detailed information about these transfers on the Financial Comments pages of contract revisions and reports.

4. Each CSB implementing a regional program accounts for and reports the funds and expenses associated with the program in its final performance contract revision and CARS reports. The fiscal agent CSB displays the total amount of the allocation as funding and all Transfers Out in its CARS reports, but it only displays in its reports the expenses for any regional program that it implements.
5. As an alternative to paragraphs 1 through 4 for some kinds of programs, such as the Discharge Assistance Program, and with the concurrence of the Department, instead of one CSB acting as a fiscal agent, all CSBs participating in that program establish a regional mechanism for managing the use of the regional program funds. The CSBs decide through this regional management mechanism how the total amount of funds for the program should be allocated among them on some logical basis (e.g., approved regional discharge assistance program ISPs). The region informs the Department of the allocations, and the Department adjusts the allocation of each participating CSB and disburses these allocations directly to the participating CSBs. Those CSBs agree to monitor and adjust allocations among themselves during the fiscal year through this regional management mechanism to ensure the complete utilization of these regional program funds, in accordance with the MOA in paragraph 2.
6. Each CSB implementing a regional program ensures that appropriate information about the individuals it serves and their services is entered into its information system, so that the CCS 3 can extract the information and report it in the CCS 3 submissions and applicable CARS reports.
7. Regional programs should receive the same state funding increases as regular CSB grant-funded activities, such as the salary increases for community services provided from time to time by the General Assembly in the Appropriation Act.

A variation of this model, the Fiscal Agent CSB-Funded Regional Local Inpatient POS Program Model, can be used to implement and manage regional local acute psychiatric inpatient bed purchases.

3.a. Fiscal Agent CSB-Funded Regional Local Inpatient POS Program Model

1. One CSB agrees to act as the fiscal agent for the regional Local Inpatient Purchase of Services (LIPOS) program. The Department disburses the regional LIPOS allocation to the fiscal agent CSB on behalf of all of the CSBs participating in the regional LIPOS program.
2. The fiscal agent CSB, in collaboration with all of the participating CSBs and with consultation from the Department, develops procedures that describe how the CSBs will implement the regional LIPOS program and jointly manage the use of these funds on a regional basis. The procedures include regional utilization management mechanisms, such as regional authorization committees (RACs) and regional procurements of beds through contracts with private providers. Such contracts may reserve blocks of beds for use by the region or purchase beds or bed days on an as available basis. The procedures also establish and describe how unused funds can be reallocated among the participating CSBs to ensure the greatest possible utilization of the funds. These procedures should be documented in a regional memorandum of agreement (MOA) that is available for review by the Department.

3. The fiscal agent CSB receives the semi-monthly payments of funds from the Department for the regional LIPOS program. The fiscal agent CSB disburses regional LIPOS funds to individual CSBs or uses such funds itself to pay for the costs of local inpatient hospitalizations that have been approved by a regional review and authorization body established by and described in the MOA in paragraph 2. The fiscal agent CSB displays such disbursements on a Transfer In/Out line of the mental health resources page in its final performance contract revision and reports, and the CSB receiving the transferred funds shows the receipt of these funds on the same line. CSBs provide more detailed information about these transfers on the Financial Comments page of contract revisions and reports.
4. The CSB that purchases local inpatient services accounts for and reports the funds and expenses associated with its LIPOS in its final performance contract revision and CARS reports. The fiscal agent CSB displays the total amount of the allocation as funds and all Transfers Out in its CARS reports, but it displays in its reports only the expenses for its own LIPOS.
5. The CSB that purchases the local inpatient services ensures that appropriate information about individuals, services, and costs is entered into its management information system, so that the CCS 3 can extract the information and report it in the CCS 3 submissions and applicable CARS reports.
6. Regional programs should receive the same state funding increases as regular CSB grant-funded activities, such as the salary increases for community services provided from time to time by the General Assembly in the Appropriation Act.

4. Fiscal Agent CSB-Funded Contract Agency Regional Program Model

1. One CSB receives state and sometimes other funds from the Department and acts as the fiscal agent for a regional program that is contracted by this fiscal agent CSB to a public or private agency. The Department disburses the regional allocation to the fiscal agent CSB on behalf of all CSB participating in the contracted regional program.

2. The fiscal agent CSB contracts with and provides set monthly payments to a regional program provided by a public or private contract agency on behalf of all of the CSB participating in this regional program. The contract may purchase a pre-set amount of specified services from the contract agency and pay the agency a predetermined cost, whether or not the participating CSBs use the services.

3. Each participating CSB referring one of the individuals it serves to this contracted regional program admits the individual, enrolls him in the regional program service, and refers him to the contract agency. The contract agency provides information to the referring (case management) CSB, and that CSB maintains information about the individual and the service units in its information system, where the CCS 3 can extract the information.

4. The fiscal agent CSB provides program cost information to each referring CSB, based on its use of the regional program, and the referring CSB enters this information in the cost column of the program services form (pages AP-1 through AP-4) but does not enter any funding or expenditure information in its performance contract report (CARS). The fiscal agent CSB enters the funding and expenditure information associated with the regional program on the financial forms in its performance contract report, but it enters cost information on the program services form only for the individuals that it referred to the regional program. Each CSB will explain the differences

between the financial and program service forms in its performance contract report on the Financial Comments page. The Department will reconcile the differences among the participating CSBs' reports using these comments. Because of the difficulty in calculating the program cost information for each participating CSB, program cost information would only need to be included in end of the fiscal year performance contract (CARS) reports.

5. All of the participating CSBs, to the extent practicable, determine individual CSB allocations of the state and sometimes other funds received from the Department, based on service utilization or an agreed-upon formula.

6. Regional programs should receive the same state funding increases as regular CSB grant-funded activities, such as the salary increases for community services provided from time to time by the General Assembly in the Appropriation Act.

This model also could be adapted by a region to handle its LIPOS services, if one CSB acts as the fiscal agent and pays all of the LIPOS providers. This adaptation should be negotiated with the Department by the participating CSBs.

Core Services Taxonomy 7.3

Appendix F: Regional Program Procedures

A regional program is funded by the Department through the community services board or behavioral health authority, hereafter referred to as the CSB, and operated explicitly to provide services to individuals who receive services from the CSBs participating in the program.

1. Purpose

The CSB may collaborate and act in concert with other CSBs or with other CSBs and state hospitals or training centers, hereafter referred to as state facilities, to operate regional programs, provide or purchase services on a regional basis, conduct regional utilization management, or engage in regional quality improvement efforts. Regional programs include regional discharge assistance programs (RDAP), local inpatient purchases of services (LIPOS), and other programs such as residential or ambulatory crisis stabilization programs. These procedures apply to all regional programs. While this appendix replaces earlier regional memoranda of agreement (MOAs), CSBs, state facilities, private providers participating in the regional partnership, and other parties may still need to develop MOAs to implement specific policies or procedures to operate regional or sub-regional programs or activities. Also, an MOA must be developed if a regional program intends to established a peer review committee (e.g., a regional utilization review and consultation team) whose records and reviews would be privileged under § 8.01-581.16 of the Code of Virginia. When the CSB receives state or federal funds from the Department for identified regional programs or activities, it shall adhere to the applicable parts of these procedures, which are subject to all applicable provisions of the community services performance contract. In the event of a conflict between any regional program procedures and any provisions of the contract, provisions of the contract shall apply.

2. Regional Management Group (RMG)

a. The participating CSBs and state facilities shall establish an RMG. The executive director of each participating CSB and the director of each participating state facility shall each serve on or appoint one member of the RMG. The RMC shall manage the regional program and coordinate the use of funding provided for the regional program, review the provision of services offered through the regional program, coordinate and monitor the effective utilization of the services and resources provided through the regional program, and perform other duties that the members mutually agree to carry out. An RMG may deal with more than one regional program.

b. Although not members of the RMG, designated staff in the Central Office of the Department shall have access to all documents maintained or used by this group, pursuant to applicable provisions of the performance contract, and may attend and participate in all meetings or other activities of this group.

c. In order to carry out its duties, the RMG may authorize the employment of one or more regional managers to be paid from funds provided for a regional program and to be employed by a participating CSB. The RMG shall specify the job duties and responsibilities for and supervise the regional manager or managers.

3. Regional Utilization Review and Consultation Team (RURCT)

a. The RMG shall establish a RURCT pursuant to § 8.01-581.16 of the Code of Virginia to, where applicable:

1.) review the implementation of the individualized services plans (ISPs) or individualized Discharge Assistance Program plans (IDAPPs) developed through the regional program to ensure that the services are the most appropriate, effective, and efficient services that meet the clinical needs of the individual receiving services and report the results of these reviews to the RMG;

2.) review individuals who have been on the state facility extraordinary barriers to discharge list for more than 30 days to identify or develop community services and funding appropriate to their clinical needs and report the results of these reviews and subsequent related actions to the RMG;

3.) review, at the request of the case management CSB, other individuals who have been determined by state facility treatment teams to be clinically ready for discharge and identify community services and resources that may be available to meet their needs;

4.) facilitate, at the request of the case management CSB, resolution of individual situations that are preventing an individual's timely discharge from a state facility or a private provider participating in the regional partnership or an individual's continued tenure in the community;

5.) identify opportunities for two or more CSBs to work together to develop programs or placements that would permit individuals to be discharged from state facilities or private providers participating in the regional partnership more expeditiously;

6.) promote the most efficient use of scarce and costly services; and

7.) carry out other duties or perform other functions assigned by the RMG.

b. The RURCT shall consist of representatives from participating CSBs in the region, participating state facilities, private providers participating in the regional partnership, and others who may be appointed by the RMG, such as the regional manager(s) employed pursuant to section II.C. The positions of the representatives who serve on this team shall be identified in local documentation.

c. The RURCT shall meet monthly or more frequently when necessary, for example, depending upon census issues or the number of cases to be reviewed. Minutes shall be recorded at each meeting. Only members of the team and other persons who are identified by the team as essential to the review of an individual's case, including the individual's treatment team and staff directly involved in the provision of services to the individual, may attend meetings. All proceedings, minutes, records, and reports and any information discussed at these meetings shall be maintained confidential and privileged, as provided in § 8.01-581.17 of the Code of Virginia.

d. For the regional program, the RURCT or another group designated by the RMG shall maintain current information to identify and track individuals served and services provided through the regional program. This information may be maintained in participating CSB information systems or in a regional data base. For example, for the RDAP, this information shall include the individual's name, social security number or other unique identifier, other unique statewide identifier, legal status, case management CSB, state hospital of origin, discharge date, state re-hospitalization date (if applicable), and the cost of the IDAPP. This team shall maintain automated or paper copies of records for each RDAP-funded IDAPP. Changes in responsibilities of the case management CSB, defined in the core services taxonomy, and the transfer of RDAP funds shall be reported to the Offices of Grants

Management and Mental Health Services in the Department as soon as these changes or transfers are known or at least monthly.

e. For RDAP, the RURCT shall conduct utilization reviews of ISPs as frequently as needed to ensure continued appropriateness of services and compliance with approved IDAPPs and reviews of quarterly utilization and financial reports and events related to the individual such as re-hospitalization, as appropriate. This utilization review process may result in revisions of IDAPPs or adjustment to or redistribution of RDAP funds. This provision does not supersede utilization review and audit processes conducted by the Department pursuant to the performance contract.

f. Although not members of the RURCT, designated staff in the Central Office of the Department shall have access to all documents, including ISPs or IDAPPs, maintained or used by this body, pursuant to applicable provisions of the performance contract, and may attend and participate in all meetings as non-voting members and in other activities of this team.

4. **Operating Procedures for Regional Programs:** These operating procedures establish the parameters for allocating resources for and monitoring continuity of services provided to individuals receiving regional program services. Some of the procedures apply to regional programs generally; others apply to particular regional programs, although they may be able to be adapted to other regional programs.

   a. Funding for a regional program shall be provided and distributed by the Department to participating CSBs or to a CSB on behalf of the region through their community services performance contracts in accordance with the conditions specified the contract, often in an Exhibit D.

   b. Each participating CSB or a CSB on behalf of the region shall receive semi-monthly payments of state funds from the Department for the regional program through its community services performance contract, as long as it satisfies the requirements of this appendix and the performance contract, based upon its total base allocation of previously allotted and approved regional program funds.

   c. Participating CSBs and state facilities shall develop agreed-upon procedures that describe how they will implement a regional program and jointly manage the use of regional program funds on a regional basis. These procedures shall be reduced to writing and provided to the Department upon request.

   d. Regional program funds may be used to support the activities of the RMG and RURCT.

   e. Within the allocation of funds for the regional program, funds may be expended for any combinations of services and supports that assure that the needs of individuals are met in community settings. ISPs or IDAPPs must be updated and submitted, as revisions occur or substitute plans are required, to the RMG for approval according to procedures approved by the RMG.

   f. Regional program funds used to support ISPs or IDAPPs shall be identified on a fiscal year basis. Amounts may be adjusted by the RMG to reflect the actual costs of care based on the regional program's experience or as deemed appropriate through a regional management and utilization review process.

g. The CSB responsible for implementing an individual's regional program ISP or IDAPP shall account for and report the funds and expenses associated with the regional program ISP or IDAPP in its community services performance contract and in its quarterly performance contract reports submitted through the Community Automated Reporting System (CARS).

h. The CSB responsible for implementing an individual's regional program ISP or IDAPP shall ensure that the appropriate information about that individual and his or her services is entered into its management information system so that the information can be extracted by the Community Consumer Submission (CCS) and reported in the monthly CCS extracts and applicable CARS reports to the Department.

i. The participating CSBs may use regional program funds to establish and provide regional or sub-regional services when this is possible and would result in increased cost effectiveness and clinical effectiveness.

j. Operation of a RDAP is governed by the Discharge Assistance Program Manual issued by the Department and provisions of Exhibit C of the performance contract.

5. General Terms and Conditions

a. CSBs, the Department, and any other parties participating in a regional program agree that they shall comply with all applicable provisions of state and federal law and regulations in implementing any regional programs to which these procedures apply. The CSB and the Department shall comply with or fulfill all provisions or requirements, duties, roles, or responsibilities in the current community services performance contract in their implementation of any regional programs pursuant to these procedures.

b. Nothing in these procedures shall be construed as authority for the CSB, the Department, or any other participating parties to make commitments that will bind them beyond the scope of these procedures.

c. Nothing in these procedures is intended to, nor does it create, any claim or right on behalf of any individual to any services or benefits from the CSB or the Department.

6. Privacy of Personal Information

a. The CSB, the Department, and any other parties participating in a regional program agree to maintain all protected health information (PHI) learned about individuals receiving services confidential and agree to disclose that information only in accordance with applicable state and federal law and regulations, including the regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 CFR Part 2, the Virginia Health Records Privacy Act, the Department's human rights regulations, and each party's own privacy policies and practices. The organization operating the regional program shall provide a notice to individuals participating in or receiving services from the regional program that it may share protected information about them and the services they receive, as authorized by HIPAA and other applicable federal and state statutes and regulations. The organization shall seek the authorization of the individual to share this information whenever possible.

b. Even though each party participating in a regional program may not provide services directly to each of the individuals served through the regional program, the parties may disclose the PHI of individuals receiving services to one another under 45 C.F.R. § 164.512(k)(6)(ii) in order to perform their responsibilities related to this regional program,

including coordination of the services and functions provided under the regional program and improving the administration and management of the services provided to the individuals served in it.

c. In carrying out their responsibilities in the regional program, the CSB, the Department, and any other parties involved in this regional program may use and disclose PHI to one another to perform the functions, activities, or services of the regional program on behalf of one another, including utilization review, financial and service management and coordination, and clinical case consultation. In so doing, the parties agree to:

1.) Not use or further disclose PHI other than as permitted or required by the performance contract or these procedures or as required by law;

2.) Use appropriate safeguards to prevent use or disclosure of PHI other than as permitted by the performance contract or these procedures;

3.) Report to the other parties any use or disclosure of PHI not provided for by the performance contract or these procedures of which they become aware;

4.) Impose the same requirements and restrictions contained in the performance contract or these procedures on their subcontractors and agents to whom they provide PHI received from or created or received by the other parties to perform any services, activities, or functions on behalf of the other parties;

5.) Provide access to PHI contained in a designated record set to the other parties in the time and manner designated by the other parties or at the request of the other parties to an individual in order to meet the requirements of 45 CFR 164.524;

6.) Make available PHI in its records to the other parties for amendment and incorporate any amendments to PHI in its records at the request of the other parties;

7.) Document and provide to the other parties information relating to disclosures of PHI as required for the other parties to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528;

8.) Make their internal practices, books, and records relating to use and disclosure of PHI received from or created or received by the other parties on behalf of the other parties, available to the Secretary of the U.S. Department of Health and Human Services for the purposes of determining compliance with 45 CFR Parts 160 and 164, subparts A and E;

9.) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that they create, receive, maintain, or transmit on behalf of the other parties as required by the HIPAA Security Rule, 45 C.F.R. Parts 160, 162, and 164;

10.) Ensure that any agent, including a subcontractor, to whom they provide electronic PHI agrees to implement reasonable and appropriate safeguards to protect it;

11.) Report to the other parties any security incident of which they become aware; and

12.) At termination of the regional program, if feasible, return or destroy all PHI received from or created or received by the parties on behalf of the other parties that the parties still maintain in any form and retain no copies of such information or, if such return or destruction is not feasible, extend the protections in this appendix to the information and

limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

d. Each of the parties may use and disclose PHI received from the other parties, if necessary, to carry out its legal responsibilities and for the proper management and administration of its business. Each of the parties may disclose PHI for such purposes if the disclosure is required by law, or if the party obtains reasonable assurances from the person to whom the PHI is disclosed that it will be held confidentially, that it will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and that the person will notify the party of any instances of which it is aware in which the confidentiality of the information has been breached.

7. **Reporting:** The CSB shall provide all required information (e.g., the number of individuals receiving services, the total expenditures for the regional program, and the total amount of regional program restricted funds expended) to the Department about the regional programs in which it participates, principally through CCS and CARS reports. CSBs shall not be required to submit more frequent standard reports or reports on individuals, unless such requirements have been established in accordance with the applicable sections of the performance contract. The CSB also shall identify all individuals in regional programs that it serves in its CCS extract submissions using the applicable consumer designation codes.

8. **Project Management**

a. The Department shall be responsible for the allocation of regional program state and federal funds and the overall management of the regional program at the state level.

b. The RMG shall be responsible for overall management of the regional program and coordination of the use of funding provided for the regional program in accordance with these procedures.

c. The CSB shall be responsible for managing regional program funds it receives in accordance with these regional program procedures.

d. Payments generated from third party and other sources for any regional program shall be used by the region or CSB to offset the costs of the regional program. The CSB shall collect and utilize all available funds from other appropriate specific sources before using state and federal funds to ensure the most effective use of these state and federal funds. These other sources include Medicare; Medicaid-fee-for service, targeted case management payments, rehabilitation payments, and ID waiver payments; other third party payors; auxiliary grants; SSI, SSDI, and direct payments by individuals; payments or contributions of other resources from other agencies, such as social services or health departments; and other state, local, or Department funding sources.

e. The Department may conduct on-going utilization review and analyze utilization and financial information and events related to individuals served, such as re-hospitalization, to ensure the continued appropriateness of services and to monitor the outcomes of the regional program. The utilization review process may result in adjustment to or reallocation of state general and federal funding allocations for the regional program.

9. **Compensation and Payment:** The Department shall disburse semi-monthly payments of state general and federal funds to the CSB for the regional program as part of its regular semi-monthly disbursements to the CSB.

Appendix G: Core Services Taxonomy Work Group Commentary

The following comments reflect the deliberations and decisions of the Core Services Taxonomy Work Group and the VACSB Data Management Committee. These comments are included for information or historical background purposes.

Peer-provided services are included and reported where they are delivered, for example, in outpatient, rehabilitation, or residential services, rather than in consumer-run services. Peer-provided services are provided by individuals who identify themselves as having mental health, substance use, or co-occurring disorders and are receiving or have received mental health, substance abuse, or co-occurring services. The primary purpose of peer-provided services is to help others with mental health, substance use, or co-occurring disorders. Peer-provided services involve partnering with non-peers, such as being hired by community mental health or substance abuse programs in designated peer positions or traditional clinical positions. Peers may serve as recovery coaches, peer counselors, case managers, outreach workers, crisis workers, and residential staff, among other possibilities. Units of service provided by peers in core services should be included with all service units collected and reported through the CCS. CSBs will report the numbers of peers they employ in each program area to provide core in their CARS management reports.

Family Support was a separate core services subcategory in Taxonomy 6; however, it was eliminated as a separate subcategory in Taxonomy 7. Family support offers assistance for families who choose to provide care at home for family members with mental disabilities. Family support is a combination of financial assistance, services, and technical supports that allows families to have control over their lives and the lives of their family members. Family is defined as the natural, adoptive, or foster care family with whom the person with a mental disability resides. Family can also mean an adult relative (i.e., sister, brother, son, daughter, aunt, uncle, cousin, or grandparent) or interested person who has been appointed full or limited guardian and with whom the person with the mental disability resides. The family defines the support. While it will be different for each family, the support should be flexible and individualized to meet the unique needs of the family and the individual with the mental disability. Family support services include respite care, adaptive equipment, personal care supplies and equipment, behavior management, minor home adaptation or modification, day care, and other extraordinary needs. Funds and expenses for family support activities should be included in the applicable core service subcategories, but numbers of individuals would not be included separately, since those individuals are already receiving the service in the category or subcategory. If an individual is receiving nothing but family support, he or she should be opened to consumer monitoring and the family member with a mental disability would be counted and reported as an individual receiving services in consumer monitoring.

Consultations include professional and clinical consultations with family assessment and planning teams (CSA), other human services agencies, and private providers. No ISPs are developed, and Department licensing is not required. In consultations, CSB staff members are not providing services or care coordination to individuals; the staff are only consulting with service providers and other agencies about individuals who are receiving services from other organizations. Since there are no individuals receiving services counted for consultations, service units will be collected through the z-consumer function in the CCS. Traditionally, consultations have been and will continue to be included in outpatient or case management services. However, if a CSB is providing other services, this is not a consultation situation; the CSB opens a case for the individual or admits the individual to a program area, depending on the other services received. For example, if a CSB is providing significant amounts of staff support associated with FAPT or Title IV-E activities, it may include this support as part of consumer monitoring services.

Appendix H: REACH Services Crosswalk and Reporting Requirements

This exhibit provides guidance to the CSBs providing Regional Education Assessment Crisis Services and Habilitation (REACH) program services about how to report those services in their monthly CCS 3 submissions to the Department. REACH program services must be reported only in emergency services, ancillary services and the developmental services program area; they must not be reported in the mental health services or substance abuse services program areas. There are only seven services that CSBs providing REACH program services directly or contractually must include in their information systems in a way that information about them can be extracted and exported to the Department through CCS 3. These services are:

1. **100 Emergency Services,** licensed by the Department as crisis intervention services;
2. **390 Consumer Monitoring Services** (ancillary services), not licensed by the Department;
3. **720 Assessment and Evaluation Services** (ancillary services), not licensed by the Department;
4. **420 Ambulatory Crisis Stabilization Services** (in the developmental services program area), licensed by the Department as mental health non-residential crisis stabilization;
5. **510 Residential Crisis Stabilization Services** (in the developmental services program area), licensed by the Department as mental health residential crisis stabilization services for adults;
6. **521 Intensive Residential Services** (in the developmental services program area),licensed by the Department as intellectual disability residential therapeutic respite group home services for adults - includes ID assessment/treatment beds; and
7. **581 Supportive Residential Services** (in the developmental services program area), licensed by the Department as REACH intellectual disability supportive in-home services for adults.

These are the only services provided to individuals who have been determined to be served in the REACH program that should be included in CCS 3 submissions to the Department. When they provide them, CSBs that operate or contract for REACH program services must include the following information about these seven services in their CCS 3 submissions.

Consumer File: Include all applicable CCS 3 consumer data elements on an individual receiving REACH program services if the individual has not already been admitted to the developmental services program area (for services 4 through 7 above) or if the CSB has not opened a case on the individual for emergency services or ancillary services (for services 1 through 3 above).

Type of Care File: Include a type of care file on the individual if he or she receives services 4 through 7 above and has not already been admitted to the developmental services program area.

Service Files: Include service files to report receipt of:

1. Emergency services (pseudo program area code 400 and service code 100) if the individual receives crisis intervention services,
2. Consumer monitoring (pseudo program area code 400 and service code 390) if the individual receives consumer monitoring services,
3. Assessment and evaluation (pseudo program area code 400 and service code 720) if the individual receives assessment and evaluation services,
4. Ambulatory crisis stabilization (developmental services program area code 200 and service code 420) if the individual receives mental health non-residential crisis stabilization,

5. Residential crisis stabilization (developmental services program area code 200 and service code 510) if the individual receives mental health residential crisis stabilization services for adults,
6. Intensive residential services (developmental services program area code 200 and service code 521) if the individual receives intellectual disability residential therapeutic respite group home services for adults, or
7. Supportive residential services (developmental services program area code 200 and service code 581) if the individual receives REACH intellectual disability supportive in-home services for adults.

When they provide these services, CSBs that operate or contract for REACH program services also must include funding, expenditure, cost, and static capacity information about these seven services in their quarterly CARS Reports submitted to the Department.

FY22-23 Minimum Ten Percent Local Matching Funds Waiver Request Attachment

A CSB should maintain its local matching funds at least at the same level as that shown in its FY 2021 performance contract. Item 322 A. of the 2021 Appropriation Act prohibits using state funds to supplant local governmental funding for existing services. If a CSB is not able to include at least the minimum 10 percent local matching funds required by § 37.2-509 of the Code of Virginia and State Board Policy 4010 in its performance contract or its end of the fiscal year performance contract report, it must submit a written request for a waiver of that requirement, pursuant to that Code section and policy, to the Office of Management Services through the performancecontractsupport@dbhds.virginia.gov mailbox with the contract or report.

If only a CSB's receipt of state funds as the fiscal agent for a regional program, including regional DAP, regional REACH, acute inpatient (LIPOS), or state facility reinvestment project funds, causes it to be out of compliance with the 10 percent local matching funds requirement in § 37.2-509, the Department may grant an automatic waiver of that requirement related to the funds for a regional program allocated to the other participating CSBs.

The request for an automatic waiver must include a complete explanation of the funds allocated to other CSBs and a recalculation of the local match percentage resulting from allocation out of those state funds. The amount of state funds the CSB uses for its own participation in the regional program is not eligible for this automatic waiver.

The CSB must submit a written request for the automatic waiver, identifying the specific amounts and types of those funds that cause it to be out of compliance with the local matching funds requirement, but without the documentation required below in items 3, 4, and 5, and the Department will approve an automatic waiver in a letter to the CSB.

The Department will not approve a waiver for those CSBs who must submit a fully justified waiver request id items 3, 4, and 5 below are not fully documented and explained in detail with significant examples.

1. State Board Policy 4010 defines acceptable local matching funds as local government appropriations, philanthropic cash contributions from organizations and people, in-kind contributions of space, equipment, or professional services for which the CSB would otherwise have to pay, and, in certain circumstances, interest revenue. All other funds, including fees, federal grants, other funds, and uncompensated volunteer services, are not acceptable.
2. Section 37.2-509 of the Code of Virginia states that allocations of state funds to any CSB for operating expenses, including salaries and other costs, shall not exceed 90 percent of the total amount of state and local matching funds provided for these expenses. This section effectively defines the 10 percent minimum amount of local matching funds as 10 percent of the total amount of state and local matching funds.
3. The written waiver request must include an explanation of each local government's inability to provide sufficient local matching funds at this time. This written explanation could include, among other circumstances, the following factors:
    a. an unusually high unemployment rate compared with the statewide or regional average unemployment rate,
    b. a decreasing tax base or declining tax revenues,
    c. the existence of local government budget deficits, or
    d. major unanticipated local government capital or operating expenditures (e.g., for flood damage).
4. Additionally, the waiver request must include information and documentation about the CSB's efforts to obtain sufficient local matching funds. Examples of such efforts could include newspaper articles, letters from CSB members to local governing bodies outlining statutory matching funds requirements, and CSB resolutions.
5. Finally, the waiver request must include a copy of the CSB's budget request that was submitted to each local government and a copy or description of the local government's response to it.

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

   Individual staff at DBHDS have shared that consultations occurred with Virginia tribes more than ten years ago. However, information on this session is very vague and occurred before tribes were federally recognized. The current administration recognizes the urgent and vital need to engage these communities and is seeking technical assistance to develop a plan for this.

2. What specific concerns were raised during the consultation session(s) noted above?

   Not known due to lack of historical information

3. Does the state have any activities related to this section that you would like to highlight?

   N/A

   Please indicate areas of technical assistance needed related to this section.

   DBHDS is seeking technical assistance and will complete a request through the appropriate channels. Current TA needs are: best practices, health disparities, research on other state behavioral health agencies' work with tribes, and help in developing a plan to initially engage these communities.

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Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- **a)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] Intervening variables (including risk and protective factors)
- **d)** [ ] Other (please list)

  Social determinants of health (SDOH) data that can help to better understand behavioral health disparities and adverse childhood experiences

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- **a)** [ ] Children (under age 12)
- **b)** [x] Youth (ages 12-17)
- **c)** [x] Young adults/college age (ages 18-26)
- **d)** [x] Adults (ages 27-54)
- **e)** [x] Older adults (age 55 and above)
- **f)** [x] Cultural/ethnic minorities
- **g)** [x] Sexual/gender minorities
- **h)** [x] Rural communities
- **i)** [ ] Others (please list)

Service Members, Veterans, and their Families

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

a) ☑ Archival indicators (Please list)

- Virginia Department of Behavioral Health and Developmental Services (DBHDS)- Treatment Admissions
- Virginia Department of Behavioral Health and Developmental Services (DBHDS)- Mental Health Services Provided
- Virginia Department of Juvenile Justice- Intake Cases, Probation Cases, and Direct Care Cases
- Virginia Department of Forensic Science- Drug Seizures
- Virginia Office of the Chief Medical Examiner- Accidental and Undetermined Fatal Drug Overdoses
- Virginia Office of the Chief Medical Examiner- Suicides
- Virginia Department of Social Services- Poverty Estimates
- Virginia Department of Social Services- Unemployment Estimates
- Virginia Department of Criminal Justice Services- Uniform Crime Reports: Drug-Related Arrests
- Virginia Department of Health- Virginia Youth Survey: Middle & High School
- U.S. Census Bureau- Population Estimates

- Virginia Adverse Childhood Experiences

b) ☑ National survey on Drug Use and Health (NSDUH)

c) ☑ Behavioral Risk Factor Surveillance System (BRFSS)

d) ☑ Youth Risk Behavioral Surveillance System (YRBS)

e) ☑ Monitoring the Future

f) ☐ Communities that Care

g) ☑ State - developed survey instrument

h) ☐ Others (please list)

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ○ Yes ◉ No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

b) If no, (please explain) how SUPTRS BG funds are allocated:

Historically, DBHDS has used a population formula for the allocation of SABG resources, however, in recent years due to a need to assess for needs and health disparities, Virginia has taken a more collaborative cross-program approach to allocation while also integrating a more thorough sub-recipient monitoring program that assesses sub-recipient risk. Additionally, Virginia is integrating WebGrants which will allow better data and access to grant information across all offices to better inform decisions and provide publicly available data for increased transparency.

6. Does your state integrate the National CLAS standards into the assessment step? ◉ Yes ○ No

a) If yes, please explain in the box below.

We have a Language Access Coordinator, Behavioral Health Equity Consultant and Refugee Mental Health Coordinator on staff that can provide training and technical assistance to CSBs. Some of the most helpful services these personnel provide are support in translating relevant documents and materials, connections to community organizations supporting specific cultural groups and providing funding opportunities to reach out to marginalized populations.

b) If no, please explain in the box below.

7. Does your state integrate sustainability into the assessment step? ◉ Yes ○ No

a) If yes, please explain in the box below.

We work to develop a partnership structure that will continue to function into the future.

b) If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Planning

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe.

The Virginia Certification Board (VCB) is a member of IC&RC, the credentialing of prevention, addiction treatment, and recovery professionals. Organized in 1981, it provides standards and examinations to certification and licensing boards in 24 countries, 47 states and territories, five Native American regions, and all branches of the U.S. military.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe mechanism used.

Virginia has a full-time position dedicated to workforce development. Additionally, OMNI Institute, the state's needs assessment and evaluation contractor, provides training and TA to our state team and local CSBs. Additionally, the state has trained over 750 Mental health First Aid trainers and 60 ASIST and/or safeTALK trainers with state general fund dollars. We have also trained 450 Master trainers in Adverse Childhood Experiences.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

a) If yes, please describe mechanism used.

A community readiness and coalition readiness assessment is a part of the the provider needs assessment process and completed bi-annually.

4. Does your state integrate the National CLAS Standards into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

We have a Language Access Coordinator, Behavioral Health Equity Consultant and Refugee Mental Health Coordinator on staff that can provide training and technical assistance to CSBs. Some of the most helpful services these personnel provide are support in translating relevant documents and materials, connections to community organizations supporting specific cultural groups and providing funding opportunities to reach out to marginalized populations.

5. Does your state integrate sustainability into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

Worked to ensure that prevention staff positions are folded into other organizations. Leverage redirected, or realigned

other funding sources or in-kind resources.

b) If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

Please see attachment - 2018 Virginia Statewide Needs Assessement

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG? (●) Yes ( ) No ( ) N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** [x] Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** [ ] Timelines
- **c)** [x] Roles and responsibilities
- **d)** [x] Process indicators
- **e)** [x] Outcome indicators
- **f)** [x] Cultural competence component (i.e., National CLAS Standards)
- **g)** [x] Sustainability component
- **h)** [ ] Other (please list):
- **i)** [ ] Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? ( ) Yes (●) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? (●) Yes ( ) No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

The EBWG has been active and visible on both the SABG and the PFS SPF and STR/SOR in order to give them a viable role in all prevention work across programs to maintain consistency in approach as we addressed prescription drugs and

opioids. Once OMNI Institute increased their capacity, the OBHW was able to utilize their resources to gather and determine the level of effectiveness of programs, practices and strategies. This came at a good time as the EBWG members in the time of COVID and other competing interests became more difficult to engage.

6. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

7. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? (●) Yes ( ) No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

The EBWG has been active and visible on both the SABG and the PFS SPF and STR/SOR in order to give them a viable role in all prevention work across programs to maintain consistency in approach as we addressed prescription drugs and opioids. Once OMNI Institute increased their capacity, the OBHW was able to utilize their resources to gather and determine the level of effectiveness of programs, practices and strategies. This came at a good time as the EBWG members in the time of COVID and other competing interests became more difficult to engage.

8. Does your state integrate the National CLAS Standards into the planning step? (●) Yes ( ) No

a) If yes, please explain in the box below.

We have a Language Access Coordinator, Behavioral Health Equity Consultant and Refugee Mental Health Coordinator on staff that can provide training and technical assistance to CSBs. Some of the most helpful services these personnel provide are support in translating relevant documents and materials, connections to community organizations supporting specific cultural groups and providing funding opportunities to reach out to marginalized populations.

b) If no, please explain in the box below.

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9. Does your state integrate sustainability into the planning step? (●) Yes ( ) No

a) If yes, please explain in the box below.

Worked to ensure prevention intervention activities are incorporated into the missions/goals and activities of other organizations.

b) If no, please explain in the box below.

.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
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6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☐ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☐ The SSA funds regional entities to provide prevention services.
- **f)** ☑ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☐ The SSA funds community coalitions to provide prevention services.
- **h)** ☐ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☐ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Media Campaign
Community Events
Social Media/Website
Resource Guides
Community Presentations/Townhalls
Brochures/Rack Cards
Permanent Drug Dropboxes
Lock and Talk - Community Presentations

b) Education:

Al's Pals: Kids Making Healthy Choices
Too Good for Drugs

24/7 Dads
Second Step
Systematic Training for Effective Parenting (STEP)
Mentor Programs
Healthy Alternatives for Little Ones
Life Skills Training (Botvin)
Understanding Dad
Strengthening Families
Active Parenting
Youth Leadership Programs
Teen Intervene
Ripple Effects Whole Spectrum Intervention

c) Alternatives:

Youth leadership programs

d) Problem Identification and Referral:

Parent coaching & referrals (indiv supportive counseling for parents) Project SUCCESS Reconnection Referrals Self Sufficiency Project Student Assistance Program (SAP) Student coaching & referrals

e) Community-Based Processes:

Multi-Agency Collaboration / Coalition
REVIVE Trainings (In person)
ACEs Training
Mental Health First Aid- Adult
REVIVE Training (Virtual)
Naloxone Trainings
Mental Health First Aid- Youth
QPR Gatekeeper Training for Suicide Prevention
Safe TALK
Applied Suicide Intervention Skills Training (ASIST)
SOS Signs of Suicide
Crisis Intervention Team (CIT)
Talk Saves Lives
Technical Assistance to Community Groups

f) Environmental:

Counter Tools
Supply Reduction - Item Distribution
Lock and Talk - Item Distribution
Lock and Talk - Social Marketing
Social Marketing Campaign
Naloxone Distribution for Virtual REVIVE
Drug Deactivation Packets
Lock and Talk - Merchant Education/Gun Shop Project
Permanent Drug Dropboxes
Merchant Education (Alcohol)
Prescription Bag Stickers
Drug Take Backs
Project Sticker Shock
Prescription Drug Lock Boxes
Smart Pill Bottles
Prescriber, Pharmacy, Emergency Department, and Patient Education
Merchant Education (Problem Gambling)
Lock and Talk - Lock Boxes
Proper Disposal with Targeted Groups
Compliance Checks
Lock and Talk - Cable Locks
Naloxone Distribution

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

a) If yes, please describe.

Annual monitoring visits are done by the Behavioral health Wellness Consultants responsible for monitoring the SUPTRS Prevention set aside. Additionally, all logic models and budgets must be approved before providers can enter data into the data system. Our evaluation team also reviews all data entered into the system to ensure it is appropriate and aligns

with the SABG requirements.

4. Does your state integrate National CLAS Standards into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

We have a Language Access Coordinator, Behavioral Health Equity Consultant and Refugee Mental Health Coordinator on staff that can provide training and technical assistance to CSBs. Some of the most helpful services these personnel provide are support in translating relevant documents and materials, connections to community organizations supporting specific cultural groups and providing funding opportunities to reach out to marginalized populations.

b) If no, please explain in the box below.

5. Does your state integrate sustainability into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

Worked to implement local level laws, policies, or regulations to guarantee continuation of strategies. Worked to gain formal adoption of prevention intervention activities into other organizations' practices.

b) If no, please explain in the box below

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

See attachment - BG Annual Report 2021 - 22 PAGE 8

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☑ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** ☑ Includes evaluation information from sub-recipients
- **c)** ☐ Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** ☑ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☑ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please list:)
- **g)** ☐ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** ☑ Numbers served
- **b)** ☑ Implementation fidelity
- **c)** ☐ Participant satisfaction
- **d)** ☑ Number of evidence based programs/practices/policies implemented
- **e)** ☑ Attendance
- **f)** ☑ Demographic information
- **g)** ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy use

- **c)** ☑ Binge use
- **d)** ☑ Perception of harm
- **e)** ☑ Disapproval of use
- **f)** ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- **g)** ☐ Other (please describe):

5. Does your state integrate the National CLAS Standards into the evaluation step? ◉ Yes ○ No

a) If yes, please explain in the box below.

We have a Language Access Coordinator, Behavioral Health Equity Consultant and Refugee Mental Health Coordinator on staff that can provide training and technical assistance to CSBs. Some of the most helpful services these personnel provide are support in translating relevant documents and materials, connections to community organizations supporting specific cultural groups and providing funding opportunities to reach out to marginalized populations.

b) If no, please explain in the box below.

6. Does your state integrate sustainability into the evaluation step? ◉ Yes ○ No

a) If yes, please describe in the box below.

Developed plans to sustain progress as part of evaluation

b) If no, please explain in the box below.

Footnotes:

Virginia Substance Abuse Prevention Block Grant Annual Report

2021-22

OMNI

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Virginia Substance Abuse Prevention Block Grant Annual Report

2021-22

Submitted to:

Nicole Gore, Director, Office of Behavioral Health Wellness
Virginia Department of Behavioral Health and Developmental Services
December 2022

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Table of Contents

Virginia Substance Abuse Prevention Block Grant

Annual Report 2021-22: Executive Summary

The Substance Abuse Block Grant (SABG) is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). Virginia's Department of Behavioral Health and Developmental Services (DBHDS) Office of Behavioral Health Wellness (OBHW) distributes grant funds to 40 Community Services Boards (CSBs) across the commonwealth to plan, implement, and evaluate prevention activities aimed at preventing and/or decreasing substance use.

This report, prepared by OMNI Institute (OMNI), provides an overview of block grant prevention activities during the 2021-22 fiscal year. OBHW has contracted with OMNI since 2014 to evaluate Virginia's block grant activities and provide training and technical assistance (TA) to build evaluation capacity among Virginia's prevention workforce. OMNI is a nonprofit, social science consultancy that provides integrated research and evaluation, capacity building, and data utilization to accelerate positive social change.

Strategic Planning and Prevention Priorities

Since 2014, OMNI and OBHW have partnered to implement the Strategic Prevention Framework within block grant activities to provide program structure, build capacity for data-driven prevention, and promote sustainability. In 2017 and 2018, OMNI conducted a statewide needs assessment to identify prevention needs and determine program direction. From this effort, the following priority areas were identified:

Block Grant Prevention Priority Areas

Alcohol	Alcohol is the most used substance in Virginia with 25% of high school youth and 56% of adults consuming alcohol in the past 30 days.
Tobacco and Nicotine	23% of high school youth used tobacco or electronic vapor products in the past 30 days. 21% of adults used tobacco products in the past 30 days.
Mental Health and Suicide	1,202 suicides were recorded in Virginia in 2020, a rate of 14 per 100,000 persons. 16% of Virginia high school youth have considered suicide.

Data on high school youth from the 2019 Virginia Youth Survey. Data on adult substance use from the 2019-2020 National Survey on Drug Use and Health. Data on suicide rates from the Center for Disease Control, 2020.

2022 Needs Assessment Process

New legislative changes in Virginia have thrust emerging focus areas into the spotlight – Gaming and Gambling, and Marijuana. Considering these developments, CSBs began conducting local needs assessments in the fall of 2021 to understand the scope of these issues and the readiness of their local communities to address them. Each CSB was tasked with completing several components as part of the needs assessment process: an environmental scan on gaming and gambling; community readiness assessments for gaming and gambling, and for cannabis; and the implementation of the Virginia Young Adult Survey.

Environmental Scan	Measure the physical landscape around gaming and gambling
Community Readiness Assessment	Determine each community's level of knowledge, leadership and attitudes around gaming and gambling, and cannabis
Young Adult Survey	Comprehensive survey of 18–25-year-olds on a variety of subjects including substance use, mental health, and gambling.

Prevention Capacity

OMNI provides capacity building services to CSBs in addition to support around assessment, planning, implementation, and evaluation of prevention efforts. **In end of year reporting, CSBs indicated that they have ample capacity to implement their block grant prevention interventions.** CSBs agreed that they have experience collaborating with other organizations on relevant prevention interventions (40), experience with relevant prevention interventions (39), and capability to use data in prevention planning (38). However, over half of all CSBs (24) disagreed or strongly disagreed that they have enough staff and only 16 CSBs reported that they have enough fiscal/financial resources.

Additionally, CSBs indicated a greater focus on specific populations experiencing health disparities than the previous fiscal year. Of note, more CSBs this year than last year increased access to (28 vs. 23) and availability of (27 vs. 22) substance use prevention services for subpopulations experiencing disparities than the prior year.

Loudon County Prevention Staff at 2022 Pride Fest

Block Grant Priority Strategies

To impact Virginia's three prevention priority areas and reach desired outcomes, the OBHW team explored data from the 2017-18 needs assessment and selected key risk and protective factors underlying the priority areas that could be targeted through new or existing prevention strategies. Based on these discussions, OBHW selected five priority strategies and began requiring their implementation in 2020. Data from the priority strategies in this fiscal year are highlighted below.

Community Mobilization and Coalition Capacity Building

Coalitions mobilize communities and are key in supporting prevention efforts and disseminating prevention messages. This fiscal year, CSBs partnered with and created local coalitions to plan and implement prevention activities, collect data, engage in community outreach efforts, and nurture partnerships with community stakeholders to spread prevention messaging.

38 CSBs led or facilitated coalitions

71 active coalitions

1,859 Coalition members

Lock and Talk Suicide Prevention and Awareness

CSBs implemented Lock and Talk efforts focused on suicide prevention through restricting access to lethal means, community and merchant education, and media messaging. Lock and Talk messaging acknowledges that suicide and overdose prevention are incomplete without knowledge of safe storage of lethal means and access to locking devices.

CSBs worked to expand Lock and Talk efforts to reach more diverse populations, including veterans, non-English speakers, and the LGBTQ+ community. Through community partnerships and coalitions, several CSBs expanded their reach to include populations that are often overlooked.

"Lock and Talk has been the one initiative that has been "pandemic resistant!""- Hanover CSB

40 CSBs implemented Lock & Talk

35,883 Total devices distributed

1.8M Total impressions/ reach

1,744,847 reached via social marketing

17,732 received lock boxes

11,371 received cable locks

7,545 reached through presentations

6,780 received trigger locks

101 gun retailers visited

Block Grant Priority Strategies

Mental Health Promotion and Suicide Prevention Trainings

Thirty-eight of 40 CSBs implemented mental health and suicide prevention trainings to over 16,000 people in their communities, more than doubling their reach from the prior year. This fiscal year, all CSBs were expected to implement Mental Health First Aid (MHFA) trainings. CSBs were also required to offer one of three suicide prevention trainings: Applied Suicide Intervention Skills Training (ASIST), Safe Talk, or Question. Persuade. Refer. (QPR).

38 CSBs conducted trainings

642 trainings

16,516 people trained

30 CSBs implemented campaigns

6.8M impressions/ reach

Thirty CSBs implemented specific mental health promotion and suicide awareness activities through media campaigns, community events, and presentations, reaching millions of people.

Walk for a New Day! Gloucester County - MPNN CSB

Adverse Childhood Experiences (ACEs) Trainings

CSBs provided ACE Interface trainings to bring awareness of the impact of ACEs on health and behavior. The ACE Interface curriculum teaches participants about the biological, health, and social impacts of ACEs as well as strategies to support the health and well-being of community members.

36 CSBs conducted trainings

341 Trainings/ presentations

9,348 people trained

After ACEs trainings, participants indicated high levels of learning and a desire to expand their knowledge and increase participation in ACEs efforts in their communities.

78% agreed or strongly agreed that they want to seek more information and guidance regarding trauma-informed practice.

79% indicated they *learned a lot* about identifying and addressing ACEs and ACEs' impact on brains and behavior.

77% agreed or strongly agreed that they want to learn more about the causes and effects of ACEs.

73% indicated they *learned a lot* about why their community needs to get organized and mobilized to identify and address ACEs.

Counter Tools Youth Retail Tobacco Prevention and Merchant Education

Though previously hindered by COVID-19 restrictions, CSBs returned to their in-person merchant education visit schedules and goals. Seventy percent of CSBs reported having met the Counter Tools goal of 100% visitation to participating merchants. The long-term relationships that have been formed between CSBs and retailers facilitated Counter Tools and merchant education strategies being perceived by retailers as informative and helpful in keeping up with the trends, and as opportunities to prevent underage tobacco, alcohol, and now vaping and marijuana use.

36 CSBs provided education

4784 merchants visited

Virginia Young Adult Survey Data

The 2022 Virginia Young Adult Survey (YAS) collected responses from 5,339 young adults across the commonwealth with all but two localities represented. Responses come from a convenience sample so the participants may not be representative of the full young adult population in the state. Sub-group analyses were conducted to better understand the needs of various populations. Findings relevant to Virginia's priorities and emerging areas are outlined below. Additional YAS data will be added to the Virginia Social Indicator Study Dashboard (VASIS) in 2023.

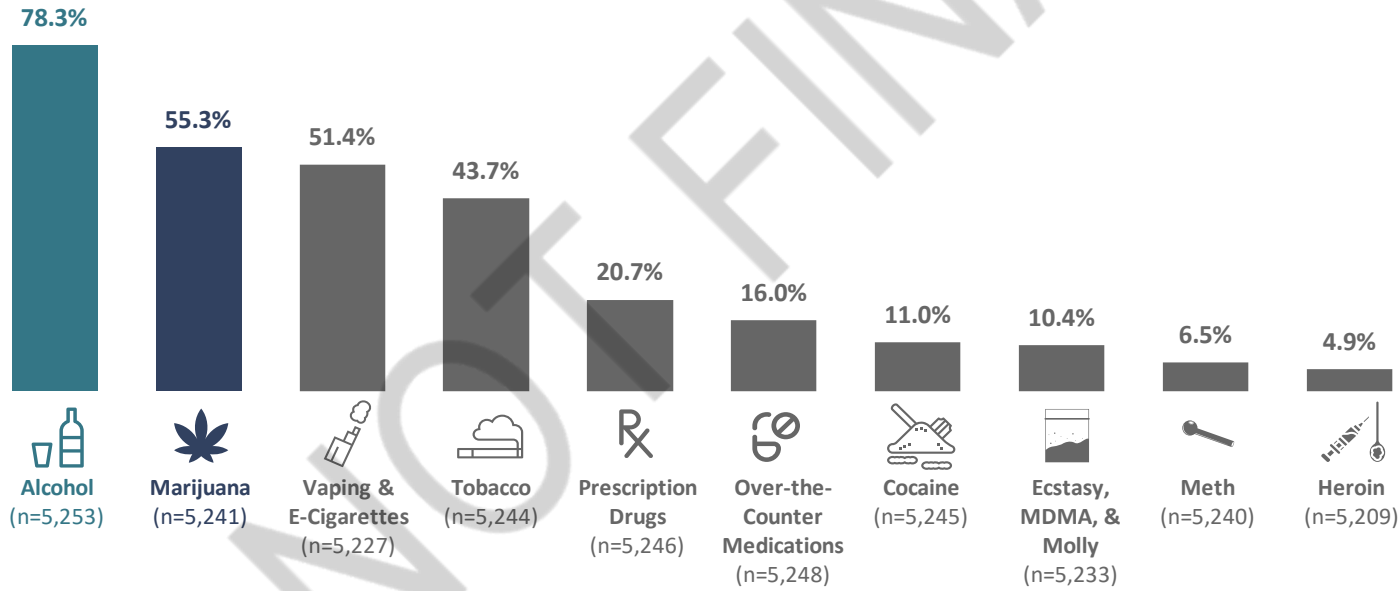
Substance Use Rates

Data related to substance use among young adults in Virginia are discussed below. These data will provide a general picture of the current state of substance use across the priority and emerging areas, as well as explore differences among sub-populations.

Lifetime Use

Young adults reported high rates of lifetime alcohol use(78.3%), confirming the need for prevention efforts still exists. Over half (55.3%) of young adults reported using marijuana at least once. The popularity of vaping and e-cigarettes in recent years, especially among youth and young adults, is clearly represented in this data. More young adults have reported using e-cigarettes or vaping devices (51.4%), which contain nicotine, than reported using tobacco (43.7%).

More than three quarters of Virginia young adults surveyed had used alcohol at least once in their lifetime, while more than half have used marijuana.



LGBQ+ young adults showed higher lifetime rates of use across all substances when compared to their peers.

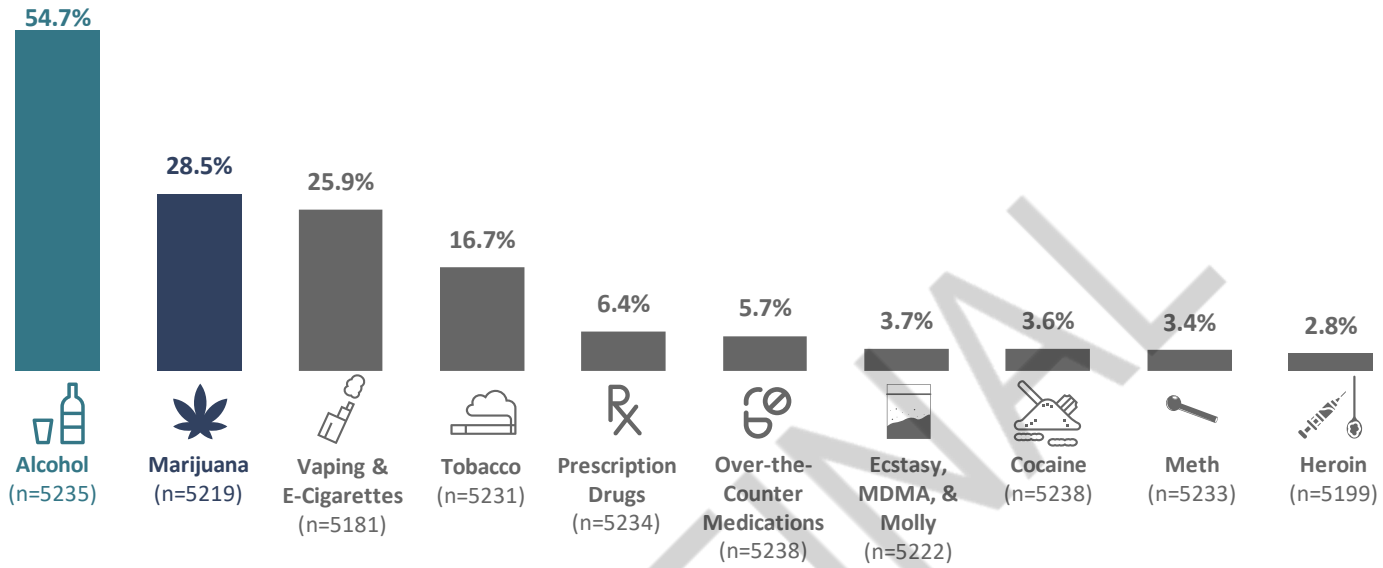
	BIPOC	LGBQ+	Trans and Gender Diverse
Alcohol		X	X
Marijuana	X	X	X
Vaping		X	X
Tobacco		X	
Prescription Drugs	X	X	X
Over-the-Counter Medications	X	X	X
Cocaine	X	X	
Ecstacy, MDMA, or Molly	X	X	X
Methamphetamine	X	X	
Heroin	X	X	

X = Higher Rate of Lifetime Use Compared to Peers

Past 30-Day Substance Use

Participants were also asked about their substance use in the last 30-days, or past month. More than half of young adults surveyed had used alcohol in the past 30-days (54.7%), and more than a quarter had used marijuana (28.5%). 30-day alcohol use rates in the YAS were lower than the 58.33% reported by NSDUH in 2018-2019, whereas 30-day marijuana use rates were higher than the 20.26% reported by NSDUH. These results suggest that prevention efforts focused on alcohol may be contributing toward lower use, while there may be a greater need for prevention efforts focused on marijuana.

Over half of young adults surveyed have used alcohol within the last 30 days and over a quarter have used marijuana.



Age at First Use

Substances that seem to have the highest early initiation rates, meaning age of first use was 11 or younger, include over-the-counter medications (8.9%), methamphetamine (7.6%) and heroin (5.9%). This means that of those who reported over-the-counter medication use, about one in ten began when they were 11 years old or younger. Interestingly, vaping had the lowest early initiation rate with 1.4%.

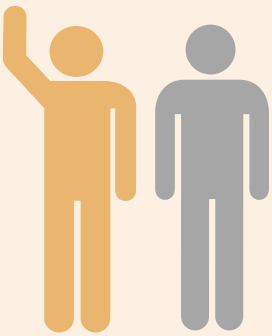
Alcohol and marijuana use is more likely to begin between ages 15-17, while tobacco use is more likely to start between 18-20 years of age. Across all substances, initiation of use is most likely between the ages of 15 and 20.

	11 or younger	12 to 14	15 to 17	18 to 20	21 to 25
Alcohol (n=4,114)	3.6%	14.3%	**40.2%**	31.6%	10.4%
Tobacco (n=2,290)	4.6%	15.9%	34.5%	**37.1%**	7.9%
Marijuana (n=2,896)	2.1%	13.8%	**39.0%**	34.0%	11.2%
Vaping (n=2,689)	1.4%	8.6%	**40.6%**	38.1%	11.3%
Over-the-Counter Medications (n=838)	8.9%	15.3%	**36.4%**	28.3%	11.1%
Prescription Drugs (n=1,087)	4.0%	12.3%	35.7%	**36.4%**	11.6%
Cocaine (n=579)	3.8%	6.9%	23.1%	**45.6%**	20.6%
Ecstasy, MDMA, or Molly (n=544)	2.8%	7.7%	25.9%	**41.9%**	21.7%
Heroin (n=256)	5.9%	11.3%	24.6%	**30.9%**	27.3%
Methamphetamine (n=342)	7.6%	8.8%	24.9%	**38.3%**	20.5%

Block Grant Prevention Outcomes

Mental Health and Suicide

13.3% of respondents reported having harmed themselves on purpose during the past 12 months, with LGBQ+ and trans and gender diverse respondents reporting far higher rates than their peers – 27.7% vs 8.1%, and 44.3% vs 11.5%, respectively. Respondents from these groups were also more likely to report having considered suicide during the past 12 months, as were BIPOC respondents. BIPOC respondents who considered suicide were significantly more likely to report having made a suicide attempt during the past 12 months than their peers.



1 in 2 respondents shared that they felt so sad or hopeless, almost every day for two weeks or more in a row over the last 12 months, that they stopped doing some usual activities. (n=5,024)

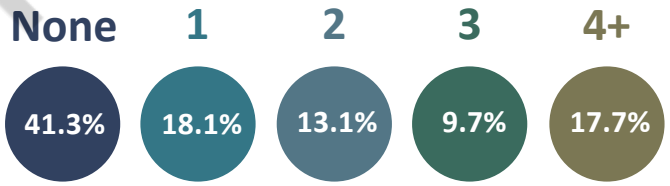
LGBQ+ and trans and gender diverse respondents were 2 or 3 times more likely to engage in self-harm and suicidal ideation behaviors compared to their peers.

Population		Engaged in self-harm?	Seriously considered suicide...?	...and made a plan for attempting Suicide?	...and attempted suicide?
Black, Indigenous, People of Color (BIPOC)	BIPOC	13.2%	17.7%	51.1%	30.8%
	Non-BIPOC	13.5%	16.9%	51.1%	17.6%
LGBQ+	LGBQ+	27.7%	31.0%	53.8%	24.5%
	Non-LGBQ+	8.1%	12.2%	12.2%	21.2%
Trans and Gender Diverse (TGD)	TGD	44.3%	43.5%	53.8%	21.2%
	Non-TGD	11.5%	15.7%	49.5%	23.0%

Adverse Childhood Experiences (ACEs)

YAS respondents were asked whether they had experienced a variety of ACEs. Less than half (41.3%) reported having experienced zero ACEs in childhood making the occurrence of ACEs in childhood more common than not. Experiencing four or more ACEs places an individual at extremely high risk of using substances. Almost one in five (17.7%) of young adults in Virginia reported having experienced four or more ACEs – the highest level of risk possible.

Over half (58.7%) of young adults reported having experienced at least one ACE before the age of 18.



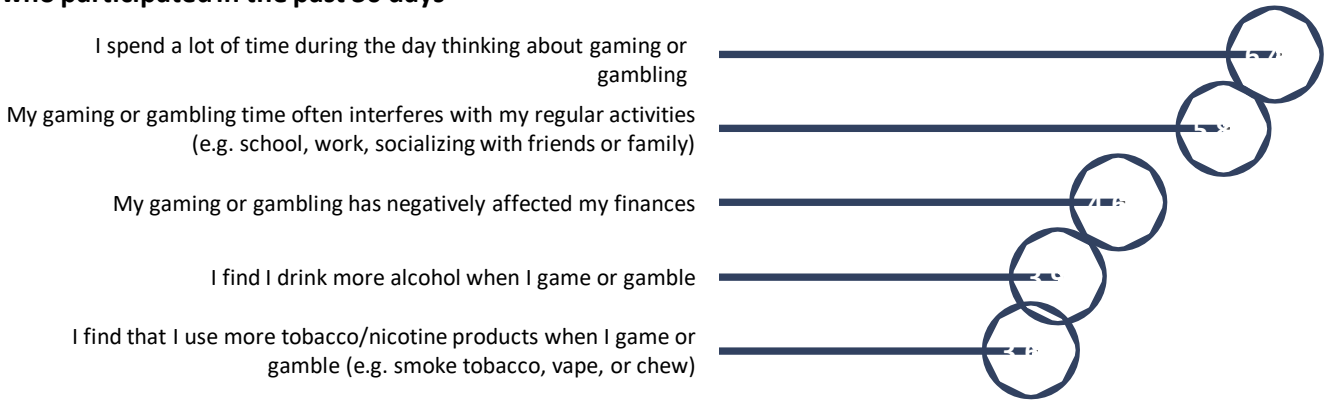
N=4,620

Gaming and Gambling

In recognition of the legalization of gambling in Virginia, measures were included to allow for a better understanding of engagement in gaming and gambling activities, as well as impact of gaming and gambling on behaviors.

63.6% of young adults in Virginia who responded to the survey had participated in at least one gaming or gambling activity in the past 30 days.

Preoccupation with gaming or gambling throughout the day was the most common negative impact for respondents who participated in the past 30 days



Introduction

The Substance Abuse Block Grant (SABG) is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). Virginia's Department of Behavioral Health and Developmental Services (DBHDS) Office of Behavioral Health Wellness (OBHW) distributes grant funds to 40 Community Services Boards (CSBs) across the commonwealth to plan, implement, and evaluate prevention activities aimed at preventing and/or decreasing substance use.

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Since 2014, OMNI and OBHW have partnered to implement the Strategic Prevention Framework[1] within block grant activities to provide program structure, build capacity for data-driven prevention, and promote sustainability. In 2017 and 2018, OMNI conducted a statewide needs assessment[2] to identify prevention needs and determine program direction. The assessment synthesized a broad array of national, state, and local secondary data sources to better understand the status and needs related to behavioral health in Virginia. The assessment also utilized primary data collection through facilitated discussions with the Statewide Epidemiological Outcomes Workgroup and OBHW staff. In addition, a SWOT (strengths, weaknesses, opportunities, and threats) analysis with local prevention staff to gather information and understand prevention priorities. From this effort, the following priority areas were identified:

Block Grant Prevention Priority Areas[3]

Alcohol	Alcohol is the most used substance in Virginia with 25% of high school youth and 56% of adults consuming alcohol in the past 30 days.
Tobacco and Nicotine	23% of high school youth used tobacco or electronic vapor products in the past 30 days. 21% of adults used tobacco products in the past 30 days.
Mental Health and Suicide	1,202 suicides were recorded in Virginia in 2020, a rate of 14 per 100,000 persons. 16% of Virginia high school youth have considered suicide.

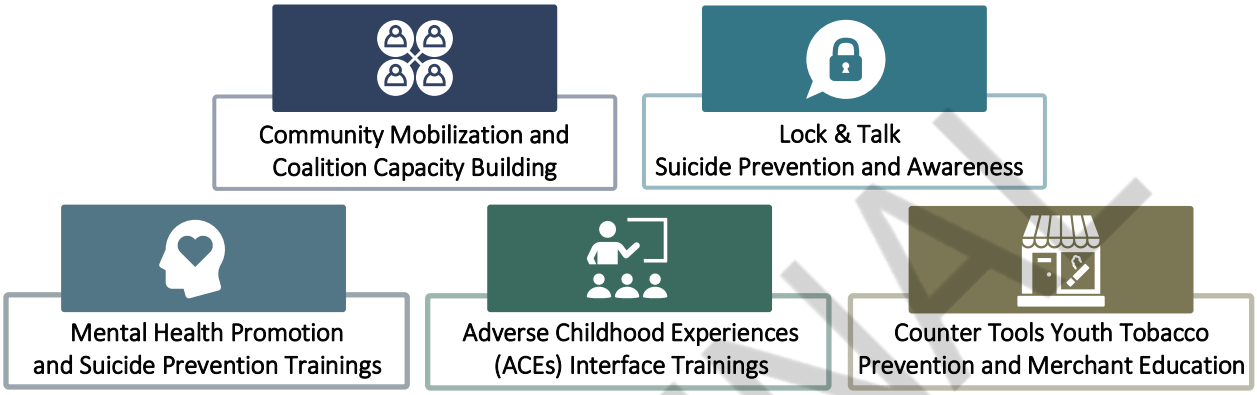
[1] Substance Abuse and Mental Health Services Administration (2019). A Guide to SAMHSA's Strategic Prevention Framework. Rockville, MD: Center for Substance Use Prevention. https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf

[2] OMNI Institute (2018). Virginia Statewide Substance Use and Behavioral Health Needs Assessment. https://vasisdashboard.omni.org/ExportFiles/VA%20Needs%20Assessment%20Report_August%202018_Final.pdf

[3] Data on high school youth from the 2019 Virginia Youth Survey. Data on adult substance use from the 2019-2020 National Survey on Drug Use and Health. Data on suicide rates from the Center for Disease Control, 2020.

To impact Virginia's three prevention priority areas and reach desired outcomes, the OBHW team explored data from the needs assessment and selected key risk and protective factors underlying the priority areas that could be targeted through new or existing prevention strategies. Based on these discussions, the OBHW team selected five priority prevention strategies to target alcohol use, tobacco use, and mental health and suicide prevention across the commonwealth. For more detailed information on the strategic planning process, please see the 2019 Strategic Planning Report produced by OMNI.[4]

Block Grant Prevention Priority Strategies



As a result of strategic planning, OMNI developed a statewide logic model for the 2020-2025 Block Grant funding period that details the shared relationships between the three priority areas, the risk and protective factors underlying these areas, the priority strategies selected to target those factors, and the desired short-term and long-term impacts of these strategies (See Appendix A). CSBs were required to implement all five priority prevention strategies, while also reserving some prevention funds to implement strategies focused on local priorities.

Evaluation Planning Process

Building on the success of the strategic planning process, OMNI developed a comprehensive process to support CSBs in creating individual prevention evaluation plans to monitor progress towards local and state outcomes. This process, known to CSBs as the "evaluation roadmap" integrates each community's logic model, measurement plan, and data entry plan into one document for ease of use in data entry and reporting. Each component of the roadmap is linked to the others and allows CSBs to organize their data to illustrate the prevalence of each priority area, demonstrate progress towards outcomes, and track implementation data. Each component of the roadmap is described in more detail below.

