



## PUBLIC NOTICE

**Richmond Behavioral Health Authority's** FY 2022 and FY 2023 Community Services Performance Contract and Exhibits are below and can be found on the RBHA website at [www.rbha.org](http://www.rbha.org). At the top of the home page, view the About Us header and click RBHA Board Information. The RBHA Board of Directors approved the Performance Contract at their meeting on July 6, 2021.

Questions or comments from the public can be emailed to the Executive Assistant, Meleese Evans, at [evansm@rbha.org](mailto:evansm@rbha.org).

## FY 2022 AND FY 2023 COMMUNITY SERVICES PERFORMANCE CONTRACT

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### Other Performance Contract Document Attachments

- Exhibit A: Resources and Services
- 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: Core Mandated Services
- Exhibit H: Regional Local Inpatient Purchase of Services (LIPOS) Requirements
- Exhibit I: Behavioral Health Wellness
- Exhibit J: Intentionally Left Blank 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

## 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 Boards (the “CSBs”) 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), developmental (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.

**Earmarked Funds** are funds identified separately in letters of notification, performance contracts, and CARS reports to be used for specified purposes; but CSBs are not required to account for or report expenditures associated with these funds to the Department. Funds are earmarked in order to track their allocation to particular CSBs. While they are not restricted in terms of separate accounting and reporting by CSBs, earmarked funds are appropriated or allocated for specified purposes, and CSBs are expected to use earmarked funds for the purposes for which they were appropriated or allocated.

**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

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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 CSBs 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 or BHA and identified in the local resolutions passed by each locality in its creation of the CSB or BHA. 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 or BHA.

The second purpose of Fiscal Agent is the specific CSB or BHA 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 CSBs, then that change must be noted in a revision to the existing MOU.

**Memorandum of Understanding (MOU)** – A memorandum of understanding 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**-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 7.3 defines these populations.

**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; CSBs 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 earmarked or un-earmarked. 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; CSBs do not have to account for or report expenditures associated with them separately to the Department. Examples of un-earmarked funds would be ongoing State General Funds and Local Matching Funds.

### 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 CSBs are described in

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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 CSBs 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 CSBs 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 7.3.

### 7. Service Change Management

The CSBs 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.

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### **B. Funding Allocations**

1. The Department shall inform the CSBs of its state and federal fund allocations in a 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 earmarked 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 sections 16.A. of this contract. The Commissioner or designee shall communicate all adjustments to the CSBs in writing.
3. Continued disbursement of semi-monthly payments of restricted or earmarked state or federal funds by the Department to the CSBs 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 CSBs 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 three 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 can attach specific conditions or requirements for use of funds, separate from those established by other authorities, only to the state and federal funds that it allocates to the CSB and not more than the 10 percent local matching funds that are required to obtain the CSB's state fund allocations.
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 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

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### 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 CSBs/BHA. 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 CSBs 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. CSB Responsibilities

### A. Exhibit A

Shall be submitted electronically through the CARS application. The CSB shall provide the services funded and the costs associated with those service in Exhibit A of CARS. 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 in Exhibit A.

### 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 7.3 defines these populations.

### C. Scope of Services

The scope of services a CSB may be responsible for providing and the specific core service categories and sub-categories are defined in the Core Services Taxonomy 7.3. See Exhibit G for the list of Code mandated services a CSB shall be responsible for providing.

1. **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 offered by the CSB that best meets his or her needs within 10 business days, sooner if indicated by 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.
  - a. 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.
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



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- 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 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.
  - e. For the population includes all individuals over age 3 who receive psychiatric medical services by the CSB. CSBs must report the screen completion and monitoring completion in CCS monthly submission.
3. **Outpatient Services** - 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.
- a. The quality of outpatient behavioral health services is the key component of this step and 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.
  - b. All CSBs 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.
  - c. 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.
  - d. Expertise in the treatment of trauma related conditions are to be established.
  - e. 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.
  - f. 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.
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 CSBs 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. CSBs 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

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- clinical guidelines from Veterans Affairs and Department of Defense can be found at <https://www.healthquality.va.gov>.
- c. CSBs 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.
5. **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.
6. **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.
7. **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.
8. **Crisis Intervention Team (CIT) Services** – If the CSB receives CIT funding it shall:
- f. Work with community stakeholders, agencies, and partners across systems to coordinate the implementation and operation of the CIT Assessment Site and provide related access to appropriate services in accordance with its RFP response approved by the Department.
  - g. Submit narrative semi-annual progress reports on these services through the Department's sFTP server and upload them to the Jail Diversion Folder within 45 calendar days of the end of the second quarter and within 60 days of the end of the fiscal year.
  - h. Reports shall include a brief narrative of program activities for all CIT aspects of the services, implementation progress against milestones identified in the approved RFP response, and specific site-related challenges and successes for the reporting period.
  - i. Instructions for naming the files are in the Data Reporting Manual provided by the Department to CSBs that received CIT funds.
  - j. Include all funds, expenditures, and costs associated with these services provided to individuals residing in the CSB's service area in its Community Automated Reporting System (CARS) reports and applicable data about individuals receiving these services and service units received in its monthly CCS extracts submitted to the Department.
  - k. Submit quarterly data files as instructed by the Department using the Excel Data Template provided by the Department to CSBs that received CIT funds. Submit quarterly data reports within 45 calendar days of the end of the first three quarters and within 60 days of the end of the fiscal year. Submit the data files through the Department's sFTP server and upload them to

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the Jail Diversion Folder. Instructions for naming the files are in the Data Reporting Manual provided by the Department.

- l. Cooperate with the Department in annual site visits and agree to participate in scheduled assessment site meetings.
9. **Forensic Services** - Upon receipt of a court order 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.
- a. Upon written notification from a state 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 back to the community, the CSB shall to the greatest extent possible provide or arrange for the provision of services 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 located, or in another location suitable for the delivery of these services to that individual to ensure the maintenance of his psychiatric stability and competency to stand trial. Services shall include treatment and restoration services, emergency services, assessment services, the provision of medications and medication management services, and other services which may be needed by the individual in order prevent his readmission to a state hospital for these services. 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.
  - b. 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.
  - c. Upon receipt of a court order, 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.
  - d. 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 local courts in placement decisions for hospitalization of individuals with a forensic status based upon evaluation of the individual's clinical condition, need for a secure environment, and other relevant factors. The CSB's staff shall conduct an assessment of risk to provide information to the Commissioner for the determination of whether an individual with a forensic status in need of hospitalization requires placement in a civil facility or a secure facility. The CSB's staff will contact and collaborate with the Forensic Coordinator of the state hospital that serves the CSB or outside of regular business hours any other personnel designated by the state hospital to manage emergency admissions in making this determination. The CSB's assessment shall include those items required prior to admission to a state hospital.
  - e. The CSB shall designate a Forensic Admissions Coordinator, a Forensic Evaluation Coordinator, and an NGRI Coordinator to collaborate with the local courts, the forensic staff of state facilities, and the Department. The CSB shall notify the Department's Director 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 the forensic training designated by the Commissioner of the

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Department as meeting the requirements for completion of forensic evaluations authorized under § 19.2-169.1, § 19.2-169.5, § 19.2-182.2, and § 19.2-182.5 of the Code of Virginia.

- f. The CSB shall provide discharge planning for persons found not guilty by reason of insanity. Pursuant to § 19.2-182.2 through § 19.2-182.7, and § 19.2-182.11 of the Code of Virginia, the CSB shall provide discharge planning, collaborate with the state facility staff in preparing conditional release plans, implement the court's conditional release orders, and submit written reports to the court on the person's progress and adjustment in the community no less frequently than every six months for acquittees who have been conditionally released to a locality served by the CSB. The CSB should provide to the Department's Director 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 for acquittees who have been conditionally released to a locality served by the CSB and copies of court orders regarding acquittees on conditional release.
  - g. 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 in collaboration with local treatment providers.
10. **Permanent Supportive Housing (PSH)** - 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

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Community Behavioral Health Services and any designated training and technical assistance providers.

11. **Residential Crisis Stabilization Units (RCSU)** - The CSB operating a RCSU shall staff and operate
  - a. the unit so that it can admit individuals 24 hours per day and seven days per week.
  - b. the unit shall accept any appropriate individuals under temporary detention orders (TDOs) and establish clinical criteria specifying the types of individuals under TDOs that it will accept.
  - c. the CSB shall provide a copy of the criteria to the Department upon request for its review and approval. The unit shall implement a written schedule of clinical programming that covers at least eight hours of services per day and seven days per week that is appropriate for the individuals receiving crisis services and whenever possible incorporates evidence-based and best practices.
  - d. the RCSU shall provide a mix of individual, group, or family counseling or therapy, case management, psycho-educational, psychosocial, relaxation, physical health, and peer- run group services; access to support groups such as Alcoholics Anonymous or Narcotics Anonymous; access to a clinical assessment that includes ASAM Level of Care and medically monitored highly intensive residential services that have the capacity for medication assisted treatment when a substance use disorder is indicated; and other activities that are appropriate to the needs of each individual receiving services and focuses on his or her recovery.
  - e. the CSB shall comply with the requirements provided by the Department in its current Residential Crisis Stabilization Unit Expectations document.
12. **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.
13. **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.

### D. 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 CSBs, 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.
  - b. The CSB shall develop, implement, and maintain, itself or in affiliation with other CSBs, a risk management plan or participate in a local government's risk management plan. The

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CSB shall work with the Department to identify how the CSB will address quality improvement activities.

- c. The CSB shall implement, in collaboration with other CSBs 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.
- e. If any CSB employees are being paid totally with Federal Mental Health or SABG funds at a direct annual salary (not including fringe benefits and operating costs) in excess of Level II of the federal Executive Schedule. They must provide written notification to the Department to include names and titles of those employees.
- f. The CSB assures that it is and will continue to be in full compliance with the applicable provisions of 45 CFR Part 54, Charitable Choice Regulations, and 45 CFR Part 87, Equal Treatment for Faith- Based Organizations Regulations, in its receipt and use of federal Mental Health Services and SABG funds and federal funds for Projects for Assistance in Transitions from Homelessness programs. Both regulations prohibit discrimination against religious organizations, provide for the ability of religious organizations to maintain their religious character, and prohibit religious organizations from using federal funds to finance inherently religious activities.

### E. 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 CSBs 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 CSBs.

#### 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 §

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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 7.3 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.) 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);
  - g.) report data and information required by the current Appropriation Act; and
  - h.) report data identified collaboratively by the Department and the CSB working
  - i.) 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

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7.3, 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 7.3; 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. **Constitution of the CSB:** The resolutions or ordinances currently in effect that were enacted by the governing body or bodies of the local government or governments to establish the CSB are consistent with applicable statutory requirements in §§ 37.2-500, 37.2- 501, and 37.2-502 or §§ 37.2-601, 37.2-602, and 37.2-603 of the Code and accurately reflect the current purpose, roles and responsibilities, local government membership, number and type of CSB board member appointments from each locality, the CSB's relationship with its local government or governments, and the name of the CSB.

### 10. 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



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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.

## 11. Compliance with Laws

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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. HIPAA

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 6.c.1.) a.) and f.) or 2.)c.) 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 CSBs, 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 6.c.1.) a.) and f.) or 2.)c.) to ensure the privacy and security of sensitive data.
6. The Department shall execute a BAA with FEI, its WaMS contractor, for the exchange of PHI, PII, and other confidential data that it or the CSB exchanges with FEI 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 CSBs, 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

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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.

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### 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.

### I. 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.

### J. Consideration of Department Comments or Recommendations

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.

### K. 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 CSBs 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 CSBs 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

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possible, in collaborative planning activities regarding the future role and structure of state hospitals and training centers.

### **L. 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.

### **M. 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 CSBs. 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.

### **N. Utilization Management**

The Department shall work with the CSBs, 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.

### **O. 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.

### **P. 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.

### **Q. Peer Review Process**

The Department shall implement a process in collaboration with volunteer CSBs 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.

### **R. 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 CSBs.

### **S. 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.

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### 12. Reporting and Data Quality Requirements

- A. In accordance with State Board Policy 1030, the Department shall work with CSBs through the VACSB DMC to ensure that current data and reporting requirements are consistent with each other and the current Core Services Taxonomy 7.3, the current CCS Extract, and the Treatment Episode Data Set (TEDS) and other federal reporting requirements.
- B. The Department also shall work with CSBs 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.
- C. 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.
- D. **Community Consumer Submission:** The Department shall collaborate with CSBs 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. The Department will receive and use individual characteristic and service data disclosed by the CSBs 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.

The Department shall follow the user acceptance testing process described in Addendum I Administrative Requirements and Processes and Procedures for new CCS Extract releases.

- E. **Data Elements:** The Department shall work with CSBs 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.
- F. **Streamlining Reporting Requirements:** The Department shall work with CSBs 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 7.3; and to maximize the interoperability between Department and CSB data bases to support the electronic exchange of information and comprehensive data analysis.
- G. **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. The Department may address persistent deficiencies that are not resolved through this process with an Individual CSB Performance Measure in Exhibit D.

## FY 2022 AND FY 2023 COMMUNITY SERVICES PERFORMANCE CONTRACT

- H. 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.

### 13. Communication

- A.** 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.
- B.** The Department shall resolve, to the extent practicable, inconsistencies in state agency requirements that affect requirements in this contract.
- C.** 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.
- D.** The Department shall issue new or revised policy, procedure, and guidance documents affecting CSBs 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.

### 14. 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.

### 15. 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:
- 1.) 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 5 of this contract;
  - 2.) termination or suspension of the contract, unless funding is no longer available;
  - 3.) refusal to negotiate or execute a contract modification;
  - 3.) disputes arising over interpretation or precedence of terms, conditions, or scope of the contract; or
  - 4.) determination that an expenditure is not allowable under this contract.
- B. Remediation Process:** The Department and the CSB shall use the remediation process mentioned in

## FY 2022 AND FY 2023 COMMUNITY SERVICES PERFORMANCE CONTRACT

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.

**C. 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 16.A. 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.
  - i. 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.
  - ii. 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.
  - iii. Any person with an interest in the dispute shall be relieved of panel responsibilities and another person shall be selected as a panel member.
- 5.) 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.
- 6.) 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.



## FY 2022 AND FY 2023 COMMUNITY SERVICES PERFORMANCE CONTRACT

- 7.) 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.
- 8.) 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.
- 9.) 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.
- 10.) 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.

### 16. 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.

### 17. 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.

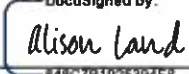
**Counterparts and Electronic Signatures:** Except as may be prohibited by applicable law or regulation, this Agreement and any amendment may be signed in counterparts, by facsimile, PDF, or other electronic means, each of which will be deemed an original and all of which when taken together will constitute one agreement. Facsimile and electronic signatures will be binding for all purposes.

### Signatures

In witness thereof, the Department and the CSB have caused this performance contract to be executed by the following duly authorized officials.

**FY 2022 AND FY 2023 COMMUNITY SERVICES PERFORMANCE CONTRACT**

**VIRGINIA DEPARTMENT OF BEHAVIORAL  
HEALTH AND DEVELOPMENTAL SERVICES**

By:  Alison Land  
DocuSigned by:  
848C7B1925394F8

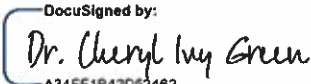
Name: Alison G. Land, FACHE

Title: Commissioner

Date: 6/22/2021 | 11:24 AM EDT

**COMMUNITY SERVICES BOARD NAME**

Richmond Behavioral Health Authority

By:  Dr. Cheryl Ivy Green  
DocuSigned by:  
A34FF1B42D62462

Name: [CHAIRPERSON NAME]  
Dr. Cheryl Ivy Green

Title: Chairperson

Date: 6/30/2021 | 2:46 PM EDT

By:  John Lindstrom  
DocuSigned by:  
C0B807FDDA684E9

Name: [EXECUTIVE DIRECTOR NAME]  
John Lindstrom

Title: Executive Director

Date: 6/30/2021 | 11:30 AM EDT

## FY 2022 AND FY 2023 COMMUNITY SERVICES PERFORMANCE CONTRACT

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

**FY2022 And FY2023 Community Services Performance Contract**

**FY 2022 Exhibit A: Resources and Services**

**Richmond Behavioral Health Authority**

**Consolidated Budget (Pages AF-3 through AF-12)**

<b>Funding Sources</b>	<b>Mental Health (MH) Services</b>	<b>Developmental (DV) Services</b>	<b>Substance Use Disorder (SUD) Services</b>	<b>TOTAL</b>
State Funds	20,670,557	7,284,566	3,923,057	31,878,180
Local Matching Funds	1,326,470	861,735	1,239,795	3,428,000
Total Fees	5,841,043	2,741,245	8,724,341	17,306,629
Transfer Fees In/(Out)	0	0	0	0
Federal Funds	609,715	0	3,889,295	4,499,010
Other Funds	292,000	0	440,000	732,000
State Retained Earnings	1,115,996	0	0	1,115,996
Federal Retained Earnings	0		0	0
Other Retained Earnings	0	0	0	0
<b>Subtotal Ongoing Funds</b>	<b>29,855,781</b>	<b>10,887,546</b>	<b>18,216,488</b>	<b>58,959,815</b>
State Funds One-Time	0	0	0	0
Federal Funds One-Time	0		0	0
<b>Subtotal One -Time Funds</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>TOTAL ALL FUNDS</b>	<b>29,855,781</b>	<b>10,887,546</b>	<b>18,216,488</b>	<b>58,959,815</b>
<b>Cost for MH/DV/SUD Services</b>	<b>20,923,563</b>	<b>10,448,622</b>	<b>16,819,561</b>	<b>48,191,746</b>
<b>Cost for Emergency Services (AP-4)</b>				<b>4,991,109</b>
<b>Cost for Ancillary Services (AP-4)</b>				<b>3,005,851</b>
<b>Total Cost for Services</b>				<b>56,188,706</b>

<b>Local Match Computation</b>	
Total State Funds	31,878,180
Total Local Matching Funds	3,428,000
Total State and Local Funds	35,306,180
Total Local Match % (Local / Total State + Local)	<b>9.71%</b>

<b>CSB Administrative Percentage</b>	
Administrative Expenses	10,504,866
Total Cost for Services	56,188,706
Admin / Total Expenses	<b>18.70%</b>

**FY2022 And FY2023 Community Services Performance Contract  
 FY 2022 Exhibit A: Resources and Services**

**Richmond Behavioral Health Authority  
 Financial Comments**

<b>Comment1</b>	AF-3 MH OTHER FEDERAL - CSB \$115,000
<b>Comment2</b>	CDBG \$100,000; USDA \$15,000
<b>Comment3</b>	
<b>Comment4</b>	AF-5 MH OTHER FUNDS \$292,000
<b>Comment5</b>	DEPT. OF JUV. JUSTICE \$60,000; COLLABORATIVE GRANT \$85,000
<b>Comment6</b>	MH DOCKET \$72,000; DISABILITY DETERMINATION \$7,000;
<b>Comment7</b>	MISCELLANEOUS \$68,000
<b>Comment8</b>	
<b>Comment9</b>	AF-5 MH CRISIS STAB - FISCAL AGENT \$2,726,878
<b>Comment10</b>	ADULT CSU \$1,999,062; CHILD CSU 727,816
<b>Comment11</b>	
<b>Comment12</b>	AF-5 MH RETAINED EARNINGS - REGIONAL \$1,115,996
<b>Comment13</b>	MH ACUTE CARE \$1,115,996 (\$382,057 WILL BE TRANSFERRED OUT TO
<b>Comment14</b>	REGION 4 CSBS)
<b>Comment15</b>	
<b>Comment16</b>	AF-8 SUD OTHER FEDERAL - CSB \$317,733
<b>Comment17</b>	TANF \$317,733
<b>Comment18</b>	
<b>Comment19</b>	AF-9 SUD OTHER FUNDS \$440,000
<b>Comment20</b>	RECIDIVISM \$440,000
<b>Comment21</b>	
<b>Comment22</b>	
<b>Comment23</b>	
<b>Comment24</b>	
<b>Comment25</b>	