[4] OMNI Institute (2019). Virginia Substance Abuse Prevention Block Grant Strategic Planning Report. https://vasisdashboard.omni.org/ExportFiles/VA%20strategic%20plan%20report_FINAL.pdf

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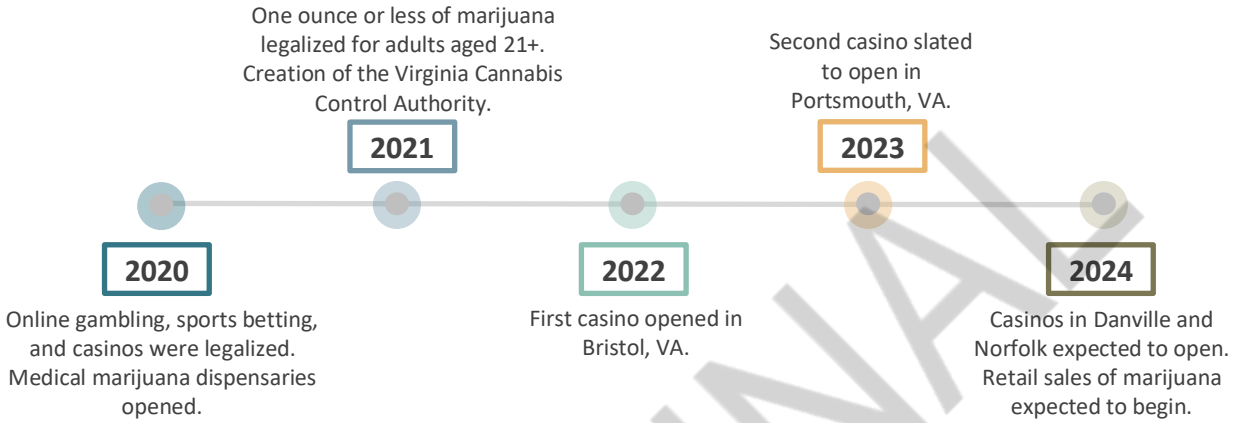

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Community Readiness Assessment	Determine each community's level of knowledge, leadership and attitudes around gaming and gambling, and cannabis.
Young Adult Survey	Comprehensive survey of 18–25-year-olds on a variety of subjects including substance use, mental health, and gambling.

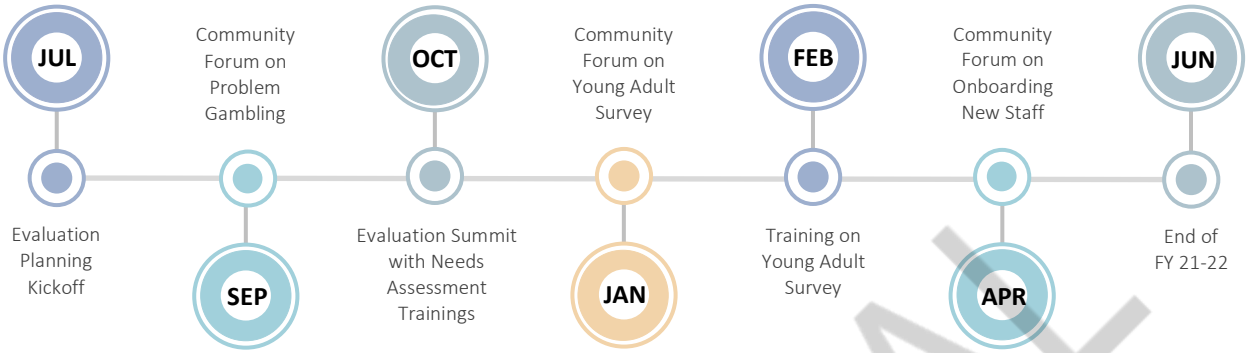
Between October 2021 and September 2022, each CSB completed components of the needs assessment within their localities. CSBs also connected with local partners to maximize outreach and recruitment for the Virginia Young Adult Survey in the spring of 2022. Over 5,000 young adults were recruited at colleges, recreation centers and local businesses to share their experiences and perspectives on substance use, mental health, and gaming and gambling. Results from the statewide survey effort are incorporated into this report.

OMNI synthesized and compiled the results of each completed Environmental Scan, and each Community Readiness Assessment, to provide a clearer picture of gaming and gambling, and cannabis across the commonwealth. Reports on each component can be requested by contacting OBHW.

Timeline of Evaluation Activities

During the 2021-22 fiscal year, OMNI worked with CSBs to support implementation of prevention strategies and their local needs assessments, provide TA around the needs assessment, data entry and

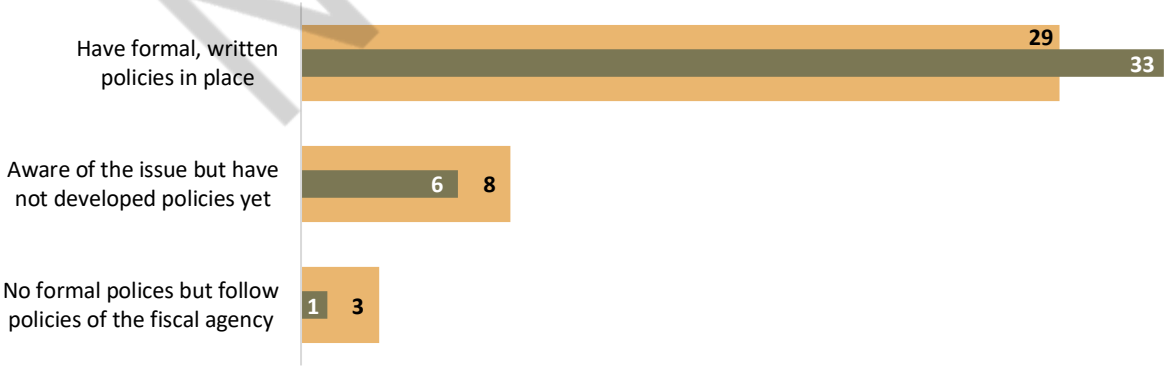
reporting requirements, and hosted events to provide ongoing discussions around timely CSB concerns. This includes providing monthly evaluation data to CSBs for both the ACEs and coalition assessments. In addition, OMNI received and approved implementation data in PBPS. The timeline below provides an overview of key activities that occurred in the 2021-22 fiscal year.



Prevention Capacity

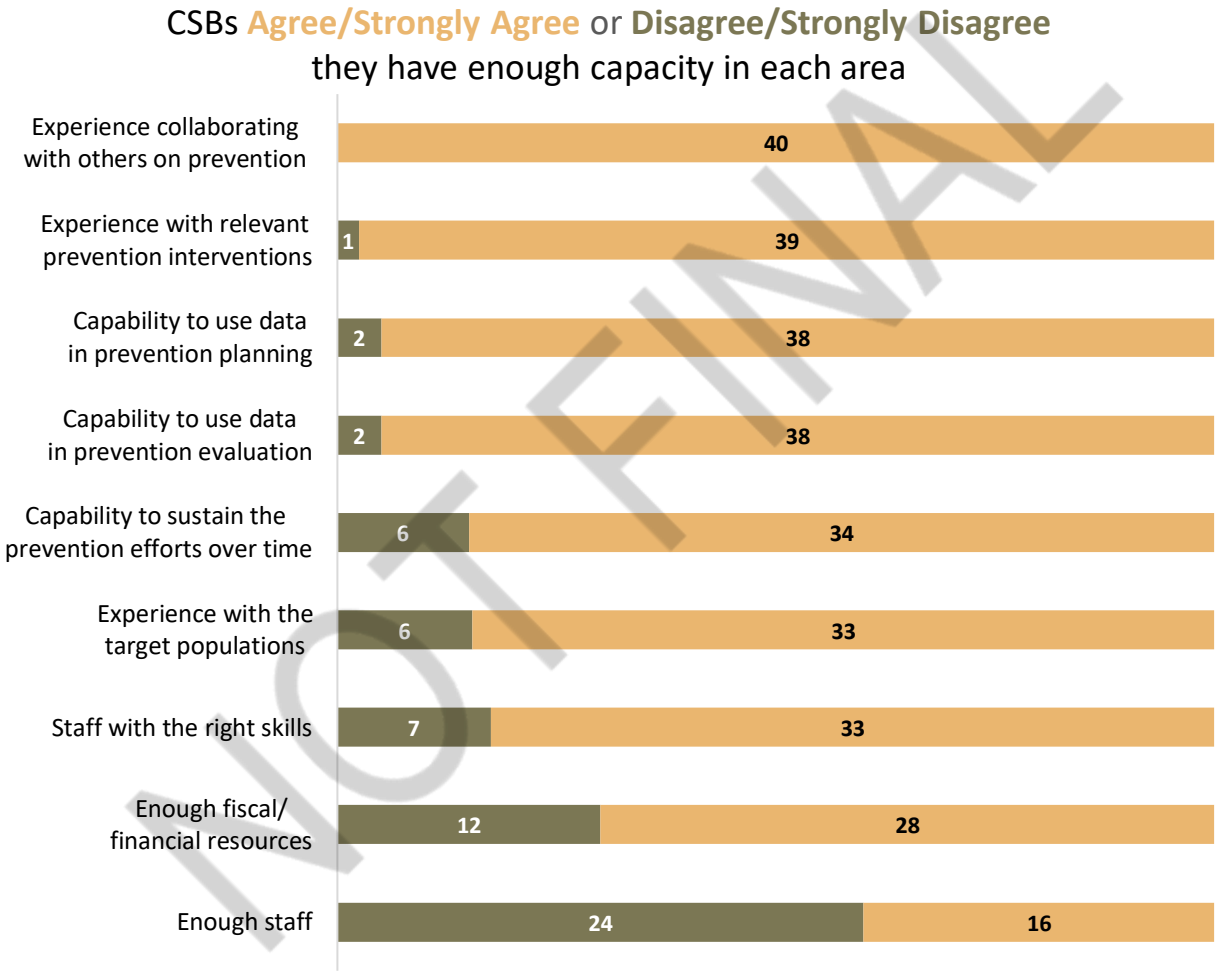
OMNI provides capacity building services to Virginia CSBs in addition to providing support around assessment, planning, implementation, and evaluation of prevention efforts. These efforts remain focused on promoting data literacy and supporting the prevention workforce in building necessary skills and relationships to effectively carry out their prevention efforts. In Block Grant (BG) Year 1 (FY20-21), OMNI developed an end-of-year survey of CSB staff to help assess the capacity of the prevention workforce across these areas, with some questions adapted from the Community Level Instrument[5]. This survey was repeated in FY21-22, with plans to repeat through all five years of the grant. Selected data from this survey are shared in this section to demonstrate the current capacity of the BG prevention workforce. In some cases, comparisons are noted for Year 1 and Year 2.

In FY21-22, more CSBs (33) reported having formal, written cultural competence policies in place than the prior year. Only one CSB reported that they follow policies of the fiscal agency, with just six sharing that they have not yet developed polices.



[5] Program Evaluation for Prevention Contract (PEP-C). (2014) Community-Level Instrument-Revised (CLI-R). https://www.samhsa.gov/sites/default/files/pfs-com-lev-inst.pdf

In FY21-22, CSBs continued to agree that they have ample capacity to implement their block grant prevention interventions. CSBs were asked how much they agreed or disagreed that their organizations have enough capacity in nine key areas to effectively implement their interventions. All 40 CSBs agreed that they have experience collaborating with other organizations on relevant prevention interventions. Nearly all agreed they have experience with relevant prevention interventions (39) and capability to use data in prevention planning (38). However, over half of all CSBs (24) disagreed or strongly disagreed that they have enough staff. This mirrors the FY20-21 data. Notably, 16 CSBs this year reported that they have enough fiscal/financial resources compared to just 12 the prior year.



"The Data to Action Resource Team (DART) is made up of individuals representing health, law enforcement, EMS, business, and more. It's committed to collecting and analyzing data on the impact of substance use and mental illness in Central Virginia. We're hopeful this data will inform the community, assist with identifying needs, aid with action plans, and help gain resources to address challenges." – **Horizon Behavioral Health CSB**

"We have lost key staff members and it has put an enormous strain on those filling in the gap. We are recruiting but struggling with getting candidates to accept the positions due to salary." – **Danville-Pittsylvania CSB**

In FY21-22, CSBs focused more on specific populations experiencing health disparities than the previous year. Health disparities subpopulations are specific demographic, language, age, socioeconomic status, sexual or gender identity, or literacy groups that experience limited availability of or access to substance use prevention services OR who experience worse substance use prevention outcomes. CSBs were asked to identify which of 14 health disparities-related activities they conducted during FY21-22. Some highlights below:

- Most CSBs (33) developed partnerships with agencies, organizations, or stakeholders to address disparities, considered disparities in prevention planning (28), and received training to increase their capacity in this area (29).

- Of note, more CSBs this year than last year increased access to (28 vs. 23) and availability of (27 vs. 22) substance use prevention services for subpopulations experiencing disparities.

- Half or more of CSBs implemented interventions specifically targeting subpopulations experiencing disparities (26), better-defined disparities subpopulations (20), and involved subpopulations experiencing disparities in activities like assessment and capacity building (23).

- Twenty CSBs adapted interventions to make them apply to subpopulations experiencing health disparities, with seven saying they evaluated changes in the number of individuals served or reached by subpopulations that face substance use health disparities. This is notable, and evidence of building evaluation capacity among the CSBs.

Loudon County Prevention Staff at 2022 Pride Fest

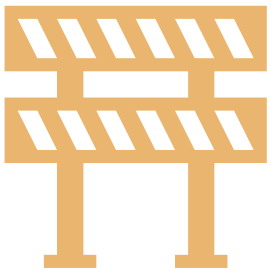
"We made a concerted effort to reach our Latino communities with trainings such as QPR and REVIVE. This was the first time in four years that we were able to train in Spanish due to staffing changes. We did this because data showed our Latino families were being greatly affected by overdoses and we noted an increase in mental health assessments at schools and our agency."
– Prince William CSB

39 CSBs reported stressful events such as COVID-19 acted as moderate or high barriers to their prevention activities. CSBs were asked to indicate which of 19 demographic, environmental, or cultural factors introduced barriers to their Block Grant prevention activities. They also shared the level of impact (low, medium, high) that each factor had in the past fiscal year. The average number of barriers reported across all CSBs was 18, an uptick from the prior year (13).

Twenty-six or more CSBs identified that every factor listed had at least some level of impact, whether low, medium, or high. The highest-impact barrier identified (stressful events) included COVID-19 and social/political unrest, which 39 CSBs indicated was a factor -- all of which said it had a high or medium impact. The response option for "other factors" outside of the list garnered additional challenges. Other listed barriers most frequently noted as having an impact are described below.

Number of CSBs Reporting Medium or High Impact for Common Barriers
• Stressful events affecting large portions of the target population, e.g., fires, hurricanes, COVID-19, or social/political unrest (39 CSBs) • Cultural norms, attitudes, or practices favoring substance use and easy access to alcohol for underage youth (37 CSBs) • Easy access to prescription drugs for nonmedical use (35 CSBs) • High poverty rates/ low socioeconomic status (33 CSBs)

Several CSBs reported other types of barriers having an impact on their prevention work:



- Geographic barriers impacting partnerships
- Increase in violence broadcast on TV nightly
- Increased youth suicide and LGBTQIA+ discrimination
- Lack of recreational facilities for children
- Legalization of marijuana
- People seem exhausted, over-extended, and disconnected to each other
- Staff capacity and turnover/workforce shortages
- Area is saturated with the alcohol industry (wineries, breweries, and distilleries) negatively impacting cultural norms around alcohol use

Valley CSB staff at Mental Health America of Augusta/Blue Ridge Community College Mental Health Fair

Despite challenges over the year, CSBs were again notably resilient in the face of COVID-19-related stressors and barriers. CSBs worked to adapt their programs and strategies prioritize the safety of their communities and adhere to state and local pandemic restrictions. These adaptations included taking indoor events outdoors when possible, masking indoors, and utilizing virtual options when available.

"The pandemic presented many challenges but with many creativities and a strong team we were able to restructure our team's mission and efforts to meet our goals and outcomes." **– Western Tidewater CSB**

Prevention Priorities

The following sections of the report describe the implementation and impact of the five priority strategies across the commonwealth during this fiscal year. Implementation data in these sections were drawn from the Performance Based Prevention System (PBPS) and narrative data were collected through an end-of-year reporting survey completed by CSB staff.

Community Mobilization and Coalition Capacity Building

Coalitions mobilize communities and are key in supporting prevention efforts and disseminating prevention messages. This fiscal year, CSBs partnered with and created local coalitions to plan and implement prevention activities, collect data, engage in community outreach efforts, and nurture partnerships with community stakeholders to spread prevention messaging.

38 CSBs led or facilitated coalitions

71 active coalitions

1,859 Coalition members

> "We found that meeting via Zoom has increased our attendance because it is more convenient for our members. The [Twin County Prevention Coalition] increased its membership this year, updated its logo and brochure, and rebranded its social media and website. In doing so, they have seen an increase in their social media followers and post impressions…" **– Mt. Rogers Community Services**

CSBs and affiliated coalitions persevered in the "new normal" of the ongoing COVID-19 pandemic, welcoming a return to in-person interactions. Coalitions had success with increased opportunities for in-person community events, trainings, and workshops; most notably hosting Community Anti-Drug Coalitions of America (CADCA) or other guest speakers at events. CSBs and coalitions continued to bolster their online presence, as they had in the prior fiscal year due to COVID-19 restrictions. This year many coalitions and CSBs launched or rebranded their website or social media pages, sent out newsletters, and successfully maintained their online presences, seeing increases in followers. One-fourth of all CSBs reported recruitment, focused priorities, or other expansion of youth-led coalitions.

Coalitions shared stories of successfully conducting data-driven activities, such as strategic assessment of their community needs and identification of new priority areas like marijuana and problem gaming and gambling prevention. Coalitions also reported prioritizing diversity in their membership with a focus on LGBTQ+ member representation, and Spanish language support at in-person events and social media spaces for Latine/x communities. Several coalitions were awarded additional grants that allowed them to hire dedicated staff to support their work towards coalition goals. CSBs that were fully staffed were successful, while those with vacant positions, mostly due to COVID-19 impact, faced challenges in completing their coalition work.

Richmond Behavioral Authority CSB recognizes mental health during Men's Health Month

Stakeholder participation was critical in addressing community needs and spreading prevention messaging. CSBs leveraged partnerships with several types of community partners, organizations, and agencies to promote their prevention messaging and engage community members. Data from the end-of-year survey show that across CSBs, the following sectors had the highest engagement in BG activities: schools and school districts; businesses; youth groups and youth representatives; health care professionals and agencies; and mental health professionals and agencies. The sectors that were least engaged in BG activities were tribal groups; military; organizations serving the LGBTQ+ community; and courts and judiciary systems.

In the 2021-22 fiscal year, 14 CSBs implemented a Coalition Readiness and Effectiveness Assessment*. A total of 110 members across 17 coalitions assessed their coalition across 8 dimensions on a scale of 1 to 4 (with 1 indicating low readiness and 4 indicating high readiness).

Coalition members reported the highest levels of readiness in the domains of context and leadership, reflecting the ability of their coalitions to address their community's most critical issues and members' confidence in their leaders.

Domains of Coalition Readiness and Effectiveness	Average score (out of 4)
Context: To what extent is the coalition working on a critical issue that affects the community?	3.51
Structure: To what extent does the coalition have effective norms, information, support, and representative membership?	3.36
Leadership: To what extent do members perceive leadership to be effective, collaborative, knowledgeable, and skilled with communication, management, and problem-solving?	3.47
Membership: To what extent do members effectively work together and have a strong commitment to the coalition?	3.31
Process: To what extent does the coalition value member opinions and make effective decisions?	3.41
Results: To what extent has the coalition set specific, measurable goals and achieved them?	3.31
Maintenance: To what extent does the coalition revise plans and share information and results with members and the larger community?	3.37
Institutionalization: To what extent is the coalition integrated into the larger community, recognized, and consulted as an authority on the topic of focus by other organizations, legislative bodies, or government entities?	3.29

**It should be noted that though CSBs are encouraged to administer this assessment at any time to evaluate their coalitions' health, the assessment guidelines state it should be deployed every other year. Most CSBs completed the assessment during 2020-21, and thus did not collect and report assessment data during 2021-22.*

Lock and Talk Suicide Prevention and Awareness

CSBs implemented Lock and Talk efforts focused on suicide prevention through restricting access to lethal means, community and merchant education, and media messaging. Lock and Talk messaging acknowledges that suicide and overdose prevention are incomplete without knowledge of safe storage of lethal means and access to locking devices.

40 CSBs implemented Lock & Talk

35,883 Total devices distributed

1.8 M Total impressions/ reach

This fiscal year all CSBs participated in Lock and Talk efforts compared with only 37 CSBs in the prior fiscal year. With the increased number of in-person events, CSBs had more opportunities to share messaging with their communities. CSBs leveraged their time by adding a brief Lock & Talk presentation, informational materials, and/or devices to their other ongoing prevention efforts. Outside of events, CSBs continued to promote Lock and Talk through social media, billboards, and other media channels.

- 1,744,847 reached through social marketing campaigns
- 17,732 received lock boxes
- 11,371 received cable locks
- 7,545 reached through presentations
- 6,780 received trigger locks
- 101 gun retailers visited

"Lock and Talk has been the one initiative that has been "pandemic resistant!""- **Hanover CSB**

CSBs worked to expand Lock and Talk efforts to reach more diverse populations, including veterans, non-English speakers, and the LGBTQ+ community. Through community partnerships and coalitions, several CSBs expanded their reach to include populations that are often overlooked. For veterans, CSBs partnered with coalitions and local organizations that focused on veterans to present on Lock and Talk efforts and distribute locking devices and information. To reach non-English speaking communities, CSBs conducted research on best practices to outreach to diverse populations and coalitions provided guidance to customize the materials to communities and their needs, such as offering multilanguage materials and resources. To raise awareness of Lock and Talk suicide prevention efforts in the LGBTQ+ community, CSBs participated in pride events and LGBTQ+ social clubs to share their messages.

Dickenson County youth at a community event in Bear Pen Pool where Lock and Talk messaging is displayed daily

Mental Health Promotion and Suicide Prevention Trainings

Thirty-eight of 40 CSBs implemented mental health and suicide prevention trainings to over 16,000 people in their communities, more than doubling their reach from the prior year. Expanding mental health supports and trainings aims to decrease substance use risk factors, prevent suicide, and promote positive mental health. This fiscal year, all CSBs were expected to implement Mental Health First Aid (MHFA) trainings. CSBs were also required to offer one of three suicide prevention trainings: Applied Suicide Intervention Skills Training (ASIST), Safe Talk, or Question. Persuade. Refer. (QPR).

38 CSBs conducted trainings

642 trainings

16,516 people trained

CSBs implemented 11 different suicide prevention trainings, with Mental Health First Aid continuing to be the most-delivered training. QPR trainings nearly doubled from the prior year (66 to 114), with gains in most other curricula, including ASIST (from 3 to 20) and Safe TALK (from 6 to 35). Trainings reached all age ranges and sectors, including youth in schools and clubs, faith groups, first responders, colleges, seniors, fellow staff, and more.

Training Type	# of Trainings
Mental Health First Aid (MHFA)- Adult	255
Mental Health First Aid (MHFA)- Youth	128
Question. Persuade. Refer. (QPR)	114
Safe TALK	35
Applied Suicide Intervention Skills Training (ASIST)	20
SOS (Signs of Suicide)	20
More Than Sad	12
Talk Saves Lives	7
Crisis Intervention Team (CIT)	4
Other (Stress First Aid Training, Zero Suicide)	25

"We reached 470 people through Adult & Youth MHFA, SafeTALK, ASIST, and Talk Saves Lives. Participants included treatment providers, parents, first responders, elderly, higher education, veterans, businesses, and parks and rec staff." **– Blue Ridge CSB**

Remaining COVID-19 restrictions and staff limitations continued to pose challenges for training delivery, but CSBs were able to implement in-person trainings more regularly. Several CSBs noted this welcome change. For instance, Northwestern CSB shared that since communities are "opening up," they've seen "an unprecedented number of requests for suicide prevention trainings." Similarly, Rockbridge CSB notes that they continued to offer virtual trainings but also "moved back into in-person trainings and collaborated with other prevention

"We returned to in-person ASIST. Feedback included, *'One of the best classes I have taken!'* We were also able to provide in-person Signs of Suicide (SOS) lessons to over 5,000 7th & 10th graders." **– Chesterfield CSB**

partners and CSBs to reach numerous individuals." However, CSBs recognize that mental health wellness challenges still prevail including social isolation, increased substance use, increased rates of depression and suicides that contribute to ongoing behavioral health issues in communities due to the COVID-19 pandemic.

CSBs are using data to adapt strategies to meet specific equity-related prevention and other needs in their communities. For instance, Eastern Shore CSB discovered that *"there was an increase in our community with adolescent suicides mostly occurring in the LGBTQIA+ youth population. These deaths were dismissed as 'teen behavior' and the community struggles to effectively address the social norms that lead to discrimination."* This opened the door to adapting strategies to better reach this population. Horizon CSB launched a six-week initiative in response to the increase in risk for mental health, suicide, and substance use during the COVID-19 pandemic by hiring community health workers to engage residents with the greatest needs. Each visit revealed *"emerging community needs, barriers to services including access to technology, lack of awareness of signs and symptoms of an emerging crisis, limited knowledge of available resources, stigmatization, as well as isolation."* Chesterfield CSB's Suicide Awareness and Prevention Coalition worked with OBHW to customize materials for their county and neighborhoods.

30 CSBs
implemented campaigns

6.8M
impressions/ reach

Thirty CSBs implemented specific mental health promotion and suicide awareness activities through media campaigns, community events, and presentations, reaching millions of people. Activities ranged from Facebook or website posts and other social media, broadcast media, and resource guide distribution, to community walks and events. Presentations were held at places of worship, senior centers, colleges, and more. Implementation with Behavioral Health Equity in mind was evident through presentations such as, "Mental Health in the Queer Community: Risk Factors and Giving Support" and "Anxiety and Depression among Seniors: When Is the Right Time To Seek Help?" Employee wellness presentations and targeted information sharing for managing grief and loss during the holidays demonstrate the breadth of reach in the community.

Walk for a New Day! Gloucester County - MPNN CSB

Regional collaboration helped expand the reach of suicide prevention messaging through virtual programming. Several CSBs from the Eastern region (Region 5) of Virginia reported participating in the sixth annual "Shatter the Silence" Regional Prevention and Awareness Conference in Hampton, VA. Region 5 CSBs also collaborated through a Regional Suicide Prevention Task Force on suicide prevention and Lock & Talk efforts. CSBs from the Central region (Region 4) of Virginia continued to partner to offer resources and training via the BeWellVA suicide prevention training plan and website. *"The website, together with social media outreach, have been wonderful tools in amplifying both CSB specific programming and regional resources."* (Hanover CSB). Richmond CSB is collaborating with the Region 4 SMVF Navigator to build community partnerships, offer suicide prevention, Lock and Talk, and cultural competency trainings for providers, and align resources for service members, veterans, and their families.

Adverse Childhood Experiences (ACEs) Trainings

CSBs provided ACE Interface trainings to bring awareness of the impact of ACEs on health and behavior. The ACE Interface curriculum teaches participants about the biological, health, and social impacts of ACEs and traumatic childhood events as well as strategies to support the health and well-being of community members. Experiencing a higher number of ACEs has been associated with a number of adverse health outcomes, with those who experience four or more ACEs being at the highest risk. Many CSBs reported adding ACEs trainers or ACEs masters to continue to increase their reach. As a result, there were an additional 46 trainings and 1,421 more participants this year compared to last year. In addition, the ACEs Collaborative Group made up of 12 CSBs across the commonwealth continued to work together to bring more trainings to their communities.

36 CSBs conducted trainings

341 Trainings/ presentations

9,348 people trained

Mount Rogers ACEs Trainers

This fiscal year, while many trainings continued to be virtual to reach across each CSBs catchment area, they also had more in-person opportunities as the COVID-19 pandemic restrictions reduced. After participants completed an ACEs training, they shared reflections of how the training will help them in their own life and community.

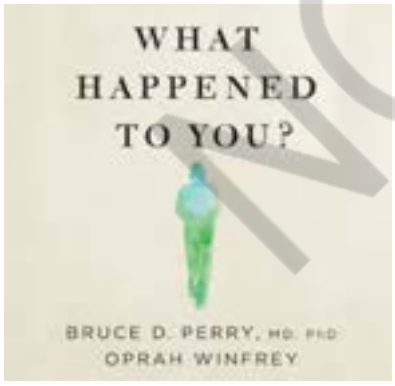


Image of "What Happened to You?" book cover

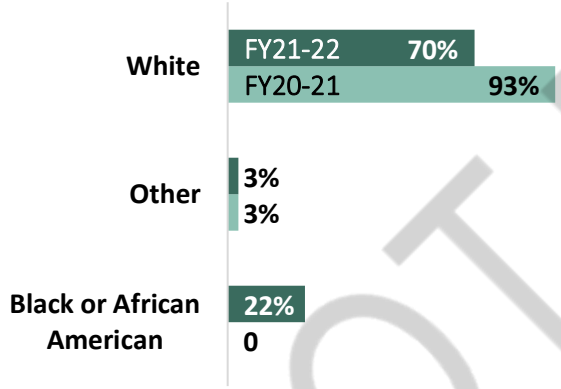
In addition to ACEs trainings, CSBs expanded the trauma informed care network continuum by holding guided discussions through ACEs focused books presentations. CSBs expanded their community engagement by hosting book clubs and community presentations or conferences. Several CSBs reported distributing copies of the book "What Happened to You" by Dr. Bruce Perry and Oprah Winfrey in their communities. Southside CSB also held a conference with Dr. Bruce Perry, an expert on trauma work. By sharing ACEs related information in non-traditional learning settings, the community was able to engage and learn about such an important topic.

"We used the 'What Happened to You' book to lead our discussions. We distributed over 1500 books out to these groups. In the jail groups, the participants were requesting books be spent to family members so they could work on these experiences together."
– **Highlands CSB**

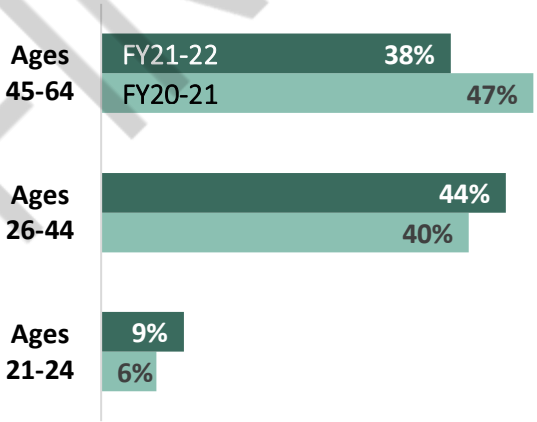
The ACEs Post-Training Evaluation Survey is helping provide insight into how learning about ACEs can impact participants' daily interactions. CSBs continued to use the ACEs Post-Training Evaluation Survey, with successful completion by 2,180 participants across 186 trainings. ACEs Training Evaluations are administered via the survey platform Qualtrics in both English and Spanish and collect information on the participants' training experience and learnings. Only 23% of total ACEs training participants completed the evaluation survey. The data below includes trainings funded by both Block Grant and the State Opioid Response Grant.

Although most participants who completed the survey identified as white and a woman, ACEs training audiences have diversified in the last year. Although there was not a significant shift in the dominant gender identity of those that took the ACEs training, there was a shift in ethnicity and age in the past year. Last year 93% of participants identified as white whereas this year, only 70% identified as white. In addition, there was also a slight trend in training younger populations. These shifts demonstrate CSBs commitment to diversifying the ACEs Training efforts to train all their communities in their area.

One-fifth of participants were Black or African American



Participants in 2021-22 were younger than those from the prior year



After ACEs trainings, participants indicated high levels of learning and a desire to expand their knowledge and increase participation in ACEs efforts in their communities.

"I want to do a little explanation for my 8th graders about how their brains work at this age, to help them understand that there are physiological reasons why they think/feel/act the way they do sometimes." **-ACEs training participant**

78% agreed or strongly agreed that they want to seek more information and guidance regarding trauma-informed practice.

77% agreed or strongly agreed that they want to learn more about the causes and effects of ACEs.

79% indicated they *learned a lot* about identifying and addressing ACEs and ACEs' impact on brains and behavior.

73% indicated they *learned a lot* about why their community needs to get organized and mobilized to identify and address ACEs.

Counter Tools Youth Retail Tobacco Prevention and Merchant Education

Though previously hindered by COVID-19 restrictions, CSBs returned to their in-person merchant education visit schedules and goals.

36 CSBs provided education

4784 merchants visited

Seventy percent of CSBs reported having met the Counter Tools goal of 100% visitation to participating merchants. Educating retailers reduces the amount of access underage youth have to tobacco and nicotine. The long-term relationships that have been formed between CSBs and retailers facilitated Counter Tools and merchant education strategies being perceived by retailers as informative and helpful in keeping up with the trends, and as opportunities to prevent underage tobacco, alcohol, and now vaping and marijuana use. CSBs mentioned that many retailers were receptive to the education and resources they provided, and that merchants "took the time to talk." Several CSBs, Arlington and Prince William County for example, employed youth in their merchant education visits, which proved to be effective and welcomed by vendors. Other CSBs trained new staff on the Counter Tools initiative, including community member volunteers.

"A retailer in [our catchment area] dedicated the last years of his life to ensure that his employees would be hyper vigilant about underage youth purchases of tobacco. His store was a repeat violator, but the merchant education visit triggered a full-blown effort to stop that trend. He did not want cancer to be part of anyone's future. His store was not on the violator's list for the past two years." **– New River Valley Community Services**

Tobacco 21 laws and Counter Tools merchant education activities complemented each other in preventing underage tobacco use.

CSBs use catchment maps, like this one for Chesterfield Community Services, to understand the density of tobacco retailers in their catchment areas. Image courtesy of Countertools.org (2022)

In July 2019, the commonwealth raised the state minimum age of sale of tobacco products from 18 to 21 years of age, in part to address the rapid growth of vaping among teens. Shortly after, the minimum age was raised to 21 at the federal level. In addition to the required Counter Tools merchant education surveys and conversations, CSBs promoted the social norm that stores do not sell tobacco products to persons under 21, by reminding merchants of the Tobacco 21 law and encouraging them to raise awareness of the law to customers. CSBs supported retailers by answering their questions about the change in laws and assisting them in navigating significant backlash from customers who still believe they should have access to tobacco prior to their 21st birthday.

Prevention Outcomes

Through their planning, capacity building, and implementation efforts, all Virginia CSBs worked toward common goals set by OBHW through the strategic planning process and the 2020-25 statewide logic model. Throughout the five-year funding period, CSBs are focused on implementing the five required strategies, as well as any additional priorities identified at the community level, and achieving short-term outcomes associated with those efforts. CSBs continue to monitor progress towards mid-term and long-term outcomes on an annual basis, allowing them to keep current with any changing needs and emerging trends. Desired long-term outcomes at the state level are presented below, along with the most recent data available related to those outcomes.[6]

Desired Outcomes	Current Indicators
Alcohol	
Decrease in youth alcohol use Decrease in young adult binge drinking	25.4% of VA high school youth in reported drinking alcohol in the past 30 days 36.1% of VA young adults ages 18-25 report binge drinking in the past month
Tobacco/Nicotine	
Decrease in youth tobacco/nicotine use Decrease in adult tobacco/nicotine use	5.5% of VA high school youth report smoking cigarettes in the past 30 days 19.9% of VA high school youth report using a vaping product in the last 30 days 17.9% of VA adults ages 18+ report cigarette use in the past month
Mental Health/Suicide	
Decrease in youth suicide attempts Decrease in youth deaths by suicide Decrease in adult deaths by suicide	7.0% of VA high school youth have attempted suicide in the past year 16.7 per 100,000 youth and young adults ages 15-24 died by suicide in VA 17.2 per 100,000 adults aged 18+ died by suicide in VA

[6] Data on high school youth from the 2019 Virginia Youth Survey. Data on adult substance use from the 2018-2019 National Survey on Drug Use and Health (NSDUH). Data on suicide rates from 2020 Centers for Disease Control and Prevention data.

Virginia Young Adult Survey Data

With emerging trends in behavioral health and wellness, including those related to Virginia policy changes around gaming and gambling and recreational marijuana use, significant data gaps have been identified that limit capacity at the state and CSB level to engage in data-driven decision-making and evaluation activities. To bridge this gap and contribute to a greater body of data around behavioral health and wellness, CSBs conducted a statewide survey to better understand the behaviors and attitudes of young adults ages 18 to 25. The Young Adult Survey was originally developed by OMNI in conjunction with the Virginia State Epidemiological Outcomes Workgroup (SEOW) in 2016 and administered to selected communities as a part of Virginia's Partnerships for Success (PFS) grant funded by SAMHSA from 2015-2020.[7] OBHW decided to administer the survey statewide in FY2021-22 to gather this valuable data from all CSBs. The survey was modified to improve cultural responsiveness and to add questions pertaining to emerging areas of interest such as gaming and gambling. Each CSB was responsible for administering the survey in their catchment area.

The 2022 Virginia Young Adult Survey (YAS) collected responses from 5,339 young adults across the commonwealth with all but two localities represented. Responses come from a convenience sample so the participants may not be representative of the full young adult population in the state. Sub-group analyses were conducted to better understand the needs of various populations. Findings relevant to Virginia's priorities and emerging areas are outlined below. Additional YAS data will be added to the Virginia Social Indicator Study Dashboard (VASIS) in 2023.

Substance Use Rates

Data related to substance use among young adults in Virginia are discussed below. These data will provide a general picture of the current state of substance use across the priority and emerging areas, as well as explore differences among sub-populations.

Lifetime Use

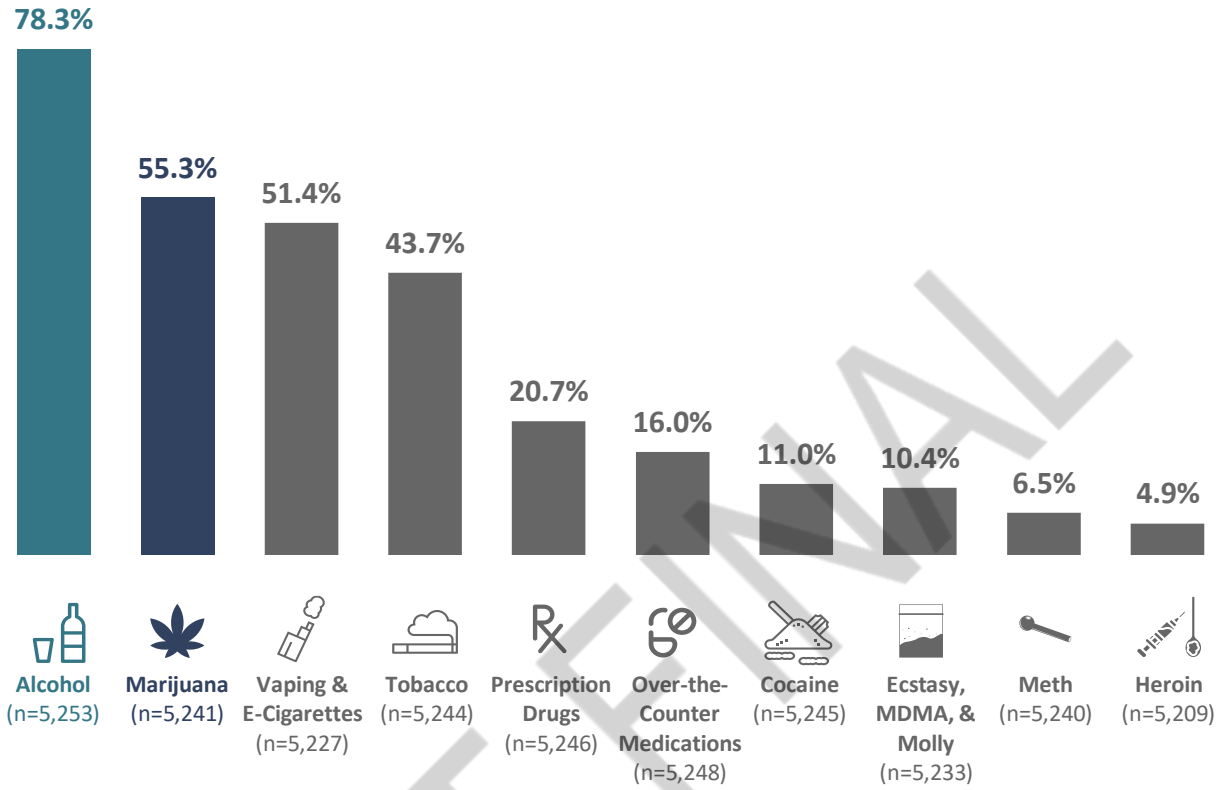
Young adults reported high rates of lifetime alcohol use (78.3%), confirming the need for prevention efforts still exists. Over half (55.3%) of young adults reported using marijuana at least once. The popularity of vaping and e-cigarettes in recent years, especially among youth and young adults, is clearly represented in this data. More young adults have reported using e-cigarettes or vaping devices (51.4%), which contain nicotine, than reported using tobacco (43.7%).

Although there is not an available comparison for lifetime use rates in a nationally representative dataset, data from the National Survey on Drug Use and Health (NSDUH) includes past year use rates for these and other substances. Past year marijuana use among Virginia young adults from the NSDUH 2018-2019 data is reported at 32.9%, which is considerably lower than the 55.3% rate reported in the YAS for lifetime use.[8]

[7] Information on prior administrations of the YAS can be found in the 2020 PFS Annual Report, available at https://datadashboard.omni.org/VASIS/ExportFiles/2019-20%20PFS%20Annual%20Report_FINAL.pdf

[8] Data from the 2018-2019 National Survey on Drug Use and Health, available at https://www.samhsa.gov/data/sites/default/files/reports/rpt32805/2019NSDUHsaeExcelPercents/2019NSDUHsaeExcelPercents/2019NSDUHsaePercents.pdf

More than three quarters of Virginia young adults surveyed had used alcohol at least once in their lifetime, while more than half have used marijuana.



Lifetime use rates for illicit substances, including cocaine (11%), methamphetamines (6.5%) and heroin (4.9%) were all higher than expected, especially when compared to past year use rates available via the NSDUH data. Past year cocaine use among Virginia adults aged 18-25 years was 5.2% - half of the rate reported by the YAS data for lifetime use. Similarly, 0.33% of 18–25-year-olds used heroin in the past year according to the NSDUH data, while 4.9% of YAS respondents reported lifetime use. Past year use of methamphetamines reported by NSDUH were 0.58% for Virginia young adults compared to 6.5% lifetime use in the YAS data. To put these values into perspective, YAS data suggest that 1 in 10 Virginia young adults have used cocaine, and 1 in 20 have used heroin at some point in their lives.

While these large discrepancies in use rates are noteworthy, any comparisons between the YAS and NSDUH data should be made cautiously for several reasons. First, it is important to note that the NSDUH and YAS are measuring two different constructs—lifetime use and past year use. It is likely that lifetime use rates may be higher than past year use rates simply because the span of time under consideration is much larger. Second, the NSDUH data are from 2018-2019, whereas the YAS data were collected in 2022—meaning that the discrepancies could point to a worrisome trend of higher substance use in recent years. Lastly, the YAS data were gathered from a convenience sample whereas the NSDUH data are representative of all Virginia young adults, which means that the YAS may have sampled young adults that simply have higher substance use rates than the general population of young adults in Virginia.

Much of the prevention work across Virginia focuses on curbing underage use of alcohol, binge drinking among youth and adults, and soon, underage use of marijuana. While these efforts have been broad,

consisting of media messaging campaigns and educational outreach, there is more room for impact, especially among delaying use of alcohol until age 21. Almost two-thirds of young adults under the age of 21 reported using alcohol in their lifetimes, while 44.3% reported using marijuana.

Young adults under the legal age of 21 for alcohol and marijuana still reported high rates of lifetime usage.

65.1% of underage respondents reported **alcohol use** in their lifetime

44.3% of underage respondents reported **marijuana use** in their lifetime

When examining lifetime substance use in Virginia among young adults, it became clear that specific sub-populations reported higher use rates than the entire young adult population. Respondents identifying as LGBQ+ individuals reported higher instances of use across all substances, while those identifying as BIPOC or trans and gender diverse only reported higher use rates across some substances. Tobacco was used at a higher rate among LGBQ+ young adults, but not across BIPOC or trans and gender diverse populations. Outreach efforts focusing on LGBQ+ youth and young adults may need to be increased to combat this trend and provide supports.

LGBQ+ young adults showed higher lifetime rates of use across all substances when compared to their peers.

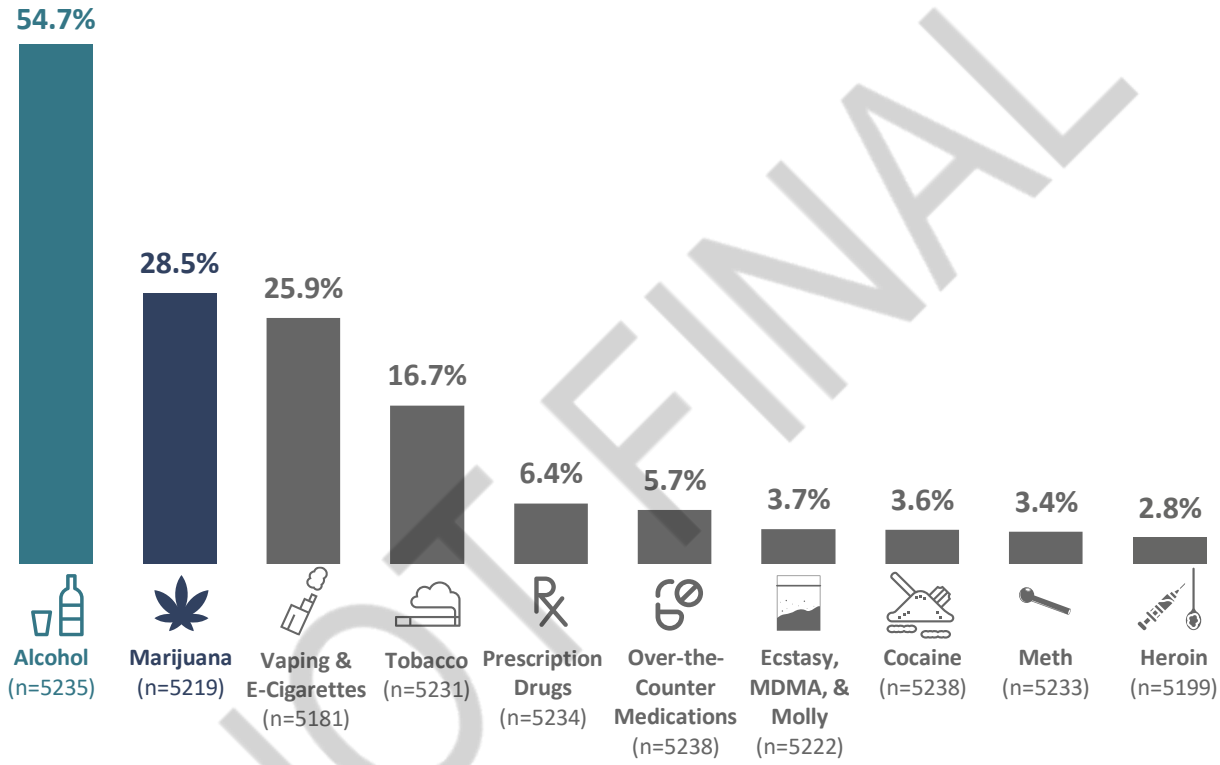
	BIPOC	LGBQ+	Trans and Gender Diverse
Alcohol		X	X
Marijuana	X	X	X
Vaping		X	X
Tobacco		X	
Prescription Drugs	X	X	X
Over-the-Counter Medications	X	X	X
Cocaine	X	X	
Ecstacy, MDMA, or Molly	X	X	X
Methamphetamine	X	X	
Heroin	X	X	

X = Higher Rate of Lifetime Use Compared to Peers

Past 30-Day Substance Use

Participants were also asked about their substance use in the last 30-days, or past month. More than half of young adults surveyed had used alcohol in the past 30-days (54.7%), and more than a quarter had used marijuana (28.5%). 30-day alcohol use rates in the YAS were lower than the 58.3% reported by NSDUH in 2018-2019, whereas 30-day marijuana use rates were higher than the 20.3% reported by NSDUH. These results suggest that prevention efforts focused on alcohol may be contributing toward lower use, while there may be a greater need for prevention efforts focused on marijuana.

Over half of young adults surveyed have used alcohol within the last 30 days and over a quarter have used marijuana.

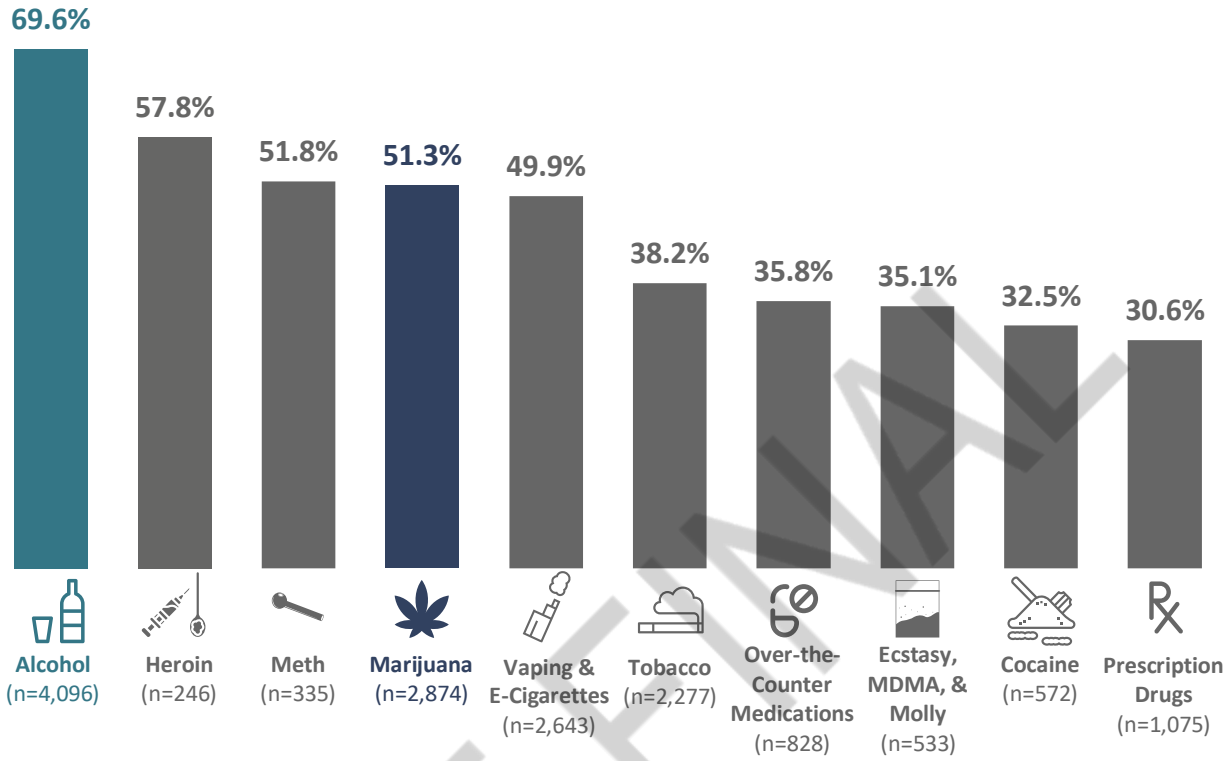


Tobacco product use in the past month via NSDUH (30.6%) was higher than 30-day use rates for tobacco products in the YAS data (16.7%), potentially reflecting a positive trend toward decreased tobacco use among young adults. However, the NSDUH does not provide a 30-day use rate for vaping products, which were used by 25.9% of young adults in the YAS.

Although the NSDUH does not include 30-day use rates for prescription drugs, ecstasy, cocaine, methamphetamines, or heroin, they do provide a 30-day use rate for illicit drug use excluding marijuana (6.2%). This rate is higher than the average 30-day rate for illicit substance use excluding marijuana in the YAS (4.1%). These data are encouraging for the prevention community and may speak to the impact of efforts aimed at decreasing illicit substance use among Virginia young adults.

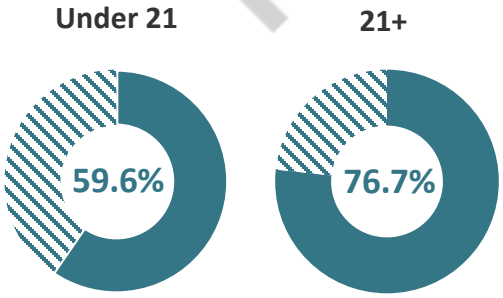
Among respondents who reported using substances at least once in their lifetime, 30-day use rates were higher than for the overall sample. The data are clear that young adults who have ever used alcohol, are continuing to use alcohol (69.6%). The same trend was also present for marijuana, with over half (51.3%) of lifetime users reporting use within the past 30-days.

When focusing only on young adults who reported lifetime use, more than two-thirds used alcohol in the last 30 days and more than half used marijuana.

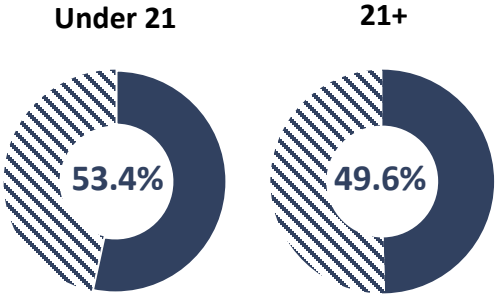


Most alarming in the YAS data are the rates of past 30-day use rates for lifetime users of heroin (57.8%) and methamphetamine (51.8%). While lifetime use of these substances was reported at much smaller levels than alcohol and marijuana, lifetime users of these substances have past 30-day use rates in line with those more common substances. This means that of those who reported ever using heroin or methamphetamine, more than half had used these substances recently.

When examining underage alcohol use, of those young adults who were 18-20 years old at the time of YAS data collection, and who had reported using alcohol at some point in their lives, almost 60% had used alcohol in the past 30-days. This rate was lower than those of legal drinking age (76.7%), but not by much. For marijuana, the opposite proved true. There was a slightly higher past 30-day use rate for those under the legal age of 21 (53.4%) compared to those considered to be of legal age (49.6%).



Of those who have used alcohol in their lifetime, 59.6% of underage users reported **alcohol use** in the past 30 days



Of those who have used marijuana in their lifetime, 53.4% of underage users reported **marijuana use** in the past 30 days

Age at First Use

Young adults who reported using substances during their lifetime were asked to share at what age they first started using substances. This is important data for prevention workers, as they can target their strategies and interventions prior to when most youth are introduced to certain substances. By knowing that alcohol use often begins when youth are between 15 to 17 years old (40.2%), they can enhance outreach and educational efforts to middle and early high school students.

Substances that seem to have the highest early initiation rates, meaning age of first use was 11 or younger, include over-the-counter medications (8.9%), methamphetamine (7.6%) and heroin (5.9%). This means that of those who reported over-the-counter medication use, about one in ten began when they were 11 years old or younger. Interestingly, vaping had the lowest early initiation rate with 1.4%. Most young adults who reported vaping in their lifetimes began when they were 15 to 17 (40.6%) or 18 to 20 (38.1%) years of age.

Alcohol and marijuana use is more likely to begin between ages 15-17, while tobacco use is more likely to start between 18-20 years of age. Across all substances, initiation of use is most likely between the ages of 15 and 20.

	11 or younger	12 to 14	15 to 17	18 to 20	21 to 25
Alcohol (n=4,114)	3.6%	14.3%	**40.2%**	31.6%	10.4%
Tobacco (n=2,290)	4.6%	15.9%	34.5%	**37.1%**	7.9%
Marijuana (n=2,896)	2.1%	13.8%	**39.0%**	34.0%	11.2%
Vaping (n=2,689)	1.4%	8.6%	**40.6%**	38.1%	11.3%
Over-the-Counter Medications (n=838)	8.9%	15.3%	**36.4%**	28.3%	11.1%
Prescription Drugs (n=1,087)	4.0%	12.3%	35.7%	**36.4%**	11.6%
Cocaine (n=579)	3.8%	6.9%	23.1%	**45.6%**	20.6%
Ecstasy, MDMA, or Molly (n=544)	2.8%	7.7%	25.9%	**41.9%**	21.7%
Heroin (n=256)	5.9%	11.3%	24.6%	**30.9%**	27.3%
Methamphetamine (n=342)	7.6%	8.8%	24.9%	**38.3%**	20.5%

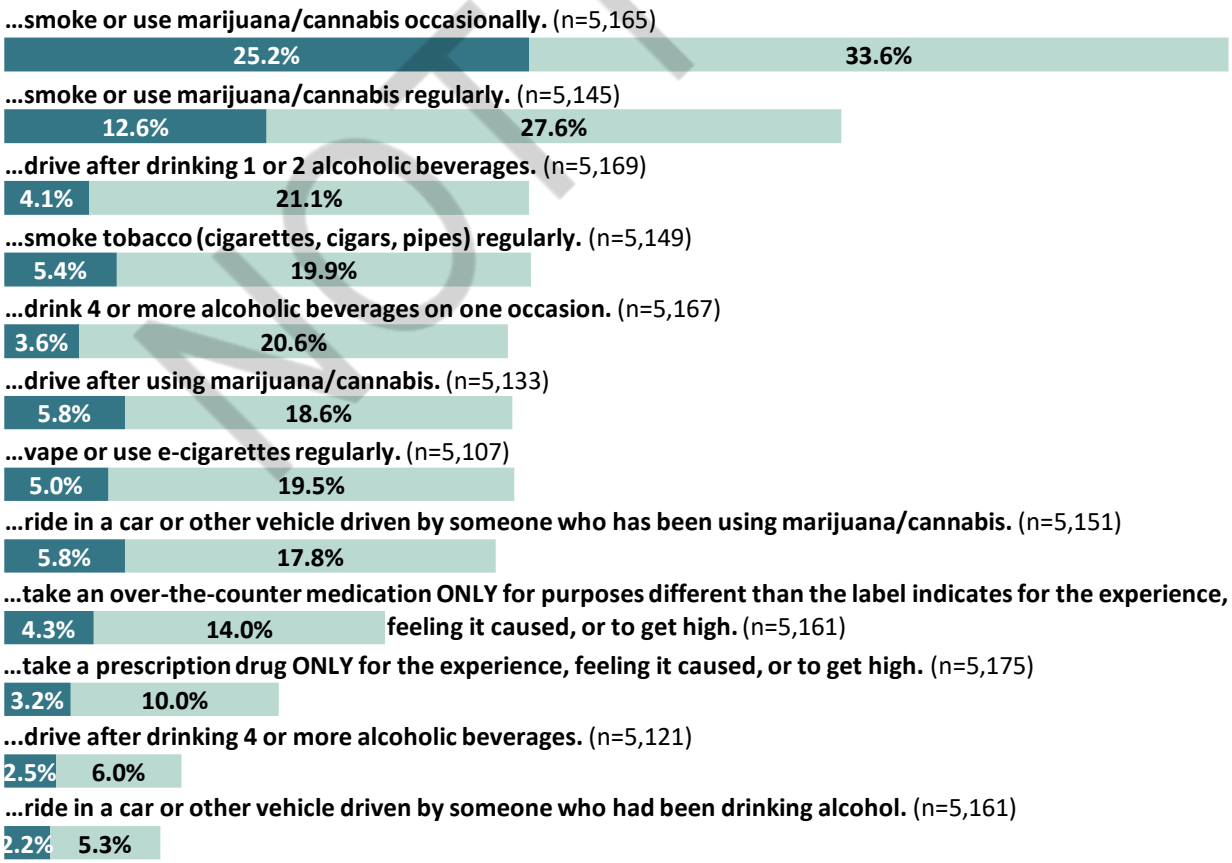
Perceptions of Risk and Peer Use

A strong indicator of future substance use is our understanding of all potential risks or harm associated with use. If a person does not believe that something will harm them, they will see less reason to avoid the behavior or action. Prevention strategies often focus on the physical, emotional, and mental health impacts of use as a way to educate and deter community members from using substances. For substances that are legal, such as alcohol, tobacco and marijuana, these efforts emphasize responsible usage – not driving while under the influence or not binge drinking.

YAS respondents were asked several questions regarding their perception of risk associated with specific behaviors. These questions were asked of all participants, regardless of whether they had indicated lifetime use. Occasional marijuana use was seen as the least risky activity among respondents, with 55.8% indicating slight or no risk. The perceived risk level increased for regular marijuana use, with 40.2% of young adults reporting slight or no risk. Very few participants (8.5%) reported low risks associated with riding in a car with someone who had been drinking alcohol. The YAS data showed that almost 85% associated moderate or great risk with riding with a driver who had been drinking alcohol.

Young adults see marijuana (occasional or regular use) as less risky than alcohol. Drinking and driving was seen as less risky than riding in a car with a driver who had been drinking.

What percent of respondents think there is no risk or only slight risk of people harming themselves, physically or in other ways, when they…

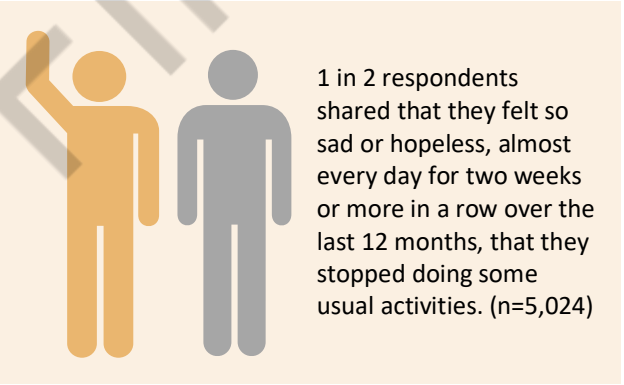


Findings also clearly indicated a disconnect between individual alcohol use and perceptions of peer use. Respondents perceive their peers to consume alcohol at much greater volumes during a night out than they do in reality. 37.7% of respondents think their peers drink five or more alcohol behaviors on a night out, while only 13.6% of respondents shared that they drink this amount personally when going out.

Young adults believe peers are drinking more alcohol during a night out than they themselves report drinking.

Over the course of 4 or 5 hours, when partying at a bar, club, or social gathering how many alcoholic beverages…	…do respondents typically consume?	…do respondents think their peers consume?
None	32.6%	8%
1 or 2	26.3%	12.9%
3 or 4	23%	36.9%
5 of more	13.6%	37.7%

Mental Health and Suicide



1 in 2 respondents shared that they felt so sad or hopeless, almost every day for two weeks or more in a row over the last 12 months, that they stopped doing some usual activities. (n=5,024)

13.3% of respondents reported having harmed themselves on purpose during the past 12 months, with LGBQ+ and trans and gender diverse respondents reporting far higher rates than their peers – 27.7% vs 8.1%, and 44.3% vs 11.5%, respectively. Respondents from these groups were also more likely to report having considered suicide during the past 12 months, as were BIPOC respondents. BIPOC respondents who considered suicide were significantly more likely to report having made a suicide attempt during the past 12 months than their peers.

LGBQ+ and trans and gender diverse respondents were 2 or 3 times more likely to engage in self-harm and suicidal ideation behaviors compared to their peers.

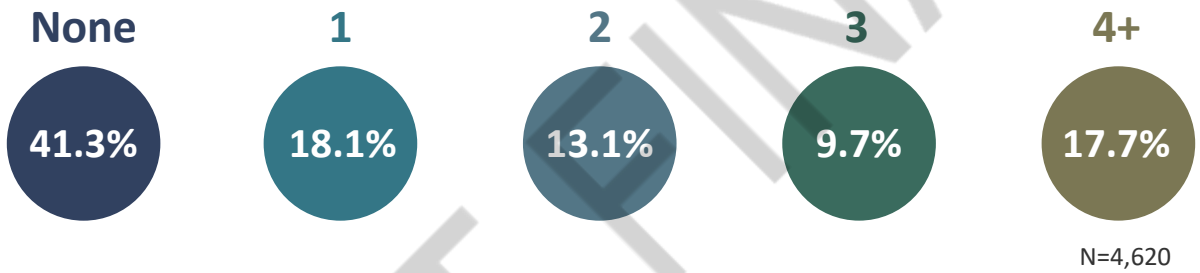
Population		Engaged in self-harm?	Seriously considered suicide…?	…and made a plan for attempting Suicide?	…and attempted suicide?
Black, Indigenous, People of Color (BIPOC)	BIPOC	13.2%	17.7%	51.1%	30.8%
	Non-BIPOC	13.5%	16.9%	51.1%	17.6%
LGBQ+	LGBQ+	27.7%	31.0%	53.8%	24.5%
	Non-LGBQ+	8.1%	12.2%	12.2%	21.2%
Trans and Gender Diverse (TGD)	TGD	44.3%	43.5%	53.8%	21.2%
	Non-TGD	11.5%	15.7%	49.5%	23.0%

Adverse Childhood Experiences (ACEs)

Adverse childhood experiences refer to events and life experiences youth under the age of 18 live through that can cause traumatic, lasting physical, mental and emotional impacts. Having a parent who uses substances, being physically abused, or growing up with food insecurity are all examples of ACEs. The more ACEs a person has experienced, the higher their risk for many health and behavioral issues, including substance use. Prevention of children living through ACEs will decrease the likelihood for substance use in the future.

YAS respondents were asked whether they had experienced a variety of ACEs situations. Less than half (41.3%) reported having experienced zero ACEs in childhood making the occurrence of ACEs in childhood more common than not. Experiencing four or more ACEs places an individual at extremely high risk of using substances. Almost one in five (17.7%) of young adults in Virginia reported having experienced four or more ACEs – the highest level of risk possible.

Over half (58.7%) of young adults reported having experienced at least one ACE before the age of 18.



N=4,620

When examining sub-populations to get a better understanding of who is experiencing such high rates of ACEs, it became very clear that LGBQ+ and trans and gender diverse individuals are disproportionately experiencing more ACEs than their peers. LGBQ+ respondents were more than twice as likely to report experiencing four or more ACEs (30.2%) compared to their non-LGBQ+ peers (13.3%). Their non-LGBQ+ peers were more than twice as likely to have experienced no ACEs in childhood or adolescence (48%) compared to LGBQ+ peers (22.9%). Trans and gender diverse respondents were more than 2.5 times more likely to report experiencing four or more ACEs (41.5%) than their non-trans and gender diverse peers (16.5%). Non-trans and gender diverse young adults also reported almost three times the level of no ACEs experiences (42.8%) compared to their trans and gender diverse peers (15%). These data may speak to the need for more focused resources and prevention efforts on LGBQ+ and trans and gender diverse populations.

LGBQ+ and Trans and Gender Diverse young adults experience higher rates of ACEs in childhood. BIPOC and White young adults report similar rates of ACEs.

Number of ACEs Reported:		0	1	2	3	4+
Black, Indigenous, People of Color (BIPOC)	BIPOC (n=1,762)	41.4%	19.1%	13%	9.7%	16.8%
	Non-BIPOC (n=3,108)	40.1%	17.8%	13.5%	9.5%	19.1%
LGBQ+	LGBQ+ (n=1,247)	22.9%	18%	15.6%	13.3%	30.2%
	Non-LGBQ+ (n=3,373)	48%	18.1%	12.2%	8.3%	13.3%
Trans and Gender Diverse (TGD)	TGD (n=260)	15%	15.4%	14.2%	13.8%	41.5%
	Non-TGD (n=4,360)	42.8%	18.3%	13%	9.4%	16.5%

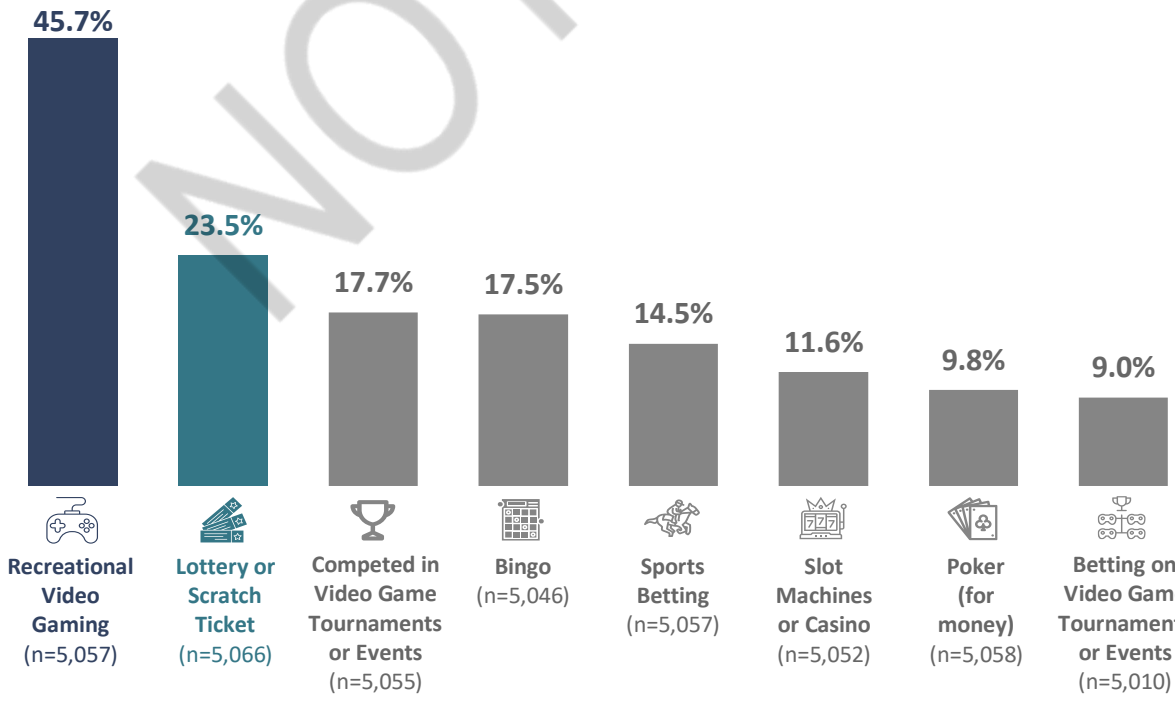
Gaming and Gambling

In recognition of the legalization of gambling in Virginia, measures were included to allow for a better understanding of engagement in gaming and gambling activities, as well as impact of gaming and gambling on behaviors. To date, there was very little existing data on gaming and gambling behaviors, especially among young adults. Virginia has legalized several gaming and gambling outlets, such as sports betting and casinos, with multiple casinos in development across the commonwealth.

Gaming, including video games, often have gambling or gambling-like components incorporated into the game itself as way for the video game producer to increase profits. This might include paying fees or making purchases within games for opportunities to win strategic gameplay, like special abilities, advanced avatars or coins.

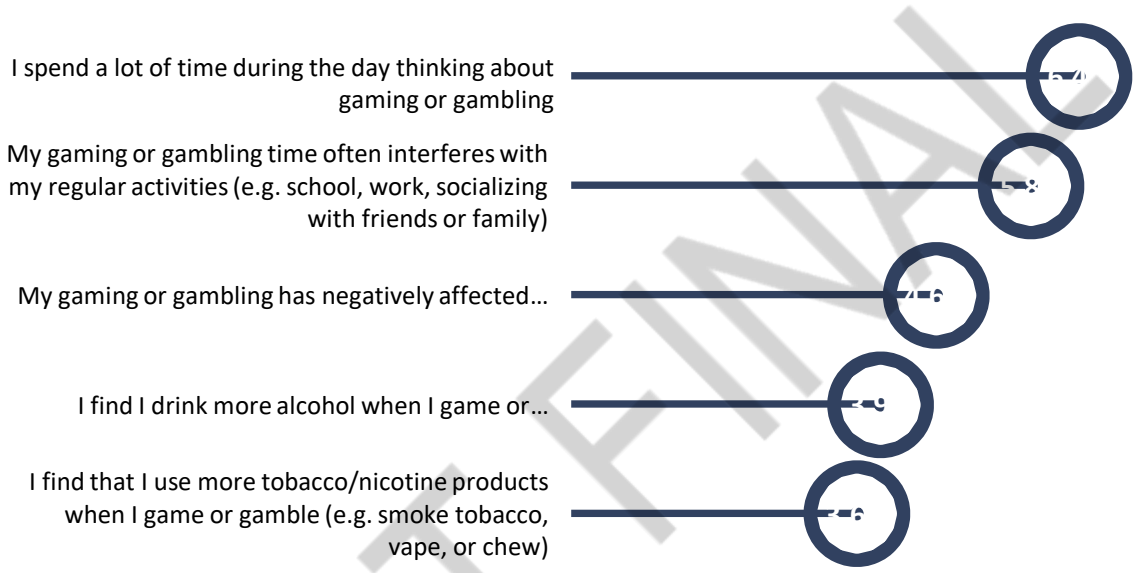
63.6% of young adults in Virginia who responded to the survey had participated in at least one gaming or gambling activity in the past 30 days. This could have included participating in video games, buying lottery tickets, playing bingo or sports betting. With almost two-thirds of young adults participating in gaming and gambling activities, it is commonplace and might be considered 'normal' behavior. Data show that 15.6% of respondents play video games recreationally daily or almost daily, with 2.8% competing in video game tournaments and 1.6% betting on online gaming tournaments daily or almost daily. It will be interesting to see if the level of gambling in casinos or using slot machines (11.6%) changes as at least three more casinos plan to open by 2025.

Almost half of respondents participated in video games in the past 30 days, while almost a quarter had purchased lottery tickets.



63.9% of respondents indicated at least one area where gaming or gambling had impacted their daily life – however, not all impacts were negative. 1 in 10 respondents (10.6%) who had participated in a gaming or gambling activity in the past 30 days shared that gaming or gambling helps them build or maintain social connections and friendships. This again illustrates how common gaming and gambling is for young adults, and how it may be ingrained in social and cultural norms. For example, bingo games to support charity organizations, or video game consoles being marketed as a holiday gift, especially to youth.

Preoccupation with gaming or gambling throughout the day was the most common negative impact for respondents who participated in the past 30 days.



Gaming and gambling remain emerging topics, and prevention efforts are newly forming in Virginia and elsewhere, as laws continue to evolve. Further study may be required to understand how best to frame prevention efforts for maximum impact.

Sustainability

All 40 CSBs worked on developing a partnership structure that will continue to function into the future. In FY21-22, all 40 CSBs again reported that they are working in one or more ways to ensure that prevention intervention activities and outcomes can be sustained in their communities. **Overall, in building sustainability, CSBs reported doing more related activities this year (167) than the year before (163)**.


Worked to develop a partnership structure that will continue to function into the future (40 CSBs)


Worked to ensure prevention intervention activities are incorporated into the missions/goals and activities of other organizations (33)


Leveraged, redirected, or realigned other funding sources or in-kind resources (27)


Worked to gain formal adoption of prevention intervention activities into other organizations' practices (27)

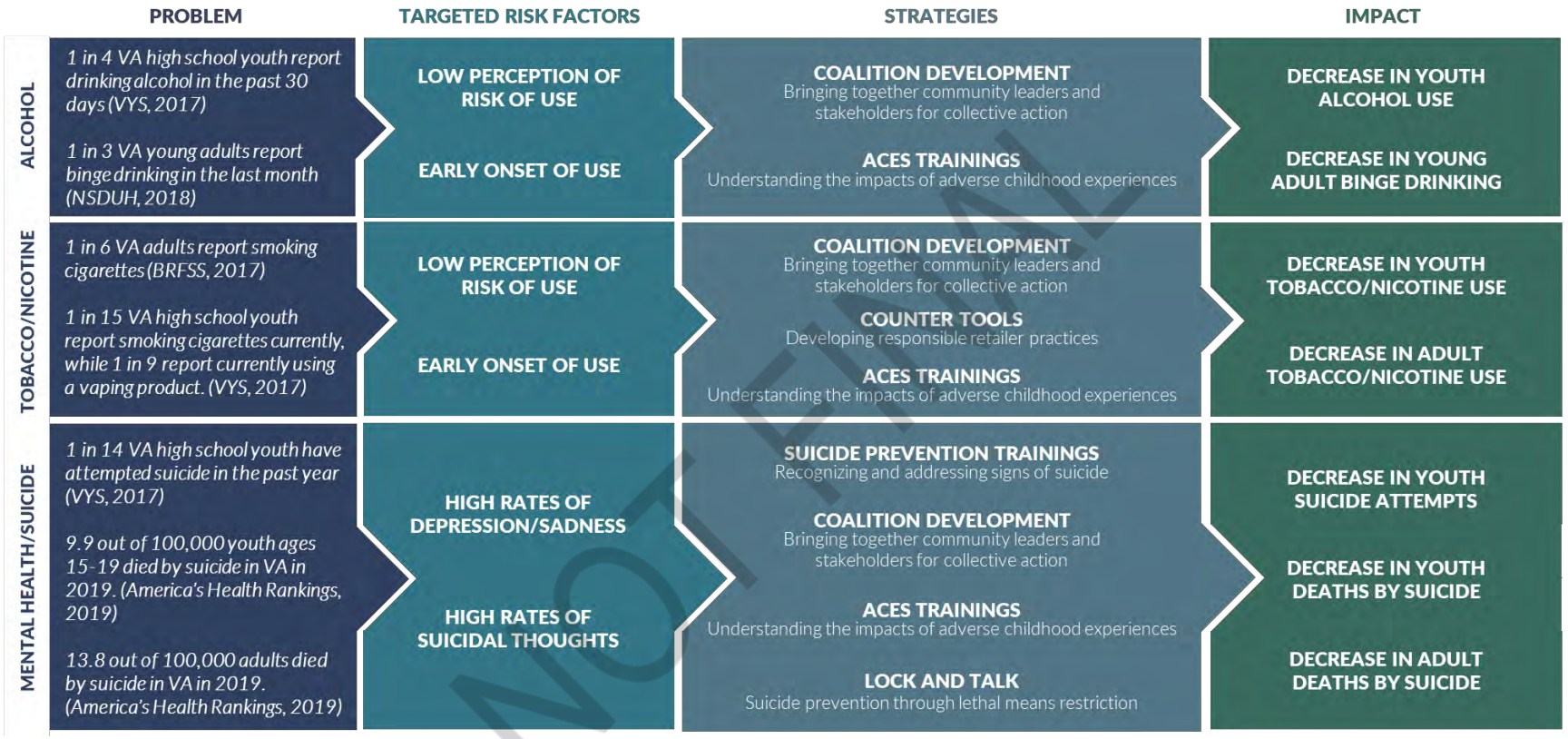

Worked to ensure that prevention staff positions are folded into other organizations (21)


Worked to implement local level laws, policies, or regulations to guarantee continuation of intervention (13)


Additional or other work was done (6)

Additional ways that CSBs worked to support their sustainability included attending town hall meetings, building community awareness via social media, and collaborating with other agencies. One CSB noted that they help build prevention capacity of other organizations. Another restructured their coalition's governance and added working committees. Thirteen CSBs also noted they developed a plan to sustain progress made in addressing substance use-related health disparities into the future.

Appendix A: Virginia Block Grant Logic Model 2020-25



Appendix B: YAS Sub-Group Breakdown

Sub-Group	Identities included in this sub-group	Comparison Group	# respondents from sub-group	% of total sample
BIPOC	Respondents who selected at least one of the following identities: • American Indian or Alaska Native • Asian or Asian American • Black, African, or African American • Middle Eastern or North African • Native Hawaiian or Other Pacific Islander • More than once race • Hispanic or Latino/Latino/Latinx	Respondents who **only** selected the following: • White • Not Hispanic or Latino/Latina/Latinx	1,976	**37%**
LGBQ+	Respondents who selected at least one of the following identities: • Asexual/Aromantic • Bisexual • Gay • Lesbian • Pansexual • Queer • Questioning • Prefer to self-identity	Respondents who **only** selected the following: • Heterosexual or straight	1,339	**25%**
Student	Respondents who selected at least one of the following identities: • College Student – full-time • College Student – part-time • High School student	Respondents who **did not** selected any of the following: • College Student – full-time • College Student – part-time • High School student	2,627	**49%**

Transgender and Gender Diverse	Respondents who selected at least one of the following identities: • Agender • Genderfluid • Non-Binary/Genderqueer • Questioning • Trans Woman, Transfeminine, MTF (AMAB) • Trans Man, Transmasculine, FTM (AFAB) • Two-Spirit/Third Gender • Prefer to self-identify	Respondents who **only** selected one or more of the following: • Man • Woman • Cisgender Man • Cisgender Woman	272	**5%**
Under 21	Respondents ages 18 through 20	Respondents ages 21 through 25	2,351	**44%**

Virginia Statewide Substance Use and Behavioral Health Needs Assessment

Submitted to the Virginia Department of Behavioral Health and Developmental Services

August 2018

Virginia Statewide Substance Use and Behavioral Health Needs Assessment

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Executive Summary

INTRODUCTION

In the spring of 2018, OMNI Institute (OMNI) collaborated with the Virginia Department of Behavioral Health and Developmental Services (DBHDS), Office of Behavioral Health Wellness to examine the status and needs related to behavioral health and substance use in Virginia. The report represents the synthesis of more than seventeen national and local secondary data sources, including: health surveys; morbidity and mortality data; criminal justice and law enforcement records; and population and social determinants of health statistics. In addition, OMNI collected primary data from over three dozen stakeholders through: a facilitated discussion of the data findings with the Statewide Epidemiology Outcomes Workgroup; a discussion of priority areas with DBHDS staff; and a SWOT analysis with local prevention staff.

KEY FINDINGS

This needs assessment revealed that the longstanding focus of prevention work on alcohol and tobacco remains a need in Virginia. As such, these two substances are designated priority areas along with mental health and suicide. The selection of these areas as priorities is supported by historical and current prevalence and consequence data, as well as input from DBHDS, the Virginia Statewide Epidemiology Outcomes Workgroup, and Community Service Boards (CSBs).

In recent years, DBHDS has shifted the prevention infrastructure in Virginia by emphasizing environmental prevention strategies and encouraging data-driven work. The recent completion of needs assessments and strategic planning by each CSB provided an excellent foundation for advancing work towards these goals.

Moving forward, DBHDS must balance its strategic direction and priority areas with emerging and topical public health issues that often shift attention from the longstanding prevention priorities. With this needs assessment and the ensuing strategic planning, DBHDS will be well-positioned to manage Virginia's prevention priorities and leverage its resources for significant impact and success.

PRIORITY AREAS

Priority areas are substances or issues that have high prevalence, significant consequences, and represent public or behavioral health challenges across the Commonwealth.

Alcohol

Alcohol is the most commonly used substance in Virginia with 25% of high schoolers and 56% of adults consuming alcohol in the past 30 days. In the past 10 years, **the rate of alcohol-related deaths has increased**. While Virginia has taken steps to address the ongoing issue of alcohol use, it remains a critical public health issue that affects many Virginians.

Tobacco and Nicotine

Twenty-six percent of Virginia adults and 16% of Virginia high schoolers have used some form of tobacco or nicotine in the past month. While tobacco use has decreased in recent years, **Virginia's 30 cent tax per pack of cigarettes is the second-lowest in the country**. In the past several years, e-cigarettes and vaping have increased in popularity, especially among youth (**33% of high schoolers have tried an electronic vapor product**). These products present a new challenge to the ongoing work of preventing tobacco use in Virginia.

Mental Health and Suicide

Mental health and suicide has been a longstanding issue in Virginia with approximately **20% of Virginians experiencing a mental illness** each year. More recently, Virginia has seen an **increase in symptoms of depression and thoughts of suicide** among youth, young adults, and adults. In addition to having high prevalence, the consequences of these trends are serious; **suicide is the leading cause of death for individuals with mental health and substance use disorders**.

AREAS TO WATCH

Areas to watch include substances or issues for which prevalence is relatively low, but trending upward. Although the consequences of these issues may be severe, the current prevalence does warrant assigning priority status. Future data may indicate that these issues should be elevated to priorities, and the data should be monitored accordingly.

Opioids

The opioid crisis was declared a national public health emergency in 2017. In Virginia, **opioids are the leading cause of fatal overdoses**.

Marijuana

In Virginia, marijuana is **more popular among youth than adults**. There are concerns about how cultural and social norms will impact marijuana use as more states legalize marijuana.

Cocaine and Meth

Rates of both cocaine and methamphetamine use remain low. However, their consequences, such as **arrests, drug seizures, and fatal overdoses, are trending upward.**

COMMUNITY INPUT AND ASSESSMENT

Thirty-one prevention staff members from across the Commonwealth participated in SWOT (Strengths, Weaknesses, Opportunities, Threats) discussions, in which they identified several strengths and weaknesses of the prevention workforce, funding structure, and CSB operations. In addition, participants identified external opportunities that could facilitate prevention work in the future, as well as threats that pose challenges to prevention work and may be areas to address in future years.

Strengths Strong **partnerships, coalition support,** and **passionate staff** are essential to prevention work, and CSBs are already successfully incorporating these items into their work in the priority areas.

Weaknesses Both CSBs and DBHDS highlighted **funding, staff resources**, and **workforce skills** as key internal weaknesses that hinder prevention work in the priority areas.

Opportunities DBHDS's **emphasis on environmental strategies** requires a switch from direct service to indirect, community-wide approaches. Many voiced the desire for additional **trainings, support, and resources** to shift their work in this direction.

Threats Larger trends in the **cultural and social acceptance of substance use**, and the **alignment of funding** with these priority areas, are perceived as major external threats to prevention work.

RECOMMENDATIONS

After reviewing data trends, discussing with DBHDS and the State Epidemiology Outcomes Workgroup, and receiving input from stakeholders across the Commonwealth, three key areas for potential growth and action emerged:

Fund Priorities Strategically impact priority areas by funding **strategies and outcomes** that address **appropriate risk and protective factors**.

Build Capacity Support the prevention workforce across Virginia with **training and peer learning opportunities**.

Lead Initiatives Lead efforts for **statewide messaging, advocacy, collaboration,** and **decision-making** that facilitate effective prevention work across the Commonwealth.

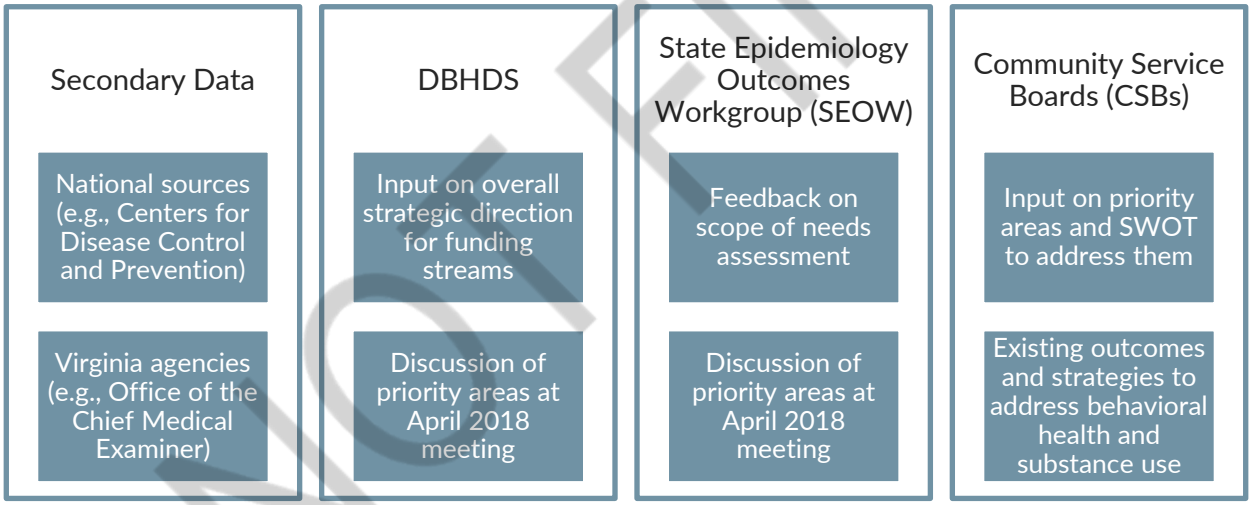
Introduction

BACKGROUND

This report was prepared by OMNI Institute (OMNI), under the direction of the Virginia Department of Behavioral Health and Developmental Services (DBHDS), Office of Behavioral Health Wellness, to examine the status and needs related to behavioral health and substance use in Virginia. OMNI has partnered with DBHDS since 2014 to provide evaluation and capacity building for the Substance Abuse Prevention Block Grant funding that is distributed to the 40 Community Service Boards (CSBs) across the Commonwealth. OMNI has also served as a technical assistance partner and evaluator for Virginia's Partnerships for Success grant since 2016, which funds nine communities to address prescription drug and heroin abuse.

METHODS AND DATA SOURCES

This report represents the synthesis of primary and secondary data from a variety of sources. OMNI completed data gathering and preparation of this report from February – June 2018.



Data collection began with the compilation of a comprehensive list of indicators measuring topics related to behavioral health and substance use from national sources, Virginia agencies, and the Virginia Social Indicator Dashboard[1]. OMNI shared this list of indicators with the State Epidemiology Outcomes Workgroup (SEOW) to solicit feedback on the scope of the needs assessment, and ensure that all relevant topics would be considered in the data collection process. A copy of the indicator list can be found in Appendix A. Needs Assessment Indicator Listand

[1] The Virginia Social Indicator Dashboard is an online interactive resource that houses behavioral health indicator data from agencies throughout Virginia. It can be used by stakeholders to examine trends across behavioral health areas, as well as to assess areas of strength and need for specific geographic areas. See https://vasisdashboard.omni.org/rdPage.aspx?rdReport=Home.

additional information about data sources included in the needs assessment can be found in the References section of the report.

OMNI gathered data based on the final indicator list, including national, state, and local indicators, as well as trends over time. After reviewing these data, OMNI identified themes and key findings to share with DBHDS and the SEOW. These findings were organized to examine the relative prevalence and trend data for seven substances (alcohol; tobacco; marijuana; prescription opioids; heroin and fentanyl; cocaine; and methamphetamines), mental health and suicide, and risk and protective factors. In April 2018, OMNI held facilitated discussions with DBHDS and the SEOW. During these meetings, the data were presented and both groups discussed what they viewed as the top behavioral health and substance use issues in the Commonwealth based on the data; what root causes were driving these issues; and what resources are needed to address these issues. A copy of the data presentation can be found on the Resources page of the Virginia Social Indicator Dashboard.[2] A copy of the discussion questions used can be found in Appendix B. The results of these discussions are included in this report and provided guidance for a second round of data collection within the identified priority areas following the April meetings.

Following the identification of priority areas, OMNI conducted an extensive SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis with CSB staff and prevention directors doing on-the-ground prevention work across Virginia. These meetings were designed to gather the perspectives of the local staff on: the internal strengths and weaknesses of CSBs; their ability to work towards the priority areas; and the external threats and opportunities surrounding their work. Eight SWOT focus groups and discussions were conducted. The focus group topics were divided by substance or behavioral health issue, allowing for two groups to focus on each of the three priority areas – alcohol; tobacco and nicotine; and mental health and suicide. An additional two discussions took place with staff from DBHDS. In total, 31 prevention staff participated in the discussions. A copy of the SWOT discussion questions can be found in Appendix C.

Finally, OMNI incorporated contextual information and data from the evaluation and technical assistance work that OMNI does with CSBs and communities across Virginia. This included aggregating information from technical assistance documents regarding strategies, resources, and outcomes in place through existing prevention funding.

[2] Direct link to the data presentation slides: https://datadashboard.omni.org/VASIS/ExportFiles/SEOW%20Needs%20Assessment%20Presentation.pdf

Substance Use and Behavioral Health in Virginia

DBHDS and the SEOW have identified priority areas to address in Virginia, along with areas to watch. Priority areas are substances or issues that have high prevalence, significant consequences, and represent public or behavioral health challenges across the Commonwealth:

- **Alcohol** is the most commonly used substance in Virginia with 25% of high schoolers and 56% of adults consuming alcohol in the past 30 days. In the past 10 years, the rate of alcohol-related deaths has increased. While Virginia has taken steps to address the ongoing issue of alcohol use, it remains a critical public health issue that affects many Virginians.
- **Tobacco and nicotine** is currently used by 26% of Virginia adults and 16% of Virginia high schoolers. While tobacco use has decreased in recent years, Virginia's 30 cent tax per pack of cigarettes is the second-lowest in the country. In the past several years, e-cigarettes and vaping have increased in popularity, especially among youth (33% of high schoolers have tried an electronic vapor product). These products present a new challenge to the ongoing work of preventing tobacco use in Virginia.
- **Mental health and suicide** has been a longstanding issue in Virginia with approximately 20% of Virginians experiencing a mental illness each year. More recently, Virginia has seen an increase in symptoms of depression and thoughts of suicide among youth, young adults, and adults. In addition to having high prevalence, the consequences of these trends are serious; suicide is the leading cause of death for individuals with mental health and substance use disorders.

Areas to watch include substances or issues for which prevalence is relatively low, but trending upward. Although the consequences of these issues may be severe, the current prevalence does warrant assigning priority status. Future data may indicate that these issues should be elevated to priorities, and the data should be monitored accordingly:

- **Opioids:** The opioid crisis was declared a national public health emergency in 2017. In Virginia, opioids are the leading cause of fatal overdoses.
- **Marijuana:** In Virginia, marijuana is more popular among youth than adults. There are concerns about how cultural and social norms will impact marijuana use as more states legalize marijuana.

- **Cocaine and Methamphetamines:** Rates of both cocaine and methamphetamine use remain low. However, their consequences, such as arrests, drug seizures, and fatal overdoses, are trending upward.

DBHDS and the SEOW recognize that these priorities do not cover the full scope of challenges in the areas of substance use and behavioral health in Virginia. However, these represent current issues of note across the Commonwealth, and offer a data-driven assessment of existing prevention priorities.

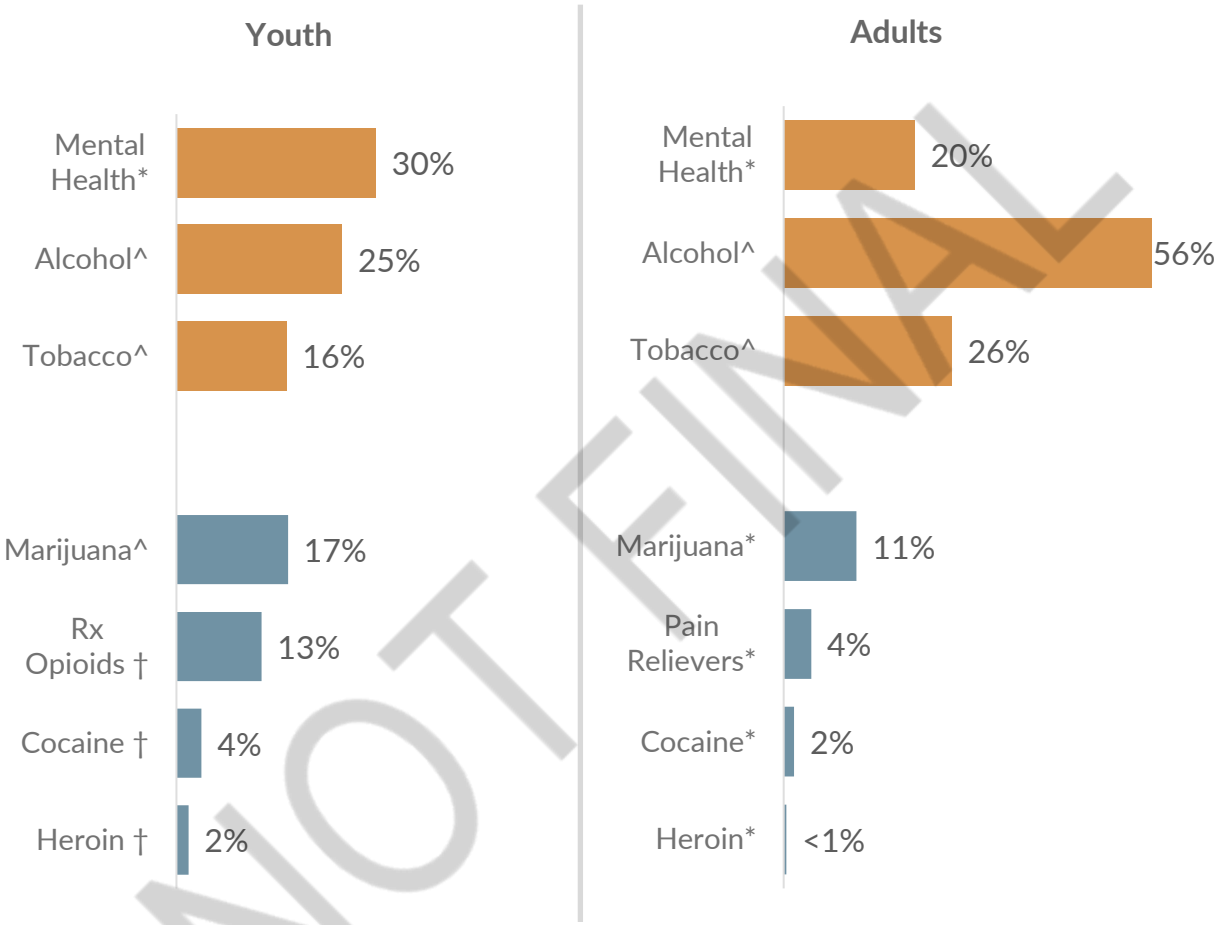
The following pages include selected data for each of the priority areas and areas to watch. These data are not comprehensive pictures of each substance or mental health issue in Virginia, but do provide insight into the prevalence, consequences, and disparities that are most pressing in each area.

Data for selected risk and protective factors are also provided. This information is integral to understanding and influencing substance use and behavioral health, and provides important context for the identified priority areas. Further, research indicates that targeting shared risk and protective factors can yield significant gains in prevention across several inter-related issue areas, including substance abuse and mental health.

Additional information about the priority areas, areas to watch, and risk and protective factors data can be found in the References section at the end of the report.

Prevalence of mental health issues and substance use are higher for **priority areas** than **areas to watch** among both youth and adults.

Across all substances, alcohol and tobacco use in the past month are most prevalent, even when compared with other substance use in the past year or in a person's lifetime.



^ Prevalence in the past month.

* Prevalence in the past year.

† Lifetime prevalence.

Youth data for high schoolers from the 2017 Virginia Youth Survey. Adult data for adults ages 18 and older from the 2015-16 National Survey on Drug Use and Health.

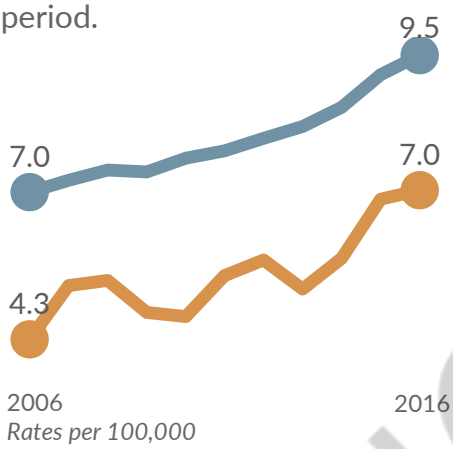
Priority Area: Alcohol

Alcohol is the most commonly used substance among youth and youth adults in Virginia. One-quarter of Virginia high schoolers (25%) report drinking alcohol in the past 30 days, which is significantly lower than the national average (30%). Since 2008, there has been a decrease in youth alcohol use, but rates remain high relative to other substances. The consequences of alcohol use, such as death and suicide, particularly affect males, 26-35 year-olds, and individuals living in Region 5 (eastern Virginia).

39%

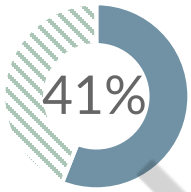
of persons who die by suicide are **intoxicated at the time of death.** [1]

From 2006 to 2016, the **rate of alcohol-induced deaths** in Virginia remained below the national rate. However, both rates increased during the period.

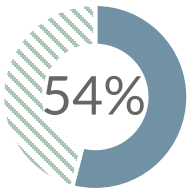


Among Virginians, in the **past 30 days:**

of underage youth had at least one drink

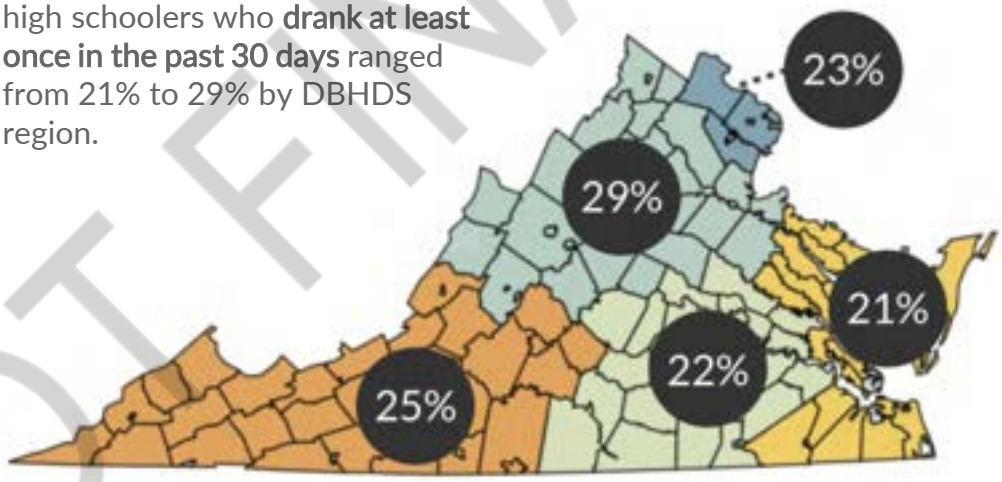


of young adults 18-25 binge drank[2] at least once

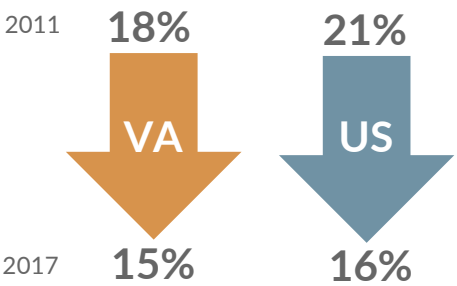


of all adults had at least one drink

Across Virginia, the percentage of high schoolers who **drank at least once in the past 30 days** ranged from 21% to 29% by DBHDS region.



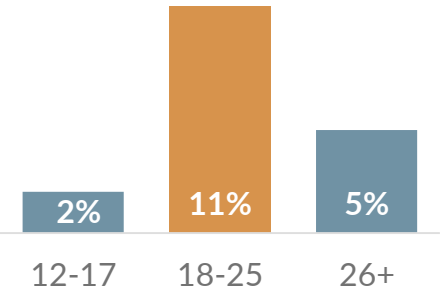
The percentage of youth in Virginia who had their **first drink of alcohol before age 13** has followed national trends and decreased significantly since 2011.



20%

of **intake cases for behavioral health** services report alcohol use, making it the most common substance of use among intake cases.

The percentage of **young adults** (ages 18-25) who **needed but did not receive treatment** for alcohol misuse in the past year is more than twice as high as adults aged 26 years and older.

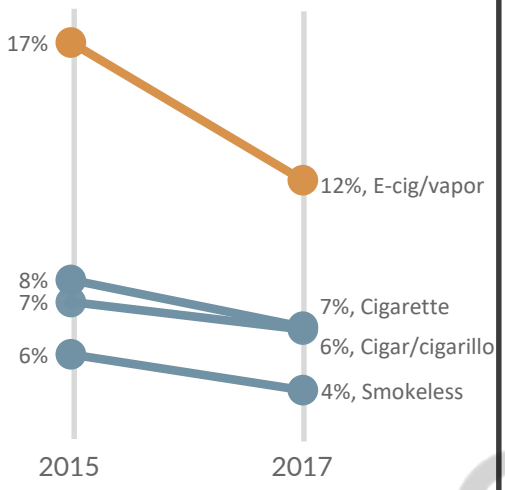


[1] Includes individuals with a Blood Alcohol Level (BAC) greater than 0%. [2] Binge drinking is

Priority Area: Tobacco and Nicotine

Tobacco was colonial Virginia's most successful cash crop and today Virginia is the fourth-largest producer of tobacco nationwide. Sixteen percent of Virginia high schoolers used some form of tobacco or nicotine in the past 30 days, which is significantly lower than the national average (20%). Use of all forms of tobacco and nicotine have decreased in recent years, however, e-cigarettes and vaping are especially popular among youth (33% of high schoolers have tried an electronic vapor product).

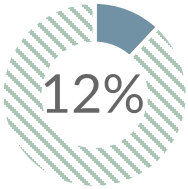
Although the percentage of youth who currently use **e-cigarettes and vapors** decreased from 2015 to 2017, it is still nearly twice as high as any **other tobacco or nicotine** product. One in six Virginia high schoolers **used some form of tobacco or nicotine in the past 30 days.**



Tax per pack of cigarettes in Virginia is the second-lowest in the country:

30¢

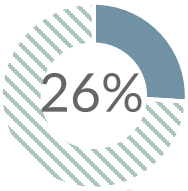
Annually, Virginia spends just



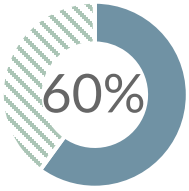
of the amount recommended by the CDC for state **tobacco control programs.**

Tobacco and nicotine use among Virginia adults:

have ever tried an e-cigarette or e-vaping product

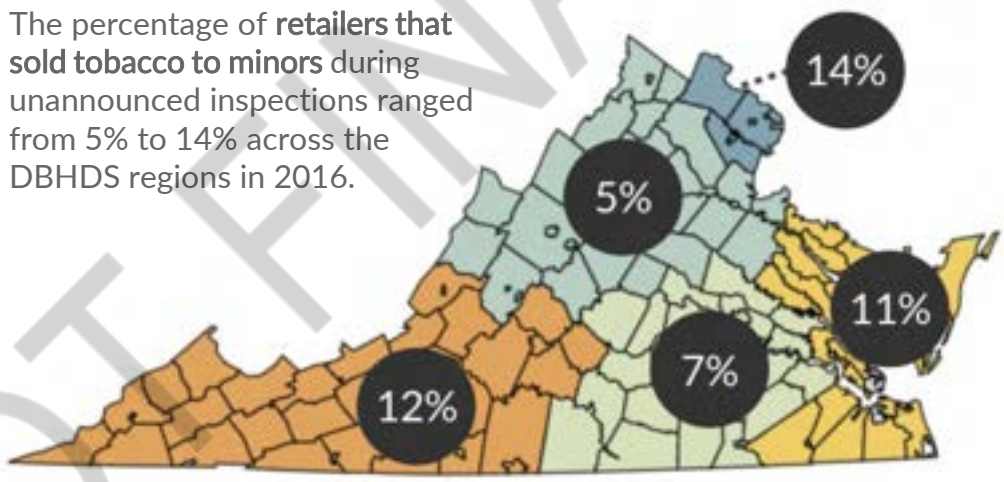


used a tobacco product in the past month

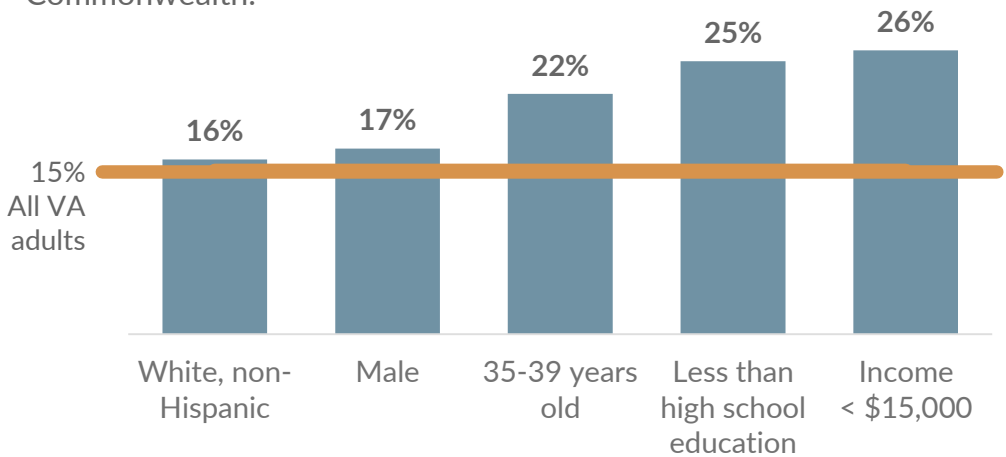


of current smokers tried to quit in the past year

The percentage of **retailers that sold tobacco to minors** during unannounced inspections ranged from 5% to 14% across the DBHDS regions in 2016.



Among **all Virginia adults**, the **current cigarette smoking rate** is 15%. However, the smoking rates among several **subpopulations** are disproportionately high compared to the average across the Commonwealth.



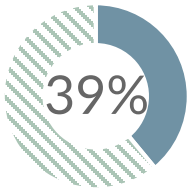
Priority Area: Mental Health and Suicide

Mental health and suicide are serious public health issues that impact individuals, families, and communities across Virginia. Suicide is the leading cause of death among individuals with substance use disorders, and individuals who have co-occurring mental illness are at an even higher risk. Across Virginia, rates of mental illness, suicidal thoughts, and intakes to mental health services have risen over recent years. Among youth, white individuals and females are more likely to report mental health concerns.

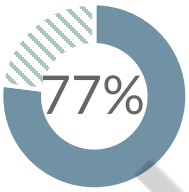
1,166

suicides were recorded in Virginia in 2016, a rate of 13 per 100,000 persons.

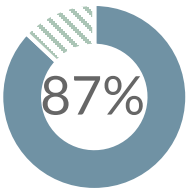
Of the **Virginians who died by suicide** from 2003-2012:



were intoxicated[1]

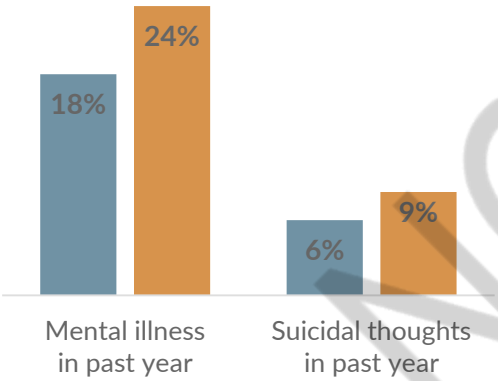


were male



were white

From 2008-09 to 2015-16, there were significant increases in the percentages of young adults (ages 18-25) who experienced **mental illness and suicidal thoughts**. These percentages are higher than those for adults 26 years and older.

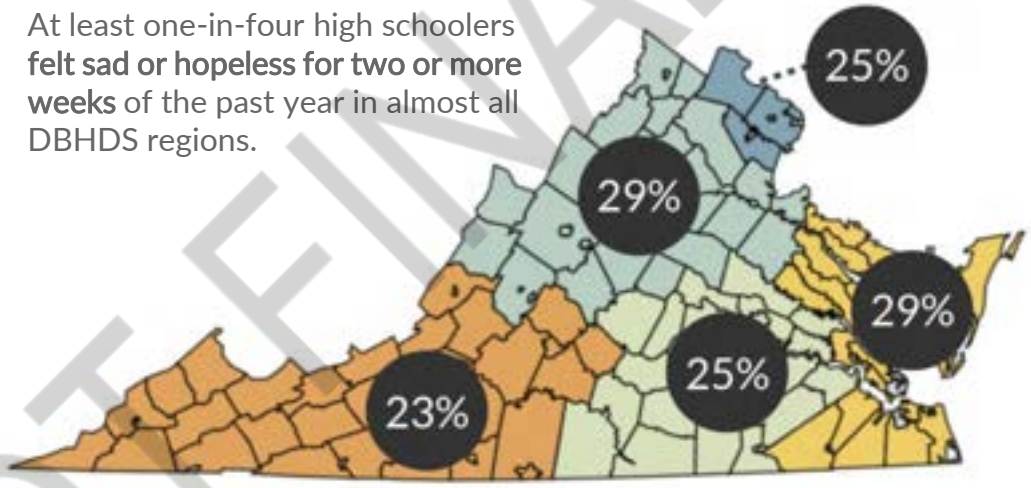


From 2008 to 2016, there was a

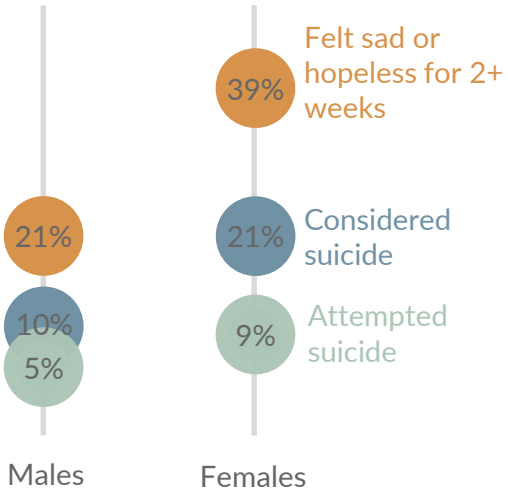
23%

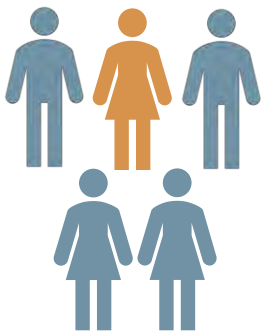
increase in the number of **intakes to mental health services** in Virginia.

At least one-in-four high schoolers **felt sad or hopeless for two or more weeks** of the past year in almost all DBHDS regions.



Among Virginia high schoolers, **mental health concerns** are significantly more prevalent in females than males.





1 in 5 adults **experienced mental illness** in the past year

[1] Includes individuals with a Blood Alcohol Level (BAC) greater than 0%.

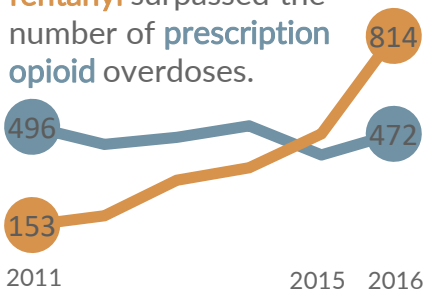
Area to Watch: Opioids

Opioids are a class of drugs that includes prescription pain relievers, heroin, and synthetic opioids such as fentanyl. Opioids have received significant attention with the federal government declaring the opioid crisis a public health emergency in 2017. In Virginia, rates of opioid use are lower compared to tobacco, alcohol, and marijuana. However, every 12 hours, a Virginian dies from an opioid overdose, and heroin/fentanyl overdoses are of particular concern due to sharply increasing trends in the past three years.

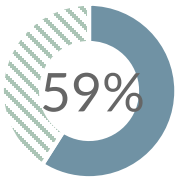
13%

of Virginia high schoolers have **misused a prescription drug.**

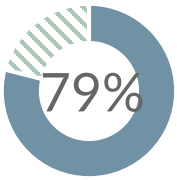
In 2015, the number of **fatal overdoses** on **heroin and/or fentanyl** surpassed the number of **prescription opioid** overdoses.



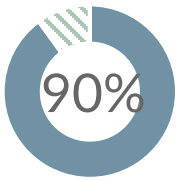
Of the **3,236 fatal prescription opioid overdose** cases from 2007-2015:



were male



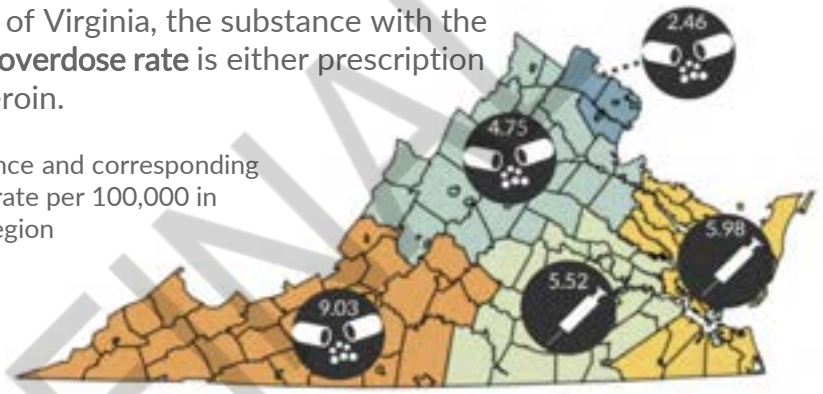
were 25-54 years old



were white

In all regions of Virginia, the substance with the **highest fatal overdose rate** is either prescription opioids or heroin.

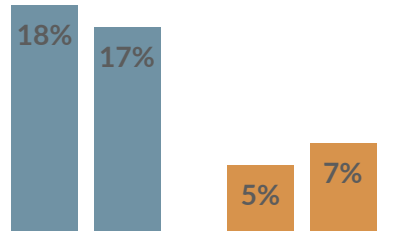
Leading substance and corresponding fatal overdose rate per 100,000 in each DBHDS region



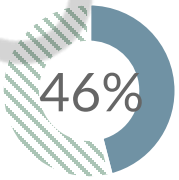
Area to Watch: Marijuana

Nine states and Washington, DC have legalized recreational marijuana use for individuals over 21. As of 201,8 recreational marijuana is not legal in Virginia, however, 17% of Virginia high schoolers had used marijuana in the past 30 days. This is significantly lower than the national rate of 20%. As has been the case for several years, youth continue to use marijuana at a higher rate than adults in Virginia.

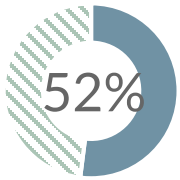
The percentage of Virginia **youth** who **used marijuana in the past 30 days** has remained steady, while **adult** use has increased a small but significant amount.



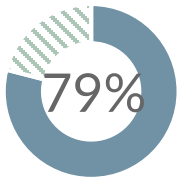
Of the **23,174 marijuana-related arrests** in Virginia in 2016:



were black



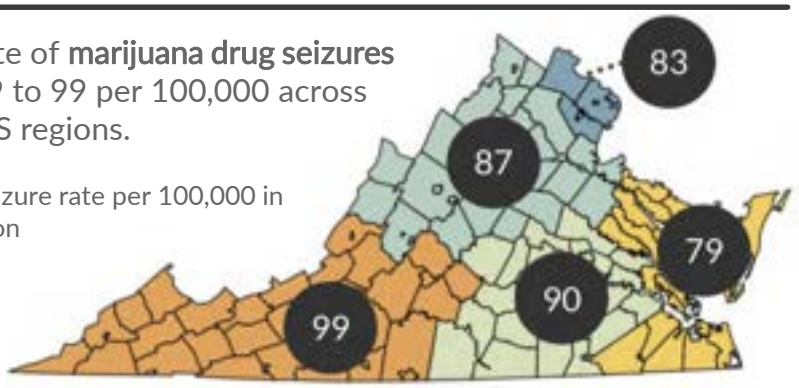
were 18-24 years old



were male

In 2016, the rate of **marijuana drug seizures** ranged from 79 to 99 per 100,000 across the five DBHDS regions.

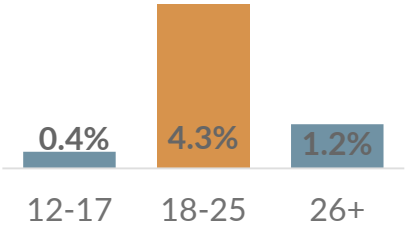
Marijuana drug seizure rate per 100,000 in each DBHDS region



Area to Watch: Cocaine

Among adults, self-reported cocaine use in the past year has remained steady since 2008, at less than 2%. A total of 3.7% of Virginia high school students have used cocaine in their lifetime which is lower than the national rate of 4.8%. More recently, the consequences of cocaine use have increased. From 2015 to 2016, arrests, drug seizures, and fatal overdoses related to cocaine began rising. These consequences disproportionately affect young adults and black individuals in Virginia.

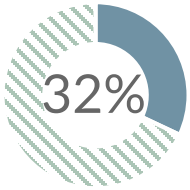
The percentage of **young adults** (ages 18-25) who **used cocaine in the past year** is more than three times as high as **youth and adults 26 years and older**.



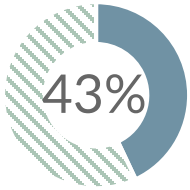
20%

of all **drug seizure cases in 2016 were cocaine-related**, making it the most commonly seized drug that year.

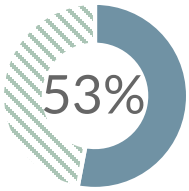
20% of Virginia's population is black, however, blacks account for:



of fatal cocaine overdoses



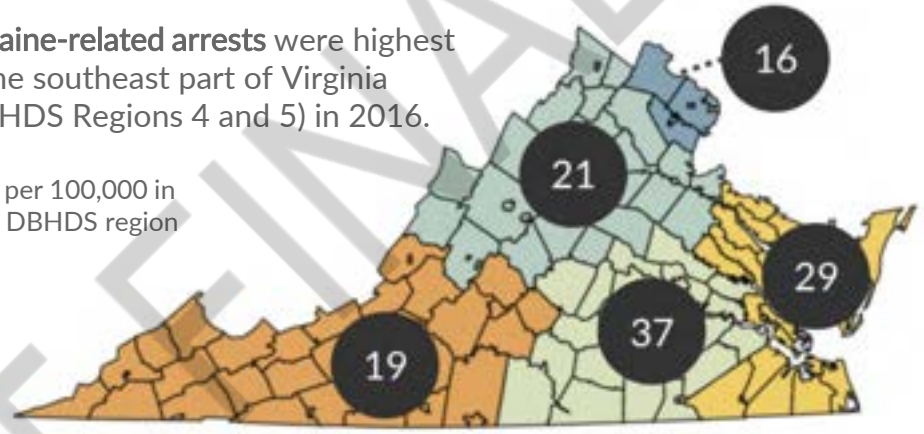
of cocaine-related behavioral health intakes



of cocaine-related arrests

Cocaine-related arrests were highest in the southeast part of Virginia (DBHDS Regions 4 and 5) in 2016.

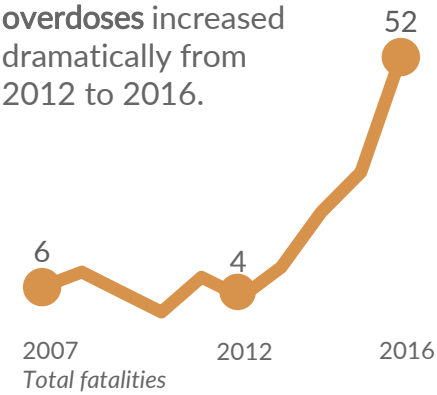
Rate per 100,000 in each DBHDS region



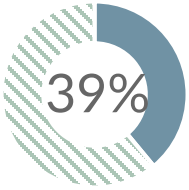
Area to Watch: Methamphetamines

Compared to other substances, the rates of methamphetamine usage are low; less than 2% of Virginia high school students used methamphetamines in the past 30 days. Similar to cocaine, the consequences of methamphetamine use have increased. The rates of fatal overdoses, arrests, and drug seizures related to methamphetamines increased between 2015 and 2016.

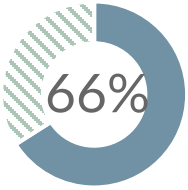
After several years without much change, the number of **fatal methamphetamine overdoses** increased dramatically from 2012 to 2016.



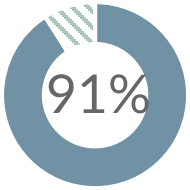
Of the **1,671 methamphetamine-related arrests** in 2016:



were 25-34 years old



were male



were white

RISK AND PROTECTIVE FACTORS

Risk factors increase the likelihood of negative outcomes, while protective factors guard against negative outcomes. Effective prevention strategies involve the use of evidence-based practices and programs designed to reduce risk factors or increase protective factors operating at multiple levels. The organization of risk and protective factors for this assessment is based on the Communities That Care (CTC) framework developed by Hawkins and Catalano, which identifies multiple domains of risk and protective factors (individual, family, school, community) that collectively determine youth risk for substance abuse, mental health issues, delinquency, and other problem behaviors.[3]

Outlined below are selected risk (—) and protective (✚) factors that are relevant to behavioral health and substance use outcomes across Virginia. Targeting these factors through prevention initiatives is an effective approach for impacting outcomes across the identified priority areas.

Individual

- — **Perceived risk of harm of substance use** among adults is lowest for smoking marijuana once per month and binge drinking 1-2 times per week.
- — Approximately 12% of 16-24 year-olds are considered **disconnected** (i.e., they are not working or in school).
- — The **teen pregnancy rate** has declined to 7.3%, however, it remains higher than the national average of 5.8%.
- ✚ **Perceived risk of harm** from substance use is highest for trying heroin, using cocaine once per month, and smoking one or more packs of cigarettes per day.

Family

- — 19.4% of Virginians **live in a household with someone who has a mental illness**. 26.9% live with someone with **substance abuse concerns**.
- — Nearly 1 in 3 Virginia youth live in **single-parent households**.
- — 55,258 children were reported as **possible victims of abuse or neglect** in 2017.
- ✚ Over two-thirds of high schoolers (71%) report **eating dinner at home with at least one parent** on four or more days in the past week.

[3] Hawkins, J.D., Catalano, R.F., & Miller, J.Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention. *Psychological Bulletin, 112*(1), 64-105.

School

- Nearly 1 in 6 youth report having been **offered, sold, or given illegal drugs on school property**.
- The percentage of students who **graduate within four years of entering high school** has risen steadily since 2008 to its current rate of 91%.
- Over 60% of youth report **having an adult to talk to at school**.

Community

- The proportion of **children living in poverty** has remained steady between 14% and 15% for the last 5 years.
- Virginia had 11,181 recipients of **SNAP, TANF, and/or Medicaid** in 2017, a number which has remained fairly stable since 2012.
- **Unemployment rates** are on the decline in Virginia, dropping from 7% in 2009 to 4% in 2016.

TARGET POPULATIONS TO MONITOR

In addition to identifying priority areas, DBHDS and the SEOW discussed target populations that may be particularly important to monitor within the priority areas. These populations emerged through a review of the data, as well as from the reflections of prevention experts who participated in the needs assessment discussions.[4] Resulting target populations reflect high-level focus areas that deserve attention and strategic planning. Communities may also identify additional target populations relevant to their particular locality that are important to consider when determining how best to address the identified prevention priorities.

Youth

Primary prevention with youth under 18 is an essential strategy to prevent initiation of substance use and build protective factors that support the prevention and identification of mental health issues.

- Among adult smokers in the U.S., nearly 90% report they began smoking before age 18.
- For most substances, use rates increase as adolescents get older. In Virginia, the percentage of 12th graders who report drinking alcohol in the past month (35%) is nearly three times higher than what is reported by 9th graders (12%).
- Nationally, half of all mental health problems begin by age 14.

Young Adults

Young adults (18-25 years old) tend to have higher substance use rates than most other age groups. They also pose a unique challenge to reach for prevention and services.

- Over 40% of Virginia's young adults report binge drinking in the past month, compared to 24% of adults 26 years and older.
- The percentage of Virginia's young adults who used marijuana in the past month (18%) is more than three times that of other adults. In addition, the percentage of young adults who perceive great risk of smoking marijuana (14%) is less than half that of other adults.
- The treatment gap for mental health is larger among young adults than youth or other adults. In 2015-16, 11% of Virginia's young adults reported needing but not receiving treatment, compared to 2% of youth and 5% of adults 26 years and older.

[4] A comprehensive assessment of all sub-populations was not included in the scope of the needs assessment. When possible, data is presented by different demographic and geographic sub-populations. The priorities shown here reflect the results of the discussion with DBHDS and the SEOW.

Active Military & Veterans

There is special concern for active military members and veterans because of the prevalence of tobacco and alcohol use in the military, and the impacts of military service on mental health.

- Half of Virginia's veterans are current or former smokers, compared to 37% of the non-veteran adult population.
- More than two-thirds of active military members nationwide (68%) report that the military culture is supportive of drinking alcohol, and more than 35% report drinking patterns indicative of possible alcohol use disorder.
- Mental health screenings of active military members nationwide show over 9% with probable depression and 8.5% with probable posttraumatic stress disorder (PTSD).

COMMUNITY INPUT AND ASSESSMENT

OMNI facilitated SWOT discussions to examine the environment in which prevention work is occurring in Virginia and to assess broader stakeholder agreement with identified priority areas. The SWOT (Strengths, Weaknesses, Opportunities, Threats) discussions were open to CSB representatives across the Commonwealth and the results of the eight discussions held with 31 prevention staff are outlined below. Discussion participants identified several strengths and weaknesses of the prevention workforce, funding structure, and CSB operations. In addition, participants identified external opportunities that could facilitate prevention work in the future, as well as threats that pose challenges to prevention work and may be areas to address in future years.

Overall Agreement on Virginia Prevention Priorities

Among the discussion participants, there was an **overall sense of agreement that the Commonwealth's priorities of alcohol, tobacco and nicotine, and mental health and suicide were important in the communities that CSBs served**. However, some felt that marijuana should also be a priority. It is a growing concern among prevention workers due to Virginia's recent legalization of some oil forms of medical marijuana. Prescription drugs, especially opioids, have also gained attention among prevention directors as a potential priority area. Some CSBs voiced concerns that tobacco has been treated as less of a priority given the recent media coverage around the opioid epidemic.

> "**If you are just looking at the use rates, that changes up the priorities**. If you're looking at marijuana creeping in as far as legislation and what's going on in the country, probably a state priority should have been marijuana. Not so much looking at use, but what's happening across the nation."

> "The problem with [alcohol and tobacco] is that **they are legal. And readily available. And they are socially accepted**."

Strengths

Strong partnerships, coalition support, and passionate staff are essential to prevention work, and CSBs are already successfully incorporating these items into their work in the priority areas.

Stakeholders were asked what helps to facilitate their prevention work, and what has worked well in their existing efforts. Overall, participants shared these strengths:

- Strong community partnerships and commitment of partners to prevention work, especially collaborations with schools, law enforcement, crisis centers, coalitions, court systems, advocacy groups, as well as DBHDS.

- Prevention staff who are passionate about what they do and the supportive leadership for prevention work around the Commonwealth.
- Diversified funding streams, particularly for tobacco prevention and behavioral health.
- Coordinated efforts for tobacco, such as Counter Tools, that every CSB has implemented.

Weaknesses

Both CSBs and DBHDS highlighted funding, staff resources, and workforce skills as key internal weaknesses that hinder prevention work in the priority areas.

Stakeholders were asked about the challenges or obstacles they face in their prevention work. Key themes included:

"Other states have been more successful in their campaigns because there is a statewide message. Then there are sub-brands under that message for different populations and areas... **The lack of a statewide, coordinated campaign [in Virginia] is a weakness."**

"There is a lot of data that we have captured [using Counter Tools] that I think could be shaped into some useful information for awareness raising, as well as helping to potentially shape policy on local levels and across the state. But **the [lack of] time and the expertise is a challenge to take the data and turn it around into telling a story."**

- Lack of skills, funding, and time to implement successful large-scale media campaigns.
- Insufficient administrative support for direct service programs (such as Mental Health First Aid) to assist with scheduling, registration, and facilitation of trainings.
- Community partner limitations, such as schools with restrictive privacy rules and policies not conducive to prevention services or evaluation.
- Lack of skills and training to shift from direct service programs to environmental approaches.
- Shortage of financial resources to carry out day-to-day prevention work alongside other CSB responsibilities.
- Limited expansion of mental health and suicide prevention activities beyond direct service programs.
- Difficulty accessing current and local epidemiological data.
- Staff training shortages due to high demand and scheduling conflicts.

Opportunities

DBHDS's emphasis on environmental strategies requires a switch from direct service to indirect, community-wide approaches. Many voiced the desire for additional trainings, support, and resources to shift their work in this direction.

CSBs were asked to reflect on what types of external factors might help their prevention work to be more successful. Overall, participants shared these factors:

- Policy prevention strategies and support to CSBs for implementation of environmental strategies.
- Opportunities for collective and collaborative learning from other CSBs about promising practices and strategies being implemented around the Commonwealth.
- Development of accessible resources and strategies for sub-demographic populations, (e.g., Latinos, LGBTQ, children, and the elderly) such as adapting program curricula and providing cultural competency training to staff.
- Statewide messaging campaigns around each of the designated priority areas.
- Effective use of Counter Tools data at the local and statewide level, as well as for regulation of tobacco retailers.

Threats

Larger trends in the cultural and social acceptance of substance use, and the alignment of funding with these priority areas, are perceived as major external threats to prevention work.

Finally, participants were asked about the outside factors that influence their prevention work. Key threats that emerged included:

- Low perceived risk of substance use – alcohol and tobacco in particular – among parents and youth.
- Cultural acceptance of alcohol and tobacco use, even in youth, as evidenced by: the historical presence of the tobacco industry in Virginia; the rise of craft breweries and wineries; and the emphasis on tobacco and alcohol as an income generator for the Commonwealth.
- Changes in political climate resulting in limited political will to invest in prevention work, especially for alcohol and tobacco.

> **"The other threat as it relates to tobacco is that we are the state of Virginia. This is the state that was founded on tobacco. It's in our backyard…** So [it's] always going to be a threat or a challenge to get tobacco-related policy laws… We are up against a lot of money that we just can't even come close to. Not to say we aren't pushing for tobacco policy changes, because we are. It's just a big hurdle compared to, you know, a state like New York that wasn't built on tobacco. That's why they have the tobacco tax that they do, and we have the second lowest in the country."