**FY2022 And FY2023 Community Services Performance Contract**

**FY2022 Exhibit A: Resources and Services**

**Mental Health (MH) Services**

**Richmond Behavioral Health Authority**

<u>Funding Sources</u>	<u>Funds</u>
<u>FEES</u>	
MH Medicaid Fees	0
MH Fees: Other	5,841,043
Total MH Fees	<u>5,841,043</u>
MH Transfer Fees In/(Out)	0
MH Net Fees	<u>5,841,043</u>
<u>FEDERAL FUNDS</u>	
MH FBG SED Child & Adolescent (93.958)	137,436
MH FBG Young Adult SMI (93.958)	0
MH FBG Crisis Services (93.958)	0
MH FBG SMI (93.958)	53,246
MH FBG SMI PACT (93.958)	268,052
MH FBG SMI SWVBH Board (93.958)	0
Total MH FBG SMI Funds	<u>321,298</u>
MH FBG Geriatrics (93.958)	0
MH FBG Peer Services (93.958)	0
Total MH FBG Adult Funds	<u>321,298</u>
MH Federal PATH (93.150)	35,981
MH Federal COVID Emergency Grant (93.665)	
MH Other Federal - DBHDS	0
MH Other Federal - COVID Support	
MH Other Federal - CSB	115,000
Total MH Federal Funds	<u>609,715</u>
<u>STATE FUNDS</u>	
<u>Regional Funds</u>	
MH Acute Care (Fiscal Agent)	0
MH Acute Care Transfer In/(Out)	0
Total Net MH Acute Care - Restricted	<u>0</u>
MH Regional DAP (Fiscal Agent)	4,423,805
MH Regional DAP Transfer In/(Out)	-244,827
Total Net MH Regional DAP - Restricted	<u>4,178,978</u>
MH Regional Residential DAP - Restricted	0
MH Crisis Stabilization (Fiscal Agent)	3,407,693
MH Crisis Stabilization - Transfer In/(Out)	-680,815
Total Net MH Crisis Stabilization - Restricted	<u>2,726,878</u>
MH Transfers from DBHDS Facilities (Fiscal Agent)	0
MH Transfers from DBHDS Facilities - Transfer In/(Out)	0
Total Net MH Transfers from DBHDS Facilities	<u>0</u>
MH Expanded Community Capacity (Fiscal Agent)	0
MH Expanded Community Capacity Transfer In/(Out)	0
Total Net MH Expanded Community Capacity	<u>0</u>

**FY2022 And FY2023 Community Services Performance Contract**

**FY2022 Exhibit A: Resources and Services**

**Mental Health (MH) Services**

**Richmond Behavioral Health Authority**

<u>Funding Sources</u>	<u>Funds</u>
MH First Aid and Suicide Prevention (Fiscal Agent)	0
MH First Aid and Suicide Prevention Transfer In/(Out)	0
<b>Total Net MH First Aid and Suicide Prevention</b>	<b>0</b>
MH STEP-VA Outpatient (Fiscal Agent)	880,786
MH STEP-VA Outpatient Transfer In/(Out)	0
<b>Total Net MH STEP-VA Outpatient</b>	<b>880,786</b>
MH STEP-VA Crisis (Fiscal Agent)	2,309,762
MH STEP-VA Crisis Transfer In/(Out)	0
<b>Total Net MH STEP-VA Crisis</b>	<b>2,309,762</b>
MH STEP-VA Clinician's Crisis Dispatch (Fiscal Agent)	806,960
MH STEP-VA Clinician's Crisis Dispatch Transfer In/(Out)	0
<b>Total Net MH STEP-VA Clinician's Crisis Dispatch</b>	<b>806,960</b>
MH STEP-VA Peer Support (Fiscal Agent)	236,726
MH STEP-VA Peer Support Transfer In/(Out)	0
<b>Total Net MH STEP-VA Peer Support</b>	<b>236,726</b>
MH STEP-VA Veteran's Services (Fiscal Agent)	222,388
MH STEP-VA Veteran's Services Transfer In/(Out)	0
<b>MH STEP-VA Veteran's Services</b>	<b>222,388</b>
MH Forensic Discharge Planning (Fiscal Agent)	0
MH Forensic Discharge Planning Transfer In/(Out)	0
<b>Total Net MH Forensic Discharge Planning</b>	<b>0</b>
MH Permanent Supportive Housing (Fiscal Agent)	1,553,034
MH Permanent Supportive Housing Transfer In/(Out)	0
<b>Total Net MH Permanent Supportive Housing</b>	<b>1,553,034</b>
MH Recovery (Fiscal Agent)	1,002,016
MH Other Merged Regional Funds (Fiscal Agent)	2,548,393
MH State Regional Deaf Services (Fiscal Agent)	0
MH Total Regional Transfer In/(Out)	-1,531,317
<b>Total Net MH Unrestricted Regional State Funds</b>	<b>2,019,092</b>
<b>Total Net MH Regional State Funds</b>	<b>14,934,604</b>
<u>Children State Funds</u>	
MH Child & Adolescent Services Initiative	236,337
MH Children's Outpatient Services	75,000
MH Juvenile Detention	54,821
<b>Total MH Restricted Children's Funds</b>	<b>366,158</b>
MH State Children's Services	25,000
MH Demo Proj-System of Care (Child)	375,000
<b>Total MH Unrestricted Children's Funds</b>	<b>400,000</b>
MH Crisis Response & Child Psychiatry (Fiscal Agent)	863,458
MH Crisis Response & Child Psychiatry Transfer In/(Out)	0
<b>Total Net MH Restricted Crisis Response &amp; Child Psychiatry</b>	<b>863,458</b>
<b>Total State MH Children's Funds (Restricted for Children)</b>	<b>1,629,616</b>

**FY2022 And FY2023 Community Services Performance Contract**

**FY2022 Exhibit A: Resources and Services**

**Mental Health (MH) Services**

**Richmond Behavioral Health Authority**

<u>Funding Sources</u>	<u>Funds</u>
<u>Other State Funds</u>	
MH Law Reform	331,492
MH Pharmacy - Medication Supports	184,007
MH Jail Diversion Services	183,250
MH Rural Jail Diversion	0
MH Docket Pilot JMHCP Match	0
MH Adult Outpatient Competency Restoration Services	0
MH CIT-Assessment Sites	408,182
MH Expand Telepsychiatry Capacity	60,128
MH PACT	863,538
MH PACT - Forensic Enhancement	0
MH Gero-Psychiatric Services	0
MH STEP-VA - SDA, Primary Care Screening and Ancillary Services	629,703
MH Young Adult SMI	0
<b>Total MH Restricted Other State Funds</b>	<b>2,660,300</b>
MH State Funds	1,446,037
MH State NGRI Funds	0
MH Geriatrics Services	0
<b>Total MH Unrestricted Other State Funds</b>	<b>1,446,037</b>
<b>Total MH Other State Funds</b>	<b>4,106,337</b>
<b>Total MH State Funds</b>	<b>20,670,557</b>
<u>OTHER FUNDS</u>	
MH Other Funds	292,000
MH Federal Retained Earnings	0
MH State Retained Earnings	0
MH State Retained Earnings - Regional Programs	1,115,996
MH Other Retained Earnings	0
<b>Total MH Other Funds</b>	<b>1,407,996</b>
<u>LOCAL MATCHING FUNDS</u>	
MH Local Government Appropriations	1,326,470
MH Philanthropic Cash Contributions	0
MH In-Kind Contributions	0
MH Local Interest Revenue	0
<b>Total MH Local Matching Funds</b>	<b>1,326,470</b>
<b>Total MH Funds</b>	<b>29,855,781</b>
<u>MH ONE-TIME FUNDS</u>	
MH FBG SMI (93.958)	0
MH FBG SED Child & Adolescent (93.958)	0
MH FBG Peer Services (93.958)	0
MH One-Time State Funds	0
MH One-Time Restricted State Funds	0
<b>Total One-Time MH Funds</b>	<b>0</b>
<b>Total MH All Funds</b>	<b>29,855,781</b>



FY2022 And FY2023 Community Services Performance Contract

FY2022 Exhibit A: Resources and Services

Developmental Services (DV)  
Richmond Behavioral Health Authority

<u>Funding Sources</u>	<u>Funds</u>
<u>FEES</u>	
DV Medicaid DD Waiver Fees	0
DV Other Medicaid Fees	0
DV Medicaid ICF/IDD Fees	0
DV Fees: Other	2,741,245
Total DV Fees	2,741,245
DV Transfer Fees In/(Out)	0
DV Net Fees	2,741,245
<u>FEDERAL FUNDS</u>	
DV Other Federal - DBHDS	0
DV Other Federal - COVID Support	0
DV Other Federal - CSB	0
Total DV Federal Funds	0
<u>STATE FUNDS</u>	
DV State Funds	1,348,236
DV OBRA Funds	0
Total DV Unrestricted State Funds	1,348,236
DV Trust Fund (Restricted)	0
DV Rental Subsidies	0
DV Guardianship Funding	0
DV Crisis Stabilization (Fiscal Agent)	3,290,688
DV Crisis Stabilization Transfer In/(Out)	0
Total Net DV Crisis Stabilization	3,290,688
DV Crisis Stabilization-Children (Fiscal Agent)	2,645,642
DV Crisis Stabilization-Children Transfer In/(Out)	0
Total Net DV Crisis Stabilization -Children	2,645,642
DV Transfers from DBHDS Facilities (Fiscal Agent)	0
DV Transfers from DBHDS Facilities - Transfer In/(Out)	0
Total Net DV Transfers from DBHDS Facilities	0
Total DV Restricted State Funds	5,936,330
Total DV State Funds	7,284,566