- Shifting priorities due to new funding opportunities, public interest and media coverage that draw the focus away from Virginia's longstanding prevention priorities.
- The rise of e-cigarettes and vaping, especially with a variety of flavors that appeal to youth, and a lack of regulations on these products.
- Efforts to legalize medical marijuana in Virginia, and the legalization of recreational marijuana in other states.
- Shortage of mental health providers and barriers to accessing mental health services due to location, cost and insurance coverage.
- Stigma associated with seeking mental health services in some communities.

> "It seems as though right now the opioids situation is taking front and center... **I see some of those things as threats because it just [takes] up your time."**

CURRENT PREVENTION EFFORTS

Prevention work occurs in Virginia every day, which has resulted in many achievements in building community coalitions, engaging stakeholders, and providing community prevention services.

DBHDS disseminates state and federal prevention-focused funding to CSBs and communities across Virginia to support behavioral health and substance prevention efforts. Three of these funding streams are outlined below, with a summary of the substances and outcomes they are targeting.

Substance Abuse Prevention Block Grant (Block Grant)

Block Grant is a federal funding stream provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) to each state for substance abuse prevention.

The structure of Block Grant funding does not mandate specific strategies or targets, but rather allows states to address their own prevention priorities. This flexibility means that states have variable systems for disseminating the funding and requirements for their sub-grantees. Because of the reach and broad scope of Block Grant funding, this needs assessment was conducted with a lens toward areas that could be addressed by strategic Block Grant funding decisions in the future.

In Virginia, DBHDS disseminates the Block Grant funding to all 40 CSBs across the Commonwealth. Nearly all CSBs use a portion of the Block Grant funds for CSB staff to engage in two common activities:

1. Completing Counter Tools activities related to tobacco prevention. This work has encompassed store mapping, store audits, and merchant education to all tobacco retail locations across the Commonwealth.
2. Providing Mental Health First Aid trainings to the public. These trainings help individuals "identify,

"Two years ago, our data indicated that 90% of our population did not know how to access treatment, [and] it was difficult to work on drug prevention initiatives collaboratively because many of our major partners believed that no one did drugs here... **The needs assessment revealed that drug use does happen here. We also learned how each sector could be a 'part of the puzzle'** to create a multi-level plan to raise awareness and to limit access to substances, alcohol, and to means of suicide while changing cultural attitudes about helping each other get help for mental health issues."

Goochland Powhatan Community Services

Block Grant-Funded Activities Addressing DBHDS's Priority Substances

Mental Health and Suicide

Mental Health First Aid trainings by CSBs across the Commonwealth.

Alcohol

25 CSBs have long-term outcomes related to alcohol use and its consequences.

Tobacco and Nicotine

All 40 CSBs are engaging in Counter Tools strategies to reduce tobacco use.

"Crossroads CSB was recognized at the 2018 VFHY Conference for being one of [the] state's champions who partnered with the 24/7 Campaign to successfully help get **100% tobacco-free school policies passed in two school districts this year."**
Crossroads Community Services

"The Regional Alliance for Substance Abuse Prevention (RASAP) worked to identified youth from all four county high schools to serve on the **RASAP Youth Advisory Council. They meet monthly to look at local data related to youth substance use. They selected underage drinking as the priority substance to address**. They developed a [week-long] youth campaign … prior to prom and graduation, and presented their campaign and ways to promote the message in all four county high schools … and then met with all four county principals."

Danville-Pittsylvania Community Services

understand and respond to signs of mental illnesses and substance use disorders in [their] community."[5,6]

CSBs direct the rest of their Block Grant funds to priority areas for their catchment area. These priority areas were identified by CSBs through a needs assessment and strategic planning process completed during the 2016-17 fiscal year.

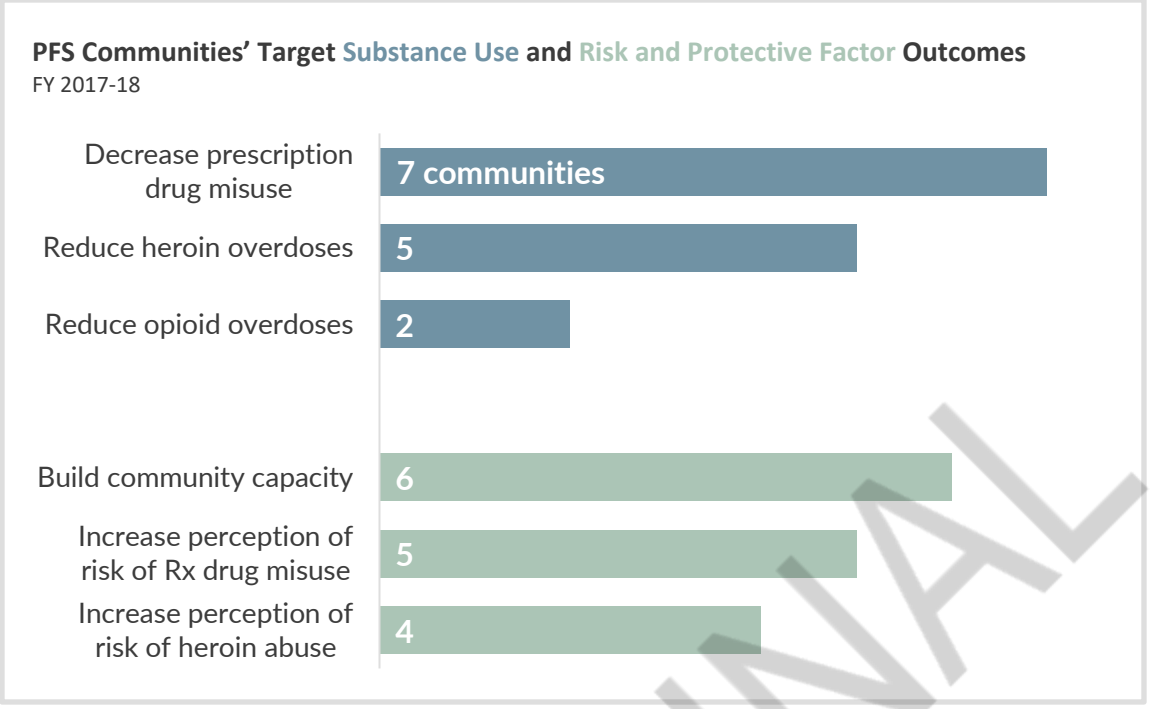
Because of the Counter Tools and Mental Health First Aid requirements, all CSBs are addressing the priority areas of tobacco and nicotine and mental health and suicide. In addition, over half are implementing alcohol prevention strategies and are targeting outcomes related to alcohol use and its consequences.

CSBs are also using Block Grant funds to target other substances that are local priorities, including marijuana (17 CSBs), prescription opioids (16), and heroin (9). None of the CSBs established target outcomes related to cocaine or methamphetamines in the 2017-18 fiscal year.

Partnerships for Success (PFS)

Virginia also receives discretionary funding from SAMHSA that is targeted to specific issue areas. Under the PFS initiative, nine community coalitions are funded to address prescription drug and heroin abuse. These communities are targeting risk and protective factors (as shown on the next page) to impact use and overdose rates of these substances. Six of nine communities have also established specific goals for building their community's capacity to address these substance use issues over the long-term.

[5] Mental Health First Aid, 2018, https://www.mentalhealthfirstaid.org/
[6] Mental Health First Aid and other mental health and suicide prevention strategies/services are funded through Virginia general fund dollars. These strategies and services intersect with Block Grant funding because prevention staff who implement these strategies are often funded through Block Grant.



Opioid Prevention, Treatment, and Recovery (OPT-R)

OPT-R funding is provided by SAMHSA to DBHDS, who distributes it to CSBs. These dollars allow CSBs to implement prevention, treatment, and recovery strategies to reduce opioid overdose deaths. The funding was first allocated in May 2017 and distributed to 35 CSBs. It was renewed for the 2018-19 fiscal year and will fund all 40 CSBs from May 2018 through April 2019. The CSBs will continue to fund and expand efforts to: build community capacity to address opioids through coalitions; heighten community awareness; and support safe storage and disposal efforts.

"Collaborating with the health department, the fire department, and the Martinsville Police Department, we visited hundreds of homes between April and October 2017 to provide information on opioids. **Volunteers and/or staff went door-to-door every Saturday to provide brochures on opioids** and took time to talk to families about the dangers and issues."

Piedmont Community Services

Recommendations

After reviewing data trends, discussing with DBHDS and the SEOW, and receiving input from stakeholders across the Commonwealth, several key areas for potential growth or action emerged. These recommendations for future focus areas and efforts are detailed below.

FUND PRIORITY AREAS

Strategically impact priority areas by funding strategies and outcomes that address appropriate risk and protective factors.

"I think one of our shortfalls is that we don't have a lot of youth who are involved in the process of prevention. And we find out anecdotally through the youth what the new trends are... **We don't have any youth at the table really helping us identify those trends up front, and helping be creative in ways to work with their peers in an effort to reduce use.**"

- Engage in **strategic planning to identify strategies and outcomes** for each priority area, targeting specific risk and protective factors.
- Commit to addressing **risk and protective factors and root causes.** This is an essential step due to the common co-occurrence of substance use and behavioral health challenges, as well as the impact of Adverse Childhood Experiences (ACEs) on behavioral health.
- Plan **shared strategies for each priority area** that all CSBs implement. Build on the successes of Counter Tools and Mental Health First Aid to implement a shared strategy for alcohol prevention.
- Consider ways to **intentionally align Prevention Block Grant funding with identified priority areas**. Allocation thresholds may be designated to target work towards priority areas within communities, or set funding to support shared strategies for each priority area. Remaining funds could be discretionary based on community needs assessments.
- **Actively engage youth** and/or provide support for local youth coalition efforts to facilitate the success of strategies aimed at youth, and to stay current on emerging trends.
- **Allocate funding** at the state level to the identified priority areas to ensure they receive consistent resources regardless of other public health concerns.

BUILD CAPACITY

Support the prevention workforce across Virginia with training and peer learning opportunities.

- Promote **prevention workforce training** by expanding current Substance Abuse Prevention Skills Training (SAPST) and ACEs training opportunities.
- Strengthen resources and provide skill-building opportunities that enable prevention staff to successfully **transition from direct-service programming to environmental strategies**.
- **Improve capacity for policy work**, including trainings on current prevention policies, potential local-level policy changes, and the local advocacy process.
- Develop **peer learning communities** to allow CSBs to learn promising practices from each other, such as monthly showcases on the online portal or recurring conference calls.

> "I feel like we are shifting from traditional prevention programs to more of a community-based, environmental [strategies]. It's a different skill set. And we have workforce that don't have that skill set… We're aware of it… **But how do you turn a fifth-grade teacher into a community mobilizer? So that's a big challenge."**

LEAD STATEWIDE INITIATIVES

Lead efforts for statewide messaging, advocacy, collaboration, and decision-making that facilitate effective prevention work across the Commonwealth.

- Develop large-scale **messaging campaigns** for each priority area with materials available for local dissemination across the Commonwealth. In particular, CSBs requested social norming campaigns to combat the social acceptance of alcohol and tobacco use for youth and to expand social acceptance of seeking mental health treatment.
- Utilize the Counter Tools data to **support tobacco control policies**, such as: licensing tobacco retailers; restricting vaping product flavors; and increasing the tobacco purchase age to 21.
- Continue to promote **data-driven decision making** through funding requirements and support for data collection and utilization activities, such as local survey efforts and ongoing support of the Virginia Social Indicator Dashboard. Consider expanding the Virginia Youth Survey to include additional prevention outcomes, such as perceptions of parental approval of substance use or impact of messaging campaigns.
- Implement systemic changes to encourage **effective collaboration across disciplines, departments, and agencies** at the state and local levels. This is especially important for impact on cross-cutting issues and policy work.

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Appendices

APPENDIX A. NEEDS ASSESSMENT INDICATOR LIST

Provided to the State Epidemiology Outcomes Workgroup in March 2018

Scope

OMNI Institute is conducting a statewide needs assessment in Virginia in the areas of substance use and behavioral health. Below is a summary of the indicators that will be reviewed as part of the needs assessment. In addition to this data, qualitative data from Community Service Boards, DBHDS staff, and the State Epidemiological Outcomes Workgroup will be collected and serve as context to the quantitative indicators. After review of the indicators and qualitative data, priority areas and emerging trends will be identified, and relevant data will be included in the final needs assessment report. The assessment process and report aim to inform future priorities for SAPTBG and other DBHDS funding statewide.

Indicator List

All indicators below are available publicly from state and national agencies, which are listed within each section header. Where available and relevant to the data review, breakout data by age, race, ethnicity, gender, and/or region will also be reviewed. National comparisons and/or trend data will be included for context when available.

In the table below, "■" denotes that breakout or comparison data is available for that indicator in some form. Note that the available breakouts vary by data source (e.g., the race categories may be different across indicators), so there will not be direct alignment of data across all indicators and breakout groupings.

		Age	Race/ Ethnic	Gender	Region	Natl
Demographic and Socioeconomic Characteristics (CDC, Census, DSS, VDH, Voices)						
Total Population	Census demographics	■	■	■	■	■
Unemployment	Percentage of population that is unemployed	■	■	■	■	■
Educational Attainment	Percentage of adults who have attained education level (some high school; high school graduate; some college or technical; college graduate)	■	■	■		■
Household Environment	Percentage of youth in single-parent households				■	

		Age	Race/ Ethnic	Gender	Region	Natl
	Number of Child Protective Services referrals	■	■	■	■	
	Percentage of children with a parent who has ever been incarcerated					
Disconnected Youth	Percentage of youth ages 16-24 who aren't working or in school					■
Income	Median household income					■
Poverty	Percentage of population in poverty and deep poverty				■	■
	Percentage of children in poverty and deep poverty		■		■	
Child Food Insecurity	Percentage of students approved for free or reduced-price lunch status				■	
	Percentage of youth who experienced food insecurity in the past year				■	
	Percentage of youth who went hungry often or always in past 30 days	■	■	■	■	
Assistance Programs	Number of recipients of TANF, SNAP, Medicaid, and Child Care Subsidy	■	■	■	■	
Healthcare Access (CDC, HRSA, Voices)						
Health Insurance Coverage	Percentage of population with any health care coverage	■	■	■		■
	Percent of children under 19 without health insurance					
Availability of Healthcare	Ratio of population to primary care physicians					■
	Ratio of population to mental health providers					■
Births (VDH)						
Substance Use During Pregnancy	Percentage of live births in which mother used substances during pregnancy (tobacco; alcohol; other drugs)	■	■			
Teen Pregnancy	Teenage pregnancy rates per 1,000; percentage of pregnancies that were teenage pregnancies	■	■			
Education (DOE, Voices)						
Graduation and Drop-Out Rates	Percentage of students in a cohort who earned diploma within four years of entering high school; percentage of total number of students in the cohort who dropped out as their cohort moved through high school		■	■		
Chronic Absenteeism	Percentage of students who miss 10% or more of days enrolled					
Suspension	Percentage of disciplinary outcomes that are short-term suspensions (less than 10 days) associated with substance use					
Trusted Adult at School	Percentage of students who report they have trusted adult at school		■	■	■	
ATOD-Related Offenses	Percentage of disciplinary incidents that are due to ATOD-related offenses		■	■		■
Substance Use and Behaviors (CDC, NHTSA, SAMHSA, VDH)						

		Age	Race/ Ethnic	Gender	Region	Natl
Substance Use	Percentage of population reporting use in the past month (underage alcohol use; alcohol; binge drinking; tobacco; illicit drugs; marijuana). Percentage of high schoolers reporting use in the past 30 days (alcohol; cigarettes; binge drinking; marijuana)	■	■	■	■	■
	Percentage of population reporting past year use (cocaine, heroin, Rx pain reliever misuse; tobacco)	■				■
	Percentage of high schoolers reporting lifetime use (heroin; meth)		■	■	■	■
Early Onset Use	Percentage of middle schoolers reporting use before age 11 (alcohol; marijuana)		■	■	■	
	Percentage of population who first used marijuana over the past year	■				■
Perceived Risk of Substance Use	Percentage of population who perceive great risk of substance use (using marijuana once a month; cocaine use once a month; heroin use once or twice; binge drinking once or twice a week; smoking 1+ packs per day)	■				■
Past Year Substance Disorders	Percentage of adults with a substance use disorder in the past year	■				■
	Percentage of adults with an alcohol use disorder in the past year	■				■
	Percentage of adults with an Illicit drug use disorder in the past year	■				■
Impaired Driving	Percentage of driving deaths with alcohol-involvement					■
	Percentage of high schoolers who drove after drinking in the past year		■	■	■	■
Mental Health and Suicide (CDC, OCME, SAMHSA, VDH)						
Poor Mental Health Status	Percentage of adults reporting at least one day of poor mental health in the past 30 days; percentage of adults reporting frequent (at least 14 days) poor mental health in the past 30 days	■	■	■		■
	Percentage of adults ever diagnosed with a depressive disorder	■	■	■		■
	Percentage of high schoolers who felt sad or hopeless for two or more weeks of the past year		■	■	■	■
Past Year Mental Health	Percentage of adults who had serious thoughts of suicide in the past year	■				■
	Percentage of adults with any mental illness in the past year	■				■
	Percentage of adults with a serious mental illness in the past year	■				■
	Percentage of high schoolers and adults who considered suicide in the past year; percentage of middle schoolers who have ever considered suicide	■	■	■	■	■
	Percentage of high schoolers who attempted suicide in the past year; percentage of middle schoolers who have ever attempted suicide		■	■	■	■
Suicide Rate	Teen suicide rate per 100,000 (overall; by firearm; by other means)	■	■		■	■

		Age	Race/ Ethnic	Gender	Region	Natl
	Suicide rate per 100,000 by circumstance (depression, substance abuse problem, treatment for mental health, opiates, mental health problem)	■	■	■	■	
Behavioral Health Treatment and Hospitalizations (DBHDS, SAMHSA, VDH)						
Needed but Didn't Receive Treatment in Past Year	Percent of population who needed but didn't receive treatment in the past year for substance use	■				■
	Percent of population who needed but didn't receive treatment in the past year for alcohol use	■				■
	Percent of population who needed but didn't receive treatment in the past year for illicit drug use	■				■
Behavioral Health Services	Rate of substance abuse intakes and mental health intakes per 10,000 (marijuana, alcohol, crack/cocaine, heroin, other opiate/synthetic, meth)	■	■	■	■	
	Percentage of adults who received mental health services in the past year	■				■
	Rate of admissions to mental health services per 10,000 (substance use; psychotic; mood; behavioral; and anxiety disorders)	■	■	■	■	
Hospitalizations	Rate of adult substance abuse and mental health hospitalizations per 100,000	■	■	■	■	
	Rate of hospitalizations for attempt at self-harm per 100,000	■	■	■	■	
Overdoses and Deaths (CDC, OCME, VDH)						
Deaths	Accidental and undetermined fatal drug overdose rate per 100,000 (alcohol, heroin, cocaine, opiate Rx drug, benzodiazepine, meth any substance)	■	■	■	■	■
	Overdose mortality rate per 100,000 (fentanyl/heroin, Rx drugs)	■			■	
	Rate of alcohol-induced and drug-induced deaths per 100,000	■	■	■		■
Overdoses	Rate of emergency department overdose visits per 100,000 (heroin, opioids	■			■	
	Rate of Narcan administrations by EMS per 100,000	■			■	
Criminal Justice (DCJS, DFS)						
Drug Cases	Rate of Department of Forensic Science cases per 100,000 (marijuana, cocaine, Rx drug, heroin, benzodiazepine, meth)				■	■
	Uniform Crime Reports rate of all drug/narcotic violations per 100,000	■	■	■	■	■
Juvenile Justice	Rate of narcotic-related intake cases per 100,000	■	■	■	■	

Data Source Abbreviation List

Abbreviation	Data Source
CDC	Centers for Disease Control and Prevention
Census	U.S. Census Bureau
DBHDS	Virginia Department of Behavioral Health & Developmental Services
DCJS	Virginia Department of Criminal Justice Services Research Center
DFS	Virginia Department of Forensic Science
DOE	Virginia Department of Education
DSS	Virginia Department of Social Services
HRSA	Health Resources & Services Administration
NHTSA	National Highway Traffic Safety Administration
OCME	Virginia Office of the Chief Medical Examiner
SAMHSA	Substance Abuse and Mental Health Services Administration
VDH	Virginia Department of Health
Voices	Voices for Virginia's Children

APPENDIX B. DISCUSSION QUESTIONS FROM APRIL 2018 SEOW AND DBHDS MEETINGS

Virginia SEOW Data Presentation and Discussion

Before Data Presentation

1. What do you perceive to be the top two behavioral health issues for Virginia? Are these new issues? Who do you believe is being impacted most by these issues?
2. What makes these issues so important? (e.g., increase trends over time; consequences/impacts of these issues)
3. Do you have any thoughts as to what factors may be driving these issues? Why do you believe these issues are happening in Virginia (e.g., root causes; contributing factors)?

After Data Presentation

1. Now that you have reviewed the data, what do you believe to be the top two behavioral health issues for Virginia? Are these new issues? Are issues increasing or decreasing over time? Who do you believe is being impacted most by these issues (geographic region; demographic; etc.)?
2. What makes these issues so important? (i.e. increase trends over time; consequences/impacts of these issues)
3. What do you think are the contributing factors driving these issues in Virginia? Why do you believe these issues are happening in Virginia (i.e. root causes; contributing factors)?
4. Where are the gaps in resources and readiness to address these issues in Virginia?

DBHDS Follow-Up Discussion

Criteria to consider when selecting which problem(s) to address:

1. **Magnitude** – Which problem seems to be the largest? Which issue areas did the SEOW prioritize? Are there discrepancies to what you are currently addressing?

2. **Time Trend** – Is the problem getting worse over time or is it getting better over time? What is the story about this change?

3. **Severity** – What is the severity of the problem? Is it resulting in mortality? Is it costly?

4. **Comparison** – How does Virginia compare to other states?

APPENDIX C. SWOT ANALYSIS DISCUSSION GUIDE

Purpose: To gather community input in the form of a SWOT analysis on the state-level substance abuse prevention priorities that were identified by stakeholders.

Intro:

Hello everyone! Welcome to toady's discussion on a SWOT analysis (or strengths, weaknesses, opportunities, and threats) of Virginia's substance abuse prevention priorities and the role your CSBs play in _____ (*decreasing substance use* or *improving mental health and decreasing suicide*) across the state. This group will focus primarily on the topic of _____ (*Alcohol, tobacco/nicotine, or mental health/suicide*).

My name is _____ and I will be your facilitator for the focus group. My colleague _____ is also with me taking notes on our discussion today.

Before we jump in, let's take a moment to ensure that everyone is ready and familiar with the GoToMeeting control panel.

First, you should have a control panel on the right side of your screen. You may minimize this panel by clicking on the orange arrow button in the upper left corner. You may expand the panel by clicking the same orange button.

Second, in just a moment, we will unmute you on our end. We ask that you stay muted when you are not talking out of courtesy for others and to improve sound quality. When you wish to speak, please take yourself off mute, and re-mute yourself when you are finished. Please keep in mind that there may be a delay in responses due to technology. We ask that you be respectful of others and speak one at a time. There will be plenty of time to hear everyone's answers. I'm hoping everyone can hear me okay; if you are having trouble hearing me, try moving your speakers and microphone away from each other, or taking yourself off speaker phone.

We have allotted one hour for this discussion, we may or may not use all of that time; it will depend on the number of responses everyone has. This focus group will be recorded so we can refer back to it in the future for our notes.

I want to remind you that the purpose of this call is to gather your input on the state-level substance abuse prevention priorities that were identified by stakeholders. The information gathered in this session will be used in the statewide needs assessment report that we are preparing for DBHDS and is an opportunity to include your voices - from CSBs across Virginia - in the report.

Before we start, I would like everyone to introduce themselves with their name, and CSB you are representing.

Thank you for introducing yourselves! As a quick overview of the discussion, we will start off by first talking about the state's priority of (*insert topic*: Alcohol abuse, tobacco use, or suicide/mental health) prevention and *internal* strengths and weaknesses of your CSBs and their ability to work towards this priority. From there we will move onto discussing the *external* threats and opportunities that you encounter in your work. Are there any questions?

State Priorities

The state identified _____ (*insert topic*: Alcohol abuse, tobacco use, or suicide/mental health) as a top priority area of prevention for CSBs. These were agreed upon by the State Epidemiological Outcomes Workgroup (SEOW) after a preliminary review of statewide data.

1. From your perspective, do you agree that these areas are also priorities in the communities that you serve?
2. How do you set priorities for where to focus your efforts in the community you serve?

Strengths

1. What resources does your CSB use to address this priority?
    - Funding?
    - Community partnerships?
    - Coalitions?
2. How has your CSB been successful in addressing (alcohol, tobacco, mental health/suicide) in the past?

Weaknesses

1. What resources are you lacking to address the priority area of (*alcohol, tobacco, and mental health/suicide*)?
2. What challenges do you face in implementing this priority?
3. What weaknesses have people you've served voiced about how CSBs address this priority?

Now I'd like the shift the discussion to identifying external opportunities and threats.

Opportunities

1. What policies are in place that facilitate your CSB's work to address this priority?
2. What partnerships have you created that facilitate the work you're doing?
3. Talk about some funding opportunities that your CSB (DBHDS) has been successful at pursuing to address this priority.

Threats

1. In what specific areas, are there shortfalls in resources that your CSB needs in order to successfully address the priority area?
    - Staff and training?
    - Funding?
    - Other shortfalls?
2. What policy changes, if any, have made your work in this area challenging?

Wrap-Up

1. Is there anything else that we haven't discussed, but you think is important to know regarding prevention of (alcohol, tobacco, mental health/suicide)?

Thank you again for your time and for sharing your feedback today. As we mentioned, this information will be incorporated into the statewide needs assessment we are currently conducting for DBHDS. If you have any follow-up questions or concerns, please reach out to the OMNI TA team.

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The Virginia Community Services Boards (CSBs) offer most of the services in #2 below, with some variations depending on location and resources.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(•) Yes ( ) No
b)	Mental Health	(•) Yes ( ) No
c)	Rehabilitation services	(•) Yes ( ) No
d)	Employment services	(•) Yes ( ) No
e)	Housing services	(•) Yes ( ) No
f)	Educational Services	(•) Yes ( ) No
g)	Substance misuse prevention and SUD treatment services	(•) Yes ( ) No
h)	Medical and dental services	(•) Yes ( ) No
i)	Support services	(•) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(•) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(•) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

All of Virginia's 40 Community Services Boards offer the majority of the services on the list above with varying levels of accessibility. The possible exceptions are in the areas of housing and educational services.

Physical Health: Many of Virginia's 40 CSBs maintain partnerships with local community health clinics or providers to offer primary care services to consumers. Primary care services may be provided in a variety of ways; some primary care is provided on-site at CSB locations by CSB-employed or -contracted healthcare providers. In other areas, the CSB partners with the local federally-qualified health center (FQHC) to offer co-located services in which either the CSB provides behavioral health services on site at the FQHC's location, or the FQHC offers primary care services on site at CSB service programs. In addition, some CSB case managers work with family members, MHSS providers, or care coordinators to ensure their consumers are transported to their PCP for ongoing follow up care. Rehabilitation Services: All 40 Virginia CSBs offer psychiatric rehabilitation services to individuals with SMI. These programs may include vocational rehabilitation and employment-related services, including the evidence-based practice of Supported Employment. This service is also provided outside of the CSB system by private community-based mental health providers, as Psychosocial Rehabilitation is a Medicaid-reimbursable service under our state Medicaid plan. Psychosocial rehabilitation, as mentioned previously in this application, is an identified step in the STEPVA system transformation process.

Housing Services: In recent years, DBHDS and the CSBs have been expanding support for Permanent Supportive Housing (PSH). In 2015 for the first time, the Virginia General Assembly allocated state funds to DBHDS for Permanent Supportive Housing, and state general funds for PSH for individuals with SMI have grown each year. To date, DBHDS has implemented 23 PSH programs across the state, expected to house more than 1400 individuals with SMI. Additionally, a small state-funded PSH program for Pregnant or Parenting Women with SUDs now serves 75 households3

3. Describe your state's case management services

Targeted case management is a Medicaid-billable service in Virginia for adults with SMI and children with SED which is also licensed by DBHDS under Title 12, Chapter 105 of the Virginia Administrative Code, "Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services." These regulations require that providers of case management services provide the following services: 1. Enhance community integration through increased opportunities for community access and involvement and creating opportunities to enhance community living skills to promote community adjustment including, to the maximum extent possible, the use of local community resources available to the general public; 2. Make collateral contacts with the individual's significant others and system of support with properly authorized releases to promote implementation of the individual's individualized services plan and his community adjustment; 3. Assess needs and planning services to include developing a case management individualized services plan; 4. Link the individual to those community supports that are most likely to promote the personal habilitative or rehabilitative and life goals of the individual as developed in the Individualized Services Plan (ISP); 5. Assist the individual directly to locate, develop, or obtain needed services, resources, and appropriate public benefits; 6. Assure the coordination of services and service planning within a provider agency, with other providers, and with other human service agencies and systems, such as local health and social services departments; 7. Monitor service delivery through contacts with individuals receiving services and service providers and periodic site and home visits to assess the quality of care and satisfaction of the individual; 8. Provide follow up instruction, education, and counseling to guide the individual and develop a supportive relationship that promotes the ISP; 9. Advocate for individuals in response to their changing needs, based on changes in the individualized services plan; 10. Plan for transitions in the individual's life; 11. Know and monitor the individual's health status, any medical conditions, and his medications and potential side effects, and assisting the individual in accessing primary care and other medical services, as needed; and 12. Understand the capabilities of services to meet the individual's identified needs and preferences and serve the individual without placing the individual, other participants, or staff at risk of serious harm.

4. Describe activities intended to reduce hospitalizations and hospital stays.

A wide variety of clinical and recovery support services are provided in the community and in our state psychiatric facilities to reduce hospitalizations and hospital stays. Most of the services in item 1 above continue to be offered in the community having been initially designed to prevent or reduce psychiatric crisis. For adults with SMI in particular, important services include psychiatric and medication management services, psychosocial rehabilitation, peer supports, and permanent supportive housing. As the need for appropriate response to psychiatric crisis continues to grow STEP VA as system transformation process is examining a significant number of these services to improve access to services as well as to better support maintaining consumers in the community.

Please indicate areas of technical assistance needed related to this section.

None at this time

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	359,467 (5.4% of adult pop)	83,888 (1.3% of adult pop)
2.Children with SED	97,781 (10% of child pop)	26,646 (2.7% of child pop)

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

The prevalence data and rates for adults with SMI and children with SED are directly from the most current state-level prevalence data provided by NRI. The incidence data and rates for adults with SMI and children with SED are the figures we submitted in URS Table 15A to NRI for the last FY.

Please indicate areas of technical assistance needed related to this section.

None at this time

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care*?

a)	Social Services	(•) Yes	( ) No
b)	Educational services, including services provided under IDEA	(•) Yes	( ) No
c)	Juvenile justice services	(•) Yes	( ) No
d)	Substance misuse preventiion and SUD treatment services	(•) Yes	( ) No
e)	Health and mental health services	(•) Yes	( ) No
f)	Establishes defined geographic area for the provision of services of such systems	(•) Yes	( ) No

Please indicate areas of technical assistance needed related to this section.

None at this time

**A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*
https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population. **See SAMHSA's Rural Behavioral Health page for program resources**

The Commonwealth of Virginia covers a wide range of geographic regions. Depending on its location, one CSB might serve a combined population of urban, suburban and ex-urban or rural areas. According to the most recent decennial census, the Census Bureau indicated that 75.5% of the population in Virginia resided in urban areas and 24.5% in rural areas. Twenty-six of the 40 CSBs contain one or more counties in their jurisdiction that are majority rural. During SFY 2018, these twenty-six CSBs served 68% of all mental health consumers and 61% of individuals receiving substance abuse treatment. Individuals in need of behavioral health services in rural areas face special challenges. Many in rural areas do not have the infrastructure to support the services that are needed in the community. Access to transportation, especially for those individuals found to be ineligible for Medicaid, is frequently an issue. In some cases access to simple daily tasks remains impossible for those with minimal support as in some areas in Virginia there may be up to a 25 minute drive to the closest grocery store with no public transit option. CSBs in these rural areas vary widely in their funding and staff capacity. They use different approaches, such as sharing services regionally with other CSBs and collaborating with local and regional contract agencies to meet the service needs of their consumers. Telepsychiatry and telecommunication, for example, are in use in some rural areas to facilitate specialty psychiatric services for adult consumers, children and their families, and veterans. In response to the COVID-19 pandemic rural areas were in some cases heavily impacted. Lack of network infrastructure, intermittent/inconsistent cell phone service, and increased stressors further complicated what was often already a strained system of care.

b. Describe your state's targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

Individuals with serious mental illness (SMI) and those with co-occurring substance use disorders (SUD) are at disproportionately high risk of homelessness. According to Virginia's 2020 annual Point in Time Count of individuals experiencing homelessness, nearly 1,000 individuals with SMI are homeless on any given night. In the 14 areas of the state with the highest prevalence rates, DBHDS allocates federal funds from the Projects for Assistance in Transition from Homelessness (PATH) Program to CSBs provide outreach, engagement and case management services to homeless persons with SMI/SUD. Through collaborative relationships with the continuum of homeless service providers in their catchment areas, Virginia's PATH programs assist consumers to access housing, mental health and substance abuse treatment services, entitlement benefits and other needed services to assist them in the process of recovery. Those who are literally homeless – meaning either living on the streets, in encampments, or other locations that are unfit for human habitation -- are the priority population served by Virginia's PATH providers.The majority of Virginia's 14 PATH programs operate in urban areas and spend significant time conducting street and shelter outreach to identify individuals with SMI who meet the PATH definition of homeless. Those programs operating in suburban and rural areas conduct outreach to homeless individuals in woods, encampments, under bridges and in other places where unsheltered persons congregate. The end goal of PATH is always to assist the individual to obtain housing, engage in behavioral health services, and access disability and other benefits. The SSI/SSDI Outreach, Access and Recovery (SOAR) model of benefits acquisition is an additional service provided across the state and led by DBHDS. Through a unique process of community-level collaboration with the Social Security Administration and Virginia's Disability Determination Services, the SOAR model provides homeless persons with SMI a greater chance of approval for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits. Access to Social Security benefits also provides access to medical insurance, making it more likely that PATH consumers, many of whom are medically vulnerable, can access medical treatment as well as behavioral healthcare.

c. Describe your state's targeted services to the older adult population. **See SAMHSA's Resources for Older Adults webpage for resources.**

DBHDS allocates $1 million in MHBG funds each year to support two regional geriopsychiatric services initiatives, one in Northern Virginia operated by Arlington CSB and one in Hampton Roads operated by Hampton-Newport News CSB. These partnerships provide mental health services specific to older adults, including care coordination, case management, psychiatric services, screening for assisted living, and other behavioral health services to prevent institutionalization and assist the older adult to remain in their home to the extent possible.

Please indicate areas of technical assistance needed related to this section.

None at this time

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders**.

Criterion 5

a. Describe your state's management systems.

See data starting on page 13 attached of Fiscal Year 2022 Annual Report

b. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

Although the pandemic has subsided, we are still navigating the system and everchanging need and workforce. , During the pandemic, services at the CSBs had changed dramatically in response to their community needs and locality expectations. DBHDS was able to help support CSB partners with the transition to telehealth services, which had not been available in most cases statewide prior to the pandemic. Block grant funds aided providers in the heavy lift for telehealth allowing services to remain open and available throughout the course of Virginia's COVID-19 response, and continues to support the CSBs in this manner. While these impacts are ongoing and still being thoroughly evaluated it is important to note that providers have reported an increase in the engagement of individuals served in many programs, especially SUD services. Workforce has continued to prove challenging due to competing agencies/providers around work life balance, with a strong promotion of remote work responsibilities.

Mobile crisis services utilizing telehealth under STEP-VA are being implemented under the broader umbrella of Virginia's Crisis System transformation. Funding has been distributed regionally to form regional mobile crisis hubs, which ultimately integrate existing mobile crisis supports for individuals with developmental disabilities with STEP-VA funds for mental health and substance use crisis response in the community. Children's mobile crisis teams were prioritized in 2020 and have responded via telehealth and in person when needed throughout the pandemic. Funding for adult mobile crisis teams is becoming available this year and will be distributed in a similar manner. Recently, Virginia invested in a crisis call center data platform to support the implementation of STEP-VA as well as federal 9-8-8 legislation. The goal is to have the call center functions operational in late calendar year 2021 or early calendar year 2022.

Please indicate areas of technical assistance needed related to this section.

None at this time

Footnotes:

COMMONWEALTH of VIRGINIA

NELSON SMITH
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

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Fax (804) 371-6638
www.dbhds.virginia.gov

December 1, 2022

To: The Honorable Glenn A. Youngkin, Governor
The Honorable Janet D. Howell, Chair, Senate Finance & Appropriations Committee
The Honorable Barry K. Knight, Chair, House Appropriations Committee

Fr: Nelson Smith, Commissioner, Department of Behavioral Health and Developmental Services

Item 310.J of the 2021 Appropriation Act requires the Department of Behavioral Health and Developmental Services (DBHDS) to submit an annual report to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees of the General Assembly by December 1 each year for the preceding fiscal year.

> *J. The Department of Behavioral Health and Developmental Services shall submit a report to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees no later than December 1 of each year for the preceding fiscal year that provides information on the operation of Virginia's publicly funded behavioral health and developmental services system. The report shall include a brief narrative and data on the numbers of individuals receiving state facility services or CSB services, including purchased inpatient psychiatric services, the types and amounts of services received by these individuals, and CSB and state facility service capacities, staffing, revenues, and expenditures. The annual report also shall describe major new initiatives implemented during the past year and shall provide information on the accomplishment of systemic outcome and performance measures during the year.*

Subsection 12 of § 37.2-304 of the Code of Virginia establishes the annual report requirement in state statute. The section lists the duties and powers of the DBHDS commissioner.

> *12. To submit a report for the preceding fiscal year by December 1 of each year to the Governor and the Chairmen of the House Appropriations and Senate Finances Committees that provides information on the operation of Virginia's publicly funded behavioral health and developmental services system. The report shall include a brief narrative and data on the number of individuals receiving state facility services or*

community services board services, including purchased inpatient psychiatric services; the types and amounts of services received by these individuals; and state facility and community services board service capacities, staffing, revenues, and expenditures. The annual report shall describe major new initiatives implemented during the past year and shall provide information on the accomplishment of systemic outcome and performance measures during the year.

In accordance with these requirements, please find enclosed the fiscal year 2022 DBHDS annual report. Staff are available should you wish to discuss this request.

CC:
The Honorable John Littel
Susan Massart
Mike Tweedy

1220 BANK STREET • P.O. BOX 1797 • RICHMOND, VIRGINIA 23218-1797
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Virginia Department of Behavioral Health & Developmental Services

Fiscal Year 2022 Annual Report
(Item 310.J)

December 1, 2022

DBHDS Vision: A Life of Possibilities for All Virginians

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DBHDS Fiscal Year 2020 Annual Report

Preface

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Table of Contents

Executive Summary

Virginia's Public Behavioral Health and Developmental Services System

Virginia's public behavioral health and developmental services system provides services to individuals with mental illness, developmental disabilities, or substance use disorders through state-operated state hospitals and centers, and 39 community services boards and one behavioral health authority (CSBs).

In FY 2022, a total of 210,947 unduplicated individuals received services in the public behavioral health and developmental services system: 210,078 received services from CSBs, 5,856 received services in state hospitals and centers, and many received services from both.

The following report provides detailed information on people who received services throughout FY 2022 from the public system, along with services and staffing capabilities, and funds received and expenditures by CSBs and DBHDS. The report also provides DBHDS' major initiatives and key accomplishments during FY 2022.

Background

CSBs function as the single points of entry into publicly funded behavioral health and developmental services, including access to state facility services through preadmission screening, case management and coordination of services, and discharge planning for individuals leaving state facilities. While not part of the Department of Behavioral Health and Developmental Services (DBHDS), locally-operated CSBs are key partners. CSBs provide services directly and through contracts with private providers, which are vital to delivering behavioral health and developmental services. Virginia's 133 cities or counties established CSBs pursuant to Chapter 5 or 6 of Title 37.2 of the Code of Virginia. DBHDS negotiates a performance contract with each CSB for the provision of services, provides state funds, monitors, licenses, regulates, and provides leadership, guidance, and direction to CSBs.

DBHDS operates 12 state hospitals and centers, as follows:

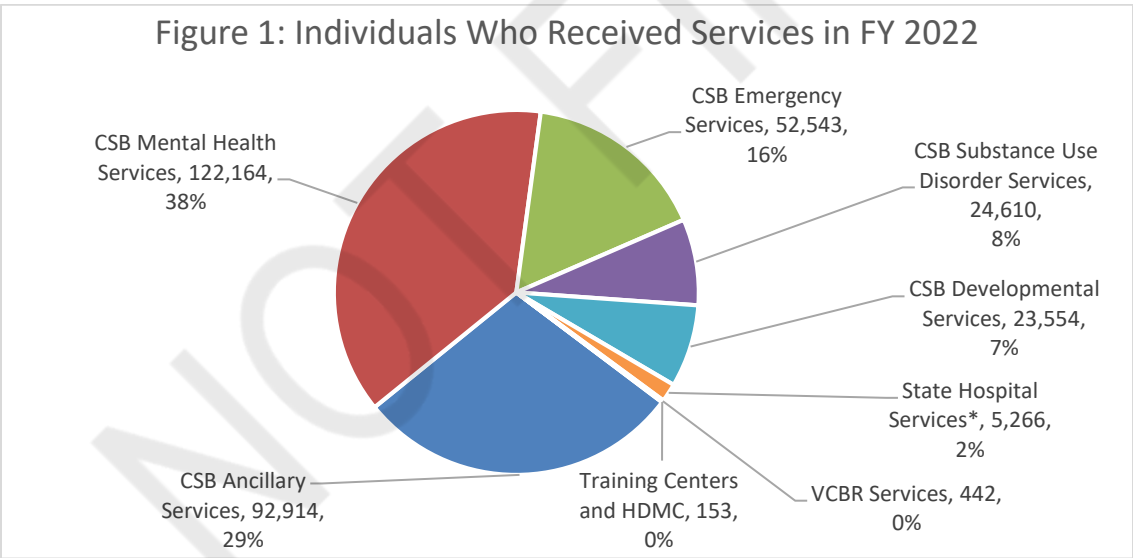
- **State Hospitals –** DBHDS operates eight state hospitals for adults: Catawba Hospital (CH) in Salem, Central State Hospital (CSH) in Petersburg, Eastern State Hospital (ESH) in Williamsburg, Northern Virginia Mental Health Institute (NVMHI) in Falls Church, Piedmont Geriatric Hospital (PGH) in Burkeville, Southern Virginia Mental Health Institute (SVMHI) in Danville, Southwestern Virginia Mental Health Institute (SWVMHI) in Marion, and Western State Hospital (WSH) in Staunton. The Commonwealth Center for Children and Adolescents (CCCA) in Staunton is the only state hospital for children with serious emotional disturbance. State hospitals provide highly structured and intensive inpatient services, including psychiatric, nursing, psychological, psychosocial rehabilitation, support, and specialized programs for older adults, children and adolescents, and individuals with a forensic status.

- **State Centers –** DBHDS provides rehabilitation services at the Virginia Center for Behavioral Rehabilitation (VCBR) in Burkeville for persons determined to be sexually violent predators. DBHDS provides medical services at the Hiram Davis Medical Center (HDMC) in Petersburg for individuals in state hospitals or other centers. DBHDS also provides provide highly structured habilitation and residential care for individuals with intellectual disability at Southeastern Virginia Training Center (SEVTC) in Chesapeake.

The DBHDS central office provides leadership that promotes partnerships among CSBs and state hospitals and centers with other agencies and providers. The central office supports the provision of accessible and effective services and supports by CSBs and other providers, directs the delivery of services in state hospitals and centers, protects the human rights of individuals receiving services, and assures that public and private providers adhere to licensing regulations.

Individuals Who Received CSB or State Facility Services

Figure 1 below depicts the numbers of individuals who received services from CSBs or state hospitals and centers and the respective percentages. Ancillary services are motivational treatment, consumer monitoring, early intervention, and assessment and evaluation.



Notes: *1) The DBHDS data warehouse identifies uniquely each individual who receives services. These are unduplicated: If someone received services at more than one CSB or at CSBs and state facilities, the individual is counted once. 2) Individuals in Figure 1 total more than the unduplicated number of 210,947individuals because many received services in multiple areas.*

Figure 2, below, shows the individuals who received services in each core service from CSBs or state facilities. It displays numbers for emergency and ancillary services and for the mental health (MH), developmental (DD), and substance use disorder (SUD) services program areas, and the total numbers of individuals receiving a core service across the three program areas.

Figure 2: Individuals Who Received CSB or State Facility Services in FY 2022		
Total Emergency Services	52,543	Community Consumer Submission 3 (CCS 3) does not include data on individuals in consumer-run services, so other tables do not include them. CARS collects a count of participants; in this FY, 4,478 individuals participated in these services.
Motivational Treatment Services	2,281	
Consumer Monitoring Services	16,061	
Early Intervention Services	1,997	
Assessment and Evaluation Services	81,183	
Total Ancillary Services[1]	94,898	

Services Available in Program Areas[1]	**MH**	**DD**	**SUD**	**Total[2]**
Training Center ICF/ID Services		72		72
State Hospital ICF/Geriatric Services	405			405
CSB MH or SUD Inpatient Services (LIPOS)	882		54	993
CSB SUD Inpatient Medical Detox Services			432	432
State Hospital Acute Psychiatric Inpatient Services	3,384			3,384
State Hospital Extended Rehabilitation Services	1,439			1,439
State Hospital Forensic Services	998			998
HDMC[3]				81
VCBR[3]				442
Total CSB Inpatient Services[1]	**3,384**		**432**	**3,816**
Total State Facility Inpatient Services[1,4]	**5,789**	**72**		**5,856**
Outpatient Services	54,657	77	17,392	69,544
Medical Services	76,445	134	2,277	78,362
Intensive Outpatient Services			3,160	3,160
Medication Assisted Treatment			4,725	4,725
Assertive Community Treatment	2,632			2,632
Total Outpatient Services[1]	105,346	211	21,709	119,372
Total Case Management Services	59,365	21,687	8,175	87,335
Day Treatment or Partial Hospitalization	993		133	1,126
Ambulatory Crisis Stabilization Services	27		1	27
Rehabilitation or Habilitation	2,671	1,946		4,613
Total Day Support Services[1]	3,686	1,946	134	5,761
Sheltered Employment	9	349		357
Individual Supported Employment	1,049	974	33	2,051
Group Supported Employment	4	355		359
Total Employment Services[1]	1,062	1,610	33	2,699
Highly Intensive Residential Services	82	257	1,155	1,494
Residential Crisis Stabilization Services	2,518	271	61	2,821
Intensive Residential Services	213	569	1,191	1,971
Supervised Residential Services	1,121	473	405	1,996
Supportive Residential Services	3,043	544	50	3,618
Total Residential Services[1]	6,698	2,063	2,364	10,918

*[1] Numbers in **Total Services** rows are unduplicated for the preceding services in each column.*
[2] Figures in this column are unduplicated numbers of individuals across program areas.
[3] HDMC and VCBR are not state hospitals, number of individuals are shown in the total column.

Figure 3, below, shows the ages of people served by CSBs in FY 2022.

Figure 3: Ages of Individuals Who Received Services from CSBs in FY 2022					
Ages	MH Services	DD Services	SUD Services	Emergency	Ancillary
0 – 12	12,933	1,729	3	2,538	9,935
13 – 17	17,438	1,500	235	7,110	14,006
18 – 64	83,125	18,603	23,603	38,877	65,114
65+	8,664	1,722	766	3,980	3,836
Unknown	4	-	3	38	23
Total	**122,164**	**23,554**	**24,610**	**52,543**	**92,914**

Figure 4, below, contains data about the gender of individuals who received CSB services.

Figure 4: Gender of Individuals Who Received CSB Services in FY 2022			
Female	99,066	Unknown	429
Male	110,583	Not Collected	0

Figure 5, below, contains data about the races of individuals who received CSB services.

Figure 5: Races of Individuals Who Received CSB Services in FY 2022			
Race	**Total**	**Race**	**Total**
Alaska Native	50	American Indian or Alaska Native & White	268
American Indian	391	Asian and White	530
Pacific Islander	0	Black or African American and White	4,761
Black or African American	56,421	American Indian or Alaska Native & Black	181
White	120,249	Other Multi-Race	3,339
Other	11,793	Unknown	7,807
Asian	4,090	Not Collected	0
Pacific Islander	198	Total Unduplicated Individuals	210,078

Figure 6, below, contains data about CSB services for adults who have serious mental illness (SMI) or children/adolescents who have or are at risk of serious emotional disturbance (SED).

Figure 6: Individuals with SMI or SED Who Received CSB MH Services in FY 2022	
Adults 18-64 with SMI	54,342
Adults 65+ with SMI	6,392
Children with or At-Risk of SED	25,004

Figure 7 contains data about individuals with autism spectrum disorder (ASD) served by CSBs.

Figure 7: Individuals with ASD Who Received CSB Services in FY 2022			
Program Area	All Services	MH Services	DV Services
Individuals With ASD	16,046	7,215	7,164

Figure 8 contains employment data about adults (18+ years old) who received CSB services.

Figure 8: Employment Status for Adults Who Received CSB Services in FY 2022						
Employment Status	MH	DD	SUD	Emergency	Ancillary	Undupl.[1]
Total Adults (18+) Who Received Services	91,789	20,325	24,369	4,2857	68,950	164,125
Employed Full Time (35+ hr./wk.)	12,914	250	6,481	4,303	11,904	22,612

Employed Part Time(<35 hr./wk.)	9,638	1509	2,645	2,708	6,765	14,758
In Supported Employment	433	1,165	42	92	457	1,504
In Sheltered Employment	206	516	34	53	201	611
Total Adults Employed	23,191	3,440	9,202	7,156	19,327	39,485
Unemployed	15,815	1,846	7,001	6,476	13,109	26,528
Not In Labor Force: Homemaker	1,462	24	306	334	792	1,922
Not In Labor Force: Student/Job Training	5,987	2,777	312	2,202	5,042	11,680
Not In Labor Force: Retired	2,190	272	313	963	1,310	3,456
Not In Labor Force: Disabled	26,325	6,775	2,718	6,338	11,174	35,246
Not In Labor Force: Institution or inmate	3,038	994	815	3,534	4,045	8,217
Not In Labor Force: Other	9,043	3,429	2,284	2,967	6,112	15,168
Unknown	2,112	154	850	2,472	1,956	5,443
Not Collected	2,626	614	568	10,415	6,083	16,980
Total Adults Unemployed	68,598	16,885	15,167	3,5701	49,623	124,640

[1] *Figures in this column are smaller than the totals of the numbers in the preceding columns for each row because some individuals received services in more than one program area.*

Figure 9, below, shows the total unduplicated number of individuals with military status who received CSB mental health, DD or substance use disorder services.

Figure 9: Military Individuals Receiving CSB Services in FY 2022	
Armed Forces on Active Duty	390
Armed Forces Reserve	141
National Guard	167
Armed Forces or National Guard Retired	606
Armed Forces or National Guard Discharged	2,373
Armed Forces or National Guard Dependent Family Member	1,726
Not Applicable	142,191
Unknown	1,716
Not Collected	9,322
Total Unduplicated Military Individuals Receiving CSB Services	**154,794**

Figure 10, below, shows unduplicated individuals who received services in DBHDS-funded initiatives.

Figure 10: Individuals Who Received Services in Specialized Initiatives in FY 2022	
Mental Health Mandatory Outpatient Treatment (MOT) Orders	246
Discharge Assistance Program (DAP)	1,448
Mental Health Child and Adolescent Services Initiative	2,911
Mental Health Services for Children in Juvenile Detention Centers	1,809
Program of Assertive Community Treatment (PACT)	2,652
Projects for Assistance in Transition from Homelessness (PATH)	1,428
Medicaid Developmental Disability (DD) Waiver Services	16,139
Developmental Enhanced Case Management (ECM) Services	7,168
Substance Use Disorder Medication Assisted Treatment (MAT)	3,276
Project Remote	11
Substance Use Disorder Recovery Support Services	814
Project LINK	948

Figure 11 contains insurance data about numbers of individuals who received CSB services.

Figure 11: Individuals Enrolled in Medicaid or Uninsured Served by CSBs in FY 2022[1]					
Services:	MH Services	DV Services	SUD Services	Emergency	Ancillary
Total Individuals	122,164	23,554	24,610	52,543	92,914
On Medicaid	94,065	22,292	17,785	29,417	60,488
Other Insurance	17,727	750	2,509	6,973	13,544
Uninsured	10,194	501	4,232	15,822	18331

[1] *Insurance status for a small number of the total individuals was unknown.*

Figure 12, below, shows the types of residences data for individuals who received mental health, developmental, or substance use disorder services.

Figure 12: Types of Residences			
Residence Status	**MH**	**DV**	**SA**
Private Residence/Household	10,1065	16,241	20,148
Shelter	820	20	254
Boarding Home	529	110	130
Foster Home/Family sponsor	923	738	17
Licensed Home for Adults (CSB or non-CSB)	2,274	827	26
Community Residential	2,075	3,780	155
Residential Treatment/ Alcohol and Drug Rehabilitation	515	141	263
Adult Transition Home	103	3	81
Other Residential Status	444	71	147
Nursing Home/Physical Rehabilitation	289	117	1
Inpatient Care	297	34	12
Local Jail/Correctional Facility	1,708	13	800
State Correctional Facility	289	117	1
Other Institutional Setting	239	219	51
Juvenile Detention Center	386	3	23
Homeless/homeless shelter	2,870	45	1,131
Veterans Health Administration	1	0	1
Unknown	10,917	1308	2,637
Not Collected	6,772	1110	1,024
Total Unduplicated Individuals	**122,164**	**23,554**	**24,610**

Dementia is general term for a wide range medical conditions caused by abnormal brain changes. Figure 13 displays the individuals with dementia in the eight adult state hospitals.

Figure 13: Individuals with Dementias in State Hospitals			
Diagnosis	**Individuals Served**	**Diagnosis**	**Individuals Served**
Adults 18 - 64	4300	Older Adults 65+	695
Other Dementias	10	Other Dementias	79
Alzheimer's	57	Alzheimer's	104
Dementia	23	Dementia	22
Unduplicated Total	83	Unduplicated Total	171
Percent of 18 - 64	2%	Percent of 65+	25%

***Note**: In FY 2022, SEVTC served only one individual with dementia, HDMC served two, and VCBR served two.*

Service Capacities of CSBs and State Facilities

Figure 14 displays full time equivalent (FTE), bed, or slot service capacities for each core service.

Figure 14: Service Capacities of CSBs and State Hospitals and Centers in FY 2022			
Emergency Services	588 FTEs	Early Intervention Services	22 FTEs
Motivational Treatment Services	18 FTEs	Assessment and Evaluation	284 FTEs
Consumer Monitoring Services	109 FTEs	**Total Ancillary Services FTEs**	434 FTEs

Services in Program Areas	**MH**	**DV**	**SUD**
CSB MH or SUD Inpatient Services	86 Beds		1 Bed
CSB SUD Inpatient Medical Detox			20 Beds
Total CSB Inpatient Services	**86 Beds**		**21 Beds**
Training Center ICF/ID Services		75 Beds	
State Hospital Adult	1,047 Beds		
State Hospital Children	24 Beds		
HDMC[2]	50 Beds		
VCBR[3]	484 Beds		
Total State Facility Inpatient Services[1]	**1,605 Beds**	**75 Beds**	
Outpatient Services	626 FTEs	1 FTEs	281 FTEs
Medical Services	383 FTEs	2 FTEs	6 FTEs
Intensive Outpatient Services			101 FTEs
Medication Assisted Treatment			113 FTEs
Assertive Community Treatment	317 FTEs		
Total Outpatient Services	**1,326 FTEs**	**3 FTEs**	**501 FTEs**
Case Management Services	1,194 FTEs	693 FTEs	119 FTEs
Day Treatment/ Partial Hospitalization	460 Slots		19 Slots
Rehabilitation/Habilitation	1,616 Slots	1,911 Slots	
Total Day Support Services	**2,076 Slots**	**1,911 Slots**	19 Slots
Sheltered Employment	11 Slots	273 Slots	
Group Supported Employment	4 Slots	343 Slots	
Total Employment Slots	**15 Slots**	**616 Slots**	
Individual Supported Employment	24 FTEs	37 FTEs	2 FTEs
Highly Intensive Residential Services	32 Beds	265 Beds	54 Beds
Residential Crisis Stabilization	113 Beds	42 Beds	2 Beds
Intensive Residential Services	178 Beds	568 Beds	191 Beds
Supervised Residential Services	875 Beds	444 Beds	79 Beds
Total Residential Beds	**1,199 Beds**	**1,319 Beds**	**328 Beds**
Supportive Residential Services	188 FTEs	105 FTEs	5 FTEs
Prevention Services	19 FTEs		166 FTEs

[1] State facility beds are as of June 30, 2022 and reflected staffed beds only

[2] HDMC is a medical center and not a state hospital. It is listed in the chart in the DV column

[3] VCBR is not a state hospital but it is listed in the chart in the MH column.

Staffing of CSBs and DBHDS

Figure 15 contains staffing data about CSBs, state facilities, and the DBHDS central office, expressed as numbers of full time equivalents (FTEs).

Figure 15: FY 2022 CSB, State Hospital and Center, and DBHDS Central Office Staffing (FTEs)	Direct Care Staff	Peer Staff	Support Staff	Total Staff
DBHDS Staff				
DBHDS Central Office (CO)	22	2	497	521
State Hospitals	1,994	6	1,494	3,495
Training Centers	194	0	93	286
HDMC	119	1	31	150
VCBR	328	108	24	460
Total State Hospital and Center and CO 2022	**2,656**	**116**	**2,138**	**4,912**
CSB Staff				
CSB Mental Health Services	4,316	137	770	5,223
CSB Developmental Services	3,276	2	405	3,683
CSB Substance Use Disorder Service	1,180	127	293	1,600
CSB Emergency & Ancillary Service	1,077	48	144	1,269
CSB Administration	0	0	1,622	1,622
Total CSB 2022	**9,849**	**314**	**3,235**	**13,397**

Notes: *A full-time equivalent is not the same as a position; a 20-hour/week part-time position is one position but ½ FTE. FTEs are a more accurate indicator of available personnel resources. Peer staff receive or have received services and are employed as peers to deliver services. Only FTEs in programs CSBs directly operate are included; contract agencies are not represented.*

Funds Received by CSBs and DBHDS

Figure 16, below, displays funds received for CSBs, state facilities, and the central office by type and the respective percentages. Fees include Medicaid payments, which consist of federal and state funds. DBHDS submits a report on Part C services to the General Assembly.

Figure 16: FY 2022 Total Funds Received by Type: $2,512,324,989

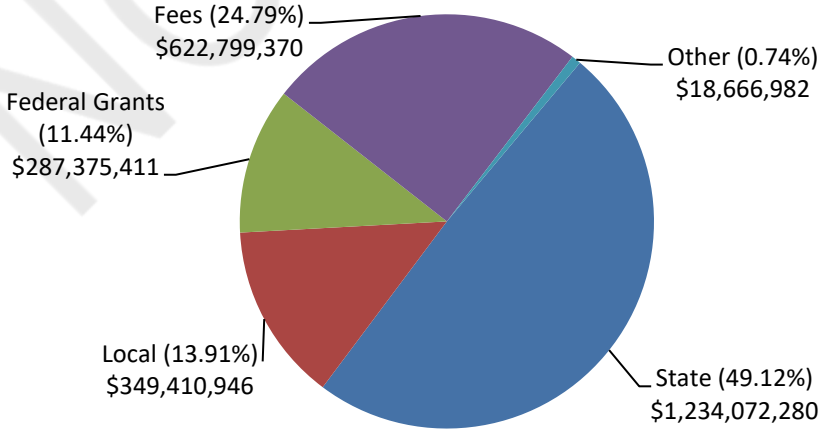
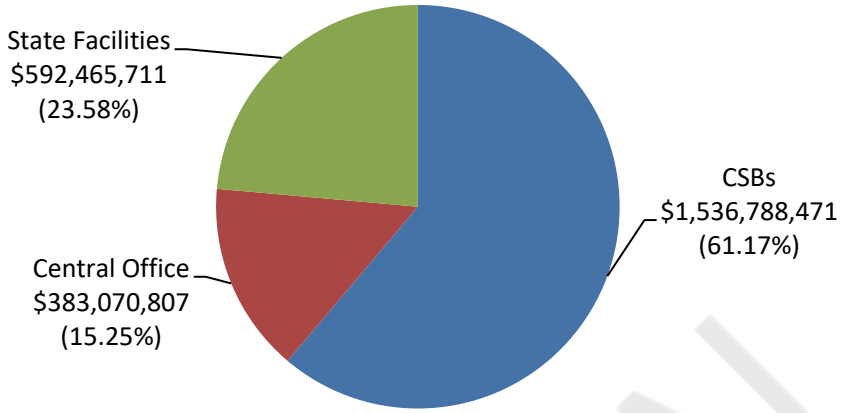


Figure 17, below, depicts funds in the publicly operated behavioral health and developmental services system for CSBs, state facilities, and the central office and the respective percentages.

Figure 17: FY 2022 Total Funds in the Public Behavioral Health & Developmental Services System: $2,512,324,989



Figures 18 and 19, below, display the specific amounts of funds from all sources reported by CSBs and state facilities. For the CSBs, local funds include local government appropriations, charitable donations, and in-kind contributions. The 133 cities or counties that established the 40 CSBs provide the overwhelming share of local funds. Fees include Medicaid, Medicare, and private insurance payments and payments from individuals. Other funds include workshop sales, retained earnings, and one-time funds.

Figure 18: FY 2022 CSB Funds Received by Program Area

Funding Source	Mental Health Services	Developmental Services	Substance Use Disorder Services	Total Funds	Percent of Total
State Funds	$388,947,392	$48,218,630	$65,718,028	$502,884,050	32.72%
Local Funds	$185,363,052	$116,113,485	$47,934,409	$349,410,946	22.74%
Medicaid Fees	$203,428,129	$218,101,817	$24,497,504	$446,027,450	29.02%
Other Fees	$46,455,013	$14,918,737	$8,685,568	$70,059,318	4.56%
Federal Funds	$48,785,352	$1,707,592	$100,068,250	$150,561,194	9.80%
Other Funds	$9,657,472	$3,244,090	$4,943,951	$17,845,513	1.16%
Total Funds	$882,636,410	$402,304,351	$251,847,710	$1,536,788,471	100.00%
Percent of Total	57.43%	26.18%	16.39%	100.00%	

Figure 19: FY 2022 State Facility Funds Received by Type of State Facility

Funding Source	State Hospitals	Other State Facilities[1]	Training Center	Total Revenues	Percent of Total
State General Funds	$420,363,310	$58,096,188	$6,346,081	$484,805,579	80%
Federal Funds	$27,197,331	$5,526,128	$1,840,547	$34,564,006	6%
Medicaid	$10,339,175	$20,988,209	$28,696,605	$60,023,989	10%
Medicare	$11,869,912	$494,174	$0	$12,364,086	2%
Commercial Insurance	$8,688,888	$25,480	$0	$8,714,368	1%
Private Payments	$2,907,261	$301,502	$621,992	$3,830,755	1%
Other Revenues	$45,868	$6,673	$169	$52,710	0%
Total Revenues	**$481,411,745**	**$85,438,354**	**$37,505,394**	**$604,355,493**	**100%**

[1] *Other State Facilities are HDMC and VCBR.*

Expenditures by CSBs and DBHDS

Figures 20 and 21, below, display expenditures reported by CSBs, state facilities, and the DBHDS central office. About 65 percent of central office funds are spent on contracts for community services.

Figure 20: FY 2022 CSB Expenditures by Program Area

	Mental Health Services	Developmental Services	Substance Use Disorder Services	Total Expenditures[1]
CSB Services	$727,588,569	$379,460,458	$202,294,444	$1,309,343,471
Percent of Total	55.57%	28.98%	15.45%	100.00%

[1]This figure includes $167,988,614 for CSB administrative expenses, 12.83 percent of the total CSB expenditures.

Figure 21: FY 2022 State Facility and Central Office Expenditures

	Expenses	Percent of Total
State Hospitals	$480,079,527	63%
Other State Facilities[1]	$80,764,979	11%
Training Centers	$30,932,844	4%
Central Office	$172,484,241	22%
Total Expenditures	$764,261,591	100%

[1] Other State Facilities are HDMC and VCBR.

Major New Initiatives and Accomplishments

In December 2021, Governor Youngkin named Nelson Smith Commissioner of DBHDS. Commissioner Smith began a strategic planning process for DBHDS in January 2022. The main objectives for the plan, called the North Star Plan, were determined in FY 2022. The North Star Plan is intended to help DBHDS successfully move forward in today's rapidly evolving healthcare environment to better serve the people and providers who depend on Virginia's behavioral health and developmental services system, and to advance the Governor's vision to make Virginia the best place to live, work and play. The North Star Plan focuses on three main objectives to accomplish before the end of 2025.

1. **Strengthen workforce systemwide** – Develop a robust, strong, well-trained, and sustainable workforce.
2. **Expand the comprehensive system of care** – Increase access, grow capacity, and ensure quality of care in the most integrated setting across a comprehensive continuum of care for individuals with mental health disorders, substance use disorders, and developmental disabilities.

3. **Modernize systems and processes** – Modernize Systems and processes that leverage best practices to drive and sustain high-quality service outcomes.

In early FY 2023, Commissioner Smith announced additional key results associated with the North Star Plan along with a new DBHDS Central Office organizational structure to fortify the department's position for transformational success, improve internal operations, better support staff, and achieve a strong customer service focus on both an internal and external basis.

The following sections describe major new initiatives and accomplishments accomplished throughout DBHDS Central Office and facilities during FY 2022.

Administrative Services

Human Resources Management

DBHDS continued to integrate human capital policies, programs, and practices into human resources management. This includes expanding learning management opportunities, developing additional career pathways, enhancing recruitment and retention strategies, evaluating compensation tools, and succession planning. Initiatives and accomplishments include:

- The Direct Support Professional Career Pathways Program aim is to increase the overall competency level of staff, leading to a more positive workplace environment and improving recruitment and retention of staff. Since the program began, 670 certificates have been awarded, and 213 employees have completed two certificate programs.
- 44 participants attended the five-day Virginia Public Sector Leadership Certificate (VPSL I) program, bringing the cumulative total of DBHDS employees completing this program to 396. The VPSL I training opportunity enhances leadership and supervision competencies for front line or recently promoted managers in DBHDS. This program also nurtures high potential employees and builds on retention and succession planning activities.
- 23 people participated in the five-day March 2022 Virginia Public Sector Leadership Certificate Program (VPSL) II program. This annual training opportunity enhances leadership and supervision competencies for emerging leaders and is a component of DBHDS' leadership development program, SystemLEAD. To date, 207 people have participated.
- The VPSL III program continued in 2022 with another 23 DBHDS executive participants participating in the program, bringing the cumulative total of DBHDS executives participating in this program to 98. Participants in this VPSL level are agency executives nominated by the DBHDS senior leadership team. VPSL III uses the same core learning areas as levels I & II but explore topics in a higher-level method.
- There were 23 employees who started SystemLEAD in FY 2022. SystemLEAD, a long-term organizational strategy, clearly defines a leader's roles, abilities, and pathway to improvement. DBHDS offers this nine-month program annually. To date, 203 people have participated in the SystemLEAD programs.
- Continued use of the compensation toolbox to help recruit and retain a quality workforce. Job fairs (hire on the spot), social media, academic partnerships, various bonuses (sign on

bonuses, referral bonuses and retention bonuses)increased alternate pay bands, increased shift differentials, and continuing the use of loan repayment programs were used.

- Following General Assembly action, increased starting pay approvals by at least five percent for facilities that had previously approved starting pay and established several new starting pay rates for various roles across the system. Increased starting rate of DSAs, LPNs, RNs, Security to the mean salary of Mercer Data (50 percent).
- Continued critical shift pay for emergent situations to properly compensate staff during critical staff shortages.

Information Technology/Security

DBHDS Information Technology made significant progress during FY 2022 on key initiatives to accomplish two key strategic goals to modernize IT systems and utilize enterprise-wide solutions whenever possible.

- Implemented 163 enhancements to the Millennium Electronic Health Record (EHR) application.
- We were the Commonwealth pilot agency for software-defined wide area network (SD-WAN) implementation for more reliable network redundancy. SC-WAN is a virtualized service that connects and extends enterprise networks over large geographical distances.
- Completed the implementation of the virtual visitation platform enabling all 12 facilities to allow family members and friends the ability to visit with those in our facilities remotely.
- Reduced the IT Portfolio from 400+ application down to 150.
- Enabled access for all facilities to use the Virginia Court System's virtual platform and attend hearings remotely.
- Migrated the DOJ library website to allow for the ability to streamline updates and modify content quickly.
- Implemented new IT solutions for the Office of Licensing (CONNECT), 988 call center (Crisis Call Center) and Office of Early Intervention Program (TRAC-IT).
- Migrated to a single Business Intelligence tool (Power BI) and removed Tableau.
- Implemented external MS Teams for collaboration with the community.
- Refined the Information Technology in Business (ITIB) process to ensure alignment with agency strategic goals.
- Standardized code storage and version control using Microsoft Azure DevOps to ensure continuity of operations.
- Implemented enterprise-wide continuous cybersecurity awareness training by conducting on-going simulated email phishing campaigns.

Internal Audit

- Completed four facility audits, primarily on the administrative areas, including Human Resources, Payroll, Procurement, Accounts Payable, Financial Reconciliation and Fixed Assets. These audit reviews are based on the DBHDS policy requirements, facility policies & procedures and state requirements including DHRM, APSPM and CAPP manual. All facilities were selected primarily based on the Auditor of Public Accounts (APA) audit cycle. Some of the work was completed virtually, however in-person visits were conducted to

complete audit work on employee documentation and any other areas that required in-person interaction.

- Completed five CSB audits. There were portions of these audits that were completed virtually, however the audit staff made onsite visits to primarily conduct audit work on patient data in the CSB's Electronic Health Records. Each audit consists of 17 areas of programmatic and administrative review, largely tied to expectations outlined in the Performance Contract.
- Completed the IT general security controls audit, two IT system security audits, two facility physical security control audits and a physical security control audit of Central Office.
- Completed three virtual CSB follow-up reviews. These reviews focus on areas where there are findings from previous years that have yet to be resolved by the CSB. 27 of 42 (64 percent) findings reviewed have been corrected and corresponding recommendations were implemented.
- Investigated and issued reports on 12 cases from the Office of the State Inspector General's Fraud, Waste, and Abuse Hotline.
- The following tables depict the audit and investigation results during FY 2022:

FY 2022 Facility Audit Summary Results	
Number of Findings	70
Number of Recommendations for Improvement	194
Number of Commendations Written	1
FY 2022 CSB Audit Summary Results	
Number of Findings	33
Number of Recommendations for Improvement	47
Number of Commendations Written	33
FY 2022 Follow up Review Results	
Number of findings reviewed	48
F Y2022 Information Technology Audit Summary Results	
Number of Findings	39
Number of Recommendations for Improvement	54
Number of Commendations Written	3
Other Results	
OSIG Fraud, Waste, and Abuse Hotline Reports Issued	12
Leave Verification Reports	46

Procurement and Administrative Services

- Executed and managed 235 contracts totaling more than $164 million of contractual obligations on behalf of DBHDS.
- Participated in user testing and led effort to for staff training in anticipation of conversion to the new eVA procurement platform.
- Helped consolidate and manage office space to utilize two fewer floors in the Jefferson Building while accommodating return to office plans.

Diversity Equity Inclusion (DEI)

The DBHDS DEI Office implemented multiple initiatives successfully, while operating with an unfunded budget in FY 2022. Accomplishments include:

- In December 2021, the first DBHDS DEI Strategic plan for FY 2021-2025 was approved as guidance for all DEI procedures, protocols and initiatives for the agency, in compliance

with House Bill 1993 § 2.2-602. Per this Code of Virginia, § 2.2-602 states "The heads of state agencies shall establish and maintain a comprehensive diversity, equity, and inclusion strategic plan. The plan shall integrate the diversity, equity, and inclusion goals into the agency mission, operations, programs, and infrastructure to enhance equitable opportunities for the populations served by the agency and to foster an increasingly diverse, equitable, and inclusive workplace environment." Strategic plan implementation began upon approval.

- In partnership with Petersburg School District and the Claude Moore Scholars program, the VA Health Sciences Highway youth apprentice program, DBHDS DEI developed new workforce roles for the program launch in FY 2022. The goal of creating Work-Based Learning Coordinators was to create a new career pathways exemplar role for existing staff seeking advancement opportunities, as well as enhance recruitment opportunities for those looking to with youth in behavioral healthcare career readiness. Future potential funding will go to increasing this internal career ladder workforce program across all 12 state hospitals, to include certifications for staff and students.
- Partnered with the Human Rights Campaign Foundation (HRCF), as part of a cohort of nationwide organizational leaders, collaborated on an equality index examining on-boarding and workforce policies for the 200,000 Virginians in the LGBTQ+ community. This group convened as part of a pilot program, to support and co-create the development of an LGBTQ+ organizational assessment originated by the HRCF.
- Partnered with Virginia Commonwealth University's (VCU) Metropolitan Educational Research Consortium (MERC) to complete the agency equity review, a three-phase, multi-method analysis, open to all workforce members for participation (5,500+ participants). The study collected data, for the purpose of creating evidence-based logic models to advance equitable workforce development policies, implement strategies for addressing the needs of a diverse workforce, such as pay equity, representative leadership, inclusive policies, as well as enhancing public service delivery for the economically disinvested and historically marginalized communities served by DBHDS.

Clinical Services

The Division of the Chief Clinical Officer provides cross disability clinical and technical expertise and support across all program areas of the agency to aid in leading system-wide transformation and enhance cross disability collaboration. The aim of the division is to support the agency in ensuring that all individuals receive high quality care and integrates evidence, best practices, and data to drive decision making and inform mental health policy and implement system change.

Response to the COVID-19 Pandemic

Since the start of the COVID-19 pandemic, DBHDS mobilized resources across the agency to respond to the COVID-19 pandemic including attending to the health and safety needs of DBHDS staff, individuals in the care of DBHDS at the state facilities or through DBHDS licensed providers, attention to supporting behavioral health of the population of the Commonwealth, and operationalizing changes necessary due to impacts of COVID-19.

Project Behavioral Health Redesign for Access, Value, and Outcomes (formerly Medicaid Behavioral Health Enhancement)

This effort is a partnership by DBHDS and the Department of Medical Assistance Services. These services are critical in the overall system of care and aid in addressing the critical need to step-down or divert individuals from acute inpatient psychiatric hospitalization, including those placed in state mental health institutions.

- During FY 2022, the following services were implemented:
  - July 1, 2021 – Assertive Community Treatment (ACT), Partial Hospitalization Programs (PHP), Intensive Outpatient Programs (IOP).
  - December 1, 2021 – Multisystemic Therapy (MST), Functional Family Therapy (FFT) Residential Crisis Stabilization Units, 23-hour Crisis Observation, Mobile Crisis, and Community Based Crisis Stabilization.
- Collaborated with DMAS, MCOs, DHP and various DBHDS Offices to conduct provider and stakeholder trainings on new services related to licensing and program development
- In collaboration with DMAS, established the Racial Equity Workgroup to prioritize the need for addressing disparities in access, quality, and cultural and racial competencies in the implementation of Project BRAVO.
- In collaboration with DMAS, CSA, DSS, and DJJ, established the Center for Evidence Based Practices with Virginia Commonwealth University, which aims to serve as single statewide resource for developing the behavioral health workforce in supporting the use and accessibility for evidence based practices in the provision of services within Project BRAVO, STEP-VA, and the Family First Prevention Services Act.

Clinical Quality Management and Community Quality Improvement

- Quality Management System Improvements
  - Revised the CSB data request process, requiring DBHDS central office and CSB collaboration prior to filling new CSB data requests (issued from DBHDS) aiding in streamlining data requests made of CSBs.
  - Developed and provided training to DBHDS staff in QI tools, practices and principles.
  - Developed a reporting schedule to ensure the regular surveillance of data that examines how well the developmental services system is ensuring individual safety and freedom from harm and other outcomes.
- Developmental Disabilities (DD) Quality Management System
  - Developed, established, and implemented a formal consultation and technical assistance program (piloted with DBHDS licensed service providers) designed to establish an effective and efficient process for providing technical assistance and consultation. The objective of the project was to introduce and demonstrate Quality Improvement (QI) tools and concepts to providers that they could implement to help them move towards compliance with licensing regulation 12VAC35-105-620 C.2.
  - Developed and implemented over 20 statewide and regional quality improvement initiatives.
  - Tracked and analyzed data for over 30 performance measure indicators designed to measure health, safety, well-being and community inclusion and integration of

individuals receiving DD waiver services, as well as DD service provider competency and capacity.
    - Aimed to decrease administrative burden on providers, developed a Master Document List that lists over 100 documents that are typically requested by review entities such as DBHDS Licensure, DMAS, and third party quality and compliance reviewers.
- National Core indicators is a voluntary effort by public developmental disabilities agencies to measure and track their own performance. The core indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety.
    - DBHDS partnered with VCU Project Living Well to conduct over 700 interviews with individuals receiving DD waiver services
    - Participated in the staff stability survey. Virginia was 1 of 27 states where providers were surveyed regarding employment and separations as well as the impact of COVID on the workforce.
- Quality Service Reviews (QSRs) evaluate whether individuals' needs are being identified and met through person-centered planning; in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice; and whether individuals are having opportunities for integration in all aspects of their lives. In FY 2022, The QSR vendor conducted its 3rd round of reviews which included 614 eligible licensed DD providers and CSBs and 1,200 individuals receiving services.
- Support Coordinator Quality Reviews (SCQR) Look Behind
    - Completed 100, onsite retrospective reviews (designed to validate the findings of the CSB case management supervisory reviews and subsequently facilitate the provision of technical assistance to the case managers and supervisors to address any needed improvements) and 50 inter-rater reliability reviews (designed to ensure consistency in reviewer comprehension and rating between DBHDS reviewers).

Mortality Review Office

- Developmental Disabilities Mortality Review Committee
    - Reviewed 408 deaths that occurred during FY 2021. This is a 15.3 percent increase from the 354 deaths from the previous year.
- State Facility Mortality Review
    - Collaborated with VDH to establish an electronic (non-paper copy) process for the sending and receipt of relevant documents.
    - Continued performance improvement of DI 315 Reporting and Reviewing Deaths establishes the Central Office process for oversight of facility mortality reviews.

Data Quality and Visualization

- Revised and implemented methodology for the Support Coordination Quality Review (SCQR). This includes the measurement of ten compliance indicators, comprehensive technical guidance to support reliable completion, sampling framework, a look behind review process, and interrater reliability. Produced CSB-specific reports for technical assistance, an annual compliance report, and tracked CSB completion on an online dashboard.
- Created the agency's first online versions of the Mental Health Statistics Improvement

Program (MHSIP) and Youth Services Survey for Families (YSS-F). Coordinated with the Division of Community Services and Old Dominion University to distribute the online version and track responses.

- Provided all analytics for the Mortality Review Committee including timeliness of review monitoring (90-day goal), facility deaths, ad hoc requests and the Annual Mortality Report.

Pharmacy Services

Pharmacy services provides clinical support across multiple programs of DBHDS to enhance clinical cost effectiveness, access to necessary therapeutics, and clinical decision support tools to improve standardization and utilization of medical and psychiatric drugs. Support for the state facilities includes serving as a central contract author/administrator for Medicare Part D Pharmacy Benefit Management (PBM) Companies (CVS Health/Caremark, RxAdvance (Walgreens), Express Scripts (Cigna), OptumRx (UnitedHealth Group) and Humana (Walmart)). Also manages additional contracts for pharmacy services, and conducts community outreach and provides technical assistance; for example, in FY 2022, pharmacy participated in Remote Area Medical Clinics to provide Revive Training and Naloxone nasal spray to participants, and established and gained approval for two pilot projects through the Board of Pharmacy to increase medication access in crisis receiving centers through the use of automatic dispensing devices

Community Services

Behavioral Health Community Services

System Transformation Excellence and Performance (STEP-VA)

DBHDS continued working with the Administration, the General Assembly, and stakeholders to implement STEP-VA, an initiative that features a uniform set of services with consistent availability and improved oversight of services across all Virginia communities. A full annual report on STEP-VA implementation is provided to the General Assembly each November. Implementation follows a three-phase approach, with phase one representing the initial stage and phase three representing full implementation:

STEP	Phase 1 CSBs	Phase 2 CSBs	Phase 3 CSBs
Same Day Access	0	0	40
Primary Care Screening	0	0	40
Outpatient Services	0	0	40
SMVF (Veterans)	0	40	0
Peer and Family Supports	0	40	0
Case Management	40*	0	0
Psychiatric Rehabilitation	40*	0	0
Care Coordination	40*	0	0

**most CSBs provide these services, but implementation has not yet been measured in a standardized way because funding only began July 1, 2022.*

Community Adult Behavioral Health Services

- Coordinated Specialty Care (CSC) – Three new CSC programs were added to Virginia's behavioral healthcare system, bringing the total number of CSBs offering this service to 10. CSC is a team-based, collaborative, recovery-oriented treatment model that emphasizes outreach to identify and engage young people experiencing a first episode of psychosis (FEP) into youth-specific treatment which can include low-dosage medications, cognitive and behavioral skills training, supported employment and supported education, case management, and family psychoeducation. CSC also emphasizes shared decision-making as a means to address the unique needs, preferences, and recovery goals of young people with FEP.
- Assertive Community Treatment (ACT) – In FY 2022, reported the following findings from a two-year pre/post study for ACT:
    - The average cost per individual served by ACT teams across Virginia in FY 2021 was $14,458, representing a consistent trend with the previous fiscal year.
    - State hospitalization usage for all ACT served individuals admitted in FY 2019 was reduced by 51 percent, representing a cost avoidance of $14,294,084 for this population.
    - All new FY 2019 ACT served individuals accounted for 29,669 state hospital bed days in the two years prior to their ACT admission, and just 14,499 in the two years after their ACT admission.
    - Across the FY 2016, FY 2017, FY 2018, and FY 2019 cohorts, the ACT program contributed to an overall cost avoidance of $43,580,170 in state hospital costs in the two years following initiation of ACT services.
    - Local psychiatric hospitalization use for all ACT served individuals admitted in FY 2019 had a 51 percent reduction, which represents a cost avoidance of $3,945,553 related to this population.
    - All new FY 2019 ACT served individuals accounted for 9,904 local hospital psychiatric bed days in the two years prior to ACT admission, and just 4,886 in the two years post ACT admission.
    - Incarceration of all ACT served individuals admitted in FY 2019 was reduced by 52 percent and represents a cost avoidance of $411,212 related to this population.
    - In the two years prior to admission to ACT, all new FY 2019 individuals served 7,829 days in confinement compared to only 3,730 days in the two years post entering ACT.
    - Across the FY 2016, FY 2017, FY 2018, and FY 2019 cohorts, the ACT program contributed to an overall cost avoidance of $2,929,363 in jail costs in the two years post initiation of ACT services.

Community Child and Family Behavioral Health Services

- The Virginia Mental Health Access Program (VMAP) has launched and has fully staffed all five regional hubs providing behavioral health consultation and care navigation services to the region's primary care providers (PCPs) who treat children and adolescents (North, East, Central, West, and Southwest). For the first time, VMAP was able to connect PCPs treating children and adolescents to local child and adolescent psychiatrists available for consultation 40 hours a week, scaling up from the previously part-time and state-wide line.
    - Published the *VMAP Guide for Promoting Child and Adolescent Behavioral and Mental Health in Primary Care (v1.0)* which is a compilation of evidence-based

practices, up-to-date resources, and practical knowledge specifically geared towards pediatric and adolescent health care providers.
    - Launched Care Navigation Advisory Committees in the first two regions (North and East). These committees, comprised of diverse professionals and community members, help to facilitate regional communication between community behavioral health services and VMAP regional hub teams. VMAP's goal is to have a Care Navigation Advisory Committee in every region by 2023.
    - Served a total number of 1,422 unique patients in FY 2022, and had a total number of 1,664 consult calls, and registered 315 new providers.
    - PCPs called the VMAP line for a variety of reasons in FY 2022; however, however, 82 percent of the calls were for medication consultation, 13 percent were for diagnostic consultation and 13 percent were for therapy/behavioral consultation.
- Served 21,048 infants and toddlers in FY 2021 through Early Intervention/Part C. The number of infants and toddlers served exceeds pre-pandemic numbers. Early Intervention Part C implemented a new data system and hosted a statewide conference for early intervention providers.
- Awarded school based mental health grants through the Consolidated Appropriations Act and the American Rescue Plan Act to 12 CSBs. The CSBs are providing school based mental health services to children and adolescents with serious emotional disturbance.
- Completed two children's mobile crisis train-the-trainer cohorts with the curriculum developer Briljent, LLC. Those that completed the train-the-trainer are now mobile crisis instructors who are able to provide training on the children's mobile crisis curriculum throughout the Commonwealth.
- Awarded a contract to develop training facilitation tool-kits for all mobile crisis trainers. The tool kits include content on Best Practices, Mentoring, and Master Training.
- Funded ten CSBs to develop adolescent-focused substance use disorder services.
- Continued funding for sustainability of the evidence-based practice Advanced Clinical Research Award (ACRA) for adolescent substance use treatment and expanded peer recovery specialists for adolescents/young adults at existing ACRA grant sites.
- Hosted an annual adolescent and young adult substance use symposium- *Adolescent & Young Adult Substance Use Symposium: Pathways to Compassion, Healing & Recovery* for 400 physicians and clinicians in the state.

Behavioral Health Wellness and Suicide Prevention

- Lock and Talk Virginia Lethal Means Safety Initiative expanded to all 40 CSBs. The initiative recognizes that promoting safe and responsible care of lethal means – while encouraging community conversations around mental wellness – is vital to the mission of preventing suicides and promoting wellness. Lock and Talk Virginia gives community members the opportunity to become educated about the signs of suicide risk and how to act as a catalyst to care. This year alone, over 18,000 medication safety devices and over 17,500 gun locks were distributed with education.
- Applied Suicide Intervention Skills Training (ASIST) – Trained 138 individuals in ASIST as of June 2022, bringing the total trained to 3,983. ASIST is designed to help caregivers recognize risk for suicide, intervene to prevent immediate harm and link persons at risk to

the next level of care. (Note: This training is only offered in-person. Numbers have been lower than expected due to limitations imposed by COVID-19 guidelines.)

- SafeTALK (Suicide Alertness for Everyone) – Trained 205 individuals in safeTALK as of June 2022, bringing the total trained to 2,744. SafeTALK helps participants become alert to suicide, and they are better prepared to connect persons with thoughts of suicide to appropriate resources. (Note: This training is only offered in-person. Numbers have been lower than expected due to limitations imposed by COVID-19 guidelines.)

- Mental Health First Aid (MHFA) – Trained 86,152 individuals in the MHFA course to date. MHFA has specific curriculums that are designed for target populations such as: adults, youth, higher education, public safety, older adults, rural communities, and Spanish (adult and youth) speaking audiences. This training has been in high demand by the higher education, youth serving and public safety sectors. Additionally, this training is available in-person and virtually.
- Behavioral Health Equity – With the VCU Center on Society and Health, refined the behavioral health index using the all claims payer database to determine the prevalence of SMI, SED, and SUD by zip code. Conducted trainings on seven topics during FY 2022. Awarded $250,000 in behavioral health equity grants for the 2022 cycle to 13 CSBs and 13 community organizations.
- Virginia Refugee Healing Partnership – This partnership, made possible by a grant awarded from the Department of Social Services, held behavioral health interpreter training attended by 125 behavioral health interpreters, 22 of them are trainers. The Behavioral Health Interpreting Curriculum was published in June 2022, and new curriculum was developed on a interpreting course for "Lay Persons and Pathways to Wellness." This initiative also held a training on trauma-informed care for 167 and provided nine mini-grants for youth substance use prevention training. Finally, this initiative conducted a statewide needs analysis survey on refugees. Survey results were shared to nine refugee resettlement agencies, 47 VRHP stakeholders, and 32 organizations across the state.
- Problem Gambling Prevention – DBHDS is tasked to provide strategies to prevent problem gambling. This effort is supported by a percentage of tax revenues generated through skills games, sports betting and in the near future, casinos pursuant to 37.2-314.2. Collaborations are underway with VDH, the Virginia Lottery, Va. Department of Agriculture and Consumer Services Charitable Gaming unit, the VA Council on Problem Gambling, and Virginia Health Information. Data was collected by DBHDS and all CSBs as part of a needs assessment:
  - Over 5,100 young adult surveys were collected;
  - Over 1,200 scans of the environment were completed;
  - All 40 CSBs are conducting Community Readiness Assessments.

  In addition, the DBHDS Office of Recovery established a steering committee of Peer Recovery Specialists with lived experiences to offer expert opinion on to how grow problem gambling awareness and recovery skills with the PRS workforce. The office developed a contract with VCU to include a treatment provider network within local communities, peer recovery network focused on gaming and gambling; continuing education and training on evidence- based practices for providers.

Substance Use Disorders

DBHDS continually received a federal State Opioid Response (SOR) grant beginning October 2018 through September 2023 for prevention, treatment, and recovery, plus a supplementary onetime allocation of $8.7 million. In FY 2017 and FY 2018, Virginia received $19.4 million. From FY 2018 to FY 2020, Virginia received $67.1 million. In FY 2021 and 2022, Virginia received $27.6 million and funds are used for the following:

- Prevention SOR grant accomplishments included:
  - Increased the capacity for communities to prevent prescription drug and heroin overdoses. Thirty-eight CSBs worked with OMNI Institute to build evaluation capacity through logic model development and data-driven strategy selection using national, state, and local data.
  - Increased community awareness of local opioid overdose problems. Thirty-eight CSBs developed prevention messaging with input from coalitions and community partners, with varied content and delivery methods depending on the identified needs of each community.
  - Increased the number of safe storage and disposal efforts to decrease the availability of prescription drugs for misuse. These efforts included distribution of drug deactivation packets, prescription drug lockboxes, and smart pill bottles. Communities also participated in drug take-back events and arranged for the installation of permanent drug drop boxes or drug incinerators.
- Treatment SOR grant accomplishments included:
  - Increased the number of individuals engaged in treatment. In 2017, 18 of the 40 CSBs across Virginia were offering MAT services. SOR funds helped to expand Medicated Assisted Treatment (MAT) coverage to all 40 CSBs by the end of 2019, significantly increasing access to treatment for Virginians. Currently, all 40 CSBs either offer on-site MAT services or partner with an MAT provider.
  - An average of 1,553 clients per quarter received MAT services.
  - An average of 2,253 clients per quarter received non-MAT services, including counseling, psychiatry, contingency management, and other therapeutic support.
  - Many treatment clients received other services, such as transitional housing, residential treatment, or wellness support.
  - Expanded availability of wraparound supports that are critical to treatment success and overcoming treatment barriers, including transportation, childcare, and service vouchers. These services enable individuals to better adhere to treatment plans and achieve desired OUD treatment outcomes.
  - Expanded treatment services provided in justice settings. As of November 2020, 17 jails were working with CSBs to offer MAT services in their facilities.
  - Distributed naloxone kits to local health departments, CSBs, harm reduction sites, and pharmacies.
  - 30,736 SOR-funded naloxone kits were distributed to local health departments, community members, CSBs, and first responders.
- Recovery SOR grant accomplishments included:
  - 37,835 individuals received SOR-funded recovery services.
  - 35 hospitals offer peer recovery services in emergency departments.

- Eight Virginia colleges and universities offer SOR-funded on-campus collegiate recovery communities as well as peer support services.
- 21 regional jails are providing SOR-funded MAT and/or recovery services.
- Hosted quarterly recovery roundtable discussions and peer support webinars with evaluation partner OMNI Institute to collaborate in the recovery field across states.
- Piloted use of a standard outcome measure (the Brief Assessment of Recovery Capital or BARC-10) to measure changes in recovery capital over time for individuals receiving a variety of recovery services in different settings. Presented BARC-10 pilot findings at three national level conferences.
- Assessed changes in recovery outcomes, including substance use, housing, education, employment, health, and social connectedness. Most (98 percent) individuals assessed stated that working with a peer is moderately, considerably, or extremely helpful with recovery and maintaining sobriety.

- The REVIVE! program accomplishments during FY 2022 included:
  - Eliminated the issue of REVIVE! kits awaiting replenishment by developing an inventory system. The system afforded CSB and all other REVIVE! trainers the security of having REVIVE! kits available and on demand for all trainings to distribute to participants.
  - Continued training and related services during the pandemic by implementing virtual "Rapid REVIVE!" for individuals at the highest risk of experiencing or encountering opioid overdoses.
  - REVIVE! Training of Trainers (TOT) training sessions were also offered on a biweekly basis, to begin the development of more Master Trainers.
  - Due to the decrease in COVID-19 restrictions, the demand for in-person trainings increased significantly. In-person training requisitions, across the Commonwealth, were accommodated by the DBHDS REVIVE! team, when requested.
  - During the 1st quarter of 2021 there were 31 individuals trained as Non-First Responder Master Trainers. During the same time, approximately 1,500 individuals were trained via Lay Rescuer and Training of Trainers (TOT).
  - DBHDS partners with VDH to coordinate the distribution of Naloxone. Comprehensive Harm Reduction (CHR) sites as well as REVIVE! trainers can register to receive Naloxone from VDH. CHR sites have distributed 11,332 doses of Naloxone. Pharmacy Naloxone distribution is about 6 percent of overall distribution.
  - DBHDS received funds from the First Responders Grant. This funding opportunity has allowed DBHDS to partner with Virginia Association of Chiefs of Police (VACP) to provide REVIVE! For First Responders training. The cohort of First Responders include: Law Enforcement agencies, non-EMS fire service agencies, and corrections/jails located in Virginia. During the time frame January 1-June 30, 2021, eight REVIVE! for First Responders Train the Trainers were conducted, 126 new trainers were certified as REVIVE! First Responders Trainers, and no Master Trainer certifications were completed.
- The State Opioid Treatment Authority (SOTA) requested and received approval from SAMHSA to allow for liberal take-homes. SOTA held daily and then weekly calls. DBHDS, DMAS, and others were able to assist the opioid treatment programs (OTPs) with reimbursement for take-homes, transportation and PPE. Virginia expanded from 38 to 46

OTPs during the pandemic. All 46 OTPs have the ability to become naloxone only distribution sites. This allows them the capability to give each client a naloxone kit.

- Substance-Use Disorder Prevention – The Substance Abuse Block Grant Prevention Set-Aside has transformed the CSB prevention system into a performance-based system by utilizing the federal Strategic Prevention Framework (SPF). This year, all 40 CSBs, in partnership with their local community coalitions, implemented individually based prevention programs that served 51,061 individuals.
    - Adverse Childhood Experiences (ACEs) – All 40 CSBs have been trained to bring awareness to their communities around the connection between ACEs and future adverse mental, emotional, and physical health outcomes. ACE Interface trainings are the foundation for growing ACE Prepared Self-Healing Communities. To date, DBHDS has trained 340 trainers who have delivered over 500 trainings to over 15,500 participants.
    - Synar – The federal Synar Amendment requires states to have laws prohibiting the sale and distribution of tobacco products to minors. Virginia's Synar rate remained at 16.8 percent for FY 2022 as retailer compliance checks were suspended due to COVID-19. This rate continues to reiterate the need for sustained, ongoing retail violation enforcement checks.
    - Disposal and Storage – CSBs implemented strategies to reduce access to opioids through proper disposal and storage, including distribution of Over 16,000 drug deactivation packets, lockboxes, and smart pill bottles.
    - Drug Take Back Events – Over 50,000 people engaged in events this year.
    - "Activate Your Wellness" – This SOR II-funded statewide media campaign invites Virginians to learn, reflect and take steps to improve individual and community wellness. The project is a collaborative effort including DBHDS, OMNI Institute, Rigaud Global Company and 20+ CSBs. The campaign used multiple media channels including radio, digital video streaming, Instagram, Facebook and YouTube--with more than 5 million impressions during July-August 2022. Traffic to the website landing page topped 1,100 views in the first month of the campaign and the average time spent on the page was over four minutes.
    - Message Reach – All 40 CSBs were SOR-funded; they developed prevention messaging with input from coalitions and community partners. Many used multiple platforms to customize information. CSBs and coalitions make data-driven decisions to customize messages and formats for different audiences. This year, 2.9 million individuals targeted with media outlets, over 260,000 items of educational material distributed, nearly 162,000 individuals reached at community events with opioid education and resources.
    - Curb the Crisis – is a website comprehensive resource and media campaign for all Virginians in the fight against opioid misuse and overdose. During FY 2022, DBHDS worked with contractor Reingold to begin a paid media campaign started in late August 2020. The site drove 170,254 page views. There were 2,757 uses of the resource locator. Facebook had 1.16 million clicks from 2.57 million impressions.

Office of Recovery Support Services (ORS)

- Workforce Development – Trained and certified peer recovery (CPRS) workforce. There are currently 863 individuals in active CPRS status and 413 of those are RCPRS-Registered with the Board of Counseling. In addition:
  - 862 people took the DBHDS 72-hour peer recovery specialist training in FY 2022.
  - 3,945 people have been trained since January 2017.
  - 70 people completed the online, on demand supervisor training in FY 2022.
- Recovery Community Organizations (RCOs) – Funded additional RCOs throughout the Commonwealth: McShin Foundation located in Richmond, Robin's Hope located in Chesterfield County, Strength in Peers located in Harrisonburg, Chris Atwood Foundation located in Reston, and Family Support Partners of Virginia, which is specific to supporting parents and caregivers, is located Mechanicsville.
- Recovery Residences – Fund collaborative efforts to ensure Virginia's most vulnerable SUD populations have safe and supportive housing choices. Virginia Association of Recovery Residencies (VARR) and Oxford House have expanded its coverage area to encompass the rural southwest regions of Virginia. Oxford Houses of Virginia provide over 3,000 beds and VARR almost 1,100 in the state.
- Peer Support House – In collaboration with the Mount Rogers CSB, DBHDS funded the development of Virginia's first Peer Support House which will serve as a voluntary alternative for individuals at-risk for or experiencing a mental health crisis needing additional support but have not yet reached a need for traditional psychiatric hospitalization. The program will be open 24/7 with Peer Support Specialist available to address guests' immediate needs. Given the rural nature of the catchment area and chronic housing crisis, the Peer Support House will be available for guest to stay up to 14 days. During this time, Peers will engage in peer-centered, recovery-oriented support, assist with the development of Wellness and Recovery Action Plans, and link guests to community resources to continue working towards recovery.

Community Cross-Disability Services

DBHDS structured several initiatives to operate across disability groups including community housing, community integration, and crisis services. DBHDS is working to build a cross-disability, child and adult crisis services delivery system.

Crisis Services for Adults and Children

Crisis services are a critical component of a comprehensive community service delivery system that can respond to individuals' needs and play a significant role in avoiding unnecessary hospitalization and further trauma.

- The statewide crisis data platform was initiated to gather data about crisis services across the Commonwealth from both private and public providers of crisis services. The vendor has built out the intake and mobile crisis portion of the platform and is working on developing a new bed registry.
- 988 launched in Virginia on July 16, 2022. DBHDS proactively prepared for this initiative through partnering with National Suicide Prevention Lifeline Providers in the

Commonwealth to operationalize Virginia's call center. Through this process Virginia increased it's in state answer rate from 55 percent to 85 percent.

- Expanded two existing crisis intervention team assessment center (CITAC) sites and opened two new crisis receiving centers (CRCs) through the use of diligently appropriated grant funding; these are intended to provide de-escalation and treatment for clients experiencing crises; these programs in Highlands and New River Valley CSBs include medical, psychiatric, and clinical supports for those in crisis.
- The child Regional Education Assessment Crisis Services Habilitation (REACH) program received 1,389 referrals. The adult REACH program received 1,973 referrals.

Community Housing

- Invested $34 million to establish and sustain 25 permanent supportive housing (PSH) providers across the state to serve more than 2,000 individuals with SMI.
- Contracted with three non-profit housing providers to work with owners of Low Income Housing Tax Credit properties to provide on-site services to tenants with SMI or I/DD.
- Invested $1.6 million to serve 75 households with a pregnant or parenting woman with substance use disorder.
- Allocated $1.5 million in federal Projects for Assistance in Transition from Homelessness (PATH) funds to 14 CSBs to provide outreach and case management services to people with SMI experiencing homelessness. Virginia PATH providers engaged more than 2,000 homeless individuals through street outreach and shelter in-reach.
- By the end of the fiscal year, nearly nine percent of adults in the Settlement Agreement population were living independently. Their housing opportunities were provided primarily through DBHDS's State Rental Assistance Program funding and through 227 housing choice vouchers committed through housing authority preferences. Since these housing efforts were initiated, 1,806 individuals have been assisted to live independently.
- DBHDS's State SOAR Coordinator provided targeted Supplemental Security Income/Disability Insurance (SSI/DI) Outreach, Access, and Recovery (SOAR) training to state hospital staff, jail discharge planners, and community homeless services providers. Virginia's SOAR approval rate for disability applications exceeded the national average.

Developmental Community Services

U.S. Department of Justice Settlement Agreement

Virginia is in the 11th year of a Settlement Agreement with the U.S. Department of Justice to improve and expand services and supports for individuals with developmental disabilities (DD) and to create a comprehensive system of home and community-based services that promotes community integration and quality improvement.

- On May 23, 2022, the federal court submitted an order extending the anticipated end of the Consent Decree to December 31, 2023.
- The results of the Independent Reviewer (IR) June 2022 report highlighted 155 of 317 total compliance indicators reviewed during 20th review period for a total of 183 compliance

indicators met or 58 percent. Of these, 100 are in sustained compliance or have been met during two consecutive review periods.

- Virginia was relieved of 34 provisions in Section IV (Discharge Planning and Transition from Training Centers) and VI.D. In addition, the Commonwealth is in sustained compliance with an additional 45 provisions: 35 in Section III (Serving Individuals in the Most Integrated Settings) and 10 in Section V (Quality and Risk Management System). This puts the Commonwealth in sustained compliance with 79 of the 122 provisions in the Settlement Agreement or 65 percent as of the end of FY 2022.
- Additionally, there are 20 provisions where Virginia is in compliance with 60 percent or more of the indicators tied to those provisions. This compliance is dependent on asserting the reliability and validity of the data.

Integrated Day/Supported Employment Services

Virginia as an "Employment First" state continues to promote the value of employment for all persons with disabilities. Achieving compliance with the Settlement Agreement will require continued expansion of qualified providers to offer new integrated day services.

- Published two semi-annual reports on employment with 100 percent participation from employment service organizations.
- The pandemic had a significant impact on individuals working in the community; however, the data is starting to rebound. The percent of individuals being employed increased from a low of 17 percent up to 20 percent in FY 2022.

Medicaid Waiver Services for Individuals with Developmental Disabilities (DD)

The Medicaid Home and Community-Based Services (HCBS) waivers prescribe the types of services Virginia may offer based on Virginia's approved applications to the U.S. Centers for Medicare & Medicaid Services (CMS). HCBS waivers provide the funding for the vast majority of children and adults receiving services through a combination of state and federal funding.

- Waiver Services and Waitlist – As of August 1, 2022, there were 16,507 individuals on assigned a waiver slot. The total wait list was 13,943 and included:
  - Priority One (services needed within one year): 3,074;
  - Priority Two (services needed in 1-5 years): 5,995; and
  - Priority Three (services needed in 5+ years): 4,874
- Virginia's HCBS Waivers (DD Waivers) are also subject to the 2014 HCBS Settings Regulation (Final Rule). The HCBS Final Rule prescribes specific characteristics that must be present in settings where waiver services are provided to demonstrate a home and community-based experience versus an institutional one. HCBS settings nationwide are required to demonstrate compliance with the rule by March 17, 2023 to continue participating in the Medicaid waivers program. There are approximately 4,000 of these settings serving children and adults in Virginia. Each group home, group day, sponsored residential, supported living, and group-supported employment setting must be assessed for compliance with the requirements. As of FY 2022, DBHDS and DMAS have created approximately 40 percent of the reviews.
- Reviews of documentation have been completed for all CSBs for a five percent sample of individuals on the DD waiver waitlist to ensure accuracy and consistency of interpretation across the state for waitlist placement criteria and priority level status.

Supports Intensity Scale®

The Supports Intensity Scale (SIS®) is a comprehensive assessment used to identify the practical supports required for individuals enrolled in DD waivers. In Virginia, external organizations accredited to perform the SIS contract with DBHDS to conduct the assessment.

- SIS vendors completed a total of 1,260 SIS assessments.
- DBHDS began collecting SIS satisfaction surveys in July 2020. From July 2020 – July 2022, an overall satisfaction rating of 93 percent favorable responses has been maintained, and the overall satisfaction rate was 96 percent for FY 2022.
- In coordination with DMAS, DBHDS hosted the annual meeting of the SIS Stakeholders Workgroup on April 20, 2022.

DD Waivers Customized Rate Program

In 2017, CMS approved a waiver amendment allowing providers to apply for a customized rate for individuals whose support needs fall outside of the standard rate structure. Any provider supporting an individual on the Family & Individual Supports Waiver or Community Living Waiver are eligible to apply for a customized rate regardless of the individual's assessed SIS© score. If approved, a rate unique to the individual and/or service is developed. In FY 2022, the DD Waiver customized rate program helped individuals successfully live in the community and avoid unnecessary hospitalization or involvement with the criminal justice system by providing funding for additional staffing supports. In FY 2022, 209 applications were approved.

Integrated Health

The Office of Integrated Health (OIH) improves access to gaps in services to improve quality of life and overall health. The Health Support Network (HSN), is under the umbrella of OIH.

- Performed 8,643 repairs to 6,535 pieces of durable medical equipment and assistive technology items (such as wheelchairs). Also completed 79 custom adaptations.
- Facilitated 599 regional community nursing meetings with a combined 1,074 attendees.
- Presented 77 educational trainings with 4,115 attendees on topics addressing challenges in health and safety and reducing risk of injury or fatal outcomes.
- Circulated 26 monthly newsletters and health and safety alerts promoting best practices in the health care and promoting safety interventions that can mitigate risk.
- At the end of FY 2022 the dental team was serving 1559 individuals with DD without using restraints or general anesthesia through the Health Support Network program.
- The Preadmission Screening and Resident Review (PASRR) process is a federally mandated process that ensures individuals with DD or severe mental illness admitted to nursing facilities meet criteria for admission. The PASRR team completed 818 evaluations for individuals who were referred to or seeking admission to nursing homes.

Provider Development

Provider Development focuses on developing and sustaining a qualified community of providers so people with DD and their families have choice and access to options that meet their needs.

- Held quarterly provider round table and support coordinator meetings attended by 2,041 representatives to share updates, initiatives, and obtain stakeholder feedback.

- Continued the implementation of a support coordination quality review process and established a process of monitoring CSB performance with the Case Management Steering Committee.
- Established a Data Quality Support process to support CSBs in identifying and resolving issues with data reliability and validity
- Processed 574 regional support team (RST) referrals to review informed choice and increase consideration of more integrated service options statewide.
- Modified the Jump-Start funding initiative to include funding for children's sponsored residential, skilled nursing, and behavioral therapeutic consultation to incentivize provider development in areas of need.
- Initiated a contract with the Arc of Virginia to implement a Peer Mentor process and launch a project focused on the sharing of online personal stories by people with DD about their experiences having more integration and more choice and control.
- Awarded $104,385 to create integrated service options in underserved areas.
- Updated the centralized Individual Support Plan to further align with the Settlement Agreement and enhance the collection of critical health information and history.

Individual and Family Support Program (IFSP)

IFSP provides financial assistance to individuals and families on the waitlist for services through one of Virginia's DD waivers to cover eligible costs that support continued living in an independent setting. There was a significant technical issue with the program's data portal in FY 2020. In FY 2022, the system experienced another significant technical issue; however, DBHDS was able to release funding. DBHDS will no longer use this data portal. In the meantime, IFSP continued to support Virginians with DD and their families in FY 2022 through:

- Distributed $4,008,000 to applicants for supports through the funding program.
- Worked with the WaMS vendor to create a new IFSP portal.
- On September 10, 2021, sent the funding announcement to 21,058 people, including families, people on the FY 2022 Waiver Waiting List, and to DD providers.

Waiver Management System (WaMS)

WaMS is the DBHDS waiver management system. FY 2022 updates included:

- Update to ISP (version 3.3) to enhance electronic health record integration and to align with DOJ compliance indicators.
- New integration with DMAS core management solution (CRMS) – Support the new interface between WaMS and DMAS' CRMS module for the Medicaid Enterprise System.
- Finalized regional support team development in WaMS to automate this process and data.

Single Point of Entry and Children's ICF Initiatives

DBHDS, along with DMAS, began the single point of entry process in May 2018. Through this process, any Virginian seeking placement in an intermediate care facility (ICF) is screened utilizing the Virginia Individual DD Eligibility Survey (VIDES) to determine eligibility.

- 47 Virginians were screened for ICF/IID placement (28 adults and 19 children).

- The Children's ICF initiative mainly focuses on Holiday House of Portsmouth and St. Mary's Home. DBHDS conducts annual level of care reviews for all residents, educates families on more integrated options, and participates in discharge planning efforts.
    - 217 Community Transition Guides were emailed/mailed. Additional guides were provided per request.
    - 34 families were linked to VCU Family to Family Network
    - Participated in the transition/discharge planning process for children at Holiday House and St. Mary's Home.

Facility Services

COVID -19 Response

The pandemic and critical staffing shortages greatly affected all 12 of the DBHDS-operated facilities in FY 2022. Implementation of limited visitation, infection control protocols, use of personal protective equipment, testing and vaccination/booster strategies, as well as ongoing consultation with the Virginia Department of Health (VDH) were critical to continuing facility operations. Admissions and visitation at the state facilities continued to be impacted. For much of the past fiscal year, all civil admissions were required to have a negative COVID-19 test prior to admission to a state facility. Forensic admissions continued throughout the pandemic, and testing was strongly encouraged in situations where it could be obtained. All of these admissions were tested, quarantined, and monitored according to DBHDS guidelines based on U.S. Centers for Disease Control & Prevention and VDH guidance. All facilities had continued COVID-19 outbreaks during the fiscal year and continued to implement quarantine units as needed. DBHDS facilities worked closely with VDH to implement plans to manage each of these outbreaks.

State Mental Health Hospital Staffing Crisis

DBHDS state hospitals have been operating at census capacity level since 2014 due to increasing obligations under §37.2-809, the "Bed of Last Resort" statute. During FY 2022, state hospitals experienced one of the most challenging periods in recent years with critical census and staffing levels across the system.

- Five state hospitals temporarily closed to civil admissions in July 2021 in an effort to bring patient to staff ratios to a safer level to reduce serious incidents and injuries.
- All closed hospitals were re-opened by early September; however, beds were re-opened at the capacity at which they could be safely staffed. Additional beds were added at each hospital as staffing levels improved. By the end of the fiscal year, 139 beds had been reopened across the state hospital system.
- Direct care staffing vacancies reached up to 69 percent in several state hospitals.
- DBHDS utilized ARPA dollars to secure direct care contract staffing (DSA, LPN, RN) to maintain hospital operations in seven of nine state hospitals during FY 2022.
- DBHDS worked closely with state hospitals to implement available strategies to mitigate staff turnover; however, staffing continued to be at crisis levels by the end of FY 2022.

- By the end of FY 2022, direct care staffing levels were not sufficient to maintain safe operations and quality care within the state hospitals and all facilities were operating at a limited capacity of 50 percent to 96 percent across the system.

Architecture and Engineering Services

Construction progressed on numerous projects despite the constraints of COVID-19. Virginia has experienced delays with the delivery of materials and supplies. These delays included but were not limited to doors, hardware, and roofing materials in particular.

- Expansion of VCBR – With the exception of a six bed female unit, VCBR has occupied all new living units (six total). This includes the transitional unit and four "standard" living units. One additional living unit is being used for temporary office space as construction progresses. Construction is continuing in support areas (vocational, treatment areas, office spaces) and in living units that were part of the existing facility. The expansion project includes renovation of the pre-existing units to add medical/treatment areas on the living units. One of the original three housing buildings (four units) is undergoing renovation at this time. Two additional housing buildings need to undergo renovations. When renovations occur, the entire building (four living units) is closed. The anticipated date for completion of all construction/renovation is March 2023. This project has experienced multiple delays due to material and service delivery delays.
- Northern Virginia Mental Health Institute – Projects are underway for replacement of the fire alarm system, anti-ligature improvements, and access control upgrades. Replacement of several rooftop air handling units, installation of a new emergency generator and electrical improvements have been completed. DBHDS is doing some preliminary work with DGS to identify potential sites for a replacement facility.
- Central State Hospital Rebuild – The 2019 session of the General Assembly provided funding for the replacement of Central State Hospital. The Department of General Services serves as the project manager for this capital project. The architectural/engineering firm of Einhorn Yaffee Prescott was selected to design the new facility and Gilbane Construction was chosen as the construction manager.

Community Integration Services (CIS)

CIS provides development and oversight of the Alternative Transportation Program, and discharge planning and community integration of individuals discharging from state hospitals. The team assists and trains discharge planners and administers Discharge Assistance Plan (DAP) funds and Local Inpatient Purchase of Service (LIPOS) funds, along with other funding sources that support community integration.

- Alternative Transportation Services – The alternative transportation program provides a person-centered and trauma-informed transportation services, versus traditional law enforcement transport during the temporary detention order (TDO) process. DBHDS contracts with Allied Universal to provide this service. During FY 2022, the alternative transportation program:
    - Navigated a buyout from the original contractor, G4S, to Allied Universal.
    - Continued operations under Allied Universal to complete 1,925 transports during FY 2022 bringing the program to just under 5,000 transports since the beginning.

- Negotiated a corrective action process with Allied Universal in order to determine whether to move forward with contract renewal and, as a result, renewed the contract with Allied for a one year term.
- Implemented a pilot program for discharge transportation from Western State and Catawba Hospitals with plans to expand to all state facilities in FY 2023.
- Implemented a pilot program to develop memorandums of agreement with local law enforcement agencies to assist with the costs of maintaining custody of individuals awaiting a state facility bed.

- DAP – DAP is a major tool for overcoming barriers to discharge for individuals in state mental health hospitals who are clinically ready to leave but unable to do so due to the lack of needed community services.
  - Oversaw the use of $62.4 million in DAP funds.
  - In FY 2022, DAP funds served 1,637 individuals, of which approximately 619 were new discharges from state hospitals.
  - Served 1,337 individuals with individual DAP plans/funding
- LIPOS – Transitioned to a reimbursement model with the CSBs in which we reimburse for what is spent instead of a pre-determined annual allocation. This allows DBHDS to adjust where LIPOS is being sent throughout the year, so the amounts the regions receive more closely match their current needs.
- Extraordinary Barriers to Discharge List (EBL) – Individuals on the EBL have been clinically ready to leave the hospital for at least seven days, but cannot be discharged safely due to non-clinical barriers. The average number of individuals on the EBL grew from 153 in FY 2015 to a high of 219 in FY 2020. In FY2021 the average number of individuals on the EBL was 209, and it was 199 in FY 2022.
- Community Integration Projects
  - Supported 145 assisted living facility beds in three locations.
  - Supported 110 transitional group home beds in locations throughout the state. All of these beds are used exclusively for individuals discharging from state hospitals.
  - Served 130 individuals in transitional group homes.
  - Served 170 individuals in assisted living facilities.
  - Added an additional transitional group for adolescents discharging from CCCA.
  - Partnered with Mount Rogers CSB and Valley Healthcare in Chilhowie to continue to operate a specialized behavioral health unit at the Valley facility for individuals discharging from state hospitals. In FY 2022, the program served 50 individuals needing nursing home level of care who discharged from state facilities.
  - Partnered with Western Tidewater CSB and Waverly Nursing Home to create a similar program in eastern Virginia. In FY 2022, this program served 20 individuals.
  - Funded two new programs focusing on assisting individuals with dementia who have been hospitalized at or are at risk of state hospitalization, and their families and caregivers, including an expansion of the Northern Virginia RAFT (Regional Older Adults Facilities Mental Health Support Team) to include a component that specifically focuses on individuals with dementia, as well as a facility in Southwest Virginia that will focus on serving individuals with dementia who have lost their housing or are unable to continue to live in their family home.

- Assisted Western Tidewater CSB in developing a new community and residential program that focuses on serving individuals with traumatic brain injury who are at risk of hospitalization at state hospitals or are discharging from a state hospital.

Facility Milestones

- Catawba Hospital achieved Joint Commission deemed status as a Behavioral Health Hospital during FY 2022.
- The Commonwealth Center for Children and Adolescents achieved Joint Commission accreditation as a Behavioral Health Hospital in June 2022.
- The Virginia Center for Behavioral Rehabilitation continues to lead the nation in the number of individuals successfully discharged from a sexually violent predator civil commitment facility.
- Eastern State Hospital received the Malcolm Baldrige Quality Award. The Malcolm Baldrige National Quality Award (MBNQA) is an award established by the U.S. Congress in 1987 to raise awareness of quality management and recognize U.S. companies that have implemented successful quality management systems. The award is the nation's highest presidential honor for performance excellence.

Forensic Population and State Hospitals

- There were 1,928 forensic admissions to state hospitals.
- There were 355 outpatient restoration cases paid.
- Since FY 2019, there have been 85 outpatient temporary custody orders. These efforts result in approximately 25,075 occupied state hospital bed days that were saved. In FY 2022, there were 27 outpatient temporary custody orders, resulting in 3,969 occupied state hospital bed days saved.
- Accommodations were made due to COVID-19 to allow the evaluator the option of conducting their evaluations via video conferencing for all commissioner-appointed not guilty by reason of insanity (NGRI) evaluations.
- Hospitals successfully managed the pending forensic admission list. The vast majority of were admitted within ten days despite the additional challenges from COVID-19 and the growing number of court orders.

Jail Diversion

- Provided oversight and support to 12 jail diversion programs.
- Provided oversight and support to nine forensic discharge planning programs at five regional jails, eight local jails, and in collaboration with 16 CSBs.
- Partially funded behavioral health dockets at Arlington, Blue Ridge, Richmond, and Valley CSBs.
- Provided oversight and support to the 38 CSBs and 38 crisis intervention teams (CIT) assessment sites.

Juvenile Competency Restoration and Evaluation

- At the close of FY 2022, the Juvenile Competency Restoration Program had 155 new court orders to provide juvenile restoration services across the Commonwealth. At no time was a hospital bed at CCCA used to provide juvenile restoration services.

- Restoration services are currently being provided in the community with appropriate social distancing, and as allowed by community facilities.
- "DJ and Alicia," an interactive Court DVD, was upgraded and is satisfactory.

Millennium Electronic Health Record (EHR) Implementation
During FY 2022, adoption of Millennium continued as enhancements and modifications improved user workflow and to provided opportunities to improve quality care, services, and end user performance moving forward.

Sexually Violent Predator (SVP) Program
- Continued to facilitate a multi-agency committee to coordinate sex offender treatment services across DBHDS, Department of Corrections (DOC), and community treatment providers. The work of this committee is steadily improving treatment consistency and building a continuum of care and supervision across Virginia.
- Continued to monitor the impact of the updated SVP screening protocol that was developed by DBHDS and DOC. This protocol appears to be successfully reducing the number of SVP evaluations requested and increasing the accuracy of the screening process.

Licensing and Human Rights

Licensing
- CONNECT – On November 3, 2021, the Office of Licensing (OL) went live with a new online-based licensing system, CONNECT. The goal of the CONNECT system is to provide a web portal that will increase efficiency for providers. The portal allows providers to submit electronically all required paperwork such as initial applications, license renewal applications, service modifications, corrective action plans and variances. CONNECT is automated with workflows to streamline licensing processes and improve transparency of data and communication with licensing staff, providing real-time information exchange and 24/7 account access. OL spent hundreds of hours transitioning providers to the new system and providing technical support on utilizing the new functions of the system.
- Regulatory Changes – The 2020 General Assembly directed DBHDS to utilize emergency authority to promulgate licensing regulations that align with the American Society of Addiction Medicine (ASAM) Levels of Care Criteria "to ensure the provision of outcome-oriented and strengths-based care in the treatment of addiction." Changes were also made to align the licensing regulations with Project BRAVO behavioral health enhancement services. The proposed stage drafts were published and public comment periods were held during FY 2022 for the following actions: Amendments to align with ASAM criteria, Amendments to align with enhanced behavioral health services, Amendments to align with ASAM criteria in children's residential facilities. Lastly, the emergency regulations to align the Children's Residential Regulations with the Family First Prevention Service Act (FFPSA) became effective January 10, 2022.
- Incident Management Unit (IMU) – The IMU supports OL's ability to implement the recommendations contained within the Office of the State Inspector General's Review of Serious Injuries and allows for better monitoring of providers' compliance with the serious incident reporting requirements contained within the Licensing Regulations. In addition,

there are a number of settlement agreement provisions and indicators that tie to the timely and accurate reporting of incidents. The IMU provides regular training and technical assistance to providers, and monitors data including specific individual, provider, and system trends related to serious incidents and deaths. The IMU triaged 22,424 serious incidents and deaths in FY 2022.

- Specialized Investigation Unit (SIU) – The SIU was developed to supplement the efforts of licensing specialists in conducting investigations to protect the health and safety of individuals with DD; and to ultimately improve the overall quality of services and supports. During FY 2022, the SIU completed 700 death investigations for individuals with developmental disabilities. The Office of Licensing also completed an additional 608 complaint/serious incident investigations during the year.
- During FY 2022, the OL processed 815 complaints.
- Licensing specialists processed 1,509 application modifications during FY 2022 and completed 2,023 total unannounced inspections.
- In Fall of 2021, began to prioritize application reviews for needed services within the Commonwealth. There is currently no waiting list for applications of prioritized services.
- Based on provider feedback, streamlined the process for sponsored residential service providers to add new locations.
- Disseminated updated training and tools to assist providers with compliance with regulations for implementing risk management and quality improvement programs.

Overview of Licensing Statistics in FY 2022*								
Fiscal Year Change:	2012	2014	2016	2018	2019	2020	2021	2022
Licensed Providers	744	917	1,041	1,071	1,176	1,290	1,359	1,434
Licensed Services	1,860	2,218	2,608	2,780	2,456	3,200	3,558	3,664
Licensed Locations	6,302	7,519	8,447	8,778	8,133	10,753	11,632	11,660

*FY2022 data includes data from the previous licensing system (OLIS) and the new system (CONNECT) and may be impacted by the conversion of data and difference in categorization of information.

Services in FY 2022 **Providers may be licensed for multiple services			
Residential Crisis Stabilization	26	Nonresidential Crisis Stabilization/crisis intervention	261
Inpatient Psychiatric Unit (41 adults/14 children)	55	Medically Monitored Intensive Inpatient Treatment	34
Substance Abuse Adult Residential Services • Clinically managed high intensity residential • Clinically managed low-intensity residential • Specific high intensity residential	49	Substance Abuse Children Residential Services • Clinically managed low-intensity residential • Clinically managed medium-intensity residential	2
DD Supportive In-Home	152	MH Intensive In-Home children/adolescents	346
Supervised Living	47	Sponsored Residential	110
Brain Injury Residential Tx Service	2	MH correctional Facility RTC	3
MH skill building	498	Case Management	192
Psychiatric Residential Treatment Facility children/adolescents	26	Therapeutic Group Home children/adolescents	75
Group Home Service and ICF/IID for adults	563	DD Children Group Home Residential and ICF/IID	23
Substance abuse partial hospitalization	46	Mental health partial hospitalization	36
Substance abuse intensive outpatient	169	Mental health intensive outpatient	41
Substance abuse outpatient	133	Mental health outpatient	131

MH Psychosocial Rehabilitation	85	Therapeutic Day Treatment	107
DD Day Support	341	Respite (residential, in-home, centered based	24
ACT/ICT	39	Medication Assisted Opioid Treatment	45

Human Rights

Human Rights is a Code-mandated internal advocacy system for DBHDS but external to programs operated, funded, or licensed by DBHDS. OHR provides direct advocacy services to individuals receiving services from programs operated, funded and licensed by DBHDS. Staff facilitate due process for individuals who allege human rights violations, examine conditions that impact individual's rights and monitor state operated facility and provider compliance with the Regulations. Staff also monitor individuals discharged from training centers and conduct onsite reviews of newly licensed Waiver providers to assess compliance with the Home and Community Based Settings (HCBS) Settings Rule. Significant activities in FY 2022 included:

- Completed 480 AIM (assess safety, initiate process, monitor compliance) reviews to ensure the safety of individuals receiving services following substantiated cases of serious abuse involving sexual assault, restraint with serious injury, and physical abuse with injury.
- Collaborated with APS and CPS to validate accurate reporting of allegations of abuse and neglect to identify 160 allegations of abuse and neglect that had not been reported, which resulted in 25 citations for substantiated abuse and neglect.
- Revised peer-to-peer reporting requirements in state facilities to address over reporting of these events, and updated guidance to determine when these incidents should be reported and investigated as allegations of neglect. Expectations were also established regarding the initial review and documentation of these incidents, in accordance with DI 401.
- Provided over 40 distinct consultation and training sessions attended by 91 licensed-provider and facility staff.
- Facilitated 21 statewide training seminars to approximately 1,865 licensed-provider & facility staff participant, and administered roughly 1,337 continuing education units/credits.
- A critical function of the OHR is due process via the Local and State Human Rights Committees. It is notable that of the 12, 505 total complaints (including those alleging abuse, neglect and exploitation) the State Committee heard a total of 22 complaints on appeal. This is less than 1% and an indicator of resolution to individual complaints at the lowest/earliest level of the process.
- Community Human Rights Complaints – In FY 2022, there were 941 human rights complaints involving licensed community programs, including CSBs with 11 percent of the total (108), resulting in a violation. Of the 10,237 total allegations of abuse, neglect, or exploitation reported, 10 percent (1,049) were substantiated following the provider investigation and staff review. There was an overall increase in allegations and identified violations (2 percent) for FY 2022. While neglect is routinely the largest category of alleged and substantiated violations, it is notable that the number of substantiated allegations resulting from peer-on-peer aggression increased from 75 to 125, and there are double digit increases for both alleged and substantiated reports of verbal abuse and unauthorized restraint. These increases may be the natural upswing of more intentioned reporting now that providers are slowly beginning to recover from staffing shortages, following a slight dip in reporting during the COVID-19 emergency health crisis. More details are found below:

Abuse/Neglect and Human Rights Complaint Statistics (July 1, 2021 – June 30, 2022)

FY 2022 Human Rights Data Reported by Community Providers				
Total Number of Human Rights Complaints				941
Total Number of Complaints That Resulted in a Violation of Human Rights				108
Total Number of Allegations of Abuse, Neglect, or Exploitation				10,237
Total Number of Substantiated Allegations of Abuse, Neglect, or Exploitation				1,049
Substantiated Allegations by Type		Exploitation	21	
Physical Abuse	100	Neglect	743	
Verbal Abuse	83	Neglect (Peer-to-Peer)	125	
Sexual Abuse	11	Unauthorized use of Restraint	52	
Resolution Levels for the 941 Human Rights Complaints and 10,237 Allegations of Abuse, Neglect, or Exploitation				
Director and Below	12,169	State Human Rights Committee		5
Local Human Rights Committee	9	DBHDS Commissioner		0

- State Hospital and Center Human Rights Complaints – In FY 2022 there were 790 human rights complaints involving state operated hospitals and centers with 11 percent (94), resulting in a violation. There were 537 allegations of abuse, neglect or exploitation, wherein 16 percent (85) determined a violation based on the facility investigation and OHR review. When compared to FY21, there was a marked decrease in the number of reported allegations, specifically neglect peer-on-peer (P2P), which can be attributed to the revised guidance concerning reporting and investigating peer aggression. In FY 2021, there were a total of 2,681 allegations reported, of these 2,219 alleged neglect P2P. In FY 2022, however, there were 115 reports of neglect P2P which after investigation and review by OHR, resulted in two violations (compared to zero in FY 202). More details are found below:

FY 2022 Human Rights Data Reported by State Hospitals and Centers				
Total Number of Human Rights Complaints				790
Total Number of Complaints That Resulted in a Violation of Human Rights				94
Total Number of Allegations of Abuse, Neglect, or Exploitation				537
Total Number of Substantiated Allegations of Abuse, Neglect, or Exploitation				85
Substantiated Allegations by Type		Exploitation	3	
Physical Abuse	25	Neglect	25	
Verbal Abuse	22	Neglect (Peer-to-Peer)	2	
Sexual Abuse	2	Unauthorized use of Restraint	8	
Resolution Levels for the 790 Human Rights Complaints and 537 Allegations of Abuse, Neglect, or Exploitation				
Director and Below	1,310	State Human Rights Committee		17*
Local Human Rights Committee	3	DBHDS Commissioner		1

**14 of the 17 complaints resolved at the SHRC level were reviewed by the SHRC Appeals Subcommittee per a variance allowing alternative procedures for addressing complaints by individuals in maximum security at CSH and residents of VCBR, when the individual is not satisfied with the director's response.*

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SUPTRS BG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes	( ) No
ii)	Education	(•) Yes	( ) No
iii)	Brief Intervention	(•) Yes	( ) No
iv)	Assessment	(•) Yes	( ) No
v)	Detox (inpatient/residential)	(•) Yes	( ) No
vi)	Outpatient	(•) Yes	( ) No
vii)	Intensive Outpatient	(•) Yes	( ) No
viii)	Inpatient/Residential	(•) Yes	( ) No
ix)	Aftercare; Recovery support	(•) Yes	( ) No

b) Services for special populations:

i)	Prioritized services for veterans?	(•) Yes	( ) No
ii)	Adolescents?	(•) Yes	( ) No
iii)	Older Adults?	(•) Yes	( ) No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots ( ) Yes (●) No

c) Expanded community network for supportive services and healthcare (●) Yes ( ) No

d) Inclusion of recovery support services (●) Yes ( ) No

e) Health navigators to assist clients with community linkages ( ) Yes (●) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance (●) Yes ( ) No

h) Providing transportation to and from services (●) Yes ( ) No

i) Educational assistance (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

DBHDS uses the following guidelines to monitor compliance and to guide corrective actions to address identified problems:
1. SAPTBG's WOMEN'S "SET-ASIDE"
The SAPT BG requires that sub-recipients provide specific services for pregnant and parenting women and their children and that they do so in certain ways

Programs must treat the family as a unit and admit both women and their children into treatment services if appropriate. Community service boards are required to use their set aside - at minimum - to provide the following services to pregnant and parenting women as well as those women who are seeking to regain custody of a child. Boards may provide these services themselves or arrange and refer the woman elsewhere to receive these services:

• Gender specific treatment services - Refers to individual and/or group services that have been adapted to address issues specific to women i.e., the role of relationships, parenting, child care, sexual and/or physical abuse, trauma etc.
• Therapeutic services for the children of these women - Includes developmental assessment
and treatment services; services that address the child's experiences of abuse, neglect or trauma; therapeutic child care etc. assessment and treatment services; services that address the child’s experiences of abuse, neglect or trauma; therapeutic child care etc.
• Primary medical care for women and their children - Boards should determine whether:
Women are receiving necessary medical care (including prenatal care, STDs and family planning). If not, the CSB should refer her to a medical provider, help her obtain necessary medical coverage and work with her to be sure she is able to access medical care. Children of these women have medical coverage. If not, the CSB should help the woman obtain coverage and refer her and her children to an appropriate medical provider. Staff should also monitor whether her children are receiving necessary immunizations, routine and emergent care and arrange for care as needed.
• Transportation and Childcare. CSBs' must provide or arrange for necessary transportation and childcare so that women are able to access substance use services. CSBs can offer these support services themselves i.e., van transportation, bus tokens, cab vouchers, on-site child
care or provide case management services targeted at resolving transportation and childcare problems.