**FY2022 And FY2023 Community Services Performance Contract**

**FY2022 Exhibit A: Resources and Services**

**Developmental Services (DV)  
Richmond Behavioral Health Authority**

<u>Funding Sources</u>	<u>Funds</u>
<b><u>OTHER FUNDS</u></b>	
DV Workshop Sales	0
DV Other Funds	0
DV State Retained Earnings	0
DV State Retained Earnings-Regional Programs	0
DV Other Retained Earnings	0
<b>Total DV Other Funds</b>	<b>0</b>
<b><u>LOCAL MATCHING FUNDS</u></b>	
DV Local Government Appropriations	861,735
DV Philanthropic Cash Contributions	0
DV In-Kind Contributions	0
DV Local Interest Revenue	0
<b>Total DV Local Matching Funds</b>	<b>861,735</b>
<b>Total DV Funds</b>	<b>10,887,546</b>
 <b><u>DV ONE-TIME FUNDS</u></b>	
DV One-Time State Funds	0
DV One-Time Restricted State Funds	0
<b>Total One-Time DV Funds</b>	<b>0</b>
<b>Total DV All Funds</b>	<b>10,887,546</b>

**FY2022 And FY2023 Community Services Performance Contract**

**FY2022 Exhibit A: Resources and Services**

**Substance Use Disorder (SUD) Services**

**Richmond Behavioral Health Authority**

<u>Funding Sources</u>	<u>Funds</u>
<u>FEES</u>	
SUD Medicaid Fees	0
SUD Fees: Other	8,724,341
<b>Total SUD Fees</b>	<b>8,724,341</b>
SUD Transfer Fees In/(Out)	0
<b>Sud Net Fees</b>	<b>8,724,341</b>
<u>FEDERAL FUNDS</u>	
SUD FBG Alcohol/Drug Treatment (93.959)	1,213,939
SUD FBG SARPOS (93.959)	177,032
SUD FBG Jail Services (93.959)	0
SUD FBG Co-Occurring (93.959)	0
SUD FBG New Directions (93.959)	700,000
SUD FBG Recovery (93.959)	100,000
SUD FBG MAT - Medically Assisted Treatment (93.959)	0
<b>Tota SUD FBG Alcohol/Drug Treatment Funds</b>	<b>2,190,971</b>
SUD FBG Women (includes LINK at 6 CSBs) (93.959)	1,008,036
<b>Total SUD FBG Women Funds</b>	<b>1,008,036</b>
SUD FBG Prevention (93.959)	372,555
SUD FBG Prev-Family Wellness (93.959)	0
<b>Total SUD FBG Prevention Funds</b>	<b>372,555</b>
SUD Federal COVID Emergency Grant (93.665)	0
SUD Federal YSAT – Implementation (93.243)	0
SUD Federal Opioid Response – Recovery (93.788)	0
SUD Federal Opioid Response – Treatment (93.788)	0
SUD Federal Opioid Response – Prevention (93.788)	0
<b>Total SUD Federal Opioid Response Funds (93.788)</b>	<b>0</b>
SUD Other Federal - DBHDS	0
SUD Other Federal - COVID Support	0
SUD Other Federal - CSB	317,733
<b>Total SUD Federal Funds</b>	<b>3,889,295</b>

**FY2022 And FY2023 Community Services Performance Contract**

**FY2022 Exhibit A: Resources and Services**

**Substance Use Disorder (SUD) Services**

**Richmond Behavioral Health Authority**

<u>Funding Sources</u>	<u>Funds</u>
<b><u>STATE FUNDS</u></b>	
<b><u>Regional Funds</u></b>	
SUD Facility Reinvestment (Fiscal Agent)	49,488
SUD Facility Reinvestment Transfer In/(Out)	0
<b>Total Net SUD Facility Reinvestment</b>	<b>49,488</b>
SUD Transfers from DBHDS Facilities (Fiscal Agent)	0
SUD Transfers from DBHDS Facilities - Transfer In/(Out)	0
<b>Total Net SUD Transfers from DBHDS Facilities</b>	<b>0</b>
SUD Community Detoxification (Fiscal Agent)	115,000
SUD Community Detoxification – Transfer In/(Out)	0
<b>Total Net SUD Community Detoxification</b>	<b>115,000</b>
SUD STEP-VA (Fiscal Agent)	0
SUD STEP-VA - Transfer In/(Out)	0
<b>Total Net SUD STEP-VA - Restricted</b>	<b>0</b>
<b>Total Net SUD Regional State Funds</b>	<b>164,488</b>
<b><u>Other State Funds</u></b>	
SUD Women (includes LINK at 4 CSBs) (Restricted)	428,522
SUD MAT - Medically Assisted Treatment	150,000
SUD Permanent Supportive Housing Women	496,019
SUD SARPOS	37,417
SUD Recovery	0
<b>Total SUD Restricted Other State Funds</b>	<b>1,111,958</b>
SUD State Funds	2,399,374
SUD Region V Residential	0
SUD Jail Services/Juvenile Detention	0
SUD HIV/AIDS	247,237
<b>Total SUD Unrestricted Other State Funds</b>	<b>2,646,611</b>
<b>Total SUD Other State Funds</b>	<b>3,758,569</b>
<b>Total SUD State Funds</b>	<b>3,923,057</b>
<b><u>OTHER FUNDS</u></b>	
SUD Other Funds	440,000
SUD Federal Retained Earnings	0
SUD State Retained Earnings	0
SUD State Retained Earnings-Regional Programs	0
SUD Other Retained Earnings	0
<b>Total SUD Other Funds</b>	<b>440,000</b>
<b><u>LOCAL MATCHING FUNDS</u></b>	
SUD Local Government Appropriations	1,239,795
SUD Philanthropic Cash Contributions	0

FY2022 And FY2023 Community Services Performance Contract

FY2022 Exhibit A: Resources and Services

Substance Use Disorder (SUD) Services

Richmond Behavioral Health Authority

<u>Funding Sources</u>	<u>Funds</u>
SUD In-Kind Contributions	0
SUD Local Interest Revenue	0
Total SUD Local Matching Funds	<u>1,239,795</u>
Total SUD Funds	<b>18,216,488</b>
 <u>SUD ONE-TIME FUNDS</u>	
SUD FBG Alcohol/Drug Treatment (93.959)	0
SUD FBG Women (includes LINK-6 CSBs) (93.959)	0
SUD FBG Prevention (93.959)	0
SUD FBG Recovery (93.959)	0
SUD One-Time State Funds	0
SUD One-Time Restricted State Funds	0
Total SUD One-Time Funds	<u>0</u>
Total All SUD Funds	<b>18,216,488</b>

**FY2022 And FY2023 Community Services Performance Contract**

**FY 2022 Exhibit A: Resources and Services**

**Local Government Tax Appropriations**

**Richmond Behavioral Health Authority**

<b>City/County</b>	<b>Tax Appropriation</b>
Richmond City	3,428,000
<b>Total Local Government Tax Funds:</b>	<b>3,428,000</b>

**FY2022 And FY2023 Community Services Performance Contract**

**FY2022 Exhibit A: Resources and Services**

**Supplemental Information**

**Reconciliation of Projected Resources and Core Services Costs by Program Area**

**Richmond Behavioral Health Authority**

	<b>MH Services</b>	<b>DV Services</b>	<b>SUD Services</b>	<b>Emergency Services</b>	<b>Ancillary Services</b>	<b>Total</b>
<b>Total All Funds (Page AF-1)</b>	29,855,781	10,887,546	18,216,488			58,959,815
<b>Cost for MH, DV, SUD, Emergency, and Ancillary Services</b>	20,923,563	10,448,622	16,819,561	4,991,109	3,005,851	56,188,706
<b>Difference</b>	8,932,218	438,924	1,396,927	-4,991,109	-3,005,851	2,771,109

**Difference results from**

**Other:** 2,771,109

**Explanation of Other in Table Above:**

DAP - 2,650,106; Acute Care - 121,093
---------------------------------------

**FY2022 And FY2023 Community Services Performance Contract**

**FY2022 Exhibit A: Resources and Services**

**CSB 100 Mental Health Services**

**Richmond Behavioral Health Authority**

**Report for Form 11**

<b>Core Services</b>	<b>Projected Service Capacity</b>	<b>Projected Numbers of Individuals Receiving Services</b>	<b>Projected Total Service Costs</b>
250 Acute Psychiatric Inpatient Services	1.5 Beds		\$59,534
310 Outpatient Services	4.4 FTEs		\$741,683
312 Medical Services	13.5 FTEs		\$3,041,524
350 Assertive Community Treatment	13 FTEs		\$1,518,218
320 Case Management Services	51 FTEs		\$4,892,734
410 Day Treatment or Partial Hospitalization	60 Slots		\$1,718,202
425 Mental Health Rehabilitation	40 Slots		\$932,705
510 Residential Crisis Stabilization Services	10.04 Beds		\$2,775,039
551 Supervised Residential Services	10 Beds		\$673,557
581 Supportive Residential Services	10 FTEs		\$4,570,367
<b>Totals</b>			<b>\$20,923,563</b>

<b>Form 11A: Pharmacy Medication Supports</b>	<b>Number of Consumers</b>
803 Total Pharmacy Medication Supports Consumers	1120