- Street outreach programs
- Frequent notification to their network of community based organizations, health care providers, and social services agencies
- Ongoing public service announcements

- Posters placed in targeted areas
- Regular advertisements in local/regional print material
- Health Fairs

Provide Services for Pregnant women within 48 hours of their request
• To reduce health risks to the woman and her unborn child, pregnant women must be admitted into treatment within 48 hours of their request
their request
• If unable to provide services within 48 hours, CSB staff must:

Contact the State to inform them of this difficulty and obtain assistance to resolve the problem. CSBs should call and provide email documentation to:
Office of Adult Community Behavioral Health Services
Department of Behavioral Health and Developmental Services

Provide "interim services" until they are able to place the woman in treatment. The following "interim services" should be provided:

• Counseling and education regarding HIV and TB, the risks of needle sharing, risks of transmission of HIV to partners and infants, steps that can be taken to reduce the risk of HIV transmission as well as referral for HIV and TB treatment if needed.
• Women not currently receiving prenatal care should be referred to a medical facility, treatment provider or - if appropriate - an emergency room where they can obtain prenatal care.
• Women should be advised regarding the impact that continued alcohol and drug use may have on her unborn child as well as any risks that she and/or her baby might experience if she were to stop her use abruptly.
• In addition, staff should attempt to:
1) Identify her trimester of pregnancy.
2) Determine what substances she is using and her last episode of use in order to assess her risk of withdrawal.
3) If staff suspect the woman may be physically dependent on opiates, alcohol and/or benzodiazepines, she should be immediately referred to a medical provider so she can be assessed regarding the" risk of withdrawal", evaluated for medically assisted treatment and, if indicated, placed on appropriate medication.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	(●) Yes ( ) No
b)	14-120 day performance requirement with provision of interim services	(●) Yes ( ) No
c)	Outreach activities	(●) Yes ( ) No
d)	Syringe services programs, if applicable	( ) Yes (●) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(●) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	( ) Yes (●) No
b)	Automatic reminder system associated with 14-120 day performance requirement	( ) Yes (●) No
c)	Use of peer recovery supports to maintain contact and support	(●) Yes ( ) No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, LGBTQI+, older adults)?	( ) Yes (●) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The Regional Block Grant Specialists assigned to the five areas of the state
communicate frequently with the CSBs
in their respective regions to monitor compliance with SAPT BG requirements.

The Performance Contract that all CSBs have executed with DBHDS includes the following requirements
related to services for PWID:
1. Preference in admission;
2. Admission within 14 days of the person requesting services
a. If unable to admit within 48 hours, provide interim services
i. Counseling and education about HIV and TB;
ii. Risks of needle sharing, risk of transmission of HIV to sexual partners

iii. Steps to prevent transmission of HIV and TB; referral for HIV/TB treatment, if necessary.
3. Must notify DBHDS within seven days if the program reaches 90 percent capacity

4. Admit PWID within 14 days of the person requesting services, or within 120 days if the program
lacks capacity and make interim services available

5. Maintain an active waiting list that includes a unique identifier for each PWID

6. Have an active means of maintaining contact with individuals awaiting admission and admit the
individual to treatment at the earliest possible time. Individuals may only be removed from the
waiting list if the person cannot be located or if the person refuses treatment.

7. Must encourage PWID to engage in treatment using outreach methods that:

a. Are utilized by trained outreach workers using scientifically sound methods including
contacting, communicating, and following up with PWID and their support systems with the
constraints of 42 CFR Part 2;
b. Promote awareness among PWID about the relationship between injecting drugs and communicable
disease, such as HIV;
c. Recommending steps that can be taken to ensure that HIV transmission does not occur; and
d. Encouraging entry into treatment.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? ○ Yes ◉ No

2. Has your state identified a need for any of the following:

   a) Business agreement/MOU with primary healthcare providers ○ Yes ◉ No

   b) Cooperative agreement/MOU with public health entity for testing and treatment ○ Yes ◉ No

   c) Established co-located SUD professionals within FQHCs ○ Yes ◉ No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   The CSB Administrative Regulations require that all CSBs follow the following requirements related to TB services.
   1. Counseling individuals with respect to TB;
   2. Testing to determine if the individual has been infected with mycobacteria tuberculosis to identify the appropriate form of treatment;
   3. Providing for or referring the individual who is infected for appropriate medical evaluation and treatment;
   4. Follow protocols established by VDH for screening, detecting and providing access to treatment for TB
   5. Report individuals with active TB to VDH/Division of TB Control, in compliance with 42 CFR Part 2.
   6. Ensure that all individuals receive these services and refer individuals who are unable to access SUD treatment services to other providers of TB services

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery? ○ Yes ○ No

2. Has your state identified a need for any of the following:

   a) Establishment of EIS-HIV service hubs in rural areas ○ Yes ○ No

   b) Establishment or expansion of tele-health and social media support services ○ Yes ○ No

   c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS ○ Yes ○ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)? ◉ Yes ○ No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ○ Yes ◉ No

3. Do any of the programs use SUPTRS BG funds to support elements of a Syringe Services Program? ○ Yes ◉ No

   If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — ( ) Yes (●) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (●) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (●) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — ( ) Yes (●) No
- **f)** Explore expansion of services for:
  - **i)** MOUD — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — (●) Yes ( ) No
- **b)** Establish a program to provide trauma-informed care — (●) Yes ( ) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — (●) Yes ( ) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — ( ) Yes (●) No
- **b)** An organized referral system to identify alternative providers? — ( ) Yes (●) No
- **c)** A system to maintain a list of referrals made by religious organizations? — ( ) Yes ( ) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — ( ) Yes (●) No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — (●) Yes ( ) No
- **b)** Review of current levels of care to determine changes or additions — (●) Yes ( ) No

c) Identify workforce needs to expand service capabilities — (●) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — (●) Yes ( ) No

c) Updating written procedures which regulate and control access to records — ( ) Yes (●) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — (●) Yes ( ) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

29 CSBs have undergone IPRs since 2005

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — (●) Yes ( ) No

b) Establishment of policies and procedures related to independent peer review — (●) Yes ( ) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — ( ) Yes (●) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — ( ) Yes (●) No

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ( ) Yes (●) No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing (●) Yes ( ) No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state (●) Yes ( ) No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services (●) Yes ( ) No

c) Performance-based accountability: (●) Yes ( ) No

d) Data collection and reporting requirements (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs (●) Yes ( ) No

b) Addition of training sessions designed to increase employee understanding of recovery support services (●) Yes ( ) No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ( ) Yes (●) No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort (●) Yes ( ) No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? ( ) Yes (●) No

b) Mental Health TTC? (●) Yes ( ) No

c) Addiction TTC? ( ) Yes (●) No

d) State Targeted Response TTC? ( ) Yes (●) No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ( ) Yes (●) No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ( ) Yes (●) No

b) Early Intervention Services Regarding HIV ( ) Yes (●) No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ( ) Yes (●) No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

The following are relevant links:
1. Title 37.2 of the Code of Virginia, which is the state law establishing our public behavioral health and developmental services system and establishing DBHDS as the responsible state agency: http://law.lis.virginia.gov/vacode/title37.2/

2. Virginia Administrative Code Chapter 105, Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services: http://www.dbhds.virginia.gov/library/licensing/ol%20%20chapter%20105%20rules%20and%20regulations%20for%20licensing%20providers%20by%20the%20department%20of%20behavioral%20health%20and%20developmental%20services%203.pdf

3. Community Services Board Administrative Regulations:
https://dbhds.virginia.gov/assets/doc/BH/oss/fy2020-pc-csb-administrative-rqmts.pdf

4. State Fiscal Year 2012 and 2023 Community Services Performance Contract:
https://dbhds.virginia.gov/assets/FY22-23%20Community%20Services%20Board%20Performance%20Contract%20and%20Amended%20Documents%20Effective%207.1.2022.pdf

If the answer is No to any of the above, please explain the reason.

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2022-FFY 2023? ○ Yes ◉ No

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

[2] *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1.	Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues?	(•) Yes ( ) No
2.	Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?	(•) Yes ( ) No
3.	Does the state provide training on trauma-specific treatment and interventions for M/SUD providers?	(•) Yes ( ) No
4.	Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?	(•) Yes ( ) No
5.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	(•) Yes ( ) No
6.	Does the state use an evidence-based intervention to treat trauma?	(•) Yes ( ) No

7. Does the state have any activities related to this section that you would like to highlight.

Please see attached 12. Trauma

Please indicate areas of technical assistance needed related to this section.

None at this time

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
58 *Ibid*

Does the state have any activities related to this section that you would like to highlight.

Please see 12. Trauma narrative attached

Please indicate areas of technical assistance needed related to this section. None at this time

Environmental Factors and Plan

12. Trauma - Requested

Does the state have any activities related to this section that you would like to highlight.

Adults

DBHDS Office of Behavioral Health Wellness (OBHW) continues to expand their Adverse Childhood Experiences (ACEs) infrastructure. This expansion builds community awareness about the impacts of early childhood developmental adversity on long term health and wellness. All 40 community services boards (CSBs) have trained ACE Interface presenters in their communities. The OBHW currently supports 450 presenters across the commonwealth. In addition, we've recently launched the Lift Up Virginia (LUV) campaign. As part of the campaign, we will host a website where presenters will have access to the latest science and presenter learning communities. In the future, the website will also be home to presenter best practices and stories of resilience from communities across Virginia.

DBHDS also oversees Project LINK, a program that offers intensive case management, care coordination and home visiting services to pregnant, parenting and any risk women with substance use and their families. Project LINK has expanded and now has 12 sites. That was an intentional increase of three more sites from the last application cycle. Many of the women who enter treatment have been exposed to trauma, and the sites throughout Virginia each utilize one or more of the following evidence-based practices to women to address trauma in their respective population: Seeking Safety, Beyond Trauma, and TREM (Trauma Recovery Empowerment Model). Each Project LINK site utilizes Nurturing Parenting program curriculum to further educated parents on healthy relationships with their children in efforts to decrease or eliminate future abuse or neglect. Project LINK has also included expansion of programming to include family members and fathers. With this, those Project LINK sites have added the evidenced based practice, “24:7 Dad” from the National Fatherhood Initiative.

Children

The Office of Child and Family Services (OCFS) offers opportunities for providers to increase their capacity to deliver trauma-specific interventions. As a part of the SOC Expansion Planning grant, DBHDS created a workforce development plan. One topic that has been

included in the plan addresses the impact of trauma on children and their families and intervention strategies that assist systems in identifying trauma and addressing the issue in the early stages of the treatment process.
The Office of Child and Family Services offered Eye Movement Desensitization and Reprocessing (EMDR) training to Community Services Boards (CSBs) in 2022-2023. A total of 90 clinicians have been trained. EMDR is an evidenced based for Post-Traumatic Stress Disorder (PTSD).

The Office of Child and Family Services (OCFS) developed a Youth Mobile Responder training curriculum. This curriculum is required for any provider of youth mobile crisis response in Virginia and includes an entire module on Trauma. Additionally, trauma informed care topics come up throughout the other five modules of the training.
Virginia has developed and maintained Trauma-Informed Community Networks (TICNs). These multi-sector coalitions focus on building resilience as well as preventing and mitigating the impact of trauma in their communities. The TICNs aim to create a more trauma-informed and resilient culture in Virginia. They work with state partners to change practices, policies, and systems within their regions and at the state level. There are bi-monthly meetings of the Virginia TICNs to support the 26 networks that currently operate. The goal of the TICNs is to help connect practice across disciplines, identify gaps, and identify how policies can be implemented. They play a large role in advancing trauma-informed policy.
The Department has a collaborative partnership with Virginia Commonwealth University (VCU) Center for and Evidence Based Practice Virginia (CEBP-VA). VCU will track the number of Virginia clinicians that are certified in TF-CBT. They will also evaluate the effectiveness of TF- CBT.

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- ☑ Coordination across mental health, substance use disorder, criminal justice and other systems
- ☑ Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- ☑ Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- ☑ Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- ☑ Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- ☑ Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- ☑ Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- ☑ Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- ☑ Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- ☑ Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- ☑ Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- ☑ Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- ☑ Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- ☑ Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- ☑ Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe. ◉ Yes ○ No

See attached 13. Criminal and Juvenile Justice

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? ◉ Yes ○ No

4. Does the state have any activities related to this section that you would like to highlight?

See attached 13. Criminal and Juvenile Justice

Please indicate areas of technical assistance needed related to this section.

None at this time

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Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. A significant proportion of justice-involved youth meet criteria for a mental disorder. In addition, youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based [illegible] Most adjudicated youth released from secure detention do not have community follow-up or supervision;

therefore, risk factors remain unaddressed.[59] Given the need for both mental health services and other supports, adequate mental health follow-up and support is critical for youth being released from commitment and secure detention.

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Environmental Factors and Plan

13. Criminal and Juvenile Justice – Requested

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Adult System

Virginia supports a number of initiatives which work diligently to identify individuals diagnosed with serious mental illnesses (SMI) and co-occurring disorders (early identification) and develop strategies to divert these identified individuals away from the criminal justice system (or penetrating further, if identified after arrest/incarceration). As part of this process the goal is to connect them with meaningful services and treatment (as early as possible, but often during initial court appearance, during incarceration, or upon release from jail). In some cases, CSBs provide jail-based mental health and re-entry planning services. Other localities have established specialty courts or mental health dockets as a means of better identifying and diverting individuals to appropriate community services.

Drug Treatment Courts:

There are 7 juvenile drug treatment courts, 2 regional DUI drug treatment courts, 4 family drug treatment courts, and 37 adult treatment courts currently operating in Virginia. These courts operate in communities as diverse as the City of Richmond, a setting significantly urban in nature, and the juvenile court district that serves the counties of Lee, Scott and Wise, located in the coalfields of Appalachia. The CSBs that serve the communities in which these courts operate are integrally involved in supporting and providing treatment services to individuals and families adjudicated through these courts.

In addition to the juvenile and adult drug treatment courts, there are four family drug treatment courts that are also administered by local juvenile and domestic relations courts. These courts focus on abuse and neglect cases in which parental substance abuse is a primary factor and operate with the goal of providing safe, nurturing, and permanent homes for children while simultaneously providing parents the necessary support and services to become drug and alcohol abstinent. Family drug treatment courts aid parents in regaining control of their lives and promote long term stabilized recovery to enhance the possibility of family reunification.

Behavioral Health Dockets:

In 2020, the Office of the Executive Secretary of the Supreme Court of Virginia performed a review of the Behavioral Health Dockets in Virginia. As part of this review, they assessed 11 existing dockets from all areas across the Commonwealth. They reviewed each docket for compliance to the established standards, data collection, and funding and resources. Their recommendations included greater development of local resources, interagency sharing and collaboration, and expansion of the mental health dockets based on their results. The Supreme Court of Virginia has created a Behavioral Health Advisory Committee,

which reviews and approves newly forming Behavioral Health Dockets. Since 2020, the number has grown to a total of 17 approved Behavioral Health Dockets in Virginia. The Department of Behavioral Health & Developmental Services has been represented on this advisory committee since its inception. In 2022, DBHDS was awarded $650,000 by the General Assembly to fund Behavioral Health Dockets and through competitive solicitation selected six dockets to receive funding starting in July 2022.

Re-entry Support:

Regarding the re-entry process for juveniles, the *Code* of Virginia (§ 16.1-293.1), requires DJJ, in consultation with DBHDS to promulgate regulations for the planning and provision of post-release services for persons committed to the DJJ if the youth has been identified as having "a recognized mental health, substance abuse, or other therapeutic treatment need." § 16.1-293.1 also specifies certain elements that must be included in the services transition process and plan. The goal is to ensure implementation and continuity of necessary treatment and services in order to improve short- and long-term outcomes for juvenile offenders with significant needs in these areas. The plan addresses the juvenile's need for, and ability to access, medication, medical insurance, disability benefits, mental health services, and funding necessary to meet the juvenile's treatment needs.

The Virginia Department of Corrections (VADOC) is focusing on identifying service needs, including behavioral health services, prior to an individual's release. VDOC re-entry or transition specialists work with individuals to identify service needs, including behavioral health services, prior to release. As such the transition specialists contact the local CSB for the area in which the inmate will be released. VADOC has utilized grant funds in some communities to support a visit from CSB staff while the identified consumer remains incarcerated to begin to establish relationships. Local CSBs participate in Regional Re-Entry Community Collaboration Councils that may be headed by VADOC and VDSS. The member agencies on the local councils help coordinate services for individuals returning to the community. Several CSBs utilize the same cognitive based therapy (Thinking for a Change) that VADOC employs with inmates in the last months of custody to provide continuity, and DBHDS is continues to develop collaboration with these partners to ensure access to EBPs for individuals who are involved with the criminal justice system.

During the 2017 General Assembly Session, DBHDS was tasked with developing a plan to provide forensic discharge planning services for individuals with Serious Mental Illness who are incarcerated in local and regional jails. DBHDS developed the plan and drafted best practice standards for forensic discharge planning from jail. DBHDS shared the plan with the General Assembly along with the associated costs of implementing this practice. During the 2018 General Assembly Session, DBHDS was awarded funds to implement forensic discharge planning in Virginia jails who have historically had a very high proportion of individuals with SMI. This funding became effective July 1, 2018, and a competitive request for proposals was published and DBHDS awarded funding to a total of nine CSBs to provide forensic discharge planning in two regional jails systems. In FY2021, funding was awarded to two additional CSBs in two local jails, and again in FY2022 DBHDS was awarded additional funding to expand forensic discharge planning to an additional five local jails. Currently, there are twenty CSBs providing forensic discharge planning services in thirteen regional and local jails across the Commonwealth. DBHDS is gathering data on the outcomes from this program and hope that the General Assembly

will fund forensic discharge planning services at the remainder of Virginia's local and regional jails.

The Joint Commission on Health Care (a joint legislative body) did complete a study on the quality of healthcare services (to include behavioral healthcare services) in jails. As a result of that study, DBHDS, the Virginia Department of Corrections, and the State Compensation Board were asked to create a statewide, uniform, release of information authorization to be used in all state psychiatric hospitals, CSBs, jails, and other healthcare providers. The JCHC study identified the lack of a uniformly accepted release of information authorization form as a major impediment to continuity of care. That form has been created. A separate bill required DBHDS to work with the CSBs and jails to develop a process to identify any inmate who has previously received behavioral healthcare services from a CSB and to develop a process to share treatment information between the CSB and the jail healthcare provider. DBHDS convened a work group and made several recommendations to improve information sharing between the CSBs and the jails, along with recommendations for funding needed to implement the proposed plan.

During the 2019 General Assembly Session, the GA ordered that the Board of Local and Regional Jails (formerly the Board of Corrections) in collaboration with DBHDS work to develop minimum standard for behavioral healthcare in jails. The minimum standards were developed and shared with the General Assembly in 2019, with recommendations for funding for implementation and oversight.

Juvenile Justice System

The nature and extent of mental health services varies across juvenile detention centers, with some facilities relying on detention center mental health staff, while others contract with the community services boards. Twenty-three community services boards (CSBs) provide mental health and substance abuse services in juvenile detention centers. CSBs dedicate staff at the local juvenile detention center to offer mental health screening/assessment and other mental health and substance abuse services as indicated through the initial intake assessment process.

The Code of Virginia § 16.1-248.2 includes a provision for emergency mental health assessments for youth that are detained. If it is determined that a youth needs an assessment, that assessment shall take place within twenty-four hours. It is the responsibility of the CSB to conduct the assessment.

The Massachusetts Youth Screening Instrument (MAYSI-II) is used in each detention center as an initial screening instrument. CSB or JDC clinicians may conduct follow up assessments as needed.

Juvenile Competency Restoration Program:

DBHDS provides restoration to competency services for any child that is involved in the juvenile justice system and ordered by the court to receive restoration services. Competency restoration is a service to the court and justice system, not comprehensive mental health services to the youth and is separate from mental health services. The juvenile does not receive mental health services unless there is a mental health disorder that is a barrier to court competence; in these cases, case management may be provided to address these needs. Over 200 children per year receive restoration services. Since July 1, 1999 the Code of Virginia, §16.1-357, has provided that the Commissioner of the DBHDS shall arrange for the provision of restoration services. Only the DBHDS Commissioner has the statutory authority to arrange for Juvenile Competency Restoration Services in Virginia.

The statutory requirements for the Commissioner of DBHDS are as follows:

- Upon receipt of a court order, arrange for the provision of restoration services in a manner consistent with the order.
- Submit reports to the court.
- Approve the training and qualifications for juvenile forensic evaluators.
- Approve the training and qualifications for individuals authorized to provide juvenile restoration services.
- Provide all juvenile courts with a list of guidelines for the court to use in the determination of qualifying individuals as experts in matters relating to juvenile competency and restoration.

Juvenile Competency Restoration Services are court ordered education, training, and intensive case management services provided to juveniles who have been found incompetent to stand trial by a Juvenile & Domestic Relations District Court. These individualized education and training services are provided on a one-to-one basis in the least restrictive environment in which the Court permits the juvenile to reside.

The Office of Child and Family Services participates on a workgroup that is related to Juvenile Justice. The workgroup is described below:

Workgroup Name	Convening Agency	Workgroup Purpose
Advisory Council for Juvenile Justice and Prevention	Department of Criminal Justice Services (DCJS)	Advises the Board, the Executive Branch, and localities on matters related to the prevention/treatment of juvenile delinquency and the administration of the juvenile justice system; reviews grant applications for Juvenile Justice & Delinquency Prevention (JJDP) Act and Juvenile Accountability Block Grant funds (when federally funded), as well as other juvenile justice-related grant applications, and makes recommendations on them to the Board.

Training and resources

The Office of Child and Family Services (OCFS) offers numerous training opportunities throughout the year. Topics have included but were not limited to ethics, evidence-based practices, and substance use disorders. Most training opportunities are available to anyone in the field regardless of discipline.

The Virginia Department of Criminal Justice Services is involved in planning, policy development, and

funding of juvenile justice and delinquency prevention initiatives provided through federal or state resources. Staff provide coordination, program support, technical assistance, training, and monitoring of programs designed to address juvenile justice system improvement and delinquency prevention and programs to improve the investigation, prosecution, and administrative and judicial handling of child abuse cases.

DCJS is unique in state government because of its system-wide perspective on criminal justice. While it directs programs and services to each component of the system, it has an overarching responsibility to view the system as a whole, to understand how changes in one part of criminal justice will affect other parts, and to work to assure that plans and programs are comprehensive. DBHDS participates on the Advisory Council for Juvenile Justice and Prevention which is convened by DCJS.

Environmental Factors and Plan

14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding the use of medications for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds?

- **a)** [x] Methadone
- **b)** [x] Buprenophine, Buprenorphine/naloxone
- **c)** [ ] Disulfiram
- **d)** [ ] Acamprosate
- **e)** [x] Naltrexone (oral, IM)
- **f)** [x] Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

Please see attached 14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

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Footnotes:

Environmental Factors and Plan

14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], 49 [4], and 63[5].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

TIP 40 - https://www.ncbi.nlm.nih.gov/books/NBK64245/ [ncbi.nlm.nih.gov]

TIP 43 - https://www.ncbi.nlm.nih.gov/books/NBK64164/ [ncbi.nlm.nih.gov]

TIP 45 - https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf [store.samhsa.gov]

TIP 49 - https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf [store.samhsa.gov]

TIP 63 - https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf [store.samhsa.gov]

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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Footnotes:

Environmental Factors and Plan

14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Does the state have any activities related to this section that you would like to highlight?

In Virginia, 42 Opiate Treatment Programs, (OTPs) are licensed by DBHDS. (The McGuire Veterans Affairs Medical Center in Richmond also operates an OTP but since it is federally operated, it is not licensed by DBHDS.) Four of these OTPs are directly operated by CSBs; the other 34 are privately owned. In addition to at least one annual announced visit from the Office of Licensing, OTPs may receive unannounced visits as well. Furthermore, all OTPs receive at least one announced visit from DBHDS as the State Opioid Treatment Authority (SOTA). The SOTA also provides technical assistance with OTPs at their request, works as a liaison between the OTPs and the CSBs, as well as provide ongoing reports to SAMHSA as needed. The SOTA meets with representatives from all of the OTPs at a centrally located quarterly meeting. DBHDS also sponsors scholarships to the annual training conference sponsored by the OTP association, the Virginia Association of Medication Assisted Recovery Programs (VAMARP), as well as to the American Association for the Treatment of Opioid Dependence (AATOD) national conference held every 18 months.

Evidence-based practices are discussed at both of these meetings and DBHDS often sponsors a speaker to address EBPs. As the Virginia Department of Medical Assistance Services developed the Addiction Recovery Treatment Services initiative (ARTS, a Center for Medicare and Medicaid Services Substance Use Disorder Waiver Waiver) to support MAT, DBHDS was an active collaborator and provided extensive technical assistance to DMAS related to OTPs, as well as the use of buprenorphine in office-based settings.

The Virginia Board of Medicine developed Standards of Care and then promulgated emergency regulations [18VAC85-21-10 et seq.] for the use of buprenorphine products in the treatment of addiction. DBHDS was represented on the workgroup that developed these standards and provided technical assistance in the development of the regulations. About half of the 40 CSBs are currently utilizing MAT, including buprenorphine.

Response to COVID-19 Pandemic

The SOTA held calls first thing in the morning 7 days a week with the OTP's to aid them as they dealt with the crisis on hand. They discussed the expanded take-home exception and how important it was to minimize the number of patients within the OTP at any one time. During the 3 month period of the daily calls, other entities joined the call, i.e.: DBHDS Licensing staff, DMAS, MCO's, CSB staff. This strategy was successful as these additional entities were instrumental in making changes here in Virginia. For example Medicaid approved payment for take-home doses as well as home deliveries of the medication. PPE was in short supply and DMAS was instrumental in getting OTPs recognized as healthcare facilities and were able to supply them with what they needed.

Throughout the 16 months that Virginia was under the State of Emergency the SOTA continued the calls and now speak with the OTP's weekly. Once the vaccine became available the SOTA was able to get the OTP staff's vaccinated as healthcare workers. The OTP's demonstrated outstanding results in terms of maintaining safety given the circumstances throughout this state of emergency as evidenced in the low positivity rate for COVID-19 within the OTP system.

Environmental Factors and Plan

15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

1 DBHDS is actively working on a comprehensive continuum of crisis services inclusive of mobile response, call centers with the equivalent of air traffic control capabilities, and Crisis Receiving and Stabilization Centers (CRSC). DBHDS is actively pursuing complete buildout and interconnection at this time.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA*

guidelines.

*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*

*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis Call Capacity

a. Number of locally based crisis call Centers in state

i. In the 988 Suicide and Crisis lifeline network

ii. Not in the suicide lifeline network

b. Number of Crisis Call Centers with follow up protocols in place

c. Percent of 911 calls that are coded as BH related

2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of first responder structures (police, paramedic, fire)

b. Integrated with first responder structures (police, paramedic, fire)

c. Number that employs peers

3. Safe place to go or to be:

a. Number of Emergency Departments

b. Number of Emergency Departments that operate a specialized behavioral health component

c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	☐	☐	☐	☐	☑	☐
Someone to respond	☐	☐	☐	☐	☑	☐
Safe place to go or to be	☐	☐	☐	☑	☐	☐

b. Briefly explain your stages of implementation selections here.

Virginia's crisis call centers are funded and meeting capacity demands. DBHDS is actively working to staff mobile crisis response teams for full geographic coverage, and increase the present, capacity, capabilities, and footprint of CRCSs throughout the commonwealth.

Virginia has two call centers that are supporting 988 as a part of a full crisis continuum. These two call centers have been supported by the Vibrant Capacity Grant as well as the two SAMHSA capacity grants. In addition, the Virginia Legislature established a surcharge on wireless plans to provide sustainable funding to 9-8-8 call centers, these efforts all provide a foundation for the implementation of 9-

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

Virginia has been actively using the SAMHSA guidelines to inform the buildout of our crisis system. The Commonwealth has attempted to gear the existing state infrastructure, identify needed enhancements, and to guide planning of crisis services in the future.

Virginia is building a technological and administrative infrastructure for maintenance and management of the integrated crisis continuum. Several key technological elements, including the service provision and risk screenings by call center staff are

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

Current plan for set aside is to improve mobile crisis response across the state and to upgrade existing crisis stabilization units to provide a no wrong door point in the crisis continuum.

Please indicate areas of technical assistance needed related to this section.

We have ongoing difficulty with the public private system of mobile crisis response within the state, and Technical Assistance related to their funding and contracting would be welcomed.

Please indicate areas of technical assistance needed related to this section.

We have ongoing difficulty with the public private system of mobile crisis response within the state, and Technical Assistance related to their funding and contracting would be welcomed.

Footnotes:

Virginia Department of Behavioral Health & Developmental Services

Summary: State Plan for the Implementation of the Marcus-David Peters Act

Overview of the Marcus-David Peters Act

The Marcus-David Peters Act is named in honor of Marcus-David Peters, a young, Black, biology teacher and VCU graduate who was fatally shot by Richmond Police in 2018 in the midst of a behavioral health crisis; it was signed into law in November 2020 by Governor Northam. The Act modifies the Code of Virginia to add ***§ 9.1-193. Mental health awareness response and community understanding services (Marcus) alert system; law-enforcement protocols***, which outlines the role of DCJS and local law enforcement in the development of three protocols for behavioral health crisis situations, sets seventeen goals for law enforcement participation in the Marcus Alert system, assigns purview between DCJS and DBHDS, and requires localities to develop a voluntary database. The Act also modifies the Code of Virginia to add ***§ 37.2-311.1. Comprehensive crisis system; Marcus alert system; powers and duties of the Department related to comprehensive mental health, substance abuse, and developmental disability crisis services.*** This requires DBHDS to develop a comprehensive crisis system based on national best practice models and composed of a crisis call center, community care and mobile crisis teams, crisis stabilization centers, and the Marcus Alert system. It also requires DBHDS, in collaboration with DCJS and a range of stakeholders, to develop a written plan for the development of the Marcus Alert system, which is represented in this document and described further in the full state plan for implementation of the Marcus-David Peters Act.

It is important to note that the Marcus-David Peters Act refers to the Act in its entirety, including state components of the comprehensive crisis system as well as the requirements for each local Marcus Alert system, which is primarily defined as three protocols.

Summary and Overview of State Implementation Plan

The state plan for the implementation of the Marcus-David Peters Act is the result of a collaborative process between Virginia Department of Behavioral Health and Developmental Services, Virginia Department of Criminal Justice Services, other state agency partners, and the Marcus Alert State Planning Stakeholder Group. The group was comprised of 45 stakeholders from across Virginia, representing local government, non-profit, private, community, lived experience, and advocacy in the areas of mental health, law enforcement, crisis intervention teams (CIT), developmental disabilities, substance use disorder, social justice and racial equity, as well as 20 state government representatives and other *ex officio* group members.

The state plan includes four broad sections. The first section provides a vision for Virginia's behavioral health crisis system, a summary of the planning group and process, and a current landscape analysis. The landscape analysis includes, as required, a catalog of existing CIT programs, crisis stabilization programs, cooperative agreements between law enforcement and behavioral health, a review of the prevalence and estimates of crisis situations across Virginia, and current funding for crisis and emergency services. The second and third sections provide information on State Components of the Plan (Section II) and Requirements for Local Marcus Alert Systems (Section III). Due to the interconnections and overlapping timelines between the state components of the comprehensive crisis system and the local protocols for the Marcus Alert system, this report provides an overview of the state components, which are necessary but not sufficient to implement the Act, as well as the specific requirements that localities, including the initial five areas, are responsible for implementing to develop their local Marcus Alert system plans. This distinction is made because the state components of the plan are not the responsibility of the initial five areas, or any localities, to implement directly; rather, it is the responsibility of DBHDS to implement these components and align the timelines for implementation to ensure that the local Marcus Alert system protocols are able to transfer calls, divert, and connect individuals to the comprehensive crisis system. The state-level components described in Section II include a four-level framework for categorizing crisis situations, regional coverage by STEP-VA mobile crisis teams and associated Medicaid rates, 988 and regional call center implementation, a statewide Equity at Intercept 0 Initiative, and statewide training standards. The local level requirements described in Section III include the local planning process, minimum standards and best practices for local law enforcement involvement in the Marcus Alert system, descriptions of different ways to achieve local

community coverage, and the system for review and approval of protocols. These are the components which the first five areas will be implementing by December, 2021. Finally, the fourth section provides frameworks for accountability and responsibility across state and local entities and how the success of the Marcus Alert system will be evaluated.

Summary of Section I: Vision, Process, and Current Landscape Analysis

The existing behavioral health crisis system in Virginia has multiple, disparate ways for people in crisis to access care, and multiple ways for the people who are staffing the crisis system to receive, assess, triage, and record these calls for care. Local community services boards/behavioral health authorities receive calls through more than 40 distinct telephone numbers bifurcated by disability, age, and, even, specific crisis situation (for example, there are three separate National Suicide Prevention Lifeline crisis call centers in the Commonwealth). This "patchwork" of access points is often confusing to the person in need of crisis services and creates multiple hurdles to access help and get appropriate care instead of a single point of entry that is outside of 911. This has contributed to an over-reliance on 911, law enforcement, and high-acuity, high cost services such as inpatient hospitalization. There is significant momentum to address Virginia's long-standing challenges and overutilization of high-acuity, high-cost services and to build an evidence-based continuum of behavioral health care that features high quality services, including comprehensive crisis services and a centralized crisis access line. The vision for Virginia's future crisis system is to keep Virginians well and thriving in their communities, meet people's needs in environments where they already seek support, provide care in the least restrictive environment, and optimize taxpayer dollars by investing in crisis prevention and crisis early intervention of mental health problems and crises. This includes a system that:

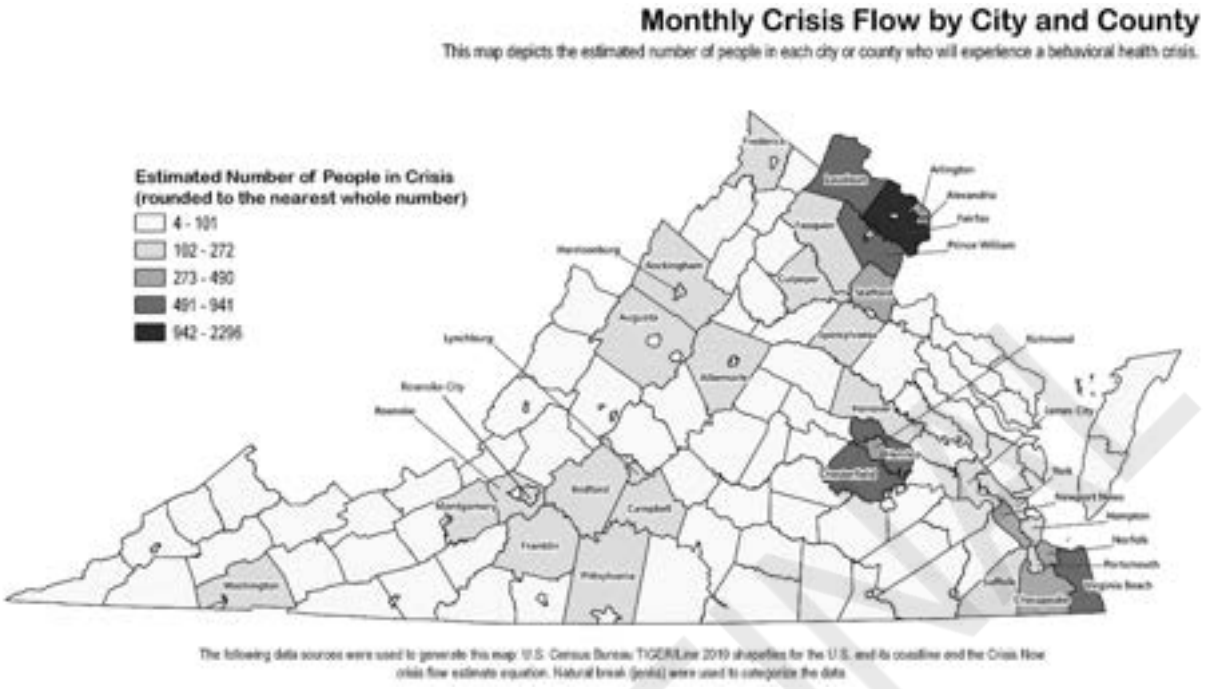
- *aligns with national best practices to serve people in the least restrictive setting possible and build on their natural supports;*
- *is centered on principles of trauma-informed care and the belief that people can and do recover;*
- *serves people, regardless of disability or diagnosis, across the life span;*
- *reduces the use of hospital emergency departments, jail bookings, and unnecessary hospitalizations; and*
- *supports crisis-trained first responders to support individuals in crisis and link them to the crisis system, decreasing reliance on law enforcement as the* de facto *crisis response.*

Understanding the current landscape is an essential first step in improving Virginia's crisis response system. To that end, an inventory survey was disseminated to community services boards (CSB), CIT programs, public safety answering points (PSAP), and law enforcement (LE) agencies. Of the entities that were contacted, 45% of CIT programs, 70% of CSBs, 24% of LE agencies, and 48% of PSAPs responded to the survey. The review of existing programs indicated that some key components of this system are present in Virginia, but there are significant gaps in access, availability, and coordinating infrastructure. For instance, among the 28 CSB respondents, 19 youth mobile crisis teams were reported, reflecting recent investments made through STEP-VA. Nonetheless, of the 19 youth mobile crisis teams reported by CSB respondents, only one was reported to operate twenty-four hours per day, seven days per week. Similarly, the four existing co-response teams with LE that were reported by CSB respondents only operate Monday through Friday, not on weekends. The situation is similar for physical resources ("somewhere to go"): While there are at least two crisis stabilization units (CSU) in each of the DBHDS regions, CSU licensed maximum bed capacity is 16 beds or less. Nonetheless, there is a desire to work collaboratively across professions to improve Virginia's crisis response system—as evidenced by the existence of interdisciplinary committees that review how best to serve individuals who frequently interface with the crisis system often (e.g., dialing 9-1-1 often).

Estimating the prevalence of crisis situations across Virginia is difficult, but estimates across levels of acuity are provided for CSB catchment areas and localities. Currently, between 4,300 (April) and 7,400 (October) crisis evaluations are completed monthly through CSB emergency services. Thirty percent of these occur under an Emergency Custody Order (ECO). Thirty one percent of these result in a Temporary Detention Order (TDO), and there are approximately 2,000 TDOs statewide per month. When considering the broader range of crisis situations, including those who can be managed with phone support and linkage to services, the Crisis Now Crisis Resource Need Calculator would estimate that there are 17,000 Virginians in crisis statewide per month. This would indicate that there is currently approximately 30-40% penetration of emergency services evaluations into the spectrum of crisis situations, and those crises which are being evaluated are skewed dramatically towards the severe end of the crisis spectrum. This highlights two things: first, the critical role of an accessible, statewide phone line (9-8-8) to connect to the crisis system, and, second, the extent to which mobile crisis services and stabilization services must be built statewide to achieve the desired statewide behavioral health response system. As one example, the Crisis Now assessment suggests that Virginia would need 346

short term beds (e.g., crisis stabilization unit beds), 406 chairs for 23-hour observation statewide, and at least 68 mobile crisis teams each responding to 4 crises per day.

Overall, the inventory survey and crisis estimations confirmed the need to continue the recent, concurrent investments in crisis services to support the implementation of the Marcus Alert—which is timely as both state and national attention has converged on the importance of a robust, health-focused, accessible crisis response system. The ultimate vision for Virginia is to align these initiatives broadly with the Crisis Now model, with Virginia specific adaptations and a focus on equity considerations. Monthly crisis estimates are depicted below.



Summary of Section II: State Level Plan Components

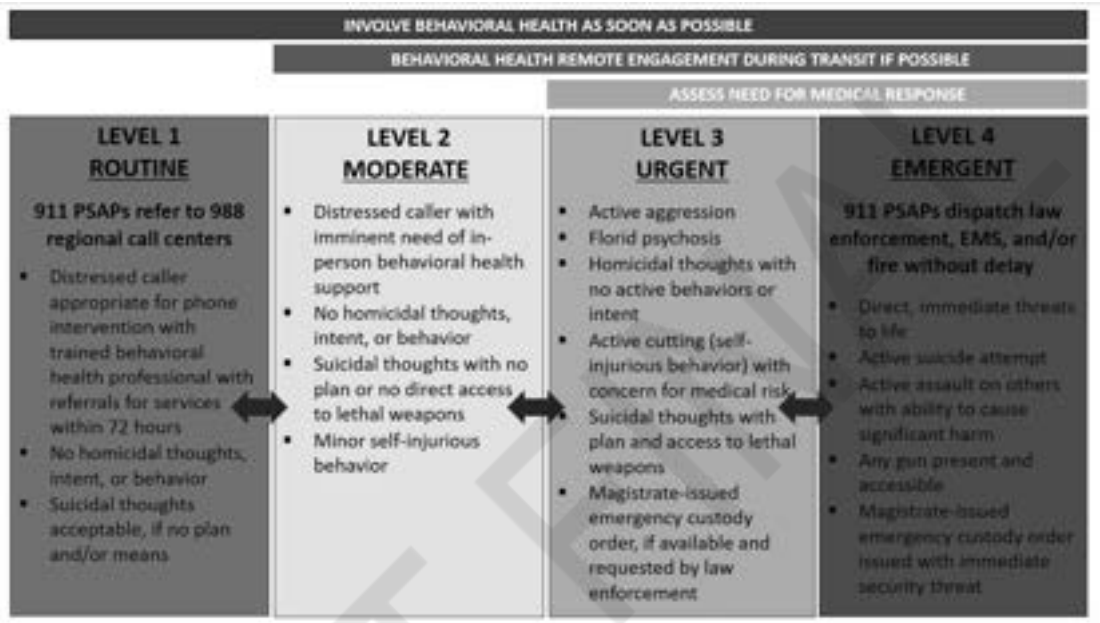
There are six components of the implementation plan that outline state-level requirements of the Act. These include a four-level urgency triage framework for assessing risk level and communicating across entities; the development of statewide coverage by STEP-VA mobile crisis teams that are employed by the regional crisis hubs; federal 988 and regional call center implementation; a statewide Equity at Intercept 0 Initiative; statewide training standards across behavioral health, law enforcement, PSAP, and other participants in crisis response/local Marcus Alert systems; and a statewide public service campaign that focuses on raising community awareness for the use of 988 as a way to access behavioral health supports in times of stress and crisis.

Four-Level Urgency Triage

A four-level urgency triage framework was developed. The four levels (Marcus Alert Level 1, 2, 3, and 4) are used throughout the state plan to support shared communication across sectors, to provide a framework for planning different responses at the local level and communicating local plans to DBHDS and DCJS in a fashion that can be understood across the state, and to plan for reporting and evaluation. Each PSAP will need to integrate coding for these levels into their respective computer-aided

dispatch (CAD) systems for reporting purposes. The four-level urgency triage is the framework local Marcus Alert systems will build their different protocols and specialized responses around. An overview is provided in this graphic:

COMMONWEALTH OF VIRGINIA
MARCUS ALERT SYSTEM TRIAGE FRAMEWORK

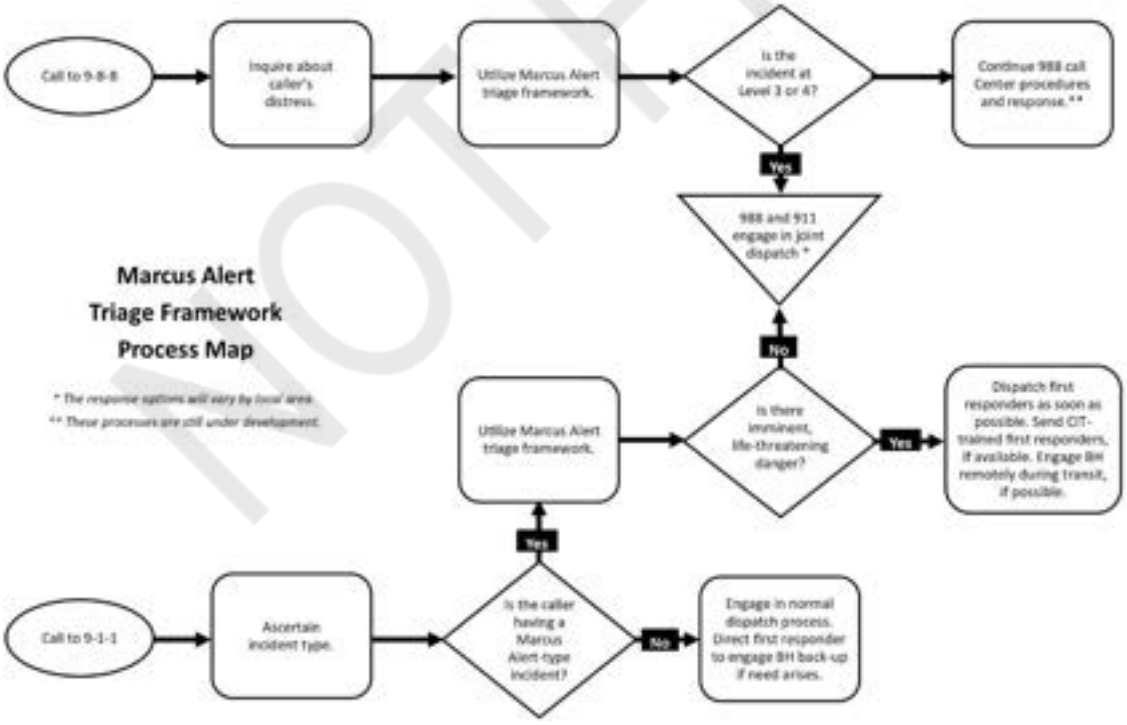


STEP-VA/BRAVO Mobile Crisis Coverage

The second state component of the implementation plan is the development of statewide coverage by STEP-VA mobile crisis teams that are employed by the regional crisis hubs. These teams do not have law enforcement members but can call for law enforcement backup, and are characterized by a one-hour response time (up to 90 minutes in rural areas) and consideration of law enforcement referrals as “preferred customers” with quicker response times. Private providers of mobile crisis services will also be under agreement with the regional crisis hubs so that they can be dispatched through the 988 system. Funds for STEP-VA adult mobile crisis teams will be disbursed to regions beginning July, 2021, thus, teams will be being built and trained as the initial five areas are implementing their local Marcus Alert systems. BRAVO rates are projected to be online in the Medicaid plan as of December 1, 2021, coinciding with the initial area implementations.

988 and Regional Call Centers

The third component of the implementation plan at the state level is the implementation of 988 as a three-digit number to access crisis services. Federally, it is required that 988 be accessible no later than July 16, 2022 to, at a minimum, the National Suicide Prevention Lifeline supports and services. Virginia accepted bids on a request for proposals for a crisis call center platform, which is essential for these crisis system components to work as an integrated system; it is expected to be implemented by December 2021. In other words, initial areas will set up their local Marcus Alert system plans with the expectation that 988 will be accessible, although early in implementation, as they launch their local systems. The 988 line will be managed by 5 regional call centers, which are under the purview of 5 CSBs representing their DBHDS regions: Region 10 CSB (Region 1), Fairfax-Falls Church (Region 2), New River Valley (Region 3), Richmond Behavioral Health Authority (RBHA; Region 4), and Western Tidewater (Region 5). Below is a high-level heuristic of how local PSAPs and 988 call centers will set-up procedures for call transfers and coordination:



Equity at Intercept 0 Initiative

The fourth state component of the implementation plan is a statewide Equity at Intercept 0 Initiative, which is focused on building supports for public-private collaboration in Virginia's publicly funded crisis services. The Initiative will seek to develop infrastructure for training and development to ensure small, community-focused providers (with a focus on Black-led, BIPOC led, and peer led providers) are integrated into the crisis services system through training and academic partnerships, partnerships around language access, and other critical projects to ensure equitable access to community-based crisis services. The Equity at Intercept 0 Initiative will also support the development of a Black-led state Crisis Coalition that will not only work with the Equity at Intercept 0 network leads but also play a role in the review and ongoing development of the Marcus Alert implementation.

Statewide Training Standards

The fifth state level component refers to statewide training standards across behavioral health, law enforcement, PSAP, and other participants in the crisis response system or any local Marcus Alert system. It is a local requirement that these training standards be adhered to, but the plan is to develop standards at the state level to ensure high-quality, consistent training throughout the state. Basic behavioral health requirements will be primarily built into developing mobile crisis training curriculums (STEP-VA). The Act stipulates that DCJS is required to collaborate with DBHDS on Marcus Alert development and training; moreover, recent legislation has enhanced DCJS' purview over the review of academy curriculum and lesson plans for both basic and in service training, with a particular emphasis on topics relevant to the Marcus Alert. Therefore, the most logical course of action is for DBHDS and DCJS to enter into an agreement regarding how DBHDS, Equity at Intercept 0, and the Black-led Crisis Coalition will provide input on Marcus Alert training requirements. This agreement will be pursued during the first year of implementation. Dispatch and PSAP telecommunicator training will be developed in tandem with the crisis call center training being developed for 988/regional call center staff. This RFP will designate a module that provides the information appropriate for 911 call takers to understand about 988 as well as basic mental health training. The module will constitute the basic/required training for PSAP staff; PSAP staff will also be welcome and encouraged to participate in the advanced Marcus Alert training.

Overview of Basic Behavioral Health Training Requirements and Competencies*

Empowerment and Engagement	Assessment	Clinical Interventions	Cultural Competency	Disability Justice	Basic Marcus alert principles
• recovery principles • harm reduction • trauma-informed and trauma-sensitive practices	• trauma sensitive assessment • collateral information • substance use assessment • cognitive impairment • risk assessment • level of care assessment	• treatment of acute agitation • safety planning • de-escalation • motivational interviewing, • treatment of intoxication and withdrawal including coordination with medical • Crisis resolution	• Racial identity development • cultural humility • implicit bias • historical trauma • family dynamics and working with natural supports • anti-racism • health disparities in behavioral health	• Federal and state structures and protections • ableism • dignity of risk • intersection of disability justice and criminal justice	• Basics of MA requirements • intersectional considerations • advanced empowerment techniques • mitigating implicit bias in the context of behavioral health crisis response

**will be integrated into required Mobile Crisis Basic Training curriculum (required for all Mobile Crisis providers and behavioral health community care team members)*

Overview of Basic and In-service Law Enforcement Training Requirements and Competencies

De-escalation training and techniques	Working with individuals with mental health and substance use disorder	Working with individuals with developmental disabilities	Cultural diversity, bias-based policing, implicit bias	Use of force in context of behavioral health crises
• To be required under DCJS uniform curriculum • Basic academy • In-service	• To be required under DCJS uniform curriculum • Basic academy • In-service	• To be required under DCJS uniform curriculum • Basic academy • In-service	• To be required under DCJS uniform curriculum • Basic academy • In-service	• To be required under DCJS uniform curriculum • Basic academy • In-service

Overview of Advanced Marcus Alert Training Requirements and Competencies*

Cultural humility and historical trauma	Disability Justice	Anti-racism	Intersection of Implicit Bias and Crisis Response	Intersection of De-escalation, Bias, Workforce Wellness
• Intrapersonal, interpersonal, and systems level cultural humility • Trauma and traumatic stress basics, including racialized trauma	• Federal and state structures and protections across professions • ableism • dignity of risk • intersection of disability justice and criminal justice	• Racial identity development • Health impacts of racism • Advanced mitigation strategies for race-based bias	• Intersections of risk assessment, implicit bias, family wellness perceptions • guardian vs. warrior, implicit bias	• Burnout and stress • Power and control • De-escalation (experiential strategies) • Intersection of personal burnout and implicit bias

**These trainings are not integrated into basic behavioral health or law enforcement requirements. A competitive RFP will be posted for a vendor to develop a high quality training and training manual. Advanced Marcus Alert trainings are projected to begin July 2022. All professions involved in the Marcus Alert system are eligible for the training.*

State Public Service Campaign

Finally, there is a sixth statewide component regarding a public service campaign that focuses on raising community awareness for the use of 988 as a way to access behavioral health supports in times of stress and crisis. Results of a community input survey conducted as part of the state planning process indicated that primary reasons for avoiding seeking help during a behavioral health crisis were the lack of control over what happens when help is sought in a behavioral health crisis, not wanting to be hospitalized, negative experiences with behavioral healthcare in the past, not wanting to be handcuffed, and past negative experiences with calling 9-1-1 for a behavioral health emergency. Respondents, who self-selected to participate in the survey, were also asked about their preferred options for handling the crisis (if all these options were available), and the most preferred responses among those with personal experience were to call a hotline where a trained behavioral health professional (social worker, counselor, peer recovery specialist, etc.) can speak for at least 30 minutes over the phone (19%), call and receive an immediate telehealth appointment with a behavioral health professional (18%), call a hotline and receive a same-day, in-person appointment with a therapist (14%), and call a hotline and talk with a peer recovery specialist over the phone (12%). These results, combined

with state laws outlining ECOs and TDOs and the local variability that will exist in Marcus Alert protocols led the group to conclude that a primary message that should be provided to the public is the existence of 988 and the range of lower level services, such as phone-based supports, that one can access through 988. A second key message is the importance of calling early in a crisis.

Summary of Section III: Local Marcus Alert System requirements, Minimum Standards and Best Practices

There are approximately eight components of the implementation plan that are the responsibility of local areas to implement. The local Marcus Alert system is described in the Act as *"a set of protocols to (i) initiate a behavioral health response to a behavioral health crisis, including for individuals experiencing a behavioral health crisis secondary to mental illness, substance abuse, developmental disabilities, or any combination thereof; (ii) divert such individuals to behavioral health or developmental services system whenever feasible; and (iii) facilitate a specialized response in accordance with § 9.1-193 when diversion is not feasible."* There are five areas that must implement their Marcus Alert system by December, 2021. All other areas must implement the protocols by July 1, 2022, whereas community coverage by different response teams is required on a phased-in timeline. The eight local components include local planning guidelines, voluntary database development, protocol #1, protocol #2, protocol #3, community coverage, and the submission and approval process, which includes a consolidated list of minimum standards across the different local requirements.

Local Planning Guidelines

First, there are guidelines for local planning group formation and initial planning activities, including crosswalking the four-level urgency triage levels to existing PSAP technical specifications. The five steps of the recommended planning process are provided in the Community Planning Roadmap and represented here:

Voluntary Database

Second, there is a description of the voluntary database which is required for each 911 center. Per the Act:

F. By July 1, 2021, every locality shall establish a voluntary database to be made available to the 9-1-1 alert system and the Marcus alert system to provide relevant mental health information and emergency contact information for appropriate response to an emergency or crisis. Identifying and health information concerning behavioral health illness, mental health illness, developmental or intellectual disability, or brain injury may be voluntarily provided to the database by the individual with the behavioral health illness, mental health illness, developmental or intellectual disability, or brain injury; the parent or legal guardian of such individual if the individual is under the age of 18; or a person appointed the guardian of such person as defined in § 64.2-2000. An individual shall be removed from the database when he reaches the age of 18, unless he or his guardian, as defined in § 64.2-2000, requests that the individual remain in the database. Information provided to the database shall not be used for any other purpose except as set forth in this subsection.

Localities can determine solutions based on consultation between 911, behavioral health, and law enforcement. Localities may consider software solutions which allow for individuals to provide information to 911 telecommunicators and dispatch, build a database related to existing lists (e.g., hazard lists or information associated with addresses), or create a new database that meets the requirements state in the Act. It is recommended that localities consult with their legal staff ensuring that there are no privacy or HIPAA concerns.

Protocol #1

Protocol #1 refers to the first local protocol required, which is a protocol to transfer calls from 911 to 988 regional call centers. To meet the minimum standards for Protocol #1, PSAPs must integrate the four-level urgency triage framework into their technical specifications and set policies and workflows to ensure that calls can be transferred from 911 to 988. The minimum standard is that Level 1 calls are diverted to 988. For Protocol #1, it is recommended that Level 2 calls are also coordinated between 911 and 988 and that a Poison Control Model be explored as a potential parallel for coordinating between entities in general (across levels).

Protocol #2

Protocol #2 refers to the second local protocol required, which is an agreement (and associated policies and procedures) to serve as backup to behavioral health mobile crisis teams. Marcus Alert Protocol #2 will ensure that there are clear expectations between the mobile crisis regional hub and any law enforcement backup. The regional mobile crisis hubs will take the lead on structuring these agreements with law enforcement partners; for example, it may be one standard agreement which could be signed by any law enforcement agency able to provide backup as needed within that area. Initial funding for the development of these crisis call centers and hubs will begin July 1, 2021, thus, these hubs are in an early development phase and these agreements can be developed over the first 12 months of implementation to meet the Marcus Alert requirement of July 1, 2022. From a technical perspective, agreements between the regional call centers and law enforcement agencies providing backup must include these four following components at a minimum: technical processes needed to request backup in the most efficient manner possible; procedures for communicating between behavioral health and law enforcement to provide details of the scene and ensure that there is shared understanding of the situation and the request for back up before back up arrives (i.e., treatment before tragedy custody function, treatment before tragedy restraint/force function, or protection for other individuals involved from an individual in crisis posing a safety risk to others); clear information regarding what training any back-up law enforcement officers sent will have; responsibilities for both parties under the MOU. It is recommended that agreements include provisions that law enforcement staffing patterns will be set (e.g., discussed and calibrated at quarterly cross-agency meetings) to

support goal that back-up officers sent will be voluntarily CIT trained or have received the advanced Marcus Alert training.

Protocol #3

Protocol #3 refers to the third required local protocol which requires that all law enforcement agencies have a specialized response when responding to a behavioral health emergency. This means that in situations where law enforcement is responding to a situation, whether or not there are any behavioral health teams or providers on scene, law enforcement agencies must have specialized requirements. Specialized response protocols are submitted in the context of a systems approach to supporting individuals in behavioral health crisis.

There is not currently evidence of a single protocol or stand-alone program to provide this function for communities; instead, it is accepted that it is a systems problem and protections should be built into all levels of the system to continually decrease risk of tragedy. Additional policies which may be impacted by the implementation of Protocol #3 include agency Americans with Disabilities Act policies, or "Responses to Persons with Mental Illness" policies. Specialized responses must take into consideration the needs of individuals with mental health and substance use disorders, developmental disabilities, and brain injuries as well as the specific needs of youth. Protocol #3 is required by July 1, 2022 statewide. Thus, a specialized response must be available by that date, even if additional community coverage by teams is expected to be developed beyond that date (e.g., if an area has a full implementation date of 2024 or 2026).

Achieving Community Coverage

Per this plan, statewide coverage by mobile crisis teams will be achieved through STEP-VA/BRAVO implementation. Thus, it is not required that areas implement additional teams in their submitted plans; rather, coverage can be achieved by linking policies and procedures to coordinate with STEP-VA/BRAVO mobile crisis teams. This may include coordination such as a Poison Control Model (described in Protocol #1) or use of telehealth/remote behavioral health intervention. However, to achieve robust coverage across the four triage levels, it is expected that many communities will determine that layering additional teams is desirable and will provide the best overall coverage. This section outlines the position types, roles, presentation, and interventions associated with different

configurations of mobile crisis response. Team types/approaches to local coverage outlined specifically include four team types: 1) investment in additional mobile crisis teams to achieve a quicker response in your area; 2) community care team with no law enforcement (often called the "CAHOOTS" model), 3) preventive community care team with law enforcement (in Virginia, best exemplified in Henrico's CIT/Services to Aid Recovery [STAR] program), and 4) co-responder teams. These local teams and additional response options (e.g., telehealth options) are layered on top of the statewide STEP-VA mobile crisis coverage; for example, with the addition of mobile crisis coverage to respond quicker than one hour, community care teams of peers, EMTs, and/or social workers could provide an immediate response and connection to the crisis continuum, enhancing the availability of co-responder units that law enforcement officers and clinicians to respond to high-acuity situations.

Minimum Standards for Community Coverage

The minimum standards for community coverage are as follows.

- *Level 1 calls must be diverted to 988.*
- *Level 2 plans must include provisions for including behavioral health as a first responder (range of options described below in "response options").*
- *Level 3 plans must include coordination among agencies and provisions for including behavioral health as a first or second responder (range of options described below in "response options").*
- *Plan must include provisions for how Level 3 calls will be handled for adults, youth, and individuals with developmental disabilities.*
- *Level 4 approaches must receive an emergent response, where the dispatch of first responders is not delayed.*

Best practice considerations for Community Coverage are as follows. These best practices are provided for guidance only as there are currently no established best practices when choosing among these approaches. The first three practices listed are considered best practices in implementation planning in general and, thus, are assumed to apply in a general sense to the Marcus Alert, whereas the fourth and fifth practices are specific to the Marcus Alert.

- *Include community stakeholders in the planning process for community coverage, with a focus on stakeholders who have been impacted by the current system (such as those in a jail re-entry program,*

families who have lost loved ones to a mental health crisis or a police encounter, and individuals who have lived experience and are from a racial or ethnic minority background).

- *Take a systems view and, when resources are constrained, build behavioral health-focused supports as a priority over other investments.*
- *Build on and integrate with other existing and emerging services and supports, such as the STEP-VA mobile crisis teams, current CIT programs and initiatives, Assertive Community Treatment, or homeless outreach providers in the area.*
- *Ensure there are behavioral health-only approaches available at Level 3 for youth and individuals with developmental disabilities, particularly if there is a law enforcement lead for your locality's adult Level 3 primary response option.*
- *Consider partnerships across jurisdictional boundaries, particularly when it increases efficiency (e.g., for any telehealth-based coverage).*
- *Consider a "layered" approach, with investments aligning with community values vs. the selection of one specific team type only.*

Minimum Standards for Law Enforcement Participation in Local Marcus Alert System

- *All localities comply with state training standards*
- *The four-level framework is adopted for standard communication and response planning and integrated into the CAD*
- *Level 1 calls and situations are diverted to 988*
- *Level 2 calls are coordinated with 988*
- *Level 3 calls include multiple response options across agencies/entities, and includes a behavioral health only response option*
- *Level 4 calls include law enforcement or EMS first responders*
- *Memorandums of agreement (consistent with the state requirements) are developed between the call center hub and any responding law enforcement agency*
- *Submission of a plan for specialized law enforcement response addressing these four areas: leadership/organizational, basic training, intermediate training, and specialized and advanced training*

- *Specialized response across all four levels is behavioral health-informed*
- *Policy regarding Marcus Alert response being utilized whenever a situation is identified as a Marcus Alert Level 1, 2, 3, or 4 situation (even if not initially identified)*
- *Appropriate coverage and preferential deployment of CIT-trained officers and officers with advanced Marcus Alert training*
- *Attendance at cross-sector quarterly local meetings*
- *Submission of quarterly data (additional details under development)*

Best Practice Standards for Law Enforcement Participation in Local Marcus Alert System

- *Level 1 calls are fully diverted to 988*
- *Level 2 calls follow a poison-control model with 988, unless community care teams have a special function at Level 2 (e.g., "frequent utilizers" case management function)*
- *Level 3 calls involving youth are coordinated with 988 and specialized children's mobile crisis teams*
- *Level 3 calls involving individuals with ID/DD are coordinated with 988 and specialized developmental disability mobile crisis teams/REACH program*
- *Back-up officers sent under agreements with regional hubs will be voluntarily CIT trained and have received the advanced Marcus Alert training*
- *At the systems level, considerations include intersections of behavioral health crisis and community policing policies and initiatives, guardian vs. warrior trainings, use of force continuum and how behavioral health crises and de-escalation are built into the use of force policy, implicit bias trainings and policies, and officer wellness supports and culture*
- *8-hour mental health first aid for all officers*
- *Ongoing de-escalation training for all officers, including basic and intermediate*
- *Interactive, scenario-based de-escalation training specific to mental health scenarios, with a focus on time as a tactic, at least yearly*
- *Advanced workshop based trainings on cultural humility and cultural competence*
- *Agencies have coverage each shift by an appropriate amount of officers who have completed 40-hour CIT training in context of voluntary participation, aptitude/interest in working with individuals in behavioral health crisis, and supervisor approval. These supports can be provided in an "on call" format based on agency staff and size, but should be available for response. CIT recommends that*

20% of officers are trained to achieve adequate coverage; percentage of appropriate coverage will vary based on side of agency.

- *Agencies have coverage each shift by an appropriate amount of officers who have completed the advanced/intersectional Marcus Alert training*
- *LE integrates special requirements regarding mental health, developmental disabilities, and substance use across key agency policies such as use of force and bias-based policing*
- *High-level engagement in cross-sector quarterly meetings and data-driven quality improvement processes at the local level*

Plan Submission

There are 10 required plan components and one optional component for areas to reach compliance with the Act by July 1, 2022. There are two supplemental documents that are important for local plan development and submission. This includes the Community Roadmap and the Marcus Alert Local Plan. The Community Roadmap provides a pathway, with both required and optional exercises, for local plan development. Resources are posted as they are finalized and can be found on the DBHDS Marcus Alert website (currently under development): https://www.dbhds.virginia.gov/marcusalert/.

The ten (and one optional) components for submission are described here. These are required to be approved by July 1, 2022 (statewide; five initial areas must have in place December, 2021). Local Marcus Alert plan submission components are:

- *Documentation of Sections 1-4 of the roadmap (when "decide and document" is noted, it should be included in your summary)*
- *List of stakeholder group members*
- *Triage crosswalk connecting 4 urgency levels to PSAP specifications*
- *Copy of Protocol #1*
- *Copy of Protocol #2*
- *Copy of Protocol #3*
- *Triage crosswalk connecting 4 urgency levels to responses/protocols 1, 2, and 3*
- *Checklist of minimum standards and best practice considerations for law enforcement involvement*
- *Statement on accountability for quarterly cross-sector meetings and quarterly data reporting*

- *Contact information for application overall and core reporting, PSAP reporting contact, and law enforcement reporting contact*
- *(Optional) statement of barriers, needs, or concerns for implementation*

Summary of Section IV: Accountability and Evaluation

Section IV provides the state plan for evaluation and accountability. Cross-sector data sharing at the local and state level is one of the key challenges of evaluating the success of crisis response systems. Recently, the General Assembly allowed for a $5 million investment in the development of a crisis call center data platform to support the coordination of crisis services across Virginia. This was put to competitive bid and the vendor will be selected in June 2021, with the work progressing over the following six months. Thus, the technical details of the Marcus Alert reporting requirements will be developed in collaboration with the development of the broader platform. There are also a number of other considerations, such as the HJ 578 study and variation in PSAP technical operations, which support the development of a Marcus Alert Evaluation Task Force to meet for the remainder of state fiscal year (SFY) 2022 to ensure that high-quality data reporting is integrated into the call center platform and that the call center data platform is accessible to all system users, including law enforcement. Membership and attendance will be asked of DBHDS and DCJS technical and program leads, crisis call center platform vendor, technical and program leads from initial area PSAPs, initial area program leads, and one subject matter expert from the initial state planning workgroup in each of these areas: law enforcement, CIT, equity, and regional mobile crisis hub/988. Although these technical details will be under development during SFY 2022, some initial details are as follows.

- *Local reporting will be required on a quarterly basis. Implementing areas will need to assign an entity accountable for each of these three areas: PSAP data, mobile crisis response team data, and law enforcement data.*
- *Required data elements will include 911 calls that meet Marcus Alert Level 1, 2, 3, and 4 and call disposition (PSAP CAD reporting). Field reporting will include individual information (presentation, race, age, diagnosis if available); law enforcement actions, including body worn camera use; use of force; and interaction outcomes (with a focus on connection to crisis continuum), including transportation. Once individuals are connected to the crisis continuum, more robust data is collected*

as part of the STEP-VA implementation evaluation. As mentioned, any data points which can be integrated into the crisis data platform will be.