**FY2022 And FY2023 Community Services Performance Contract**

**FY2022 Exhibit A: Resources and Services**

**CSB 200 Developmental Services**

**Richmond Behavioral Health Authority**

**Report for Form 21**

Core Services	Projected Service Capacity	Projected Numbers of Individuals Receiving Services	Projected Total Service Costs
310 Outpatient Services	1.5 FTEs		\$217,599
320 Case Management Services	27 FTEs		\$2,650,723
425 Developmental Habilitation	11 Slots		\$298,716
430 Sheltered Employment	8 Slots		\$6,400
465 Group Supported Employment	32 Slots		\$291,819
460 Individual Supported Employment	2 FTEs		\$131,830
510 Residential Crisis Stabilization Services	12 Beds		\$2,530,327
551 Supervised Residential Services	6 Beds		\$1,421,290
581 Supportive Residential Services	1 FTEs		\$153,519
610 Prevention Services	20 FTEs		\$2,746,399
<b>Totals</b>			<b>\$10,448,622</b>

**FY2022 And FY2023 Community Services Performance Contract**

**FY2022 Exhibit A: Resources and Services**

**CSB 300 Substance Use Disorder Services**

**Richmond Behavioral Health Authority**

**Report for Form 31**

Core Services	Projected Service Capacity	Projected Numbers of Individuals Receiving Services	Projected Total Service Costs
310 Outpatient Services	3 FTEs		\$588,167
312 Medical Services	0.3 FTEs		\$1,149,433
313 Intensive Outpatient Services	4.5 FTEs		\$672,202
335 Medication Assisted Treatment Services	4.5 FTEs		\$2,344,142
320 Case Management Services	16.5 FTEs		\$1,650,602
501 Highly Intensive Residential Services (Medically Managed Withdrawal Services)	3 Beds		\$2,221,630
521 Intensive Residential Services	50 Beds		\$6,470,470
551 Supervised Residential Services	20 Beds		\$923,383
610 Prevention Services	3.35 FTEs		\$799,532
<b>Totals</b>			<b>\$16,819,561</b>

**FY2022 And FY2023 Community Services Performance Contract**

**FY2022 Exhibit A: Resources and Services**

**CSB 400 Emergency and Ancillary Services**

**Richmond Behavioral Health Authority**

**Report for Form 01**

<b>Core Services</b>	<b>Projected Service Capacity</b>	<b>Projected Numbers of Individuals Receiving Services</b>	<b>Projected Total Service Costs</b>
100 Emergency Services	39.5 FTEs		\$4,991,109
318 Motivational Treatment Services	2 FTEs		\$85,513
390 Consumer Monitoring Services	3.5 FTEs		\$314,208
720 Assessment and Evaluation Services	11.7 FTEs		\$2,606,130
	<b>Totals</b>		<b>\$7,996,960</b>

**FY2022 And FY2023 Community Services Performance Contract**

**Table 2: Board Management Salary Costs**

<b>Name of CSB: Richmond Behavioral Health Authority</b>		<b>FY 2022</b>		
<b>Table 2a:</b>	<b>FY 2022</b>	<b>Salary Range</b>	<b>Budgeted Tot.</b>	<b>Tenure</b>
<b>Management Position Title</b>	<b>Beginning</b>	<b>Ending</b>	<b>Salary Cost</b>	<b>(yrs)</b>
Executive Director	\$176,181.00	\$179,705.00	\$179,705.00	7.00

**Table 2: Integrated Behavioral and Primary Health Care Questions**

1. Is the CSB participating in a partnership with a federally qualified health center, free clinic, or local health department to integrate the provision of behavioral health and primary health care?

No

2. If yes, who is the partner?

a federally qualified health center  
Name:

a free clinic  
Name:

a local health department, or  
Name:

another organization  
Name:

3. Where is primary health (medical) care provided?

on-site in a CSB program,  
 on-site at the primary health care provider, or  
 another site --specify:

4. Where is behavioral health care provided?

on-site in a CSB program,  
 on-site at the primary health care provider, or  
 another site --specify:

**EXHIBIT B FY 2022 AND FY 2023: CONTINUOUS QUALITY IMPROVEMENT (CQI) PROCESS AND CSB PERFORMANCE MEASURES**

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# EXHIBIT B FY 2022 AND FY 2023: CONTINUOUS QUALITY IMPROVEMENT (CQI) PROCESS AND CSB PERFORMANCE MEASURES

## Introduction

Meaningful performance expectations are part of a CQI process developed and supported by the Department and CSBs that will monitor CSB progress in achieving those expectations to improve the quality, accessibility, integration and welcoming, person-centeredness, and responsiveness of services locally and to 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.

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.

CSB Administrative Requirements provides further clarification for those implementation activities, so that each CSB can be successful in designing a performance improvement process at the local level. The CSB will comply with the performance expectations and goals. Additionally, supplementary information about STEP-VA quality and accountability process development and expectations can be found in the documentation provided by the Department. If the CSB cannot meet certain performance expectations and goals, it shall provide a written explanation and submit to the [performancecontractsupport@dbhds.virginia.gov](mailto:performancecontractsupport@dbhds.virginia.gov) mailbox. The CSB shall have a plan for complying with the identified expectation or goal, including specific actions and target dates. The Department will review this plan and negotiate any changes with the CSB.

The CSB and Department agree to implement, monitor, and take appropriate action on the following performance measures.

### I. Exhibit B Performance Measures

#### A. Continuity of Care for State Hospital Discharges

1. **Measure:** Percent of individuals for whom the CSB is the identified case management CSB who keep a face-to-face (non-emergency) mental health outpatient service appointment within seven calendar days after discharge from a state hospital.
2. **Benchmark:** At least 80 percent of these individuals shall receive a face-to-face (non-emergency) mental health outpatient service from the CSB within seven calendar days after discharge.
3. **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.

#### B. Residential Crisis Stabilization Unit (RCSU) Utilization

1. **Measure:** Percent of all available RCSU bed days for adults and children utilized annually.
2. **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.
3. **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.

**EXHIBIT B FY 2022 AND FY 2023: CONTINUOUS QUALITY IMPROVEMENT (CQI) PROCESS AND CSB PERFORMANCE MEASURES**

**C. Regional Discharge Assistance Program (RDAP) Service Provision**

1. **Measure:** Percentage of the total annual state RDAP fund allocations to a region obligated and expended by the end of the fiscal year.
2. **Benchmark:** CSBs in a region shall **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 benchmark does not include one-time state RDAP allocations provided to support ongoing DAP plans for multiple years.
3. **Monitoring:** The Department shall monitor this measure using reports from regional managers and CARS reports. If CSBs in a region cannot accomplish this measure, the Department may work with the regional management group (RMG) and participating CSBs to transfer state RDAP funds to other regions to reduce extraordinary barriers to discharge lists (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. See Exhibit C for additional information.

**D. Assertive Community Treatment (ACT) Program Provision**

After the implementation phase of ACT in their Exhibit D, CSBs shall comply with this CQI process for ACT performance measures.

1. **Measure:** The ACT team is of a sufficient size to consistently provide for necessary staffing diversity and coverage.
2. **Benchmark:** Team staffing is dependent on the program size and the maximum individual to team member ratio (psychiatric care providers and program assistants excluded from ratio calculation). Three program sizes may be implemented: small, mid-size, and large ACT teams:
  - a. **Small teams:** serve a maximum of 50 individuals with at least six staff (excluding psychiatric care provider & program assistant) for a ratio of 1 team member per 8 or fewer individuals;
  - b. **Mid-size teams:** serve 51-74 individuals with at least eight staff (excluding psychiatric care provider & program assistant) for a ratio of 1 team member per 9 or fewer individuals; and
  - c. **Large teams** serve 75-120 individuals with at least 10 staff (excluding psychiatric care provider & program assistant) for a ratio of 1 team member per 9 or fewer individuals.
- d. Movement onto (admissions) and off of (discharges) the team may temporarily result in breaches of the maximum caseload. Therefore, teams shall be expected to maintain an annual average not to exceed 50, 74, and 120 individuals, respectively.
- e. To maintain appropriate ACT team development, each new ACT team is recommended to titrate ACT intakes (e.g., 4–6 individuals per month) to gradually build up capacity to serve no more than 100–20 individuals (with a 1:9 ratio) and no more than 42–50 individuals (a 1:8 ratio) for smaller teams.
3. **Outcomes:** Given the provision of High-Fidelity ACT team services, it is expected that individuals will reduce the amount of time spent in institutional settings and become more integrated within their own community.
4. **Monitoring:** The Department shall monitor this measure using data from the CCS consumer and service files, the ACT data system, and through ACT fidelity monitoring using the Tool for Measurement of Assertive community Treatment (TMACT).

**E. Provision of Developmental Enhanced Case Management Services**

1. **Measures:** Percentage of individuals receiving DD Waiver services who meet the criteria for receiving enhanced case management (ECM) services who:
  - a. Receive at least one face-to-face case management service monthly with no more than 40 days between visits
  - b. receive at least one face-to-face case management service visit every other month in the
  - c. individual's place of residence.
2. **Benchmark:** The CSB shall provide the case management service visits in measures 1.a and b to **at least 90 percent** of the individuals receiving DD Wavier services who meet the criteria for ECM.

**EXHIBIT B FY 2022 AND FY 2023: CONTINUOUS QUALITY IMPROVEMENT (CQI) PROCESS AND CSB PERFORMANCE MEASURES**

3. **Monitoring:** The Department shall use data from CCS consumer, type of care, and service files to monitor these measures and work with the CSB to achieve this benchmark if it did not meet it.
  - a. The CSB agrees to monitor the percentage of adults (age 18 or older) receiving developmental case management services from the CSB whose case managers discussed integrated, community-based employment with them during their annual case management individual supports plan (ISP) meetings. The Department agrees to monitor this measure through using CCS data and work with the CSB to increase this percentage. Refer to State Board Policy (SYS) 1044 Employment First for additional information and guidance. Integrated, community based employment does not include sheltered employment.
  - b. The CSB agrees to monitor the percentage of adults (age 18 or older) receiving developmental case management services from the CSB whose ISPs, developed or updated at the annual ISP meeting, contained employment outcomes, including outcomes that address barriers to employment. The Department agrees to monitor this measure through using CCS data and work with the CSB to increase this percentage. Employment outcomes do not include sheltered employment or prevocational services.
  - c. The CSB agrees to monitor and report data through CCS about individuals who are receiving case management services from the CSB and are receiving DD Waiver services whose case managers discussed community engagement or community coaching opportunities with them during their most recent annual case management individual support plan (ISP) meeting. Community engagement or community coaching supports and fosters the ability of an individual to acquire, retain, or improve skills necessary to build positive social behavior, interpersonal competence, greater independence, employability, and personal choice necessary to access typical activities and functions of community life such as those chosen by the general population; it does not include community opportunities with more than three individuals with disabilities.
  - d. The CSB agrees to monitor and report data through CCS about individuals who are receiving case management services from the CSB and are receiving DD Waiver services whose individual support plans (ISPs), developed or updated at the annual ISP meeting, contained community engagement or community coaching goals.
4. **CSB 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. intensity of engagement of adults receiving mental health case management services,
  - b. Individuals, including children (ages 6-17) and adults (ages 18 or over) who received a suicide risk assessment in the last 12 months
  - c. adults with SMI who are receiving mental health case management services who received a complete physical examination in the last 12 months,
  - d. Initiation and engagement, in substance use disorder services for adults and children who are 13 years old or older with a new episode of substance use disorder services.
  - e. Individuals receiving targeted case management services who received a primary care screen at the CSB in the last 12 months,
  - f. Individuals over the age of 3 prescribed an antipsychotic by a CSB prescriber who receives regular metabolic screening, and
  - g. 6-month change in DLA-20 scores for youth (ages 6-17) and adults (age 18 or over).

**F. Same Day Access**

1. **Measures:** Percentage of individuals who received a SDA assessment and were determined to need a follow-up service who:
  - a. Are offered an appointment at an appropriate service within 10 business days; an
  - b. Attend a scheduled follow-up appointment within 30 calendar days.



**EXHIBIT B FY 2022 AND FY 2023: CONTINUOUS QUALITY IMPROVEMENT (CQI) PROCESS AND CSB PERFORMANCE MEASURES**

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2. **Benchmarks:** 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. 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.
3. **Monitoring:** The Department shall monitor through the use of data from CCS monthly submission and other established data collection tools agreed upon by the Department and CSB.

**G. Substance Use Disorder Treatment Engagement**

1. **Measures:** Percentage of individuals 13 years or older with a new episode of substance use disorder services who initiate services within 14 days of diagnosis and attend follow up services within 34 days.
2. **Benchmarks:** The CSB shall aim to have **at least 50 percent** of SUD clients engage in treatment per this definition of engagement.
3. **Monitoring:** The Department shall monitor through the use of data from CCS monthly submission and other established data collection tools agreed upon by the Department and CSB.

**H. 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.
  - b. 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.
  - c. 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.
2. **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.
3. **Benchmark:** CSB and DBHDS will work together to established.
4. **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.
5. **Monitoring:** CSBs must report the screen completion and monitoring completion in CCS monthly submission to reviewed by the Department.

**I. 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.

**EXHIBIT B FY 2022 AND FY 2023: CONTINUOUS QUALITY IMPROVEMENT (CQI) PROCESS AND CSB PERFORMANCE MEASURES**

- a. All CSBs 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.

**J. Service Members, Veterans, and Families (Rev.7.1.2021)**

1. **Training**
  - a. **Measures:** Percentage of CSB direct services staff who receive military cultural competency training
  - b. **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.
2. **Presenting for Services**
  - a. **Measures:** Percentage of clients with SMVF status presenting for services
  - b. **Benchmark:** Is tracked for 90% of individuals presenting for services
3. **Referral Destination**
  - a. **Measures:** Percentage served referred to SMVF referral destination
  - b. **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
4. **Columbia Suicide Severity Rating Scale**
  - a. **Measure:** Percentage of SMVF for whom suicide risk screening using the Columbia Suicide Severity Rating Scale brief screen is conducted
  - b. **Benchmark:** Is conducted for 60% of SMVF for Year 1 (July 1, 2021 through June 30, 2022)
5. **Monitoring:** CSBs must report all data through its CCS monthly submission.

**K. Peer and Family Support Services**

1. **Certification and Registration**
  - a. **Measure:** Peer Supporters will obtain certification and registration (Board of Counseling) within 18 months of hire.
  - b. **Benchmark:** 80% of Peer Supporters will become a Peer Recovery Specialist within one year of hire.
2. **Unduplicated individuals receiving Peer Services**
  - a. **Measure:** Total number of unduplicated individuals receiving Peer Services will continue to increase.
  - b. **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 review going into year two.
3. **Individual contacts (repeat/duplicated) receiving Peer or Family Support Services**
  - a. **Measure:** Total number of individual contacts (repeat/duplicated) receiving Peer or Family Support Services will increase annually for individual and group.
  - b. **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.
4. **Peer Support Service units (15-minute increments)**

## EXHIBIT B FY 2022 AND FY 2023: CONTINUOUS QUALITY IMPROVEMENT (CQI) PROCESS AND CSB PERFORMANCE MEASURES

- a. **Measure:** Total number of Peer Support Service units (15-minute increments) provided will increase annually for individual and group.
  - b. **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.
5. **Closing Programs**
- a. **Measure:** CSBs will inform DBHDS when Recovery oriented peer services programs are closing,
  - b. **Benchmark:** SCB will inform Office of Recovery Services (ORS) Director within 30 days prior to Recovery oriented peer services programs are set to close.
6. **Monitoring:** CSBs must report data through its CCS monthly submission.
- 7.

### II. CQI Performance Expectations and Goals

#### A. General Performance Goal and Expectation

1. 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.
2. 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.

#### B. Emergency Services Performance Goal and Expectation

1. 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. Urban and rural CSBs are listed in the current Overview of Community Services in Virginia at [www.dbhds.virginia.gov/OCC-default.htm](http://www.dbhds.virginia.gov/OCC-default.htm).
2. 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.
3. 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)

## **EXHIBIT B FY 2022 AND FY 2023: CONTINUOUS QUALITY IMPROVEMENT (CQI) PROCESS AND CSB PERFORMANCE MEASURES**

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.

4. 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.
5. 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.

### **C. Mental Health and Substance Abuse Case Management Services Performance Expectation**

1. 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.
2. 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.
3. 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.
4. 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

## EXHIBIT B FY 2022 AND FY 2023: CONTINUOUS QUALITY IMPROVEMENT (CQI) PROCESS AND CSB PERFORMANCE MEASURES

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.

5. 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.

### D. 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 on-site reviews, staff from the Department's Office of Community Behavioral Health Services may examine a sample of service records to verify this affirmation.

### E. Data Quality Performance Expectation

1. 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.
2. 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.
  - a. 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.
  - b. 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.
  - c. 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.
3. The Department will monitor this affirmation by analyzing the CSB's CCS submissions.

**EXHIBIT B FY 2022 AND FY 2023: CONTINUOUS QUALITY IMPROVEMENT (CQI) PROCESS AND CSB PERFORMANCE MEASURES**

**F. 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.

1. 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.
2. 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.
3. 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.
4. 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.

**Exhibit E: FY2022 AND FY2023 Performance Contract Schedule and Process**

<b>DUE DATE</b>	<b>DESCRIPTION</b>
5-21-21	<ol style="list-style-type: none"> <li>The Department distributes the FY 2022 Letters of Notification to CSBs by this date electronically with enclosures that show tentative allocations of state and federal block grant funds.  <i><u>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.</u></i></li> <li>Contracts shall conform to Letter of Notification allocations of state and federal funds or amounts subsequently revised by or negotiated with the OMS and confirmed in writing and shall contain actual appropriated amounts of local matching funds.</li> <li>The Department's Office of Information Services and Technology (OIS&amp;T) distributes the FY 2022 Performance Contract package software in the Community Automated Reporting System (CARS) to CSBs.</li> <li>CSB Financial Analysts in the Department's Office of Fiscal and Grants Management (OFGM) During June and July, prepare electronic data interchange transfers for the first two semi- monthly payments (July) of state and federal funds for all CSBs.</li> </ol>
06-25-21	<p>FY 2022 Exhibit A submitted electronically in CARS, are due by this date. Table 2 Board Management and Salary Cost and Integrated Behavioral and Primary Health Care Questions of Exhibit A shall be submitted with in CARS.</p>
07-01-21	<ol style="list-style-type: none"> <li>All required signature pages for the FY2022 performance contract shall be signed and submitted electronically. This shall include the any applicable Exhibits D that may be due at this time to the Office of Management Services (OMS) attached by email and sent to the <a href="mailto:performancecontractsupport@dbhds.virginia.gov">performancecontractsupport@dbhds.virginia.gov</a> email address.</li> <li>If the CSB has not included the minimum 10 percent local matching funds in the contract, it shall submit a written request for a waiver of the matching funds requirement, pursuant to § 37.2-509 of the Code and State Board Policy 4010, to the OMS attached by email and sent to the <a href="mailto:performancecontractsupport@dbhds.virginia.gov">performancecontractsupport@dbhds.virginia.gov</a> email address.</li> <li>If the amount of CSBs local match in their end of year report results in reducing the local match below the required 10%, then this requirement also applies to end of the fiscal year performance contract reports. The waiver shall conform to the Minimum Ten Percent Matching Funds Waiver Request Guidelines.</li> <li>The CSB Financial Analysts prepares the transfers for payments 3 and 4 during July and August (August payments) of state and federal funds. CSB Financial Analysts prepare the transfers for payments 5 and 6 during August and September (September payments) of state and federal funds.</li> <li>Payments may not be released without complete contracts. Once the completed contract is received transfers for these two semi-monthly payments will be processed and funds will be disbursed with the next scheduled payment.</li> </ol>