- *A framework for local accountability is described in the state plan. It includes quarterly, cross-sector meetings where critical incident reviews and local system development and issues will be considered. Twice yearly, a local stakeholder/community group should be convened and provided with data and reporting on the performance of the system, including racial disparities in access or outcomes; feedback should be collected from this group for the ongoing development of the local system.*
- *State accountability framework builds on existing structures between DBHDS, CSBs, DCJS, law enforcement, and PSAPs. There will be ongoing planning regarding role of VDEM and OEMS.*
- *In addition to existing oversight structures, the stakeholder group will continue to meet twice yearly through 2027 to review statewide data and ongoing system development. As described in the summary of state-level components, the Equity at Intercept 0 Initiative will support the development of a Black-led Crisis Coalition as well as Equity at Intercept 0 network leads who will also attend these twice yearly meetings and will continue to be involved in oversight processes each year, including providing input into the yearly report.*
- *DBHDS and DCJS will enter into a written agreement regarding shared oversight and input on training materials for modules relevant to the success of the Marcus Alert, including the described entities in the review of training materials.*

Conclusion

The Marcus-David Peters Act is a complex piece of legislation that defines a comprehensive crisis continuum and a local Marcus Alert system which operates to ensure that individuals in behavioral health crisis are met with a therapeutic, health-focused response and diverted to the behavioral health system. Although the overlapping timelines of these integral components of the system (988 implementation, DOJ Settlement Agreement, STEP-VA, BRAVO rates, Marcus Alert protocols) create a complicated implementation plan, they also provide Virginia with a unique opportunity to ensure that equity and equal access across the system are key considerations throughout planning and implementation.

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders.

Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a)	Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?	(•) Yes	( ) No
b)	Required peer accreditation or certification?	(•) Yes	( ) No
c)	Use Block grant funding of recovery support services?	(•) Yes	( ) No
d)	Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?	(•) Yes	( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? ( ) Yes (•) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

See attached narrative 16. Recovery

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

See attached narrative 16. Recovery

5. Does the state have any activities that it would like to highlight?

See attached narrative 16. Recovery

Please indicate areas of technical assistance needed related to this section.

None at this time

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Does the state support (d) involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

Yes. As a result of DBHDS strategic planning efforts to expand the participation of peers, family members and service recipients in implementing the agency's vision and mission, in January 2015, DBHDS established the Office of Recovery Services (ORS). The ORS Director is a person with lived experience. The position is funded with a combination of SAPT and MH block grant dollars. ORS has increased its staff from three to nine full-time staff members with lived experience. ORS staff facilitates the continuing development of strategies that use person-centered, participant-led care in the public and private sectors of our system, including peer-run organizations and agencies that use peer supporters within their continuum of care. ORS is proactive in meeting the diverse needs of a rapidly increasing and evolving workforce of peer supporters.

Individuals and families with lived experience participate on a variety of state-level councils, committees and work groups. Similarly, the same happens at the local level. One important mechanism to ensure this happens is outlined in Title 37.2 of the Code of Virginia providing that at least one-third of the members of the State Board of Behavioral Health and Developmental Services be consumers or family members of consumers, with at least one member being a direct consumer of services. The State Board has the statutory authority for the establishment of policy for DBHDS, our state facilities, and the Community Services Boards (CSBs) and Behavioral Health Authorities (BHAs). Members of the State Board are appointed by the Governor and confirmed by the General Assembly. The Code has the same requirement of the CSBs' oversight boards (also called Community Services Boards). In this way, the DBHDS and our primary partners in the public behavioral health system have substantive input by peers/consumers and family members.

DBHDS and the CSBs collaborate with a wide variety of stakeholder groups in the development of public policy, programs and services. The following are some examples; additional groups exist at the local level which may not be reflected here:

Organization	Constituency

Center for Excellence in Aging and Lifelong Health	Older adult individuals and family members
Cultural Linguistic Competency Steering Committee	Individuals, providers, advocates
McShin Foundation	Individuals and advocates
Mental Health America of Virginia	Individuals and family members
NAMI Virginia	Individuals and family members
Roads to Recovery	Individuals and family members
Substance Abuse and Addiction Recovery Alliance of Virginia (SAARA)	Individuals and family members
Virginia Association of Community Services Boards	Providers
Virginia Behavioral Health Advisory Committee (formerly the Mental Health Planning Council)	Individuals, family members, providers, advocates
Virginia Coalition for Language Access	Minority and multicultural communities
Virginia Family Network	Parents of children with behavioral health challenges
Virginia Intercommunity Transition Council	Families, providers, advocates
Virginia Military and Veterans Coordinating Committee	Veterans, Veteran service organizations, family members, Virginia National Guard, active-duty military representatives
Virginia Organization of Consumers Asserting Leadership (VOCAL)	Individuals
Virginia's Refugee Wellness Partnerships	Minority and Multicultural Communities
Virginia Association for Recovery Residences	Individuals, Providers
Voices for Virginia Children	Parents and family members
YouthMOVE	Young adults with behavioral health challenges

Virginia Recovery Initiative

The Virginia Recovery Initiative is an extension of the SAMSHA 2012 initiative where DBHDS was selected by SAMHSA to participate in the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Policy

Academy to develop a framework for recovery-oriented care and expand peer services within CSBs, facilities, and peer run advocacy and service groups. This initiative focuses on building and expanding a recovery oriented system of care for persons with behavioral health challenges, as well as for their families and those who care about them.

This is being accomplished through continued education about the value peer services, the role of the peer supporter, developing the peer workforce, and providing technical assistance on how to integrate peer support into the continuum.

The initiative focused on moving away from supporting individuals only through episodes of acute care to a model of supporting and maintaining a path to recovery and resilience. It also includes providing trauma informed and person-centered services.

The Virginia Recovery Initiative (VRI), has developed an official statement of recovery and recovery values that captures the vision of recovery, resiliency and self-determination for all populations served by the Virginia public behavioral health and developmental services system. The official definition meets Virginia's unique characteristics while aligning with SAMHSA's definition. The work of the state-level team is supplemented by regional VRI teams across the state which are collaborating locally and regionally to implement the DBHDS vision of a recovery-oriented system of care.

The mission of the Virginia Recovery Initiative is the same as SAMHSA's mission and purpose statement of *"Moving people, health authorities, policy makers, researchers, treatment providers, and other health and human service organizations toward a Recovery Orientation regarding mental wellness, and freedom from addiction."* VRI sustains the focus on people in recovery from behavioral health conditions through project development and community based strategies designed to highlight strengths and gaps in recovery capital such as housing, transportation, and access to recovery supports.

The regional VRI groups are the network hubs for dissemination of best or emerging practices and share successful, innovative, recovery-oriented service delivery strategies. DBHDS provides leadership, technical assistance and structural support to these regional groups. The regional VRI groups have evolved and thrived since their original inception; they now provide impetus to local behavioral health entities to hire Peer Recovery Specialists, host workshops about trauma-informed services, and promote widespread use of recovery language in written and oral communications. Regional VRI groups are also exploring collaboration among public agencies to provide housing, transportation and employment to people who are overcoming mental health and addiction challenges.

Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

<u>Adults with SMI</u>

Our state system includes a wide variety of recovery support services. CSBs, state hospitals and private providers offer access to recovery support groups, peer support services, recovery-oriented clinical and rehabilitative services, etc. January 2017, Virginia recognized the Certified Peer Recovery Specialist in State code and Medicaid reimbursement for peer support in behavioral health services became effective. This policy change came about as a result of Center for Medicare and Medicaid Services' approval of an SUD Waiver which led to the development of Virginia Medicaid's Addiction Recovery Treatment Services (ARTS), which is discussed in further detail below.

Certification standards have been essential to developing peer support services as a reimbursable mainstream service option in our system. DBHDS has included Family Support Services by Family Support Partners (FSPs) under the Peer Recovery Support program. DBHDS adopted the International Certification and Reciprocity Consortium (IC&RC) co-occurring Certified Peer Recovery Specialist (CPRS) certification for this initiative. In accordance with IC&RC standards, performance competencies, professional ethics and training standards are fundamental elements of the certification. The performance contract between DBHDS and the CSBs includes the use of CPRSs and FSPs in a multitude of settings, including crisis intervention, assertive community treatment, jail diversion, and recovery education.

DBHDS also provides significant financial support for peer-run organizations through both the MH and SAPT block grants as well as state general funds. With MHBG funds, DBHDS contracts with sixteen providers, twelve of whom are independent recovery community organizations, for the delivery of behavioral health peer support services.

In addition, MHBG funds support statewide organizations such as NAMI Virginia; which provides programming such as the Family to Family, In Our Own Voice and Connection programs; Mental Health America of Virginia, which offers, among other services, the Consumer Empowerment Leadership Training curriculum; the Virginia Organization of Consumers Asserting Leadership (VOCAL); Virginia's SAMHSA-designated state consumer network, which offers technical assistance to peer-run programs, trains WRAP facilitators, and supports a statewide peer network and an annual conference for individuals receiving services; and the Substance Abuse and Addiction Recovery Alliance of Virginia (SAARA), the only statewide addiction recovery advocacy organization, which provides technical assistance and an advocacy platform for individuals and families that are affected by substance use/addiction.

Virginia's Advance Directives Initiative began in 2010 after amendments to the Virginia Health Care Decisions Act in 2009 provided the ability for individuals to pre-plan for mental health crisis through the use of an Advance Directive (AD). (Unlike in most other states, the Commonwealth incorporated mental health care planning into its AD format instead of developing a separate Psychiatric AD.) In 2020, through a partnership with Honoring Choices of Virginia and a

variety of stakeholders that included peer supporters, service providers and advocacy organizations, began implementation of this initiative to educate consumers, family members and service providers about the importance of pre-planning for mental health crisis care. ORS will continue to promote the mental health care planning advanced directive. More detail is available on this effort in Section 5.

The DBHDS Office of Child and Family Services (OCFS) supports the Statewide Family Network, known as the Virginia Family Network (VFN). VFN is a grassroots network of families committed to providing opportunities that support, educate, and empower other families with children and youth with mental health needs while also promoting family driven and youth guided policy throughout the child serving systems. The initiative is designed to "meet the family where they are" through activities such as providing support groups, training, resources, and mentorship from other families with children and youth with mental health needs. The VFN has grown over the past two years as a result of Systems of Care efforts statewide through the development of groups, trainings, and other resources for families. The VFN currently has 37 Family Support Groups in four of the five regions across the state with three of those being specifically for parents/caregivers of youth. Parents/caregivers are also welcome to attend family support groups

The parent groups facilitate the following activities:

- Identifying and referring families to trainings and other community groups.
- Expanding and utilizing List-servs to provide families with information, education, training, and support opportunities.
- Mentoring and training youth and families through information and resources shared at monthly support group meetings.
- Community networking with local agencies.
- Providing information and resources on how to utilize natural supports.
- Providing training, mentoring, and support on how parents/families can work effectively with their services providers.
- Mentoring, supporting and preparing parents/families to participate on workgroups, boards, and commissions.
- Serving as parent representatives for their local Family Assessment and Planning Teams, which assist children and youth with emotional disturbances and other issues to obtain needed community services, and various CSB committees and councils.

In addition, the Office of Child and Family Services has sponsored several trainings specifically for families, including Family Support Activities, workshops on co-occurring disorders, and support for families and professionals to attend conferences to learn about best practices around children and family services.

<u>Young Adults with Lived Experience</u>

Virginia supports Youth MOVE Virginia. Youth MOVE (Motivating Others through Voices of Experience) is a national youth-led organization devoted to improving services and systems that support positive growth and development by uniting the voices of individuals who have lived experience in various systems including mental health, juvenile justice, education, and child welfare.

While working in partnership with youth and young adult leaders, NAMI affiliates, and other community organizations, the goal is to have at least one youth group in every region with an array of trainings being offered throughout the year, all of which are available and within reach of our affiliates. The vision is to be a resource to youth, young adults, affiliates and other organizations, as they grow their efforts to reach youth and young adults.

Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

DBHDS allocates both MH and SABG block grant funds to support peer-run programs and family and consumer advocacy organizations. In addition, DBHDS has been appropriated additional State General Funds to contract for recovery support services for individuals with SUD. Organizations supported with state and federal funds include peer-run recovery centers, resource centers and advocacy organizations operated by and for people with mental health, substance use disorder and co-occurring disorder lived experience that foster the development of skills related to self-directed care and informed choice. These organizations offer a wide variety of peer recovery support services, including individual and group peer support, Action Planning Prevention and Recovery (APPR), recovery coaching, peer-led help groups, mutual aid groups and telephone warm lines.

DBHDS currently either contracts with or has provided financial support to a variety of organizations that provide peer and family supports, all of which are designed to enhance individuals' skill and ability to engage in informed self-directed care and intervention. DBHDS has also fostered the development of peer recovery support services into more mainstream settings such as the CSBs, non-profit non-governmental agencies, federally qualified heath centers, public health centers, private providers, etc. Housing, employment and responsive access to services are foundational throughout the state. SAPT Block Grant and state general funds for SUD recovery services currently support nine recovery support programs.

<u>Addiction Recovery Treatment Services Medicaid Waiver</u>

Through the ARTS initiative, Virginia Medicaid will reimburse organizations eligible for ARTS reimbursement for peer and family support services. In order to qualify for ARTS funding, organizations must be licensed by DBHDS and meet service level criteria established by the American Society of Addiction Medicine Criteria, or a hospital emergency department licensed by VDH. Peer services can be integrated into any ASAM level of care.

In addition, peer support services will be reimbursed in the following settings where people may be entering care because of mental health challenges and may also have addiction challenges:

- Acute Care General Hospitals licensed by the Virginia Department of Health
- Freestanding psychiatric hospital and inpatient psychiatric units licensed by DBHDS
- Outpatient mental health clinic services licensed by DBHDS
- Outpatient psychiatric services provider (where the practitioner is licensed by DHP
- Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC)
- Day Treatment/ Partial Hospitalization licensed by DBHDS
- Psychosocial Rehabilitation licensed by DBHDS
- Crisis Intervention licensed by DBHDS
- Intensive Community Treatment licensed by DBHDS
- Crisis Stabilization licensed by DBHDS
- Mental Health Skill-building Services licensed by DBHDS;
- Mental Health Case Management licensed by DBHDS.

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include:

Housing services provided	(•) Yes ( ) No
Home and community-based services	(•) Yes ( ) No
Peer support services	(•) Yes ( ) No
Employment services.	(•) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (•) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Please see attached- State Plan for Independent Living

Please indicate areas of technical assistance needed related to this section.

None at this time

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

STATE PLAN FOR INDEPENDENT LIVING (SPIL)

Rehabilitation Act of 1973, as Amended, Chapter 1, Title VII

PART B - INDEPENDENT LIVING SERVICES
AND
Part C - Centers for Independent Living

State:
Virginia

FISCAL YEARS:
Effective Date: October 1, 2020
through September 30, 2023

APPROVED BY ACL 9/22/20

The Virginia Statewide Independent Living Council works to promote policies, programs, and activities to maximize independence of people with disabilities by: developing, monitoring, reviewing, and evaluating the State Plan for Independent Living; supporting and expanding the state network of Centers for Independent Living; creating a culture for full integration and independence, advocating systems change for full access and equality in community life; educating policy makers and stakeholders about the importance of independent living, as well as, developing a strategy for collaboration among stakeholders in the disability community. The Council finds each of these actions necessary for the full inclusion and independence of people with disabilities in the Commonwealth.

This 2021-2023 Virginia State Plan for Independent Living includes three overarching goals supporting the Council's mission: to increase our members' knowledge, to support the Core Service of Transition, and support the expansion of the Independent Living Network across the Commonwealth. Each of the Goals within this Plan are thoughtfully supported with objectives and activities that have desired outcomes.

The Council, along with stakeholders and consumers have worked to make this Plan achievable and specific, while also planning for emergencies, funding changes, and changes to the network of Centers for Independent Living. This Plan sets forth four priorities, and the order for each, for the use of funds (by funding source; including Part B funds, Part C funds, State funds, and other funds, whether current, increased, or one-time funding and the methodology for distribution of funds) focused on building the capacity of existing Centers and establishing new Centers, and/or increasing the state-wideness of our Network. This Plan also includes necessary objectives and actions to building a diverse Council, representative of the Commonwealth's diverse population.

The Virginia Statewide Independent Living Council, along with the Network of Centers, Consumers, and stakeholders recommend the approval of this 2021-2023 State Plan for Independent Living and look forward to investing the time and work to achieving the Plan's stated goals.

Section 1: Goals, Objectives and Activities

1.1 Mission:
Mission of the Independent Living Network and the SPIL.

Mission of the Virginia Statewide Independent Living Council (VASILC):
The Virginia Statewide Independent Living Council will promote policies, programs, and activities to maximize independence of people with disabilities by: developing, monitoring, reviewing, and evaluating the State Plan for Independent Living; supporting and expanding the state network of Centers for Independent Living; creating a culture for full integration and independence, advocating systems change for full access and equality in community life; educating policy makers and stakeholders about the importance of independent living, developing a strategy for collaboration among stakeholders in the disability community; leading to full inclusion and independence of people with disabilities in the Commonwealth.

Mission of Virginia Association of Centers for Independent Living (VACIL):
People with disabilities will have a community-based, consumer-directed service delivery system.

Mission of the Department for Aging and Rehabilitative Services (DARS); DSE:
The Department for Aging and Rehabilitative Services, in collaboration with community partners, provides and advocates for resources and services to improve the employment, quality of life, security, and independence of older Virginians, Virginians with disabilities, and their families.

1.2 Goals:
Goals of the IL Network for the three-year period of the plan.

Goal I
The Statewide Independent Living Council increases member knowledge.

Goal II
The Center for Independent Living (CIL) Network promotes and implements transition, the fifth core CIL service.

Goal III
The IL network supports the expansion of Independent Living Centers to all geographical areas of the state.

1.3 Objectives
Objectives for the three-year period of the plan – including geographic scope, desired outcomes, target dates, and indicators. Including compatibility with the purpose of Title VII, Chapter 1.

Goal(s) Section 1.2	Objective to be achieved Section 1.3
Goal I	Objective 1.1 - The Council will, at each quarterly meeting, participate in group trainings to better understand Council functions and best practices. Measurable Indicators: *Number of trainings is no less than four per year. *Council members increase personal understanding of IL philosophy, Council operations, and relative governance. Geographical Scope: Council Part B Funds Allocated: $1,500 in Years 1, 2, and 3. Three Year Performance Target: • Four trainings in Years 1, 2, and 3 for total of 12 group trainings; all held during Quarterly meetings of the Council. Timeframe for interim progress: Quarterly Activities: Trainings to include, but not limited to: • Annual PPR (704) reporting requirements and best practices. • Use of ILRU, APRIL, and NCIL webinars to fill knowledge gaps. • Parliamentary Procedure • Freedom of Information Act and Virginia Freedom of Information Act and Virginia Conflict of Interest Act • Education from CIL Network, community partners, and government entities on issues relating to SILC Mission and IL Philosophy. • Legislative updates • Advocacy training. • Identifying best practices for the VASILC, as well as investigating the development of Ethics Statement to assist Council Members understanding of Council Policies and Procedures, Bylaws, and boundaries. • Individual member trainings, both on personal time and those requested and supported by SILC funds (as available). IL Partner(s) Responsible: SILC, CILs, VACIL, DARS, other community partners

Goal I	Objective 1.2 - The Council shall hold at least one meeting per year at a Center for Independent Living to better understand unique needs of Planning Districts. Measurable Indicators: *Number of meetings held at a Center for Independent Living. *Other modalities of meeting and interacting with CILs may be necessary considerations in instances of disaster or emergency.* Geographical Scope: Statewide Part B Funds Allocated: $2500 in Years 1, 2, and 3. Three Year Performance Target: • At least one meeting per year will be held at a Center for Independent Living. • No less than three meetings, at different Centers for Independent Living, during the three-year cycle. Timeframe for interim progress: Annually IL Partner(s) Responsible: SILC, CILs, VACIL
Goal I	Objective 1.3 – In order to maintain the highest quality membership, the Council shall appropriately and actively: deliver orientation prior to new members at their first meeting, and mentor all new members for a period of no less than one year. Measurable Indicators: *New members receive a standard, up-to-date, orientation prior to attending their first meeting, or before being eligible to vote on Council matters. *New members receive Conflict of Interest Training within 60 days of appointment and before their first meeting. *New members are to be paired with a Mentor. This Mentor should be knowledgeable, in good standing, and, preferably, have served on the Council for at least two years. Geographical Scope: Statewide. Part B Funds Allocated: $300 in Years 1, 2, and 3. Three Year Performance Target: • One hundred percent (100%) of members receive standard orientation. • One hundred percent of members appointed receive no less than one year of Mentoring. • One hundred percent (100%) of members complete COI training, COI filing, and annual Financial Disclosure requirement. Timeframe for interim progress: Annually Activities: • Years 1, 2, 3 – Maintaining up to date training materials and learning modules.

	IL Partner(s) Responsible: SILC, VACIL • Years 1, 2, 3 – Seeking out educational opportunities and presentations to best suit the needs and requests of Council. IL Partner(s) Responsible: SILC • Years 1, 2, 3 – Administrator attends events on behalf of the Council, relative to Independent Living, to gather information important to Council Member knowledge. • IL Partner(s) Responsible: SILC Years 1, 2, 3 – Administrator matches mentors to mentees based on individual needs, requests, and input from Council. IL Partner(s) Responsible: SILC
Goal II	Objective 2.1 - The network of the CILs implements the fifth core service to ensure that people with disabilities have a smooth transition into the community or remain in the community of their choosing. Measurable indicators: *Number of people with disabilities in nursing facilities the CIL had direct contact with *Number of nursing facilities involved in CIL led outreach and training activities *Number of hospital staff responsible for long term care screening involved in CIL led outreach and training activities *Number of preadmission screening team staff involved in CIL led outreach and training activities *Number of high school students involved in CIL led outreach and training activities *Number of youth who have left public education and not yet 25 years of age involved in CIL led outreach and training activities *Number of public school, college, DARS and CSB staff involved in CIL led outreach and training activities ***These Measurable Indicators are to be used in Year 1, and shall be reevaluated annually, or as necessary in emergencies, by VACIL and VASILC for changes. Changes must be made prior to contract renewal.*** Geographical Scope: Statewide. Part B Funds Allocated: This amount can change with increases/decreases in available funding for CIL contracts; $399,500 in Years 1, 2, and 3. $15,000 allocated for Part B Coordination contract in Years 1, 2, and 3. Total for three years = $1,243,500. Three Year Performance Target: • Part B Funding amounts allocated for CIL contracts: $399,500 per year, as available, is expended. • Part B Funding amounts allocated for Coordination contract: $15,000 in

	Years 1, 2 and 3 is expended. Timeframe for Interim Progress: Quarterly Activities: • Year 1 - Developing, reviewing and awarding a grant application package and deliverables, e.g., transition from a nursing facility, prevention of entering into a nursing facility, and youth with disabilities transition services, for available Part B IL funding. IL Partner(s) Responsible: DARS, VACIL • Year 1 - Developing a grant application and deliverables to VACIL to coordinate the grant activities of the CILs and provide technical assistance. IL Partner(s) Responsible: DARS • Years 1, 2, 3 – Continue to develop, operationalize, and document best practices regarding Transition. IL Partner(s) Responsible: CILs, VACIL, SILC • Years 1, 2, 3 – Evaluating additional agencies for ex officio appointments, including the Virginia Department of Medical Assistance Services. IL Partner(s) Responsible: SILC
Goal II	Objective 2.2 - Prospective youth with disabilities are identified and targeted for outreach activities concerning the IL movement and philosophy. Measurable indicators: *Number of youth who enroll as a NCIL or APRIL member. *Number of youth who attend the Annual Conference on Independent Living (NCIL or APRIL), as well as VACIL and individual CIL events, trainings, and conferences. Geographical Scope: Statewide. Part B Funding amounts allocated: $3,800 in Years 1, 2, 3. Three Year Performance Target: • One hundred percent of allocated Part B funding expended in Years 1, 2, 3 Timeframe for Interim Progress: Quarterly. Requests for funding that are $250.00 or less may be reviewed and decided on by Administrator; all requests over $250.00 are to be reviewed and decided on by full Council. Activities: • Years 1, 2, 3 - Identifying youth to become National Council on Independent Living (NCIL) or Association of Programs for Rural Independent Living (APRIL) members for one year, up to two youth referred by each CIL, using Part B funds to pay for the memberships. IL Partner(s) Responsible: CILs, SILC • Years 1, 2, 3 - Identifying youth from Virginia to attend the NCIL Conference, APRIL Conference, or VACIL and individual CIL events/trainings.

	IL Partner(s) Responsible: CILs, SILC
Goal III	Objective 3.1 - The SILC and the network of the CILs will raise awareness of the IL philosophy and services in geographically unserved and underserved areas. Measurable indicators: *Number of individuals who live in the unserved areas identified to serve as potential SILC members. *Number of nomination forms submitted to the Secretary of the Commonwealth to obtain identified appointments from un/underserved areas. *Number of events attended in un/underserved areas Geographical Scope: Statewide, with emphasis in Planning Districts 13, 14, 17 and the lower part of 9. Part B funds allocated: $500 in Years 1, 2, and 3. Three Year Performance Target: • Ten percent (10%) increase in the number of applications for consideration of appointment to the SILC as reported by the Secretary of the Commonwealth. • One hundred percent (100%) funds expended to provide financial support for the VACIL Annual Report. Timeframe for Interim Progress: Yearly. Activities: • Years 1, 2, 3 - Providing the content of the SILC website, materials, and brochures in identified languages to ensure diverse recruitment. IL Partner(s) Responsible: SILC • Years 1, 2, 3 - Attending regional events with culturally diverse audiences to provide information about the SILC and general IL philosophy. IL Partner(s) Responsible: SILC • Years 1, 2, 3 - Providing financial support to the Virginia Association of Centers for Independent Living (VACIL) to develop, print, and disseminate their annual report, an outreach tool used to promote the IL philosophy and services. IL Partner(s) Responsible: VACIL, SILC • Years 1, 2, 3 - Pursuing and identifying appointments of potential candidates who reside in unserved/underserved geographical areas. IL Partner(s) Responsible: SILC, VACIL, CILs • Years 1, 2, 3 - Supporting and recommending potential candidates who reside in unserved/underserved geographical areas to the Secretary of the Commonwealth for appointments. IL Partner(s) Responsible: SILC

Goal III	Objective 3.2 - The SILC continues to partner with the consumer-directed CIL, disAbility Resource Center, in order to provide funding for focused guidance and mentoring in the unserved geographical areas of lower Planning District 9 (Counties of Rappahannock, Madison, Culpeper, and Orange). Measurable indicators: *Amount of Part B funds awarded to a CIL. *Quarterly reports of activities from the CIL grantee. *Number of organizations that are equipped to pursue funding at the end of Year 3 to avoid area from becoming unserved again. Geographical Scope: The lower part of Planning District 9. Part B Funding amounts allocated: $15,000 in Years 1, 2, and 3. Three Year Performance Targets: • Seventy percent (70%) of the CILs will provide input about unserved planning districts. • One-hundred percent (100%) of Part B budgeted funds ($45,000) will be expended by Year 3. Timeframe for Interim Progress: Quarterly Activities: • Years 1, 2, and 3 - Awarding Part B IL Funds to the grantee quarterly. IL Partner(s) Responsible: SILC, DARS • Year 2 - Awarding the continuation of funds. IL Partner(s) Responsible: SILC, DARS • Years 2, 3 - Receiving ongoing reports from the grantee about progress, barriers, and community stakeholders identified IL Partner(s) Responsible: DARS, SILC, CIL grantee • Year 3 - Ensuring that there is a grassroots organization equipped to pursue local, state and/or federal funding to establish a CIL in the unserved area. IL Partner(s) Responsible: CIL grantee
Goal III	Objective 3.3 - The Virginia SILC and the Centers for Independent Living increase outreach efforts to identified culturally and linguistically diverse populations in their catchment areas. Measurable indicators: *Number of consumers served who self-identify as culturally/linguistically diverse individuals. *Number of CIL staff who self-identify as proficient in languages other than English. *CIL PPR 704 Annual Reporting information. *Number of candidates who identify as minorities, or culturally and/or linguistically diverse, that apply for membership on the VASILC, as reported by the Secretary of the Commonwealth's office.

	Geographical Scope: Statewide. Part B Funds Allocated: $0 Three Year Performance Target: • Five percent (5%) increase in number of CIL consumers served who are self-identified as culturally/linguistically diverse individuals. • Thirty percent (30%) increase in the number of applications for consideration of appointment by minority candidates to the SILC, as reported by the Secretary of the Commonwealth. Timeframe for Interim Progress: Annually Activities: • Years 1, 2, 3 – Evaluating effectiveness of language identification posters in the CIL lobbies to assist in Consumer indication of native, or preferred, language and communication. IL Partner(s) Responsible: CILs • Years 1, 2, 3 - Comparing 704 CIL data with regional population statistics to identify populations for outreach. IL Partner(s) Responsible: SILC, CILs • Identifying areas of weakness in outreach and possible strategies to strengthen outreach and service to culturally and linguistically diverse populations within the catchment area. IL Partner(s) Responsible: CILs • Identifying possible minority and culturally and/or linguistically diverse candidates to serve on the SILC through: networking and advocacy activities by the Council, its Administrator, CIL recommendations, and Secretary of the Commonwealth recommendations. IL Partner(s) Responsible: SILC • Years 1, 2, 3 - Providing the content of the SILC website, materials, and brochures in identified languages to ensure diverse recruitment. IL Partner(s) Responsible: SILC • Years 1, 2, 3 - Attending regional events with culturally diverse audiences to provide information about the SILC. IL Partner(s) Responsible: SILC

1.4 Evaluation

Methods and processes the SILC will use to evaluate the effectiveness of the SPIL including timelines and evaluation of satisfaction of individuals with disabilities.

Goal(s) and the related Objective(s) from Section 1	Method that will be used to evaluate
Goal I Goal II Goal III	SPIL Implementation Timeline: One of the methods that the SILC employs to evaluate the effectiveness of the Plan is the SPIL Implementation Timeline, which is developed by the Council, and tracks each goal, objective, and activity. The timeline review is a permanent and central item on the Council agenda. The tracking and progress are documented on a matrix and shared with all SILC members and ex-officio representatives. The timeline specifies dates of reviews over a three-year period, tasks to be completed, and the responsible party/parties.
Goal I Goal II Goal III	CIL Consumer Satisfaction Survey: Surveys are conducted by the funding agency, the Department for Aging and Rehabilitative Services, approximately every few years, or as determined necessary by the IL Staff in cooperation with the CIL Directors. Surveys are typically mailed by the Department and analyzed by the Department's evaluation staff. The survey will be made available on-line through accessible methods. SILC Consumer Needs and Input surveys: Surveys are conducted by the SILC routinely within any three year SPIL cycle in order to plan each SPIL. This can be a Consumers Needs survey, a Consumer Input survey, or both. The SILC will partner with CILs wherever possible to maximize survey response by CIL Consumers.
Goal I Goal II Goal III	Quarterly Progress Reports: At each quarterly meeting, SILC members will receive updates on ongoing areas of focus in relation to the SPIL. The reports will focus on the overall, statewide progress made toward the SPIL Goals on broad issues such as youth involvement in SPIL activities, policy changes in community integration, and member education opportunities/completed trainings. The results are documented onto work plan matrix, and subsequently included in the 704 Reporting Instrument. These frequent and routine reports help the SILC to build a foundation of consumer needs and issues for the next SPIL cycle, providing the SILC with preliminary findings in which to draft the first SPIL for public commenting and consideration.

Goal I Goal II Goal III	Public input consisting of emails, survey responses, phone calls, and comments at meetings: Public input about the development and progress of the SPIL is accepted at any time, and this statement is posted on the Virginia SILC website. Input can be submitted using a variety of methods (e.g., email, written correspondences, or telephonically), depending on the needs and preferences of the individual. The email address, phone and fax numbers for the SILC Administrator are published and made available to the public. Feedback from the public outside of the regularly scheduled meetings is collected by the Administrator and forwarded to the most appropriate party, Committee, and/or the full Council for further consideration and action.
Goal I Goal II Goal III	Grantee Quarterly Reports: Grant awards will be monitored for measurable outcomes though the grantee quarterly reporting format. Measurable outcomes will be aggregated to assess policy and programmatic changes throughout the State. On a yearly basis, goals, objectives and tasks, as well as grant awards, will be evaluated to ensure that appropriate changes can be made for the following year's tasks, thereby creating continuous monitoring and refining of the Plan. Additionally, the Part B Project Coordinator attends each SILC meeting and provides a progress report on Part B grant activities to the Council. Any questions or concerns about CIL Part B activities are addressed at this time between the SILC and the Coordinator in a proactive manner.

1.5 Financial Plan

Sources, uses of, and efforts to coordinate funding to be used to accomplish the Goals and Objectives. Process for grants/contracts, selection of grantees, and distribution of funds to facilitate effective operations and provision of services.

Fiscal Year(s): 2021, 2022, and 2023 (per year)					
Sources	**Projected Funding Amounts and Uses**				
	SILC Resource Plan	IL Services	General CIL Operations	Other SPIL Activities	Retained by DSE for Administrative costs (applies only to Part B funding)
Title VII Funds					
Chapter 1, Part B (including state	70,117	414,500	0	19,300	0

match)					
Chapter 1, Part C	0	0	1,899,087	0	
Other Federal Funds					
Sec. 101(a)(18) of the Act (Innovation and Expansion)	30,410	0	0	0	
Social Security Reimbursement	0	0	180,402	0	
CARES Act			1,835,669		
Non-Federal Funds					
State Funds	0	0	5,696,858	0	
Other	0	0	0	0	

Description of financial plan narrative:
Part B funds will support SPIL Goals I, II and III, and the specified objectives. Ten percent of Part B funding must be made in match by the DSE; this financial plan reflects 10% of $458,106 awarded in 2020. The state match is used for the salary of the Administrator. Goal I and its corresponding objectives were developed to strengthen Council member knowledge through specified, targeted, education and opportunities. Goal II provides Centers with funding for each of the seventeen CILs to implement the federally-mandated fifth core service of transition. This mandate was established as a result of the Workforce Innovation and Opportunity Act (WIOA), but there are not sufficient federal funds appropriated to implement the service, which actually has three components. Non-competitive grants to the seventeen CILs, awarded and monitored by the DSE, will total a minimum of $399,500. The Virginia Association of Centers for Independent Living (VACIL) will be awarded $15,000 each year to coordinate the transition project by acting as a statewide Part B Coordinator. The role of the VACIL Coordinator is to organize the Part B CIL activities explained in Objective 2.1, specifically by: facilitating monthly conference calls with Part B CIL staff, providing training and technical assistance as needed, facilitating relationships between the CIL network and community and state agency partners, identifying best practices, acting as a mentor to Part B staff, and representing CIL interests on various boards and councils, such as the State Rehabilitation Councils for both DARS and the Department for the Blind and Vision Impaired. Part B Coordination activities will document successes and barriers in implementing the fifth core service through quarterly programmatic reports that are submitted to the SILC and DSE. Federal Part C funds are utilized for the ongoing maintenance of the CILs.
Within Goal II (Objective 2.2), The SILC will support a future generation of IL leaders by providing opportunities for youth with disabilities to become members of the National Council on Independent Living (NCIL) or Association for Programs in Rural Independent Living (APRIL) members. Additionally, the SILC, with recommendations from the CILs, will select youth(s) with disability(s) to attend the NCIL Annual Conference on Independent Living, APRIL

Conference on Independent Living, and/or VACIL and individual Center events and training each year (memberships and conferences/events up to $3,800/year).
The 2021-2023 SPIL will continue to address the expansion of the CIL network into lower Planning District 9, a geographical region of the state that is currently unserved by a Center. The Council has planned for a total of $15,000 in Year 1, 2, and 3 to be awarded to disAbility Resource Center by the DSE, using Part B funds, to provide technical assistance and mentoring to a grassroots group in the region. Part B funds will also be utilized to promote the IL philosophy and educate community partners about IL, as a part of its fulfillment of SILC statutory duties, by awarding up to $500 per year to VACIL towards developing and printing their annual report, as well as the SILC attending events in unserved areas to assist in developing relationships and awareness of IL.
Chapter 2, Older Blind funds, are non-applicable to the SPIL.
The Social Security Reimbursement row has been calculated using only those funds coming to Centers for reimbursement from "Ticket to Work" Services and allowable Representative Payee Services. No pass-thru funds are included in this figure. These amounts represent funds received as reimbursement for completed services in FY19, and can change annually.
In regards to CARES Act funds received in FY20, five of the six Part C Centers will share CARES Act funded provisions (example: necessary PPE) with the eleven (11) non-federally funded Centers. In addition, efforts will be made to make CARES Act funded provisions available to the four unserved areas of the Commonwealth. These funds will be utilized in accordance with the current guidance from ACL (May 4, 2020). ECNV has advised that they will be using all of their CARES Act funding. Further details of CARES Act funding and uses are outlined in Section 3.1 of this Plan.

Section 2: Scope, Extent, and Arrangements of Services
2.1 Services
Services to be provided to persons with disabilities that promote full access to community life including geographic scope, determination of eligibility and statewideness.

Table 2.1A: Independent living services	**Provided using Part B** (check to indicate yes)	**Provided using other funds** (check to indicate yes; do not list the other funds)	**Entity that provides** (specify CIL, DSE, or the other entity)
Core Independent Living Services, as follows:			
- Information and referral	No	Yes	CIL, DSE, SILC
- IL skills training	No	Yes	CIL
- Peer counseling	No	Yes	CIL
- Individual and systems advocacy	No	Yes	CIL
- Transition services including:	Yes	Yes	CIL, DSE
▪ Transition from nursing homes & other institutions			
▪ Diversion from institutions			
▪ Transition of youth (who were eligible for an IEP) to post-secondary life			

Table 2.1A: Independent living services	**Provided using Part B** (check to indicate yes)	**Provided using other funds** (check to indicate yes; do not list the other funds)	**Entity that provides** (specify CIL, DSE, or the other entity)
Counseling services, including psychological, psychotherapeutic, and related services	No	Yes	DSE
Services related to securing housing or shelter, including services related to community group living, and supportive of the purposes of this Act and of the titles of this Act, and adaptive housing services (including appropriate accommodations to and modifications of any space used to serve, or occupied by, individuals with disabilities) Note: CILs are not allowed to own or operate housing.	No	Yes	CIL, DSE
Rehabilitation technology	No	Yes	DSE
Mobility training	No	Yes	CIL, DSE
Services and training for individuals with cognitive and sensory disabilities, including life skills training, and interpreter and reader services	No	Yes	CIL, DSE
Personal assistance services, including attendant care and the training of personnel providing such services	No	Yes	DSE
Surveys, directories, and other activities to identify appropriate housing, recreation opportunities, and accessible transportation, and other support services	No	Yes	CIL, DSE
Consumer information programs on rehabilitation and IL services available under this Act, especially for minorities and other individuals with disabilities who have traditionally been unserved or underserved by programs under this Act	No	Yes	CIL, DSE
Education and training necessary for living in the community and participating in community activities	Yes	Yes	SILC, CIL, DSE
Supported living	No	Yes	DSE
Transportation, including referral and assistance for such transportation	No	Yes	DSE
Physical rehabilitation	No	Yes	DSE
Therapeutic treatment	No	Yes	DSE

Table 2.1A: Independent living services	Provided using Part B (check to indicate yes)	Provided using other funds (check to indicate yes; do not list the other funds)	Entity that provides (specify CIL, DSE, or the other entity)
Provision of needed prostheses and other appliances and devices	No	Yes	DSE
Individual and group social and recreational services	No	Yes	CIL, DSE
Training to develop skills specifically designed for youths who are individuals with significant disabilities to promote self-awareness and esteem, develop advocacy and self-empowerment skills, and explore career options	Yes	Yes	SILC, CIL, DSE
Services for children	No	Yes	CIL
Services under other Federal, State, or local programs designed to provide resources, training, counseling, or other assistance, of substantial benefit in enhancing the independence, productivity, and quality of life of individuals with disabilities	No	Yes	CIL, DSE
Appropriate preventive services to decrease the need of individuals with significant disabilities for similar services in the future	No	Yes	DSE
Community awareness programs to enhance the understanding and integration into society of individuals with disabilities	Yes	Yes	CIL, DSE
Such other services as may be necessary and not inconsistent with the Act	No	Yes	CIL, DSE

2.2 Outreach

Identify steps to be taken regarding statewide outreach to populations that are unserved or underserved by programs that are funded under Title VII, including minority groups and urban and rural populations.

The Virginia SILC and CIL Executive Directors continue discussions about outreach to targeted populations during SPIL Development Meetings which took place regularly beginning in April, 2018. The SILC and CILs identified four areas/populations that will be targeted for CIL programs utilizing these sources: 1) CIL quarterly Part B programmatic reports; 2) CIL annual PPR 704 reports; 3) SPIL 2021-2023 public comment survey; and 4) Ongoing dialogue with consumers, stakeholders and CIL staff. A thorough analysis contributed to identifying these targeted populations beginning in 2015, and in implementing transition: 1) Individuals living in nursing homes or other segregated settings who desire to move to the community (Objective 2.1); 2) Individuals who are diverted from entering a nursing facility by CIL services (Objective

2.1); 3) Youth with disabilities in need of transition services (Objective 2.1 and 2.2), and 4) Minority populations as identified by 704 data (Objectives 3.3).

Identify the geographic areas (i.e., communities) in which the targeted populations reside: Outreach efforts by both the Statewide Independent Living Council and the network of the CILs will continue in the unserved geographical areas of the state. Discussions about those areas have created a stark understanding that limited resources hinder the development of new Centers. These geographical areas are targeted for technical assistance and mentoring through the SILC, the Virginia Association of Centers for Independent Living, and the DSE. Continued resources for grass-roots, consumer-based organization have been identified within the proposed SPIL budget (Objective 3.2). Currently, the unserved counties are:

1) Lower part of PLANNING DISTRICT 9: Rappahannock, Culpeper, Madison and Orange Counties.
2) PLANNING DISTRICT 14: Buckingham, Cumberland, Amelia, Prince Edward, and Nottoway Counties.
3) PLANNING DISTRICT 13: Charlotte, Lunenburg, Halifax, Mecklenburg and Brunswick Counties.
4) PLANNING DISTRICT 17: Richmond, Northumberland, and Lancaster Counties.

These outreach plans align with the CIL Expansion Plan detailed further in Section 3.2 of this Plan.

Describe how the needs of individuals with significant disabilities from minority group backgrounds will be addressed:

Virginia is a geographically and culturally diverse state consisting of distinct urban, suburban and rural regions. Although the overall population of Virginia has grown by less than one percent in each year since 2010, the growth rates between cities and counties are uneven, with more growth taking place in urban areas (Weldon Cooper Center for Public Service Demographics Research Group and 2010 Census).
The Centers for Independent Living have long implemented specific and flexible strategies to address the needs of local populations residing in their respective catchment areas.
The SILC and the CILs recognize that certain ethnic and minority groups may benefit from outreach and education about the IL philosophy and programs. The Hispanic population in Virginia is the fastest-growing minority, while the Asian population is the second (2010 Census). The SILC will continue to conduct a comprehensive analysis of PPR 704 reports completed by Virginia's seventeen CILs and compare with the most recent data (Objective 3.3). Each Center will be asked to identify one minority population in their catchment area and identify strategies specific to serving that population. Data will be continue to be collected and shared for possible replication of best practices. This additional step with Virginia's Network of CILs is necessary due to the large and diverse cultural and linguistic populations.
Strategies for outreach have been written into this SPIL and include use, and evaluation of effectiveness, of language identifier posters in CIL office lobbies for consumers to identify appropriate interpreter needs, as well as continuing to produce CIL and SILC materials in Spanish. Lastly, the Virginia SILC will promote and recommend appointments to the Council and other Virginia Boards and Commissions of individuals with significant disabilities from those targeted minority groups identified by various community partners (Objective 3.3). Under Objective 3.3, the SILC will also support and recommend potential Council members from unserved/underserved geographical areas of the state, continuing its past successful efforts.

2.3 Coordination

Plans for coordination of services and cooperation among programs and organizations that support community life for persons with disabilities.

The SILC has been successful in joining other state and community based agencies to promote independent living philosophy and services for individuals with disabilities. A meaningful and valuable partnership has long existed between the SILC and the network of the CILs. Representatives from the Virginia Association of Centers for Independent Living (VACIL) regularly attend SILC meetings and provide updates, often leading to problem solving and critical thinking discussions.

The SILC-DSE working relationship is also effective and mutually supportive. The Commissioner of the DSE is invited to attend quarterly meetings to address the Council, followed by an open discussion session to enhance communication between the entities. The Deputy Commissioner currently serves as the DSE ex officio, bringing a wealth of agency and professional IL knowledge to discussions. These conversations are mutually beneficial in sharing IL issues and concerns, while proactively steering the future of the DSE/SILC partnerships. The Commissioner of DBVI also sends updates to the SILC through that agency's ex officio member. The Director of the Virginia Department for the Deaf and Hard of Hearing also serves as an ex officio, and routinely provides updates and project information. State agency staff, such as the building code official with Department of General Services and the webmaster with DARS, have attended SILC meetings to share information and participate in roundtable discussions about overlapping issues of concern.

SILC representatives officially serve on the following councils/boards, to maximize resources and coordinate statewide efforts:

State Rehabilitation Council of DARS
State Rehabilitation Council of DBVI
Community Integration Implementation Team

Several SILC and VACIL members serve on other planning bodies, and relevant information shared with the SILC, these include:

The Virginia Board for People with Disabilities
Youth Leadership Forum
Regional chapters of the Arc of Virginia
Department for Behavioral Health and Developmental Services Settlement Agreement Stakeholder Group
Virginia Department of Emergency Management
Virginia Commonwealth University Partnership for People with Disabilities Stakeholder Group
Virginia Interagency Housing Committee
Virginia Housing and Supportive Services Integration Team

To illustrate how major partners in Virginia work together, the DSE, SILC, VACIL, DBVI and other state agencies have provided leadership to implement Virginia's Olmstead Plan and made yearly recommendations to the Governor concerning community integration of individuals with disabilities. VACIL provides continued consultation to the Department for Medical Assistant Services regarding best practices and implementation of transition services and coordination. All collaborative efforts strive to increase community based supports and services that allow people with disabilities to live independently.

Section 3: Network of Centers

3.1 Existing Centers
Current Centers for Independent Living including: legal name; geographic area and counties served; and source(s) of funding. Oversight process, by source of funds (e.g., Part B, Part C, state funds, etc.) and oversight entity.

The existing network consists of seventeen fully functional and compliant CILs and three Satellite CILs covering all but 3 1/2 Planning Districts (PD) in the state. The 17 full-fledged Centers receive State General Funds and Federal Part B Funds. Six of the fifteen Centers also receive Federal Part C Funds. All Centers are actively involved as members of the Virginia Association of Centers for Independent Living, and are valuable partners of the SILC and the DSE. All Virginia CILs work cooperatively to provide a full complement of services and advocacy to consumers in the respective localities.
Although the Peninsula Center for Independent Living (PCIL) assists in providing services on the Eastern Shore, there is a state-funded Center located there. An agreement was put into place that assures PCIL will provide assistance with direct services, advocacy, and technical assistance to boost the relatively small amount of resources allocated to the state-funded Eastern Shore Center for Independent Living (ESCIL).
Service areas are based on availability of state and federal Parts B and C dollars, and can be changed within the three-year SPIL cycle. The service areas and demographics for Virginia CILs are listed below. All Centers, including those that are state funded, as well as those that are federally funded, are compliant to Section 725 (b) and (c) of the Act as documented in routine Site Visit Reviews every three years.
In FY20, each of the six Virginia Centers for Independent Living that receive Part C funds were awarded one-time funding in the CARES Act (Coronavirus Aid, Relief, and Economic Security Act). These funds were allocated to the Part C Centers directly from ACL and totaled $1,835,669. Five of the six Centers receiving funds will be using them in collaboration with the eleven state funded Centers, and partner organizations, to share necessary, purchased provisions on a statewide level, including the four areas not served by a CIL. Endependence Center of Northern Virginia indicates they will be using all of their CARES Act funds within their service area. Any CARES Act funds, or other one-time funds issued, are to be used as prescribed by, and according to, any funder guidelines, specifically the guidance provided on May 4, 2020. The individual CARES Act grant award information is:
Blue Ridge Independent Living Center - $285,002
Endependence Center, Inc. - $387,851
Endependence Center of Northern Virginia - $387,850
Peninsula Center for Independent Living - $287,851
Resources for Independent Living - $387,851
Valley Associates for Independent Living - $99,847

FEDERALLY FUNDED PART C CENTERS FOR INDEPENDENT LIVING

BLUE RIDGE INDEPENDENT LIVING CENTER
SPIL signatory - Yes

Area Served - Cities of Roanoke, Salem, Covington; Counties of Roanoke, Botetourt, Craig, Allegheny
State Funding - Yes
Federal Part C Funding – Yes
CARES Act Funding Received - Yes
Federal Part B Funding – Yes
Oversight Process – Annual PPR
Oversight Entity – ACL
*Estimated Total Population – 277,764
**Estimated Number of People with Disabilities - 31,665
***Number of Consumers served 2019 – 318

ENDEPENDENCE CENTER, INC.
SPIL signatory - Yes
Area served - Cities of Norfolk, Virginia Beach, Chesapeake, Suffolk, Portsmouth; Counties of Isle of Wight, Southampton, Franklin. (Subsequent to the original Part C grant for the Center, an additional Center was established that other serves an area which includes Franklin.)
State Funding - Yes
Federal Part C Funding – Yes
CARES Act Funding Received - Yes
Federal Part B Funding – Yes
Oversight Process – Annual PPR
Oversight Entity – ACL
Estimated Total Population - 1,252,134
Estimated Number of People with Disabilities – 142,743
Number of Consumers served 2019 - 1,098

ENDEPENDENCE CENTER OF NORTHERN VIRGINIA
SPIL signatory - Yes
Area served - Cities of Arlington, Alexandria, Fairfax, Falls Church; Counties of Fairfax, Loudoun, Prince William. (Subsequent to the awarding of the original Part C grant funds for the Center, a Satellite Center was established using State dollars in Loudoun due to the large and dense population in that area and another Center was established serving an area which includes the County of Prince William.)
State Funding – Yes
Federal Part C Funding – Yes
CARES Act Funding Received - Yes
Federal Part B Funding – Yes
Oversight Process – Annual PPR
Oversight Entity – ACL
Estimated Total Population - 2,438,208
Estimated Number of People with Disabilities - 277,956
Number of Consumers served 2019 – 691

PENINSULA CENTER FOR INDEPENDENT LIVING
SPIL signatory - Yes

Area served - Cities of Hampton, Newport News, Williamsburg, Poquoson; Counties of James City, York, Northampton, Accomack. (Subsequent to the original Part C grant for the Center, an additional state-funded Center was established that serves an area including Accomack and Northampton Counties.)
State Funding - Yes
Federal Part C Funding – Yes
CARES Act Funding Received - Yes
Federal Part B Funding – Yes
Oversight Process – Annual PPR
Oversight Entity – ACL
Estimated Total Population – 534,216
Estimated Number of People with Disabilities – 60,901
Number of Consumers served 2019 – 1,361

RESOURCES FOR INDEPENDENT LIVING
SPIL signatory - Yes
Area served - City of Richmond; Counties of Henrico, Chesterfield, Hanover, New Kent
State Funding - Yes
Federal Part C Funding – Yes
CARES Act Funding Received - Yes
Federal Part B Funding – Yes
Oversight Process – Annual PPR
Oversight Entity – ACL
Estimated Total Population - 1,037,594
Estimated Number of People with Disabilities - 118,286
Number of Consumers served 2019 - 1,009

VALLEY ASSOCIATES FOR INDEPENDENT LIVING
SPIL signatory - Yes
Area served - Cities of Buena Vista, Harrisonburg, Lexington, Staunton, Waynesboro; Counties of Rockingham, Highland, Augusta, Bath, Rockbridge
State Funding - Yes
Federal Part C Funding – Yes
Cares Act Funding Received - Yes
Federal Part B Funding – Yes
Oversight Process – Annual PPR
Oversight Entity – ACL
Estimated Total Population – 302,140
Estimated Number of People with Disabilities - 34,444
Number of Consumers served 2019 – 527

STATE FUNDED CENTERS FOR INDEPENDENT LIVING
ACCESS INDEPENDENCE
SPIL signatory - Yes
Area served - City of Winchester; Counties of Frederick, Clarke, Warren, Page, Shenandoah

State Funding - Yes
Federal Part C Funding - None
Federal Part B Funding – Yes
Oversight Process – Annual PPR; regular site reviews and monitoring by DSE
Oversight Entity – DSE
Estimated Total Population - 238,150
Estimated Number of People with Disabilities - 27,149
Number of consumers served 2019 - 448

APPALACHIAN INDEPENDENCE CENTER
SPIL signatory - Yes
Area Served - Cities of Galax and Bristol; Counties of Washington, Grayson, Smyth, Wythe, Bland, Carroll
State Funding - Yes
Federal Part C Funding - None
Federal Part B Funding – Yes
Estimated Total Population – 186,481
Oversight Process – Annual PPR; regular site reviews and monitoring by DSE
Oversight Entity – DSE
Estimated Number of People with Disabilities - 21,259
Number of Consumers served 2019 - 131

CLINCH INDEPENDENT LIVING SERVICES
SPIL signatory - Yes
Area served - City of Grundy; Counties of Dickenson, Buchanan, Russell, Tazewell
State Funding - Yes
Federal Part C Funding - None
Federal Part B Funding – Yes
Oversight Process – Annual PPR; regular site reviews and monitoring by DSE
Oversight Entity – DSE
Estimated Total Population - 110,381
Estimated Number of People with Disabilities - 12,583
Number of Consumers served 2015 - 343

disABILITY RESOURCE CENTER
SPIL signatory - No
Area served - City of Fredericksburg; Counties of Caroline, Spotsylvania, Stafford, King George, as well as: lower portion of Planning District 9 (SILC funded project in Counties of: Culpeper, Rappahannock, Orange, and Madison)
State Funding - Yes
Federal Part C Funding - None
Federal Part B Funding – Yes
Oversight Process – Annual PPR; regular site reviews and monitoring by DSE
Oversight Entity – DSE
Estimated Total Population – 480,725
Estimated Number of People with Disabilities – 54,803
Number of Consumers served 2019- 807

DISABILITY RIGHTS & RESOURCE CENTER
SPIL signatory - Yes
Area served - Cities of Martinsville, Danville; Counties of Patrick, Henry, Franklin, and Pittsylvania
State Funding - Yes
Federal Part C Funding - None
Federal Part B Funding – Yes
Oversight Process – Annual PPR; regular site reviews and monitoring by DSE
Oversight Entity – DSE
Estimated Total Population - 209,536
Estimated Number of People with Disabilities - 23,887
Number of Consumers served 2019- 91

EASTERN SHORE CENTER FOR INDEPENDENT LIVING
SPIL signatory - Yes
Area served - Counties of Accomack, Northampton
State Funding - Yes
Federal Part C Funding - None
Federal Part B Funding – Yes
Oversight Process – Annual PPR; regular site reviews and monitoring by DSE
Oversight Entity – DSE
Estimated Total Population - 44,371
Estimated Number of People with Disabilities - 5,058
Number of Consumers served 2019 - 211

INDEPENDENCE EMPOWERMENT CENTER
SPIL signatory - Yes
Area served - Cities of Manassas, Manassas Park; Counties of Prince William, Fauquier
State Funding - Yes
Federal Part C Funding - None
Federal Part B Funding – Yes
Oversight Process – Annual PPR; regular site reviews and monitoring by DSE
Oversight Entity – DSE
Estimated Total Population – 594,471
Estimated Number of People with Disabilities - 67,770
Number of Consumers served 2019 - 658

INDEPENDENCE RESOURCE CENTER
SPIL signatory - Yes
Area served - City of Charlottesville; Counties of Albemarle, Fluvanna, Louisa, Greene, Nelson
State Funding - Yes
Federal Part C Funding - None
Federal Part B Funding – Yes
Oversight Process – Annual PPR; regular site reviews and monitoring by DSE
Oversight Entity – DSE
Estimated Total Population – 257,452
Estimated Number of People with Disabilities - 29,350

Number of Consumers served 2019 - 318

JUNCTION CENTER FOR INDEPENDENT LIVING
SPIL signatory - Yes
Area served - City of Norton; Counties of Lee, Scott, Wise
State Funding - Yes
Federal Part C Funding - None
Federal Part B Funding – Yes
Oversight Process – Annual PPR; regular site reviews and monitoring by DSE
Oversight Entity – DSE
Estimated Total Population – 87,333
Estimated Number of People with Disabilities – 9,956
Number of Consumers served 2019 - 897

LYNCHBURG AREA CENTER FOR INDEPENDENT LIVING
SPIL signatory - Yes
Area served – City of Lynchburg; Counties of Amherst, Appomattox, Bedford, Campbell
State Funding - Yes
Federal Part C Funding - None
Federal Part B Funding – Yes
Oversight Process – Annual PPR; regular site reviews and monitoring by DSE
Oversight Entity – DSE
Estimated Total Population – 262,428
Estimated Number of People with Disabilities - 29,917
Number of Consumers served 2019 - 528

NEW RIVER VALLEY DISABILITY RESOURCE CENTER
SPIL signatory - Yes
Area served - Cities of Radford; Counties of Giles, Montgomery, Pulaski, Floyd
State Funding - Yes
Federal Part C Funding - None
Federal Part B Funding – Yes
Oversight Process – Annual PPR; regular site reviews and monitoring by DSE
Oversight Entity – DSE
Estimated Total Population – 184,532
Estimated Number of People with Disabilities – 21,037
Number of Consumers served 2019 - 171

SATELLITE CENTERS FOR INDEPENDENT LIVING
Note: The three Satellite Centers in Virginia are not, at the present time, compliant with Section 725 of the Rehabilitation Act. The long-range goal is for each Satellite Center to break off from the Parent CIL and become an independent CIL, compliant with all Standards and Assurances outlined in the Act.

CRATER DISTRICT CIL SATELLITE (Parent CIL: RIL)
Area served - Cities of Colonial Heights, Emporia, Hopewell, Petersburg; Counties of Dinwiddie, Greensville, Prince George, Surry, Sussex
State Funding - Yes

Federal Part C Funding - None
Federal Part B Funding – None
Oversight Entity – Resources for Independent Living, Inc.

MIDDLE PENINSULA SATELLITE (Parent CIL: PCIL)
Area served - Counties of Essex, Gloucester, King & Queen, King William, Mathews, Middlesex
State Funding - Yes
Federal Part C Funding - None
Federal Part B Funding – None
Oversight Entity: Peninsula Center for Independent Living

LOUDOUN ENDEPENCE CENTER SATELLITE (Parent CIL: ECNV)
Area served - County of Loudoun
State Funding - Yes
Federal Part C Funding - None
Federal Part B Funding – None
Oversight Entity – Endependence Center of Northern Virginia

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*Population according to 2019 Population Estimates, Weldon Cooper Center for Public Service Demographics Research Group and 2010 Census
**Disability percentage, all ages, all disabilities, non-institutionalized, male and female, residing in Virginia, according to Disability Statistics = 11.4%
***Number of consumers served according to 2019 PPR 704 Reports

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3.2 Expansion and Adjustment of Network
Plan and priorities for use of funds, by funding source, including Part B funds, Part C funds, State funds, and other funds, whether current, increased, or one-time funding and methodology for distribution of funds. Use of funds to build capacity of existing Centers, establish new Centers, and/or increase statewideness of Network.

Priority One – Raise all existing CILs to a minimum of $387,000, including permanent federal and state
funding.

A. New federal Part C funds would be distributed in the following order:
    a. according to federal stipulations, if required;
    b. equally among the CILs that do not meet the $387,000 threshold, if the CIL becomes a Part C CIL; or
    c. if the amount of new funding is inadequate to be reasonably provided as described in items a or b above, divide the funds equally among the Part C CILs.

B. New state funds would be distributed equally among the Virginia CILs, regardless of the $387,000 threshold defined in this Plan.

Priority Two – Increase the Loudoun and Middle Peninsula satellites base funding to $75,000 each.

Priority Three – Establish four new satellites with $75,000 each in the following areas:

A. Northern Neck (Westmoreland, Richmond, Lancaster, Northumberland)
B. Southside (Brunswick, Greensville, Halifax, Mecklenburg, Lunenburg, Charlotte)
C. PD14 (Buckingham, Cumberland, Amelia, Prince Edward and Nottoway)
D. LowerPD9 (Rappahannock, Culpeper, Orange, Madison)

Priority Four – Establish seven new CILs.

A. Crater in the counties of Dinwiddie, Prince George, Surry, and Sussex would be the first satellite to become a CIL.
B. The remaining satellites will move into CIL status be based on the criteria below. If more than one satellite is ready to become a CIL and funding is only available for one CIL, CILs will be established based on the chronological date they were established as a satellite.

New Satellite Criteria:
1. Existing CIL willing to sponsor
2. Unserved geographical area
3. Availability of $75,000
4. Local group ready to be involved with satellite

Existing Satellite Readiness to Become a CIL:
1. $387,000 of local, state or federal funds available
2. 501(c)3 organization ready to be established
3. Established sole purpose board, consumer controlled, promotes a philosophy of IL cross disability (meeting the federal and state definition of a CIL)
4. Local community ready to commit local funds

Minimum funding level for a Center and formula/plan for distribution of funds to bring each Center to the minimum. Exceptions must be explained with sufficient detail:
A minimum funding of $360,000 was adopted in the 2017-2019 State Plan from a study by the National Council on Independent Living (NCIL) and is now adjusted for 2021-2023 using the Bureau of Labor Statistics consumer price index. Today's prices in 2020 are 7.48% higher than average prices since 2016. The U.S. dollar experienced an average inflation rate of 1.82% per year during this period (2016-2020), meaning the real value of a dollar decreased. In other words, $360,000 in 2016 is equivalent in purchasing power to about $386,945.21 in 2020. Virginia recognizes this difference, and finds that the minimum funding level needed for a Center in Virginia is now $387,000. This number will include both federal and state permanent Independent Living dollars. This level of funding provides the best opportunity for CILs to provide quality, comprehensive services to individuals with disabilities in their home communities.

Action/process for distribution of funds relinquished or removed from a Center and/or if a Center closes:
Any Part B funds distributed, but not used, shall be reimbursed in the amount not used to the SILC, but payable to the DSE for fiscal accounting purposes. All Part B contract payments are contingent on quarterly reports and reported outcomes. Part B payments are only to be made if funds are available. Relinquished or removed funds will go into the SILC resource budget, not to exceed 30% of Part B funding. If Part B relinquishment or removal is in excess, it will then go

towards funding other SPIL Goals, as appropriate and necessary, and only as agreed to by the full Council in a majority vote.
Any State or Part B funds that are relinquished or removed, will be payable to the DSE unless otherwise advised by DSE.
In the event that a Center's operations or physical location must close due to natural disaster or emergency, the Center location may move temporarily. A Center may still provide necessary services to Consumers in alternative methods during times of emergency. All alternative operations must be disclosed to the DSE and SILC prior to taking place, and in accordance with contract deliverables.
If a Center must close temporarily, it may also be necessary that a neighboring Center take over, or assist with, services. In these instances, funding may be diverted to the neighboring Center. This funding diversion must be temporary, formally and specifically requested of DSE, SILC, and ACL (in instances of Part C funding), and mutually agreed to by neighboring Center and Center affected, the funding source(s), DSE, as well as the SILC if Part B funds are diverted.
If a Center must close its office temporarily, but the Center remains operational (example: pandemic or other threat to public safety), the SILC approves all alternative programmatic and operational approaches so long as they meet the needs and safety of the Center staff and Consumers, alike, while also fulfilling SPIL goals and objectives. Changes in programmatic activity may need to be addressed through changes to the quarterly reporting on transition activity. Temporary programmatic changes should be agreed to by VACIL first, and then submitted to the Council for review and documentation of such changes. The SILC also approves diverting funds to neighboring Centers in the instance of an emergency, as well as network collaboration, to ease inequities in service areas. Such collaboration and diversion of funds should be reported to the SILC, and if required, to the funder(s).
If a Center closes permanently, regardless of funding source, Virginia would initiate a competitive Request for Proposals (RFP) process in the same catchment area, taking precedence over current priorities laid out in previously stated priority positions. The notice inviting applications would be made to the appropriate entity (DSE or ACL) and the SILC and DSE would support a qualified proposal in federal and/or state application process.
If a currently funded Part C Center loses funding, due to unforeseen circumstances or non-compliance issues, Virginia would support a competitive RFP process in the same catchment area, taking precedence over current priorities laid out in previously stated priority positions. Notice inviting applications would be made and the SILC and DSE would support a qualified proposal in federal and/or state application process. If there is no qualified proposal, the funds and the service area may be divided amongst one or more neighboring, border, Centers, so long as those Centers indicate that they are willing and able to provide services. The SILC must be advised of any change in service area, as well as any other funder.

Plan/formula for adjusting distribution of funds when cut/reduced:
When Part B funds are cut or reduced, the Council may appropriately adjust the resource budget, the contract payments to the Centers for Transition services, and contract payments for the grassroots effort in Planning District 9.
When state funds are cut, or reduced, the DSE may appropriately adjust the state contract award amounts for each Center.
When federal funds are cut, or reduced, the DSE may appropriately adjust the state fund contract award amounts to ease burden of cut/reduction.

Any changes or adjustments to funding should be made with the input of the network (VACIL, SILC, DSE).

Plan for changes to Center service areas and/or funding levels to accommodate expansion and/or adjustment of the Network:
If lower Planning District 9 receives local or state funding, equal to or greater than the amount the SILC provides, the SILC may re-evaluate whether Part B funds will continue to be used to support the grassroots effort. If it is decided by the Council that the other sources of funding are sufficiently supporting this area and the work intended, the Council may first evaluate the resource budget and evaluate distributing excess funds amongst the Centers equally and take action accordingly.
If a Center is created, or closed, adjustment to network will be made, consistent with the Planning District areas defined in Virginia and within this SPIL. Such changes will be in collaboration with the DSE, CILs, SILC, and all funders.

Plan for one-time funding and/or temporary changes to Center service areas and/or funding levels:
Should additional Part B funds be received, the Council will first look to make sure the resource budget is funded fully at, but not to exceed 30% of total funding. Any additional funds beyond that will then be distributed equally among all Centers' contract amounts for Goal II – Transition services.
Should additional Part C funds above Cost of Living Adjustment (COLA), yet under the $387,000 minimum, become available (including existing state funds as a part of that total), VACIL will make every attempt to utilize these funds in accordance with the stated priorities. If the available funds are insufficient to reasonably support the stated goals, these funds would then be distributed equally among the existing Part C funded CILs.
Should additional state or local funds become available, those funds are to be delivered and overseen by the DSE. If the funds are below the $387,000 minimum, the funds will be equally divided between all Centers receiving state funds, unless otherwise directed by the legislation creating the funds or the DSE. Additional state funds may be used to support satellite centers, Centers, or un/underserved areas.