**Exhibit E: FY2022 AND FY2023 Performance Contract Schedule and Process**

<b>DUE DATE</b>	<b>DESCRIPTION</b>
<b>07-12-21</b>	The OIS&T distributes FY 2021 end of the fiscal year performance contract report.
<b>07-30-21</b>	CSBs submit their June Community Consumer Submission (CCS) extract files for June to the OIS&T in time to be received by this date.
<b>08-20-21</b>	CSBs submit their complete CCS reports for total (annual) FY 2021 CCS service unit data to the in time to be received by this date. The Department will not accept any corrections to the FY2021 end of year CCS report after this date.
<b>08-31-21</b>	<ol style="list-style-type: none"> <li>1. CSBs send complete FY 2021 end of the fiscal year electronic CARS performance contract reports to the OIS&amp;T in time to be received by this date.</li> <li>2. The OMS reviews services sections of the reports for correctness, completeness, consistency, and acceptability; resolves discrepancies with CSBs; and communicates necessary changes to CSBs.</li> <li>3. OFGM CSB Financial Analysts review financial portions of reports for arithmetic accuracy, completeness, consistency, and conformity with state funding actions; resolve discrepancies with CSBs; and communicate necessary changes to CSBs.</li> <li>4. Once they complete their reviews of a CSB’s reports, the OMS and OFGM CSB Financial Analysts notify the CSB to submit new reports reflecting only those approved changes to OIS&amp;T.</li> <li>5. CSBs submit new reports to correct errors or inaccuracies no later than <b><u>09-17-2021</u></b>. The Department will not accept CARS report corrections after this date.</li> <li>6. Submitting a report without correcting errors identified by the CARS error checking program may result in the imposition by the Department of a one- time, one percent reduction not to exceed \$15,000 of state funds apportioned for CSB administrative expenses.</li> <li>7. CSBs shall submit their July 2022 CCS monthly extract files for July to in time to be received by this date.</li> </ol>

**Exhibit E: FY2022 AND FY2023 Performance Contract Schedule and Process**

<b>DUE DATE</b>	<b>DESCRIPTION</b>
<b>09-30-21</b>	<ol style="list-style-type: none"> <li>1. Department staff complete reviews by this date of contracts received by the due date that are complete and acceptable.</li> <li>2. The OFGM analyzes the revenue information in the contract for conformity to Letter of Notification allocations and advises the CSB to revise and resubmit financial forms in Exhibit A of its contract if necessary.</li> <li>3. The Offices of Community Behavioral Health, Child and Family, and Developmental Services review and approve new service proposals and consider program issues related to existing services based on Exhibit A.</li> <li>4. The OMS assesses contract completeness, examines maintenance of local matching funds, integrates new service information, makes corrections and changes on the service forms in Exhibit A, negotiates changes in Exhibit A, and finalizes the contract for signature by the Commissioner. The OMS notifies the CSB when its contract is not complete or has not been approved and advises the CSB to revise and resubmit its contract.</li> <li>5. The OIS&amp;T receives CARS and CCS submissions from CSBs, maintains the community services database, and processes signed contracts into that database as they are received from the OMS.</li> <li>6. CSBs submit their CCS monthly consumer, type of care, service, diagnosis, and outcomes extract files for August in time to be received by this date.</li> </ol>
<b>10-01-21</b>	<ol style="list-style-type: none"> <li>1. After the Commissioner signs the contracts, a fully executed copy of the Contract will be send to the CSBs.</li> <li>2. CSB Financial Analysts prepare transfers for payments 7 and 8 during September and October (October payments).</li> <li>3. Payment 7 or 8 may not be released without receipt of a CSB’s final FY 2021 CCS consumer, type of care, service, diagnosis, and outcomes extract files and FY 2021 end of the fiscal year by the due date.</li> <li>4. CSB Financial Analysts prepare transfers for payments 9 and 10 during October and November (November payments).</li> </ol>
<b>10-15-21</b>	CSBs submit Federal Balance Reports to the OFGM in time to be received by this date.
<b>10-29-21</b>	<ol style="list-style-type: none"> <li>1. CSBs submit CCS monthly consumer, type of care, service, diagnosis, and outcomes extract files for September to the OIT&amp;S in time to be received by this date.</li> <li>2. CSB Financial Analysts 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.</li> </ol>
<b>11-30-21</b>	CSBs submit their CCS monthly consumer, type of care, service, diagnosis, and outcomes extract files for October to the OIT&S in time to be received by this date.
<b>12-03-21</b>	1. CSBs that are not local government departments or included in local government audits send one

**Exhibit E: FY2022 AND FY2023 Performance Contract Schedule and Process**

<b>DUE DATE</b>	<b>DESCRIPTION</b>
	<p>copy of the 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) by this date.</p> <ol style="list-style-type: none"> <li>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 by this date. For programs with different fiscal years, reports are due three months after the end of the year.</li> <li>3. The CSBs shall have a management letter and plan of correction for deficiencies which must be sent with these reports.</li> <li>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.</li> <li>5. The CSB must forward a plan of correction for any audit deficiencies to the OBFR by this date.</li> <li>6. To satisfy federal block 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 Mental Health Services and Substance Abuse Prevention and Treatment Block 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.</li> <li>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 may negotiate an Exhibit D that addresses the deficiencies or disclaimer and includes a proposed plan with specific timeframes to address them.</li> </ol>
<b>12-31-21</b>	<ol style="list-style-type: none"> <li>1. CSB Financial Analysts prepare transfers for payment 13 through 16 (January and February payments). For CSBs who's FY 2021 end of the fiscal year performance contract reports have been not verified as accurate and internally consistent, and whose CCS monthly extracts for October have been not received, payments may not be released.</li> <li>2. CSBs submit their CCS monthly extract files for November in time to be received by this date.</li> </ol>
<b>01-07-22</b>	The OIS&T distributes FY 2022 mid-year performance contract report software in CARS
<b>01-31-22</b>	CSBs submit their CCS monthly consumer, type of care, service, diagnosis, and outcomes extract files for December in time to be received by this date.
<b>02-18-22</b>	<ol style="list-style-type: none"> <li>1. CSBs send complete mid-year performance contract reports and a revised Table 1: Board of Directors Membership Characteristics to the OIS&amp;T electronically in CARS.</li> <li>2. CSB Financial Analysts prepare 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.</li> <li>3. CSB Financial Analysts prepare transfers during March for payments 19 and 20 (April payments) for CSBs whose complete FY 2022 mid-year performance contract reports not received by the due date, payments may not be released.</li> </ol>
<b>02-25-22</b>	CSBs submit their CCS extract files for January to the OIS&T in time to be received by this date, for CSBs whose monthly CCS extract files for January were not received by the end of the month, payments may not be released.

**Exhibit E: FY2022 AND FY2023 Performance Contract Schedule and Process**

<b>DUE DATE</b>	<b>DESCRIPTION</b>
<b>03-31-22</b>	<ol style="list-style-type: none"> <li>1. CSBs submit their CCS extract files for February to the OIS&amp;T in time to be received by this date.</li> <li>2. CSB Financial Analysts prepare transfers during March 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 CCS extract files for February were not received by the end of the month. Payments may not be released.</li> </ol>
<b>04-29-22</b>	<ol style="list-style-type: none"> <li>1. CSBs submit their CCS monthly consumer, type of care, service, diagnosis, and outcomes extract files for March to the OIS&amp;T in time to be received by this date.</li> <li>2. CSB Financial Analysts prepare 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.</li> </ol>
<b>05-31-22</b>	<ol style="list-style-type: none"> <li>1. CSBs submit their CCS monthly extract files for April to the OIS&amp;T in time to be received by this date, for CSBs whose monthly CCS extract files for April were received by the end of May.</li> <li>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.</li> </ol>
<b>06-30-22</b>	CSBs submit their CCS monthly extract files for May to the OIS&T by this date.

## **Exhibit E: FY2022 Performance Contract Schedule**

### **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, and monthly CCS extracts to the Department.

- A.** The performance contract and any revisions submitted by the CSB shall be:
1. complete, that is 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 in the Department-provided CARS software and any subsequent instructional memoranda; and
  4. received by the due dates listed in Exhibit E of this contract.
- B.** If the CSB does not meet these performance contract requirements, the Department may delay future semi-monthly 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, that is all required information is displayed in the correct places, all required data are included in the electronic CARS application reports, and any required paper forms that gather information not included in CARS are submitted;
  2. consistent with the state and federal block grant funds allocations in the Letter of Notification or figures subsequently revised by or negotiated with the Department;
  3. prepared in accordance with instructions;
  4. (i) internally consistent and arithmetically accurate: all related funding, expense, and cost data are consistent, congruent, and correct within a report, and (ii) submitted only after errors identified by the CARS error checking programs are corrected; and
  5. received by the due dates listed in Exhibit E of this contract.
- 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 semi-monthly payments state and federal funds 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 following requirements in its end-of-the-fiscal year CARS report:
1. a one percent reduction not to exceed \$15,000 for failure to comply with requirement of section C.4. of this exhibit; and
  2. a one percent reduction not to exceed \$15,000 for failure to comply with requirement of section C.5. of this exhibit, unless an extension has been obtained from the Department through the process on the next page.
- E.** The CSB shall submit monthly consumer, type of care, service, diagnosis, and outcomes 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. The submissions shall satisfy the requirements.
- F.** If the CSB fails to meet the extract submission requirements in Exhibit E of this contract, the Department may delay semi-monthly payments until satisfactory performance is achieved, unless

## Exhibit E: FY2022 Performance Contract Schedule

### Administrative Performance Requirements

the Department has not provided the CCS extract application to the CSB in time for it to transmit its monthly submissions.