Section 4: Designated State Entity
The Virginia Department for Aging and Rehabilitative Services (DARS) will serve as the entity in Virginia designated to receive, administer, and account for funds made available to the state under Title VII, Chapter 1, Part B of the Act on behalf of the State. *(Sec. 704(c))*

4.1 DSE Responsibilities
- **(1)** receive, account for, and disburse funds received by the State under this chapter based on the plan;
- **(2)** provide administrative support services for a program under Part B, and a program under Part C in a case in which the program is administered by the State under section 723;
- **(3)** keep such records and afford such access to such records as the Administrator finds to be necessary with respect to the programs;

(4) submit such additional information or provide such assurances as the Administrator may require with respect to the programs; and
(5) retain not more than 5 percent of the funds received by the State for any fiscal year under Part B. for the performance of the services outlined in paragraphs (1) through (4).

4.2 Grant Process & Distribution of Funds
Grant processes, policies, and procedures to be followed by the DSE in the awarding of grants of Part B funds.

Independent Living Services, funded by federal Part C and Part B funds, state General Funds, and other federal program funds, are provided by Centers for Independent Living that meet all requirements cited within the Rehabilitation Act.
Through individual award documents and the CIL Policy Manual, and substantiated by regular Site Visits, each of the Centers within Virginia's CIL network is required to meet compliance with the Rehabilitation Act, as amended, Title VII Standards and Assurances, and also Financial Requirements set forth therein (Sec 704(M)(3). The Centers are also required to meet state regulations and fiscal standards and policies. Additionally, all Centers submit two separate quarterly fiscal reports, one for Part B grants and one for state grants. The Part B fiscal reports are actively monitored by the SILC and DSE. The DSE maintains overall oversight and fiscal control for the Part B grant awarded to Virginia.
Programs funded under Chapter I, Part B are carried out through a grant with each of the 17 Centers for Independent Living, as delineated in Goal II (fifth core service - transition). Part B funds are also granted to the Virginia Association of Centers for Independent Living to coordinate the project by providing technical assistance and support to the CIL staff. Lastly, to grow and expand the CIL network and provide statewide coverage, a Part B grant will be awarded to provide support to a Center for the local grass-roots group in lower Planning District 9. Grants are administrated by the Department for Aging and Rehabilitative Services (DARS). Report data and outcomes are monitored on a quarterly basis by the SILC and the DSE. When carryover funds are present in the second year of any grant period, or in any quarter, those funds are spent first to ensure Part B funds are expended entirely within their two year (federal fiscal year) award period. Carryover still present, and undesignated, at the end of any assigned two year grant period, are to be absorbed by the DSE.

4.3 Oversight Process for Part B Funds
The oversight process to be followed by the DSE.

The DSE maintains overall oversight and fiscal control for the Part B grant awarded to Virginia. This oversight is in accordance with Virginia's procurement procedures and in adherence with all Federal statutes. Through individual award documents and the CIL Policy Manual, and substantiated by regular Site Visits, each of the Centers within Virginia's CIL network is required to meet compliance with the Rehabilitation Act, as amended, Title VII Standards and Assurances, and also Financial Requirements set forth therein (Sec 704(M)(3). The Centers are also required to meet state fiscal standards and policies. Additionally, all Centers submit two separate quarterly fiscal reports, one for Part B grants and one for state grants. The Part B fiscal reports are actively monitored by the SILC and DSE

4.4 Administration and Staffing
Administrative and staffing support provided by the DSE:

The Department for Aging and Rehabilitative Services (DARS), has accepted the role and the responsibilities of the DSE as identified in WIOA. DARS provides the administrative support of the State Independent Living Services (SILS) Part B program by developing and disseminating grant packages and awards, processing payments of Part B funds, tracking expenditures, tracking measurable outcomes, assuring compliance with state policies and procedures, and providing both fiscal and programmatic technical assistance. Administrative support also includes site visit reviews, audits as necessary, and staff training to both the SILC and the CIL staffs as requested. The IL Program Director's position is supported by state general funds.

In-kind resources provided through the Department for Aging and Rehabilitative Services (DARS) to the SILC are:

- Develop Requests for Proposals, grant packages and contracts
- Fiscal Services and budget assistance
- Processing of all bills/reimbursements related to the Council
- Provision of 1 FTE (SILC Administrator). When able, the DSE will also provide part time staff support to the Council Administrator.
- Office space
- Copier equipment, telephones, office furniture, filing cabinets, storage closet, supplies (paper, envelopes, etc.), basic computer software and IT services, video and teleconference calling and equipment, meeting rooms, fax, scanner, internet access, and email
- Publication design services
- Website domain, design, and maintenance assistance
- Document repository for public documents
- Public relations and marketing services for press releases and postings to the DARS Facebook page
- Survey design and analysis, and assistance with building databases

4.5 State Imposed Requirements
State-imposed requirements contained in the provisions of this SPIL including: *(45 CFR 1329.17(g))*

- State law, regulation, rule, or policy relating to the DSE's administration or operation of IL programs
- Rule or policy implementing any Federal law, regulation, or guideline that is beyond what would be required to comply with 45 CFR 1329
- That limits, expands, or alters requirements for the SPIL

None.

4.6 722 vs. 723 State

Check one:
X 722 (if checked, will move to Section 5)
_____ 723 (if checked, will move to Section 4.7)

4.7 723 States
Order of priorities for allocating funds amounts to Centers, agreed upon by the SILC and Centers, and any differences from 45 CFR 1329.21 & 1329.22.

How state policies, practices, and procedures governing the awarding of grants to Centers and oversight of the Centers are consistent with 45 CFR 1329.5, 1329.6, & 1329.22.

Section 5: Statewide Independent Living Council (SILC)

5.1 Establishment of SILC
How the SILC is established and SILC autonomy is assured:
The SILC was created by an Act of the Virginia General Assembly in 1994 as outlined in Section 51.5-164 of the Code of Virginia:
51.5-164. Statewide Independent Living Council created.
The Statewide Independent Living Council is hereby created to plan, together with the Department, activities carried out under Title VII of the federal Rehabilitation Act of 1973 (29 U.S.C. 796 et seq.) and to provide advice to the Department regarding such activities. Membership and duties shall be constructed according to federal provisions. The Department shall provide staff support for the Council.
(1994, c. 81, 51.5-25.1; 2006, cc. 110, 169; 2007, cc. 473, 556; 2011, cc. 7, 166; 2012, cc. 803, 835.)
Additionally, the former DSUs, DARS (current DSE) and DBVI, entered into a cooperative agreement in past years that fully supported the necessary autonomy of the SILC as cited and mandated in both state and federal code. Both state agencies recognized that the decision making authority for SILC activities is the responsibility of appointed Council members. DARS and DBVI pledged to partner with the SILC in their mandate as the statewide planning authority for independent living and in its role as an autonomous, freestanding body that controls its own resource plan and programmatic (SPIL) budget. This agreement formally set the course for the full autonomy and independence of the Council which is still honored and respected today by state agencies. With the SILC's autonomy and independence ensured by the two state VR agencies, there are no immediate plans for the SILC to become a non-profit agency. Furthermore, the SILC shall continue to be housed within the DSE, physically and fiscally, during this SPIL.

5.2 SILC Resource plan
Resources (including necessary and sufficient funding, staff/administrative support, and in-kind), by funding source and amount, for SILC to fulfill all duties and authorities:
Funding for the SILC Resource Plan is utilized to carry out the statutory duties outlined in Section 705(c) of the Rehabilitation Act, as amended. Specifically, the resource plan expenditures include lodging, meals, and mileage to enable Council members and staff to attend quarterly meetings; training costs for staff and members; reasonable accommodations such as sign language interpreters and personal assistance services; equipment, postage, supplies, copier, printing and telecommunications. The salary for the SILC Administrator is paid through state match funds.
Sources and Amounts (from SILC Resource Plan) - Years 1, 2, and 3:

Title VII Funds, Chapter 1, Part B - $24,306
Other Federal Funds, Section 101 (a)(18), I&E - $30,410
Non-Federal Funds, State Funds (Title VII Part B State G/F match) - $45,811

Process used to develop the Resource Plan:
The 2021-2023 SPIL goals, objectives and activities were developed based on realistic and conservative financial projections. The SILC carefully considered input from the public, the CIL Directors, and CIL staff during SPIL development activities, in light of the current economic climate in the state and nation. The SILC, through the SPIL, will utilize limited funding to continue system change advocacy efforts and to support the required fifth core service. These efforts are already in place within the CIL network and have obviously resulted in positive impacts on the lives of Virginians with disabilities. Based on limited staffing and funding levels, the resource plan is consistent with Virginia's available resources and the SPIL goals/objectives/activities are realistically feasible within the three-year period.

Process for disbursement of funds to facilitate effective operations of SILC:
The SILC determines an annual budget for the resource plan and all programs which are guided through the SPIL, in concert with its CIL partners. Expenditures are paid and tracked through the DSE as the Fiscal Agent. All financial transactions and record-keeping are made in compliance with applicable federal fiscal and accounting requirements, as well as applicable DARS financial policies and procedures. The SILC financial reports and records are subject to audits and compliance reviews, and are reconciled on a monthly basis by the Administrator. The Administrator has the responsibility of obtaining departmental approvals of all resource plan expenditures in advance. Invoices are paid within 30 days of receipt.
The SILC Executive Committee and full Council monitor the resource plan and programmatic budgets through quarterly reports which are presented at the SILC meetings. Grants and contracts are made according to the SPIL and are monitored by both the SILC and the DSE. All Virginia SILC meetings are open to the public and the corresponding supporting documents are available for the public's review. Comments from the public about any budgetary or spending concerns are taken and considered.

Justification if more than 30% of the Part B appropriation is to be used for the SILC Resource Plan.
No more than 30% of Part B funds will be used for the SILC Resource fund.

5.3 Maintenance of SILC
How State will maintain SILC over the course of the SPIL:
Members of the Council are appointed by the Governor of Virginia. The SILC and the DSE recommend nominees to the Secretary of the Commonwealth for the Governor to consider for appointment as vacancies occur. These recommendations are based upon membership and composition requirements defined in Title VII of the Rehabilitation Act, as amended by WIOA. The CILs remain active in recruiting for the SILC as well, especially reaching out to new and former board members. Other recommendations for appointments to the Council may be made from independent sources.
Yearly board profiles are submitted to the Secretary of the Commonwealth and contain detailed updates about membership composition and other pertinent matters. Once the appointment is

confirmed, a new member receives a comprehensive policy and procedures manual and attends an orientation session prior to voting at the first meeting. Existing members serve as mentors to assist in further developing a new member's qualifications. The SILC Administrator also keeps in frequent contact with new members to ensure that they understand the material and to answer any pertinent questions. One Virginia SILC member is a CIL Director nominated by the Virginia Association of Centers for Independent Living, and three members serve as non-voting, state agency representatives, including the DSE.

The Chair, Vice Chair, Secretary, and Treasurer of the Council are elected by the membership for a one-year term with a limit of two terms, unless special circumstances are identified to allow more than two years. Special circumstances include, but are not limited to: inability for other members to serve, inability to identify candidates willing to serve, instances of emergency making a change in service disruptive or disadvantageous. Council members are appointed for a three-year term with the possibility of reappointment to a second three year term. No member may serve more than two consecutive terms. This process is outlined within the bylaws of the Virginia SILC.

The SILC Administrator is a state employee, and as such, all personnel rules and evaluation processes are conducted in accordance with the Commonwealth's law. The Administrator is not associated with the Independent Living Services within DARS. While the Deputy Commissioner of DARS is required to have sign-off authority on performance reviews and personnel issues of the Administrator position, the SILC Chairperson maintains oversight and supervision of the position, as it relates to Council activities, and completes their own evaluation which is an addendum to the DARS yearly performance evaluation.

Any administrative support position is also a state employee, and all personnel rules and evaluation processes apply. Oversight, maintenance and evaluations are conducted by the Administrator.

According to the SILC's Programmatic and Fiscal Policies and Procedures Manual, "The Executive Committee evaluates the performance of the Administrator and completes the evaluation form by the deadline set forth in the performance review cycle. The form is sent to the Administrator's supervisor as an addendum to overall performance evaluation. The Employee Work Profile (e.g., job description) is reviewed and updated yearly by the Administrator. The Administrator's immediate supervisor signs the profile and submits it to the Human Resources Unit of DARS." Additionally, the Administrator provides a written report of operational duties on a quarterly basis which is presented at each Executive Committee meeting. The Committee reviews and discusses the Administrator's job duties to ensure that daily operational functions of the SILC are carried out appropriately. Adjustments are made as needed, subject to full Council approval, and any final changes will be submitted to the Administrator's immediate supervisor

Section 6: Legal Basis and Certifications

6.1 Designated State Entity (DSE)

6.2 The state entity/agency designated to receive and distribute funding, as directed by the SPIL, under Title VII, Part B of the Act is the Virginia Department for Aging and Rehabilitative Services .

Authorized representative of the DSE Kathryn A. Hayfield

Title Commissioner .

6.3 Statewide Independent Living Council (SILC)

The Statewide Independent Living Council (SILC) that meets the requirements of section 705 of the Act and is authorized to perform the functions outlined in section 705(c) of the Act in the State is the __Virginia Statewide Independent Living Council .

6.4 Centers for Independent Living (CILs)

The Centers for Independent Living (CILs) eligible to sign the SPIL, a minimum of 51% whom must sign prior to submission, are:

Access Independence
Appalachian Independence Center
Blue Ridge Independent Living Center
Clinch Independent Living Services
disAbility Resource Center
Disability Rights and Resource Center
Eastern Shore Center for Independent Living
Endependence Center, Inc.
Endependence Center of Northern Virginia
Independence Empowerment Center
Independence Resource Center
Junction Center for Independent Living
Lynchburg Area Center for Independent Living
New River Valley Disability Resource Center
Peninsula Center for Independent Living
Resources for Independent Living, Inc.
Valley Associates for Independent Living

6.4 Authorizations

6.4.a. The SILC is authorized to submit the SPIL to the Independent Living Administration, Administration for Community Living. _YES_ (Yes/No)

6.4.b. The SILC and CILs may legally carryout each provision of the SPIL. _YES_ (Yes/No)

6.4.c. State/DSE operation and administration of the program is authorized by the SPIL. _YES_ (Yes/No)

Section 7: DSE Assurances

Kathryn A. Hayfield, Commissioner , acting on behalf of the DSE Virginia Department for Aging and Rehabilitative Services located at _8004 Franklin Farms Dr., Henrico, Virginia 23229; (804) 662-7010; kathryn.hayfield@dars.virginia.gov *45 CFR 1329.11* assures that:

7.1. The DSE acknowledges its role on behalf of the State, as the fiscal intermediary to receive, account for, and disburse funds received by the State to support Independent Living Services in the State based on the plan;

7.2. The DSE will assure that the agency keeps appropriate records, in accordance with federal and state law, and provides access to records by the federal funding agency upon request;

7.3. The DSE will not retain more than 5 percent of the funds received by the State for any fiscal year under Part B for administrative expenses;[1]

7.4. The DSE assures that the SILC is established as an autonomous entity within the State as required in *45 CFR 1329.14*;

7.5. The DSE will not interfere with the business or operations of the SILC that include but are not limited to:
1. Expenditure of federal funds
2. Meeting schedules and agendas
3. SILC board business
4. Voting actions of the SILC board
5. Personnel actions
6. Allowable travel
7. Trainings

7.6. The DSE will abide by SILC determination of whether the SILC wants to utilize DSE staff:
1. If the SILC informs the DSE that the SILC wants to utilize DSE staff, the DSE assures that management of such staff with regard to activities and functions performed for the SILC is the sole responsibility of the SILC in accordance with Sec. 705(e)(3) of the Act (Sec. 705(e)(3), 29 U.S.C.796d(e)(3)).

7.7. The DSE will fully cooperate with the SILC in the nomination and appointment process for the SILC in the State;

7.8. The DSE shall make timely and prompt payments to Part B funded SILCs and CILs:
1. When the reimbursement method is used, the DSE must make a payment within 30 calendar days after receipt of the billing, unless the agency or pass-through entity reasonably believes the request to be improper;
2. When necessary, the DSE will advance payments to Part B funded SILCs and CILs to cover its estimated disbursement needs for an initial period generally geared to the mutually agreed upon disbursing cycle; and
3. The DSE will accept requests for advance payments and reimbursements at least monthly when electronic fund transfers are not used, and as often as necessary when electronic fund transfers are used, in accordance with the provisions of the Electronic Fund Transfer Act (15 U.S.C. 1693-1693r).

The signature below indicates this entity/agency's agreement to: serve as the DSE and fulfill all the responsibilities in Sec. 704(c) of the Act; affirm the State will comply with the aforementioned assurances during the three-year period of this SPIL; and develop, with the SILC, and ensure that the SILC resource plan is necessary and sufficient (in compliance with

section 8, indicator (6) below) for the SILC to fulfill its statutory duties and authorities under Sec. 705(c) of the Act, consistent with the approved SPIL.[1]

Kathryn A. Hayfield, Commissioner; Virginia Department for Aging and Rehabilitative Services
Name and Title of DSE director/authorized representative

Kathryn Hayfield (signature sent as PDF)_____June 16, 2020_____
Signature Date

Electronic signature may be used for the purposes of submission, but hard copy of signature must be kept on file by the SILC.

Section 8: Statewide Independent Living Council (SILC) Assurances and Indicators of Minimum Compliance

8.1 Assurances
Shawn Utt, Chairperson, acting on behalf of the Virginia Statewide Independent Living Council located at 8004 Franklin Farms Dr., Henrico, Virginia 23229; telephone: (804)663-7817; email: sutt@pulaskitown.org *45 CFR 1329.14* assures that:

(1) The SILC regularly (not less than annually) provides the appointing authority recommendations for eligible appointments;
(2) The SILC is composed of the requisite members set forth in the Act;[1]
(3) The SILC terms of appointment adhere to the Act;[1]
(4) The SILC is not established as an entity within a State agency in accordance with 45 CFR Sec. 1329.14(b);
(5) The SILC will make the determination of whether it wants to utilize DSE staff to carry out the functions of the SILC;
    a. The SILC must inform the DSE if it chooses to utilize DSE staff;
    b. The SILC assumes management and responsibility of such staff with regard to activities and functions performed for the SILC in accordance with the Act.[1]
(6) The SILC shall ensure all program activities are accessible to people with disabilities;
(7) The State Plan shall provide assurances that the designated State entity, any other agency, office, or entity of the State will not interfere with operations of the SILC, except as provided by law and regulation and;
(8) The SILC actively consults with unserved and underserved populations in urban and rural areas that include, indigenous populations as appropriate for State Plan development as described in Sec. 713(b)(7) the Act regarding Authorized Uses of Funds.[1]

Section 8.2 Indicators of Minimum Compliance

Indicators of minimum compliance for Statewide Independent Living Councils (SILC) as required by the Rehabilitation Act (Section 706(b), 29 U.S.C. Sec 796d-1(b)), as amended and supported by 45 CFR 1329.14-1329.16; and Assurances for Designated State Entities (DSE) as permitted by Section 704(c)(4) of the Rehabilitation Act (29 U.S.C. Sec. 796c(c)(4)), as amended.

(a) STATEWIDE INDEPENDENT LIVING COUNCIL INDICATORS. –

(1) SILC written policies and procedures must include:
    a. A method for recruiting members, reviewing applications, and regularly providing recommendations for eligible appointments to the appointing authority;
    b. A method for identifying and resolving actual or potential disputes and conflicts of interest that are in compliance with State and federal law;
    c. A process to hold public meetings and meet regularly as prescribed in 45 CFR 1329.15(a)(3);
    d. A process and timelines for advance notice to the public of SILC meetings in compliance with State and federal law and 45 CFR 1329.15(a)(3);
    e. A process and timeline for advance notice to the public for SILC "Executive Session" meetings, that are closed to the public, that follow applicable federal and State laws;
        i. "Executive Session" meetings should be rare and only take place to discuss confidential SILC issues such as but not limited to staffing.
        ii. Agendas for "Executive Session" meetings must be made available to the public, although personal identifiable information regarding SILC staff shall not be included;
    f. A process and timelines for the public to request reasonable accommodations to participate during a public Council meeting;
    g. A method for developing, seeking and incorporating public input into, monitoring, reviewing and evaluating implementation of the State Plan as required in 45 CFR 1329.17; and
    h. A process to verify centers for independent living are eligible to sign the State Plan in compliance with 45 CFR 1329.17(d)(2)(iii).
(2) The SILC maintains regular communication with the appointing authority to ensure efficiency and timeliness of the appointment process.
(3) The SILC maintains individual training plans for members that adhere to the SILC Training and Technical Assistance Center's SILC training curriculum.
(4) The SILC receives public input into the development of the State Plan for Independent Living in accordance with 45 CFR 1329.17(f) ensuring:
    a. Adequate documentation of the State Plan development process, including but not limited to, a written process setting forth how input will be gathered from the

state's centers for independent living and individuals with disabilities throughout the state, and the process for how the information collected is considered.

b. All meetings regarding State Plan development and review are open to the public and provides advance notice of such meetings in accordance with existing State and federal laws and 45 CFR 1329.17(f)(2)(i)-(ii);

c. Meetings seeking public input regarding the State Plan provides advance notice of such meetings in accordance with existing State and federal laws, and 45 CFR 1329.17(f)(2)(i);

d. Public meeting locations, where public input is being taken, are accessible to all people with disabilities, including, but not limited to:

   i. proximity to public transportation**,**

   ii. physical accessibility, and

   iii. effective communication and accommodations that include auxiliary aids and services, necessary to make the meeting accessible to all people with disabilities.

e. Materials available electronically must be 508 compliant and, upon request, available in alternative and accessible format including other commonly spoken languages.

(5) The SILC monitors, reviews and evaluates the State Plan in accordance with 45 CFR 1329.15(a)(2) ensuring:

a. Timely identification of revisions needed due to any material change in State law, state organization, policy or agency operations that affect the administration of the State Plan approved by the Administration for Community Living.

(6) The SILC State Plan resource plan includes:

a. Sufficient funds received from:

   i. Title VII, Part B funds;

      1. If the resource plan includes Title VII, Part B funds, the State Plan provides justification of the percentage of Part B funds to be used if the percentage exceeds 30 percent of Title VII, Part B funds received by the State;

   ii. Funds for innovation and expansion activities under Sec. 101(a)(18) of the Act, 29 U.S.C. Sec. 721(a)(18), as applicable;

   iii. Other public and private sources.

b. The funds needed to support:

   i. Staff/personnel;

   ii. Operating expenses;

   iii. Council compensation and expenses;

   iv. Meeting expenses including meeting space, alternate formats, interpreters, and other accommodations;

v. Resources to attend and/or secure training and conferences for staff and council members and;
vi. Other costs as appropriate.

The signature below indicates the SILC's agreement to comply with the aforementioned assurances and indicators:

Shawn Utt
Name of SILC chairperson

Shawn Utt (Signature sent as PDF) June 15, 2020
Signature Date

Electronic signature may be used for the purposes of submission, but hard copy of signature must be kept on file by the SILC.

Section 9: Signatures

The signatures below are of the SILC chairperson and at least 51 percent of the directors of the centers for independent living listed in section 6.3. These signatures indicate that the Virginia Statewide Independent Living Council and the centers for independent living in the state agree with and intend to fully implement this SPIL's content. These signatures also indicate that this SPIL is complete and ready for submission to the Independent Living Administration, Administration for Community Living, U.S. Department of Health and Human Services.

The effective date of this SPIL is October 1, 2020 (year)

Shawn Utt (Signature sent as PDF) June 15, 2020
SIGNATURE OF SILC CHAIRPERSON DATE

Shawn Utt
NAME OF SILC CHAIRPERSON

Electronic signatures may be used for the purposes of submission, but hard copy of signature must be kept on file by the SILC.

CIL signatory pages sent to ACL as PDF; hard copy maintained on file with Administrator to Virginia SILC.

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[4].

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5].

According to data from the 2017 Report to Congress[6] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system.
2. improve emotional and behavioral outcomes for children and youth.
3. enhance family outcomes, such as decreased caregiver stress.
4. decrease suicidal ideation and gestures.
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and

employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[6] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? (●) Yes ( ) No

b) The resilience of children and youth with SED? (●) Yes ( ) No

c) The recovery of children and youth with SUD? (●) Yes ( ) No

d) The resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Health care? (●) Yes ( ) No

c) Juvenile justice? (●) Yes ( ) No

d) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems? (●) Yes ( ) No

d) Does the state have an established FEP program? (●) Yes ( ) No

Does the state have an established CHRP program? (●) Yes ( ) No

e) Is the state providing trauma informed care? (●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

Please see attached. 18. Children and Adolescents M/SUD Services

7. Does the state have any activities related to this section that you would like to highlight?

Please see attached. 18. Children and Adolescents M/SUD Services

Please indicate areas of technical assistance needed related to this section.

None at this time

Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

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According to data from the 2015 Report to Congress[68] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

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- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

See the attached narrative "Virginia 19 - Children and Adolescents' Behavioral Health Services

7. Does the state have any activities related to this section that you would like to highlight?

See the attached narrative "Virginia 19 - Children and Adolescents' Behavioral Health Services

Please indicate areas of technical assistance needed related to this section.

None at this time

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

18. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

6. Describe how the state provides integrated services through the system of care.

For thirty years Virginia has had the opportunity to participate in several initiatives to expand and implement Systems of Care (SOC) statewide. Some of the most successful of past initiatives are summarized below:

Children's Services Act (CSA)

- Landmark legislation, to create a collaborative system of services and funding that is child-centered, family-focused, community-based and cost-effective when addressing the strengths and needs of troubled and at risk youths and their families in the Commonwealth *(Code of Virginia § 2.2-5200).*
- A primary purpose of the law is to preserve and strengthen families through providing appropriate services in the least restrictive environment, enabling children to remain in their homes and communities when possible, while protecting the welfare of children and maintaining public safety.
- Funding streams placed in the CSA funds pool came from the Departments of Education (DOE), Department of Social Services (DSS), Department of Behavioral Health and Developmental Services (DBHDS), and the Department of Juvenile Justice (DJJ).
- The State Executive Council (SEC) is the Supervisory council that provides leadership for CSA *(Code of Virginia §2.2-2648).* It oversees the development and implementation of state interagency program and fiscal policies. The SEC is chaired by the Secretary of Health and Human Resources or a designated deputy.
- The State and Local Advisory Team (SLAT) is required by statute to advise the SEC by managing cooperative efforts at the state level and to provide support to community efforts. It is comprised of a parent, private provider association representative, representatives from six state agencies, juvenile and domestic relations judge, local CSA Coordinator and local CPMT representatives from community service boards, local departments of social services, court service units, health departments, and schools.
- Community Policy and Management Teams (CPMTs) have the statutory authority and accountability for developing interagency policies that govern CSA in the community. They

manage local CSA fund allocations and coordinate community wide planning to develop needed resources and services. They are comprised of a parent, local government official, agency heads from local child serving agencies (community services boards, courts service units, health, social services, and public schools) and private provider. Community agency representatives are authorized to make policy and funding decisions for their agencies. Localities must have a utilization management process and report minimum data on child demographics, services and funding.

- Family Assessment and Planning Teams (FAPTs) are established by CPMTs to provide for family participation, assess the strengths and needs of children and their families, and develop individual family services plans. They make recommendations to the CPMTs. They are comprised of a parent, representatives from local child serving agencies (community services boards, courts service units, social services, and public schools). They may include a local health department and private provider representatives.
- CSA Coordinators are hired by many communities to manage local implementation, including program, fiscal, and administrative responsibilities.

System of Care Grant

Virginia received a SOC Expansion and Sustainability Grant which focused on these key strategies:

1) Establishment of regional SOC Expansion Centers in each of the five DBHDS regions in the state to expand the SOC approach in additional local government jurisdictions through HFW.
2) Demonstration project with previous SOC grant communities to pilot Family Support Partner services outside of HFW.
3) Wraparound Center of Excellence continues to offer training and coaching support.
4) The Virginia Family Network and Youth MOVE Virginia will continue to engage and support families and youth through strategic planning, training, and support.
5) Establishment of a statewide SOC data driven strategic planning process.

7. Does the state have any activities related to this section that you would like to highlight?

Working with other State Agencies

The Office of Child and Family Services (OCFS) at DBHDS actively participates and collaborates with many state agencies. The following chart provides a sample of some of the partnerships:

Name of Entity	Meeting Frequency	Lead Agency	Purpose of DBHDS Participation
FAMIS Advisory Committee	Quarterly	DMAS	The purpose of the committee is to assess the policies, operations and outreach efforts for Family Access to Medical Insurance Security (FAMIS) and FAMIS Plus (children's Medicaid) and to evaluate enrollment, utilization of services, and health outcomes of children eligible for such programs. DBHDS is mandated by the Code of Virginia to have a member serve on CHIPAC.
Child Welfare Advisory Committee	Quarterly	DSS	The Advisory Committee will be the primary organization to advise the Director of the Division of Family Services on child welfare issues including policy and CFSR Plans of Improvement. The Advisory Committee should ensure that all child welfare activities are child centered, family focused, and community based. Child welfare programs include Adoption, Child Protective Services, Family Preservation, Foster Care, and Interstate Compact on the Placement of Children (ICPC).
Commission on Youth	Quarterly	Legislative Branch	Issues impacting children. Serve on COY study committees when needed.
Center for Evidence-Based Partnerships Governance Committee	Monthly	DBHDS/OCS /DMAS/DJJ/ DSS/VCU	Governance committee representing child-serving agencies and VCU in a partnership to advance EBP standards, quality, training and outcomes across shared children's initiatives such as Family First, Project BRAVO and STEP VA.

Outcomes for Children and Youth in Services

DBHDS adopted measurement-based care, using the standardized, Daily Living Activities- 20 (DLA-20), instrument to monitor treatment progress. The DLA-20 beginning in January 1, 2019 will be completed for each child age 6 and up and adult receiving a behavioral health service in a CSB. This includes mental health, substance use disorders, and co-occurring issues. On March 1, 2019, Community Services Boards fully implemented the DLA-20.

In addition, the Office of Child and Family Services (OCFS) annually reviews output data on all 40 CSB's related to outpatient, case management and medical services for youth under the age of 18. Trend data is analyzed and technical assistance is provided by OCFS to CSB's regarding changes in their service delivery. Under STEP-VA, DBHDS has required investments in children's outpatient and mobile crisis services.

The DBHDS Office of Management Services (OMS), formerly known as the Office of Support Services negotiates and administers performance contracts and monitors the accomplishment of contract objectives, performance and outcome measures, and compliance with contract assurances directly and in conjunction with other DBHDS offices. In addition, OMS facilitates the receipt of CSB data, consults on CSB administrative and management issues, interprets policies and procedures, fosters mutual understanding and cooperation between CSBs and DBHDS, and works with advocacy organizations and stakeholders.

Evidence Based Practice Training

- The Office of Child and Family Services at DBHDS offered Eye Movement Desensitization and Reprocessing (EMDR) training to Community Services Boards (CSBs) in 2022-2023. A total of 90 clinicians have been trained.

- The Center for Evidence Based Partnerships-Virginia (CEP-VA) is a collaborative effort between Virginia's child serving agencies and Virginia Commonwealth University. Through thoughtful use of evidence, CEP-VA provides scientific input to stakeholders on the performance of the behavioral health system and paths for enhancing workforce capacity. Alongside its partners, CEP-VA co-designs plans to move Virginia toward equitable, accessible, and evidence-informed behavioral health services. Currently, CEP-VA is providing training in several Family First Prevention and Services Act well supported EBPs including Multisystemic Therapy, Functional Family Therapy, Brief Strategic Family Therapy and Parent Child Interaction Therapy. In addition to providing training support, CEP-VA is providing technical assistance (TA) to Virginia's Family First Prevention and Services Act. This TA includes building fidelity and outcome measurement models, collecting these data, and building reports of these data for federal and other reporting requirements.

Virginia Mental Health Access Program (VMAP)

VMAP seeks to strengthen the ability of primary care providers (PCPs) to manage mild to moderate behavioral health needs of their pediatric patients, enabling child and adolescent psychiatrists to manage more serious and complex conditions.

The program has three pillars:

- Education opportunities for primary care providers on screening, diagnosis, management and treatment of pediatric mental health conditions including infant/early childhood mental health primarily through Resources for Advancing Children's Health (REACH), Project ECHO and Quality Improvement (QI) Screening Projects.
- Access via a consult line for primary care providers to regional hubs that offer mental health consultation and care navigation for patients 21 and under. Consult line is comprised of Child and Adolescent psychiatrists, Developmental Behavioral Psychiatrists, and/or licensed mental health providers.
- Care Navigation to help families and providers identify additional regional mental health resources that may benefit families.

VMAP is a collaborative effort funded by state general fund dollars appropriated to the Department of Behavioral Health and Developmental Services (DBHDS) and is managed in the Office of Child and Family Services. It is also funded through federal grant dollars from the Health Resources and Services Administration managed at the Virginia Department of Health and local efforts. In January 2020, the Medical Society of Virginia Foundation (MSVF) was awarded a contract through DBHDS to become the state program administrator for VMAP. As such, MSVF is tasked with coordinating efforts among VMAP partners to expand the program statewide.

Adolescent to Transition Age Substance Use Treatment

In Virginia, youth and young adults ages 16-25, often referred to as "transition-age," are underserved in the Commonwealth's behavioral health system. Those who are diagnosed with substance use disorders

and/or co-occurring substance use and mental health disorders are often trapped between an adolescent system that is inconsistent in the array of services provided and an adult system that does not always address the need for developmentally appropriate, evidence- based treatment and recovery supports. Furthermore, the lack of integrated services perpetuates the "silo" effect for both treatment providers and the youth and families who seek help. DBHDS is addressing these needs by bringing together stakeholders across the systems servicing the population of focus to strengthen the existing network to enhance and expand treatment services, develop policies, expand workforce capacity, disseminate evidence-based practices and implement financial reforms to improve the integration and efficiency of SUD treatment and the recovery support system.

By collaborating with other public and private providers and agencies that serve transition-age youth and their families, the Commonwealth of Virginia has the opportunity to make systemic changes to the service system in the treatment of substance use and/or co-occurring disorders among this underserved age group. Implementation of this initiative enables the Commonwealth to build upon the efforts of Coordinated Specialty Care, an evidence-based practice for the treatment of emerging serious mental illness for transition-age youth and young adults currently being rolled out in Virginia while assuring youth and young adults have access to evidence-based assessments, treatment models and recovery services supported by strengthening the existing infrastructure system. DBHDS is implementing this project in four geographically diverse regions of Virginia. Providers were selected from among the 40 Community Services Boards located throughout the Commonwealth and DBHDS is working with them to implement services and activities for the population of focus that are evidence-based and client-focused.

Virginia Youth SBIRT (VA-YSBIRT) Project

In the Fall of 2021, DBHDS launched the SAMHSA-funded Virginia Youth SBIRT (VA-YSBIRT) Project which is based on the screening, brief intervention, and referral to treatment (SBIRT) protocol. Designed to expand/enhance the continuum of care for substance use disorder (SUD) services and reduce alcohol and other drug (AOD) consumption and its negative health impact, VA-YSBIRT provides a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Risk stratification is followed by an abbreviated version Motivational Interviewing – the Brief Negotiated Interview (BNI) and an Active Referral to Treatment (ART) if needed. BNI is a specialized brief intervention with a focus to generate behavior change plans in a brief amount of time. ART involves finding the appropriate and affordable resources and services and ensuring a warm hand-off.

Adolescent Community Reinforcement Approach (A-CRA)

To sustain the work established under the Youth Substance Abuse and Treatment Grant (YSAT) and continue the implementation and sustainability of Adolescent Community Re-enforcement Approach (A-CRA) evidence-based practice**,** DBHDS supports the needs of the community with training toward A-CRA certification as needed. A-CRA addresses the treatment needs of substance using adolescents and young adults between the ages of 16 and 25. A-CRA clinicians provide Substance Use and Mental Health case management services to clients who are receiving A-CRA. This includes linking clients to educational, employment, and community prosocial opportunities. These staff also provide input on clients that are having difficulty obtaining additional treatment services and assist family members with similar needs. A recent addition to the Commonwealth's A-CRA sustainability plan is the A-CRA Peer Recovery Specialist who provides one-on-one peer support, navigation to services, facilitation of support groups, and connecting youth and young adults to recovery support services in the community.

Department of Social Services, Services for Older Youth

Fostering Futures is a foster care program offered by the Virginia Department of Social Services available to teens and young adults in foster care after they turn 18. This voluntary program allows local departments of social services (LDSS) to provide financial and social support and services until youth and young adults up to 21 years of age. It can cover things like

- housing (with foster parents, room and board at school, or supervised independent living when you are ready),
- education and/or job training assistance, and
- other independent living needs.

Great Expectations is also available to youth and young adults in foster care. It is a nationally recognized program that helps Virginia's foster youth earn the postsecondary credentials they need to achieve an independent and successful life. Great Expectations is currently available at 21 of Virginia's Community Colleges.

Great Expectations was created in 2008 as a partnership between Virginia's Community Colleges and philanthropists supporting the Virginia Foundation for Community College Education. The program launched at five Virginia Community Colleges, each of which received a grant to pilot components of the program. Since then, the program has expanded to 18 community colleges across the Commonwealth.

Great Expectations helps Virginia's foster youth complete high school, gain access to a community college education and transition successfully from the foster care system to living independently.

Key components include:

- Individualized tutoring
- Help applying for college admission and financial aid
- Career exploration and coaching
- Help applying for and keeping a job
- Life skills training, including managing finances
- Personalized counseling
- Student mentors

Family First Prevention and Services Act

Virginia used a Three Branch approach for Family First Prevention and Services Act implementation. This approach brought together multiple stakeholders from child serving agencies as well as legislative members. At present, the Virginia Department of Social Services, by providing training to qualified providers, is expanding the evidence-based service (EBS) array in the Commonwealth in order to meet the needs of Virginia's families.

School-based Mental Health

DBHDS has used federal funding through the Consolidated Appropriations Act and the American Rescue Plan Act to address the mental health needs resulting from the COVID-19 pandemic. These funds have specifically been used to support mental health needs of students at risk of/or with Serious Emotional Disturbance as a priority. The agency has issued grants to our Community Services Boards

(CSBs) and non-profit providers to contract with schools to support mental health services. Currently, there are 10 CSBs receiving American Rescue Plan Act Funding and 5 Receiving Consolidated Appropriations Act Funding. With this funding, CSBs and nonprofits have been able to provide a range of services in schools. Examples include providing mental health staff within schools to conduct screenings and assessments, delivering trauma informed and culturally responsive services, develop plans for family outreach and engagement for school based mental health services and provide training to staff and personnel on how to make referrals for additional services when needed.

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

See 19. Suicide Prevention

3. Have you incorporated any strategies supportive of Zero Suicide? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ( ) Yes (●) No

If yes, please describe how barriers are eliminated.

DBHDS does not have any initiatives currently that are specific to suicidal patients. DBHDS does have specific protocols for CSBs and hospitals to follow when discharging patients who have been on suicide precautions while in a state hospital (specifically the development of a safety and support plan that is shared with providers).

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

See 19. Suicide Prevention

Please indicate areas of technical assistance needed related to this section.

None at this time

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Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

Have you begun any targeted or statewide initiatives since the FFY 2022-FFY 2023 plan was submitted?

If so, please describe the population targeted.

See attached 19. Suicide Prevention

Please indicate areas of technical assistance needed related to this section.

None at this time

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19- Suicide Prevention

Describe activities intended to reduce incidents of suicide in your state.

DBHDS Office of Behavioral Health Wellness coordinates state Suicide Prevention efforts across the lifespan, which is codified in state code. Our efforts are focused on the following strategies:

- Fund and sustain a fulltime Suicide Prevention Coordinator through state general funds.

- Facilitate a statewide interagency group (SPIAG) to plan and address suicide across the lifespan and the Commonwealth. SPIAG is comprised of key stakeholder groups, both public and private, such as universities, state agencies, the military, non-profits, etc. This group meets quarterly and is responsible for our “Suicide Prevention across the Lifespan Plan for the Commonwealth”, as well as our annual report to the General Assembly that identifies goals and strategies and documents their progress.

- Build and support a regional suicide prevention infrastructure at the community level that covers the entire geographic areas of the state. The state has 6 Regional Suicide Prevention Initiative Coalitions that have developed plans utilizing the Strategic Prevention Framework (SPF) planning model. These coalitions report quarterly on their efforts.

- Build workforce capacity to address suicide by providing trainings in ASIST- Applied Suicide Intervention Skills Training and safeTALK. We also provide training materials and other

resources for distribution.

- Implementation of “Lock and Talk Virginia” a lethal means safety strategy to prevent access to not only firearms, but also prescription drugs and over the counter drugs which may be diverted and used for suicide attempts.

Have you begun any targeted or statewide initiatives since the FFY 2022-FFY 2023 plan was submitted?

If so, please describe the population targeted.

Each region has used local data and local partnerships to implement strategies geared to meet the needs of their communities. There have been many efforts to use social media to provide resources and access to services. We also offer virtual education sessions and training opportunities. Additionally, we participate in the Governor’s Challenge to Prevention Suicide among Service Members, Veterans, and their Families.

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

If yes, with whom?

See attached. 20. Support of State Partners

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

A state planning workgroup was formed to drive the development of the statewide Marcus Alert plan, with a number of stakeholder groups required to be involved per the Act. The full workgroup met 12 times between January, 2021 and May, 2021. Initial meetings focused on exposure to general systems information and the adoption of a systems perspective. It was acknowledged early in the workgroup that the task of the workgroup is not one where a “roadmap” already exists. Other states have had separate initiatives to build out the crisis services continuum and/or to define and implement law enforcement reforms;

therefore, we did not have an example of when these have been done in tandem from a planning or implementation perspective. Yet, the workgroup agreed that the joint goals of the workgroup also provided a unique opportunity for Virginia to implement a crisis response system in an equitable manner.

The vision for Virginia's crisis system with the implementation of MARCUS Alert is to keep Virginians well and thriving in their communities, meet people's needs in environments where they already seek support, provide care in the least restrictive environment, and optimize taxpayer dollars by investing in crisis prevention and crisis early intervention of mental health problems and crises.

Additionally, in collaboration with DMAS, CSA, DSS, and DJJ, DBHDS established the Center for Evidence Based Practices with Virginia Commonwealth University, which aims to serve as single statewide resource for developing the behavioral health workforce in supporting the use and accessibility for evidence based practices in the provision of services within Project BRAVO, STEP-VA, and the Family First Prevention Services Act.

Project Behavioral health Redesign for Access, Value, and Outcomes (BRAVO) The Chief Clinical Officer is the DBHDS lead for interagency collaboration with DMAS, for the Project BRAVO, to develop an evidence-based, trauma-informed, cost-effective, comprehensive continuum of behavioral health services for the Commonwealth. • Throughout FY 2021, stakeholder engagement and workgroups proceeded to begin implementation of six critical services starting July 1, 2021: Program of Assertive Community Treatment (PACT), Multisystemic Therapy (MST), Functional Family Therapy (FFT), Partial Hospitalization Programs (PHP), Intensive Outpatient Programs (IOP), Residential Crisis Stabilization Units, 23-hour Crisis Observation, Mobile Crisis, and Community Based Crisis Stabilization. • Collaborated with DMAS, MCOs, DHP and various DBHDS Offices to conduct provider and stakeholder trainings on new services related to licensing and program development. • In collaboration with DMAS, established the Project BRAVO Racial Equity Workgroup to prioritize the need for addressing disparities in access, quality, and cultural and racial competencies in the implementation of Project BRAVO. • In collaboration with DMAS, CSA, DSS, and DJJ, established the Center for Evidence Based Practices with Virginia Commonwealth University, which aims to serve as single statewide resource for developing the behavioral health workforce in supporting the use and accessibility for evidence based practices in the provision of services within Project BRAVO, STEP-VA, and the Family First Prevention Services Act.

Please indicate areas of technical assistance needed related to this section.

None at this time

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Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

2. Has your state identified the need to develop new partnerships that you did not have in place?

If yes, with whom?

Please Section 20. Support of State Partners

Please indicate areas of technical assistance needed related to this section.

None at this time

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Environmental Factors and Plan

20. Support of State Partners -Required for MHBG

Has your state identified the need to develop new partnerships that you did not have in place? If yes, with whom?

Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

DBHDS has in place a number of strategic partnerships with other governmental entities that will assist Virginia in successfully implementing both treatment and prevention initiatives detailed in its Behavioral Health Assessment and Plan. These are the current state partnerships and new updates regarding their developments.

TREATMENT PARTNERSHIPS

- **Department of Medical Assistance Services (DMAS)** –DBHDS continues to partner with the Department of Medical Assistance Services (DMAS) to prepare in relation to the Addiction, Recovery and Treatment Services ("ARTS") initiative that began implementation April 1, 2017 (with CPRS coverage initiating July 1, 2017). This initiative remains an impactful collaboration with positive results throughout the system of care.
- **Department of Aging and Rehabilitative Services (DARS)** – DBHDS contracts with DARS for delivery of vocational services to local CSB service recipients. In addition, DBHDS collaborates with the Division for the Aging within DARS on behavioral health policy and services for older adults.
  Virginia Department of Health (VDH) – DBHDS collaborates with VDH in suicide prevention, surveillance of drug-related death, suicide, and early childhood home visiting services, and DBHDS' opioid overdose prevention program, REVIVE!, and Naloxone Saturation. DBHDS remains a collaborator with VDH in relationship to initiatives related to the ongoing opioid epidemic. DBHDS also collaborating with the Virginia Association of Chiefs of Police in training First Responders to include Emergency Medical Technicians(EMS) and volunteer rescue squads to use naloxone to reverse opioid overdose. DBHDS has been a key player with VDH in providing leadership to the Governor's Executive Leadership Team on Addiction. In July 2022, the General Assembly has granted VDH permission to establish Comprehensive Harm Reduction (CHR) sites in any jurisdiction in Virginia. CHR includes the distribution of sterile and disposal of used hypodermic needles and syringes, education, referral to drug treatment, testing, and an

array of other health services. VDH continues to make naloxone available through all local health departments, and DBHDS will be providing funding (from SOR Opioid funds) to support this project.

- **Department of Veterans Services (DVS)** – DBHDS is a partner with DVS on delivering services and supports to service members, veterans and their families through the Virginia Veteran and Family Support. Areas of collaboration include delivery of behavioral health services across the 40 CSBs via a regional structure, state- and program-level input into services and supports for service members, veterans and their families, and suicide prevention.
- **Department of Social Services (DSS)** – DBHDS collaborates with DSS to coordinate services for substance exposed and/or substance affected children and their caregivers. This now includes collaborating on the families' first initiative.
- **Department of Criminal Justice Services (DCJS**) – DBHDS and DCJS have worked closely to develop curriculum to train local law enforcement officers to administer naloxone to overdose victims. DCJS and DBHDS continue to partner in relationship to the CARA grant funds related to (1) improving treatment services for justice involved individuals and (2) naloxone and overdose reversal and prevention among local law enforcement.
- **Department of Corrections (DOC)** – DBHDS frequently provides training to DOC Probation and Parole Officers about working with individuals with SUD.
- **Virginia Commission on Alcohol Safety Action Programs (VASAP)** - a legislative agency, VASAP has oversight over 24 local alcohol safety action programs that provide an alternative to conviction for individuals who are arrested while driving under the influence. By Code of Virginia, the SSA is a member of the Commission and provides input on policy related to clinical treatment for offenders who elect to participate in ASAP.

Planning Partners

Virginia is well positioned with partnerships in place to address the goal areas described in this Block Grant Plan. Key agency partners have participated in developing Plan goals in critical areas, including:

- **Child and Adolescent Services** – Agency stakeholders such as DMAS, OCS, DJJ, DOE, and DSS provided stakeholder input into the priorities for system development. See the section "Child and Adolescent Services Partnerships" below for more detailed information.

  Substance Abuse Treatment Services –DOC, DJJ, DCJS, VDH, DHP, DSS, DMAS, DARS and the State Supreme Court have been involved in developing Plan goals for this area. In addition, providers, both public and private, as well as consumer advocacy organizations participated in the development of Plan goals. DJJ, DCJS, and State Supreme Court of Virginia continue to coordinate services through the work of the State Drug Treatment Court Advisory Committee. All other noted agencies are coordinating services to address MOUD and AUD, overdose rates, increase harm reduction efforts, and address trending increase in use of stimulants through the work of a Weekly Overdose stakeholder call.

- **Housing** – DBHDS is a member of several interagency planning bodies including the Governor's Coordinating Council on Homelessness, the Housing and Supportive Services Interagency Leadership Team, the Permanent Supportive Housing Steering Committee and the SMI Housing Strategy Stakeholder group. Together, these entities work to implement

strategies to improve access to housing and services for vulnerable populations.

- **Employment** – The VA SELN Advisory Group was established to assist DBHDS to develop its strategic employment plan, to set the targets for the number of individuals who will be employed, and to provide ongoing assistance to implement the plan and the Employment First Policy. The SELN Advisory Group was renamed the Employment First Advisory Group. Its members are appointed for two-year terms. The E1AG has twenty-six members. It includes self-advocates, family members, advocacy organization representatives, CSB staff, employment providers, and representatives of the following state agencies: DBHDS, DMAS, DARS, and VDOE. This Advisory Group has several sub-committees: membership, training and education, best practice, data, and interagency collaboration. The membership of the group was expanded in January 2019 to include persons who represent the needs of all individuals served by DBHDS including those with serious mental illness and/or substance use disorders.
-
- **Criminal Justice** – DBHDS collaborates with DCJS DJJ, and DOC planning relating to the needs of individuals with behavioral health problems who are re-entering their communities post-incarceration. As a result of past close collaboration with DCJS, DBHDS continues to support implementation of, Crisis Intervention Teams (CIT), Cross-Systems Mapping and other strategies used to identify individuals diagnosed with serious mental illnesses (SMI) and co-occurring disorders (early identification). This approach, diverts individuals from the criminal justice system (or penetrating more deeply, if identified after arrest/incarceration), and connects individuals to meaningful services and treatment (as early as possible, but often during initial court appearance, during incarceration, or upon release from jail). Similarly, DBHDS works closely with DJJ to address the needs of court-involved youth with behavioral health problems. DBHDS is a sitting member of the State Drug Treatment Court Advisory Committee, part of the State Supreme Court, which reviews and approves the operation of new and existing drug treatment courts.

Existing Cross-Agency Partnerships

Virginia has in place several structures external to DBHDS that foster cross-agency collaboration, policy-making, management and service delivery. Examples include:

The State Executive Council (SEC) – This is the policy-making authority for services to children and youth provided under the Comprehensive Services Act. The SEC includes members from the Departments of Education, Social Services, Behavioral Health and Developmental Services, Health, Juvenile Justice, the Supreme Court of Virginia, the Governor's Office, and the General Assembly.

- **Governor's Housing Policy Advisory Committee** – This is a cross-agency gubernatorial effort to expand affordable and accessible housing for all Virginians, including persons with disabilities (see above). The Transformation effort is led by the DBHDS CJ/MH Transformation Director.

- **Substance Abuse Services Council** – This 29-member council is established in the *Code* of Virginia (§2.2-2696) to provide policy advice to the Governor, the General Assembly, and the State Board of DBHDS. It includes representatives from state agencies including DBHDS, Health, Corrections, Juvenile Justice, Criminal Justice Services, Motor Vehicles, Alcohol Safety Action Program, Medical Assistance Services, Social Services, Alcoholic Beverage Control, and the VA Foundation for Healthy Youth. Also included are representatives from the Virginia Association of Community Services Boards (VACSB), drug court association, the sheriffs' association, substance abuse provider organizations, consumer advocacy organizations, and the Virginia General Assembly (four members from the House of Delegates, two from the Senate.)
- **Virginia Drug Treatment Court Advisory Committee** – The Virginia General Assembly established special docket drug treatment courts under the Drug Treatment Court Act(§18.2-254.1). The goals of drug treatment courts in Virginia include: reducing drug addiction and drug dependency among offenders, reduce the incidence of drug use, drug addiction, family separation due to parental substance abuse, and drug related crimes. As cited by the Drug Treatment Court Act, the state drug court advisory committee is established to evaluate and recommend standards for the planning and implementation of drug treatment courts; assist in the evaluation of their effectiveness and efficiency; and encourage and enhance cooperation among agencies that participate in their planning and implementation. The committee membership includes executive branch agencies (DBHDS, DCJS, DJJ, DOC, & DSS), and local community-based probation and pretrial services agencies, legal and law enforcement entities, and representatives from the Virginia Drug Court Association. Membership includes executive branch agencies (DBHDS, DCJS, DJJ, DOC, & DSS), and local community-based probation and pretrial services agencies, legal and law enforcement entities, and representatives from the Virginia Drug Court Association.
- **Behavioral Health System Reform** -- In addition, DBHDS is collaborating with ILPPP, the court system, and other community stakeholders to review its Mandatory Outpatient Treatment law (known as Assisted Outpatient Treatment in other states). The goal is to strengthen the various partnerships required to run successful programs, develop recommendations to modernize the program to better meet the needs of Virginians and their communities as they have been impacted by the mental health crisis, and the addiction epidemic. Recommendations are anticipated to align with other states and SAMHSA, standardize and strengthen the program and processes across the Commonwealth, in order to prevent/reduce unnecessary and

costly hospitalization, and to serve individuals in the community whenever possible.

CHILDREN'S SERVICES PARTNERSHIPS

Virginia relies heavily on strategic partnerships with other child serving agencies. A System of Care Expansion Team was developed to advise the System of Care Planning Grant, and this planning team continued with the System of Care Expansion Grant.

DBHDS partners with a number of other interagency workgroups which help to support Virginia's priorities. For almost thirty years Virginia has had the opportunity to participate in several initiatives to expand and implement Systems of Care (SOC) statewide.

Virginia has in place several structures external to DBHDS that foster cross-agency collaboration, policy-making, management and service delivery. Examples include:

- **The State Executive Council (SEC)** – This is the policy-making authority for services to children and youth provided under the Comprehensive Services Act. The SEC includes members from the Departments of Education, Social Services, Behavioral Health and Developmental Services, Health, Juvenile Justice, the Supreme Court of Virginia, the Governor's Office, and the General Assembly.
- **State Child Fatality Review Team** - A multi-disciplinary team which is defined in statute and includes physicians and representatives from state and local agencies who provide services to families and children or who may be involved in the investigation of child deaths. Through the death review process, the Team identifies gaps in laws, policies, and a program

designed to keep children safe and healthy; and develops recommendations to address these gaps, to prevent similar deaths in the future, and to improve child death investigations in the state.

- **Child Welfare Advisory Committee** - An Advisory Committee that serves as the primary organization to advise the Director of the Division of Family Services on child welfare issues. This Committee ensures that all child welfare activities are child centered, family focused, and community based. Child welfare programs include Adoption, Child Protective Services, Family Preservation, Foster Care, and Interstate Compact on the Placement of Children (ICPC).

DBHDS is the lead agency for Virginia's Part C of IDEA- Early Intervention program. DBHDS has been the lead agency since Virginia began participating in Early Intervention. The DBHDS contracts with forty (40) local lead agencies to provide services to infants, toddlers, and their families. In Virginia, children from birth to age three are eligible for Part C Early Intervention services if:

- They are functioning 25% or more below their chronological age or adjusted age in one or more areas of development (i.e., having a 25% or greater delay in cognitive, physical, communication, social, emotional, or adaptive development); and/or
- They show atypical development (e.g., behavioral disorders, affective disorders, abnormal sensory-motor responses); and/or
- They have a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

Virginia has adopted evidenced-based practices for the provision of services. These include providing services in natural environments and using coaching techniques to fully engage the family. Over 20,000 infants and toddlers were served in the Part C – Early Intervention program in State Fiscal Year 2020. The Virginia Department of Education oversees all programs under Individuals with Disabilities Education Act (IDEA) Part B.

PREVENTION PARTNERSHIPS

DBHDS prevention services are housed in the Office of Behavioral Health Wellness (OBHW), which provides direction and guidance for substance abuse prevention, suicide prevention and mental health promotion. DBHDS OBHW has garnered many partnerships in the planning and implementation of many initiatives to include:

- **Virginia Office on Substance Abuse Prevention (VOSAP) Collaborative** which is comprised of multiple state systems and numerous professional organizations to ensure prevention services address issues related to education, health, child development, law enforcement, juvenile justice, substance abuse including alcohol, tobacco and other drugs, veterans, fire safety, and others.

- **Virginia Suicide Prevention and Mental Health Promotion Steering Committee**- state level suicide prevention planning to include Mental Health First Aid
- **Virginia Association of Community Services Boards (VACSB) Prevention Council**- SABG provider network
- **Virginia Foundation for Healthy Youth** -merchant education and workforce development training
- **Virginia Alcoholic Beverage Control Board**- Synar Inspection and Compliance Checks
- **Virginia State Epidemiological Workgroup (SEOW)** leads the Social Indicator Study (SIS) efforts that result in state and county/city epidemiological profiles based on risk indicators for substance abuse and mental illness is comprised of epidemiologic staff from any state agency that collects behavioral health related data.
- **Community Coalitions of Virginia (CCOVA)**- a key partner in building Virginia's community coalition network that addresses substance us disorder prevention

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SUPTRS BG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[1]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc.)

The Council is provided with drafts of the application and reporting and holds a meeting on August 16 2023 to discuss both a provide needs/concerns and recommendations for the block grants and state behavioral health plan and initiatives. Those are then included in a letter to the DBHDS Commissioner and is attached to this application. The Commissioner will then draft a response to provide input on the feedback provided by the Council.

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?

DBHDS has provided individuals from the Office of Community Behavioral Health Services, Office of Child and Family Services, Office of Recovery Services, and Office of Veteran's Services to staff the Council. Previously, the director of substance use prevention also staffed the Council but that office no longer has representation which could be an option to reconsider. Individuals with lived experience in a variety of backgrounds participate in the Council as members as many also represent organizations that do community work in mental health, substance misuse, and recovery.

Currently, the Council is undergoing strategic planning development and has also contracted with the Center for Human Potential for SAMHSA technical assistance. The technical assistance will be focused on best practices, what other states are doing effectively, onboarding, and improving structure and roles of the Council's membership.

In response to SAMHSA's expectations that states integrate their Mental Health Planning Councils to include substance abuse and addiction recovery perspectives, DBHDS began discussing the integration of Virginia's Mental Health Planning Council in the summer of 2011. The Council embraced the idea, and December 2011, voted to change its name from the Virginia Mental Health Planning Council to the Virginia Behavioral Health Advisory Council (BHAC). The Council subsequently voted to modify its bylaws to add seats specifically for individuals who have lived experience with substance use disorders or with co-occurring mental health and substance use disorders, their family members, substance abuse/addiction recovery advocates, and providers of substance abuse treatment services. Seats also were added for state agencies that had particular relevance for addiction services that were not represented on the Council, including the Virginia Department of Health and the Department of Criminal Justice Services.

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

4. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ( ) Yes (●) No

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery,

families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Vision: Effective, efficient, and accessible behavioral health services for all Virginians.

Mission: To transform Virginia's behavioral health system to reflect the highest quality of health, recovery, and wellness across the lifespan.

Per its bylaws, the Council serves as an advisory and information-sharing body which meets six times each year. In that role, the Council is responsible for reviewing and providing input to Virginia's annual behavioral health plan. As the combined Single State Agency and State Mental Health Authority, DBHDS retains responsibility for planning, allocating and managing the Mental Health and Substance Abuse Prevention and Treatment block grants. As an advisory and information-sharing body, the Council's role currently is to provide input on those components from a peer-led and multidisciplinary perspective as well as to advocate regarding behavioral health issues across the Commonwealth.

BHAC held another virtual retreat in 2022 and developed some Strengths, Opportunities, Aspirations, and Results
The aspirations developed by the Council were:

-Staff in mental health system have adequate pay and benefits
-Tangible coordination and collaboration with the governors and commissioner's offices; more visible presence, conversation, letters, correspondence, inviting BHAC to be engaged and be invested in the work of the council, BHAC at the table in significant ways
-Written and visible representation for state level offices to ensure that parties are a part of discussion, decision, processes, etc., to include the secretaries office
-Increase awareness/visibility of the council itself
-BHAC will be recognized and referenced for contributions (particularly stakeholders perspectives) to advances in legislation, services, etc.
-Peers with mental illness in the forefront and leadership positions, visible and out front in advocacy, administration and all aspects of the work
-Utilize recovery oriented language in all we do, ex. No longer using "consumer" but "individual"; "peer" refers to a "peer supporter"; "substance use challenges" and "mental health challenges," "trauma challenges," "a person who experiences reality differently than you," i.e. first person language.
-Data must always be available- reliable accessible, evaluated, reevaluated, etc.

The desired results developed by the Council were:
-Increase in membership
-Attitude of membership toward council
mission and vision statement that is sustainable, that we live by
-All committees have chairs and report at the council meetings with regularity
-Increased engagement with Governors, commissioners, and secretaries offices, (speed dial if you will)
-Numbers of trainings that members share with other council members
-Information readily shared for all council members to have ready access to events, activities, board portal, etc.; add those items to places that all council members would have access to it, like on a meeting agenda
-A more welcoming and responsive mental health service delivery system, per feedback from individuals receiving services; more direct input into care, what barriers are experienced, successes experienced, etc.
-Surveys to individuals in the community (CSB's) and that date being shared back to BHAC
-Youth centered requests for information from the council to provide resources
-Data must always be available- reliable accessible, evaluated, reevaluated, etc.

Because BHAC membership consists of a broad array of perspectives and also logistically only meets six times per year, it remains crucial to have achievable goals and identify objectives that are achievable and provide success upon which the Council can build. BHAC identified 2023 as a year for internal developmental following the 2022 strategic planning retreat and the initiation of SAMHSA technical assistance.

The technical assistance planning started in spring of 2023 and the first informational session will occur in August 2023. The technical assistance plan includes the following:

Receiving information regarding current best practices for planning councils in reviewing and providing impactful advisory input for the mental health and substance use block grants

· Hearing what other states are doing with their planning councils and their different roles and strategies for achieving their goals and objectives

· Determining what roles the state behavioral health agency and other state agency representatives should have on the council and how those roles differ from peers with lived experience

· Balancing the mandated role with reviewing the block grants with the desired role of also advocating on broader behavioral health issues within the state

· Establishing a more consistent yearly framework for meetings and structure to achieve block grant goals, advocating for legislative improvements to behavioral health, and providing input on the state behavioral health plan.

Historically, prior to 2023 which is a year for internal development, BHAC has developed and engaged committees to strategically do some of the work towards goals and objectives in between full council meetings. Those committees are:

1. Executive. This committee is responsible for coordinating the operations of the Council.
2. Bylaws and Policy. This committee continuously reviews the Bylaws and policy manual with regard to the structure and functioning of the organization.
3. Membership and Training. This committee continuously reviews the membership for compliance with federal law, evaluating council need for further diverse representation and perspectives as well as inclusive policies and practices; seeks and recruits potential members, including managing the Membership Application Process;
Nominations. This committee proposes a slate of officers for election and conduct the election with who meet the qualifications as stated in the policies and procedures manual.
5. Adult and Elder Services. This committee reviews adult and elder services, recommends modifications to existing services, and collaborates in the development of additional or new service models, while promoting best practices. It advocates for the rights and needs of adults with mental health and substance abuse issues while obtaining input from consumers, their families and advocacy organizations.
6. Child and Youth Services. This committee reviews child and youth services, recommends modifications to existing services, and collaborates in the development of additional or new service models, while promoting best practices. It advocates for the rights and needs of children and youth with mental health and substance abuse issues while obtaining input from consumers, their families and advocacy organizations.
7. Block Grant Committee. This committee continuously monitors, evaluates and reviews the Federal Block Grant to keep the Council informed and on track to meet federal mandates and provide thoughtful and impactful input regarding block grant policies and practices

The Council's membership has diversity and includes/has included racial and ethnic minority group members, LGBTQIA members, and representation from urban and rural areas of the state though this is always a need in terms of recruiting individuals with different lived experience and backgrounds. Because many members are in recovery or have multiple professional and personal roles, consistent membership and engagement has always been a challenge for BHAC. BHAC has committed in terms of strategic planning to improve onboarding and to learn some best practices in recruitment and retaining key members. The goal is for the Council to have streamlined achievable goals and objectives as well as structure so that when new members are on-boarded, they have an understanding of what the Council is doing and what their role is.

Please indicate areas of technical assistance needed related to this section.

BHAC is currently undergoing technical assistance after requesting it from SAMHSA.

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Footnotes:

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Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.
State Medicaid Agency

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Patrice Beard	Parents of children with SED			
Donna Bonessi	State Employees			
Eli Bouldin-Clopton	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Kathryn Clark	Persons in recovery from or providing treatment for or advocating for SUD services			
Karlyn Clevert-Smith	Providers			
Cristy Corbin	Parents of children with SED			
Bruce Cruser	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Caitlin DiBenedetto	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Ashlee Fallin	Providers			
Shatada Floyd-White	Providers			
Katharine Hunter	State Employees			
Livia Jansen	State Employees			
Carmen Lehigh	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Mary McQuown	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Sandra Nichols	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			

Heather Orrock	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Mary Ottinot	Parents of children with SED			
Nicholas Pappas	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Patricia Parham	State Employees	Virginia Department of Corrections		
Heather Pate	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Hilary Piland	State Employees	VACSB		
Nathanael Rudney	State Employees			
Dreamel Spadey	Providers			
Kristinne Stone	State Employees			
Justin Wallace	State Employees			

*Council members should be listed only once by type of membership and Agency/organization represented.

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Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	8	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	1	
Parents of children with SED	3	
Vacancies (individual & family members)	12	
Others (Advocates who are not State employees or providers)	0	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**24**	**60.00%**
State Employees	8	
Providers	4	
Vacancies	4	
Total State Employees & Providers	**16**	**40.00%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	4	
Individuals/Family Members from LGBTQI+ Populations	1	
Persons in recovery from or providing treatment for or advocating for SUD services	1	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	0	
Total Membership (Should count all members of the council)	**40**	

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Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? (●) Yes ( ) No

b) Posting of the plan on the web for public comment? ( ) Yes ( ) No

If yes, provide URL:

https://dbhds.virginia.gov/behavioral-health/mental-health-services/
https://commonwealthcalendar.virginia.gov/Event/Details/63710

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

https://dbhds.virginia.gov/behavioral-health/mental-health-services/
https://commonwealthcalendar.virginia.gov/Event/Details/58332

c) Other (e.g. public service announcements, print media) (●) Yes ( ) No

Please indicate areas of technical assistance needed related to this section.

None at this time

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Footnotes:

Environmental Factors and Plan

23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and

HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

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Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
No Data Available					

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