- G.** If the Department negotiates an Exhibit D with a CSB because of unacceptable data quality, and the CSB fails to satisfy the requirements in Exhibit D 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<sup>1</sup> on the CSB.
- H.** Substance abuse prevention units of service data and quarterly reports shall be submitted to the Department through the prevention data system planned and implemented by the Department in collaboration with the VACSB DMC.
- I.** The Department will calculate state funds apportioned for CSB administrative expenses by multiplying the total state funds allocated to the CSB by the CSB's administrative percentage displayed on page AF-1 of the contract.
- J.** The CSB shall not allocate or transfer a one-time reduction of state funds apportioned for administrative expenses to direct service or program costs.
- K.** 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 in time to be received in the Department by the due date, the executive director must inform the Office of Management Services (OMS) Director that it is requesting an extension of this due date. This request should be submitted as soon as possible and it shall be in writing, 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 written 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](mailto: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 on the second business day before the due date.
- L.** 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;

## **Exhibit E: FY2022 Performance Contract Schedule**

### **Administrative Performance Requirements**

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 software and the same procedures used for the original performance contract.

## Exhibit F: FY22-23 Federal Grant Compliance Requirements

### Background

State agencies often administer federal awards received as pass-through funds to other non-federal entities. These non-federal recipient entities are called Subrecipient and they assist in carrying out various federally-funded programs. Subrecipient 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 Subrecipient. Federal regulations require that pass-through entities provide monitoring of their Subrecipient which is outlined in Sections 200.330 through 200.345 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 compliance requirements and other general grant information for the federal grant funds that DBHDS passes-through to the CSBs.

### 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 SFA awarded 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 SFA.

**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.



## Exhibit F: FY22-23 Federal Grant Compliance Requirements

**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. The number of the announcement pertaining to this SFA is included in the Grant Specific Requirements in Section VI.

**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 \$1,000 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. A copy of the NOA is included in Attachment B.

**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 as a result of this agreement.

**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]

## Exhibit F: FY22-23 Federal Grant Compliance Requirements

**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.

### **I. 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):

- 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:
  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. The Department shall 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. The Department is 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.

## Exhibit F: FY22-23 Federal Grant Compliance Requirements

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.

### II. 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 GRANT

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 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 signature of its Exhibit D or Notice of Award. Once the Exhibit D or Notice of Award is signed by the subrecipient, the contents of the Exhibit D or Notice of Award are binding on the subrecipient unless and until modified and signed by DBHDS.

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.>)

## Exhibit F: FY22-23 Federal Grant Compliance Requirements

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 this SFA as outlined in their Exhibit D or Notice of 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 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 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, 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

## Exhibit F: FY22-23 Federal Grant Compliance Requirements

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 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 (12).
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 3, 2021, the salary limitation for Executive Level II is \$199,300.
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.

## Exhibit F: FY22-23 Federal Grant Compliance Requirements

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,

## Exhibit F: FY22-23 Federal Grant Compliance Requirements

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:** 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):

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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 funded by this SFA 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 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 31 U.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 45 CFR 75.215, 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



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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 this agreement/contract. Please consult [www.healthit.gov](http://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](mailto: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.

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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.

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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 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. This amount may be paid for participation in each required follow-up interview.
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.

## Exhibit F: FY22-23 Federal Grant Compliance Requirements

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.

### III. 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 as a result of this agreement.

- 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](https://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.
- a. **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.

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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, 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

**b. Closeout:** Final payment request(s) under this 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. 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 as defined in this agreement

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 75<sup>th</sup> 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

Failure to return unexpended funds in a prompt manner may result in a denial of future federal Subrecipient awards from DBHDS.

In consideration of the execution of this agreement by 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 this agreement. Subrecipient's obligations to DBHDS under this agreement 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 this 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 as a result of this agreement.

- 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.

## Exhibit F: FY22-23 Federal Grant Compliance Requirements

- 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:

1. 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)).
2. 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)).
3. 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)).
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. 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. Medicaid and private insurance, if available, must be used first. 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:
  - i. Pregnant injecting drug users;
  - ii. Pregnant substance abusers;
  - iii. Injecting drug users;
  - iv. All others

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

## Exhibit F: FY22-23 Federal Grant Compliance Requirements

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). Treatment and competency restoration services may be provided to individuals with a serious mental illness or serious emotional

- c. **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, 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.

- d. **Closeout:** Final payment request(s) under this 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. 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:

DBHDS

PO Box 1797

Richmond, VA 23218-1797

C/O Eric Billings

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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.

In consideration of the execution of this agreement by 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 this agreement. Subrecipient's obligations to DBHDS under this agreement 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 this 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 as a result of this agreement.

- 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, 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



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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 after 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, 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.

- d. **Closeout:** Final payment request(s) under this 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. 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:

DBHDS

PO Box 1797

Richmond, VA 23218-1797

C/O Eric Billings

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In consideration of the execution of this agreement by 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,

## Exhibit F: FY22-23 Federal Grant Compliance Requirements

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 this agreement. Subrecipient's obligations to DBHDS under this agreement 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 this 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 as a result of this agreement.

- 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:
    - i. Outreach services;
    - ii. Screening and diagnostic treatment services;
    - iii. Habilitation and rehabilitation services;
    - iv. Community mental health services;
    - v. Alcohol or drug treatment services;
    - vi. 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;
    - vii. Case management services including:
      1. 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;
      2. 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;
      3. 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;
      4. Referring the eligible homeless individual for such other services as may be appropriate; and
      5. 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;
    - viii. Supportive and supervisory services in residential settings;
    - ix. Referrals for primary health services, job training, educational services, and relevant housing services;
    - x. Minor renovation, expansion, and repair of housing (as defined in the Definitions section of this Exhibit);
    - xi. Planning of housing;
    - xii. Technical assistance in applying for housing assistance;
    - xiii. Improving the coordination of housing services;
    - xiv. Security deposits;

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- xv. The costs associated with matching eligible homeless individuals with appropriate housing situations;
  - xvi. One-time rental payments to prevent eviction;
  - xvii. 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:
    - i. Are suffering from a serious mental illness; or
    - ii. Are suffering from a serious mental illness and from a substance use disorder; and
    - iii. 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:
    - i. Has a policy of excluding individuals from mental health services due to the existence or suspicion of a substance use disorder; or
    - ii. 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.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, 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.

- d. **Closeout:** Final payment request(s) under this 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. 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 395<sup>th</sup> 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

## Exhibit F: FY22-23 Federal Grant Compliance Requirements

Richmond, VA 23218-1797

C/O Eric Billings

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### SubrecipientSubrecipient5. **Young Adult Substance Abuse Treatment Implementation Grant**

Pursuant to the Notice of Award received by DBHDS and the Funding Opportunity Announcement (TI-17-002) associated with the Youth Treatment Implementation Grant, the following are requirements of the funding distributed to the Subrecipient as a result of this agreement.

- a. **Restrictions on Expenditures:** Young Adult Substance Abuse Treatment Implementation Grant funds may not be used for any of the following purposes:
1. Pay for any lease beyond the project period.
  2. Provide services to incarcerated populations (defined as those persons in jail, prison, detention facilities, or in custody where they are not free to move about in the community).
  3. Pay for the purchase or construction of any building or structure to house any part of the program. (Subrecipient may request up to \$5,000 for renovations and alterations of existing facilities, if necessary and appropriate to the project.)
  4. Pay for housing other than residential mental health and/or substance use disorder treatment.
  5. 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.)
  6. Provide inpatient treatment or hospital-based detoxification services. Residential services are not considered to be inpatient or hospital-based services.
  7. Only allowable costs associated with the use of federal funds are permitted to fund EBPs. Other sources of funds may be used for unallowable costs (e.g. meals, sporting events, entertainment). Other support is defined as funds or resources, whether federal, non-federal or institutional, in direct support of activities through fellowships, gifts, prizes, or in-kind contributions.
  8. Make direct payments to individuals to induce them to enter prevention or treatment services. However, grant funds may be used for non-clinical support services (e.g. bus tokens, child care) designed to improve access to and retention in prevention and treatment programs.
  9. Make direct payments to individuals to encourage attendance and/or attainment of prevention or treatment goals. However, grant funds may be used for non-cash incentives of up to \$30 to encourage attendance and/or attainment of prevention or treatment goals when the incentives are built into the program design and when the incentives are the minimum amount that is deemed necessary to meet program goals. SAMHSA policy allows an individual participant to receive more than one incentive over the course of the program. However, non-cash incentives should be limited to the minimum number of times deemed necessary to achieve program outcomes. A grantee or treatment or prevention provider may also provide up to \$30 cash or equivalent (coupons, bus tokens, gifts, child care, and vouchers) to individuals as

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incentives to participate in required data collection follow-up. This amount may be paid for participation in each required interview.

10. Meals are generally unallowable unless they are an integral part of a conference grant or specifically stated as an allowable expense in the Performance Contract. Grant funds may be used for light snacks, not to exceed \$3.00 per person.
11. Consolidated Appropriations Act, 2016, Division H states, SEC. 520, notwithstanding any other provision 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.
12. Pay for pharmacologies for HIV antiretroviral therapy, Sexually Transmitted Diseases (STD)/Sexually Transmitted Illnesses (STI), TB, and hepatitis B and C, or for psychotropic drugs.

### b. Grant Guidelines:

1. Funds must be used to improve capacity to increase access to treatment and to improve the quality of treatment for adolescents and transitional youth aged 16-25, and their families/primary caregivers through:
  - i. Expanding and enhancing SUD treatment services for adolescents and transitional youth aged 16-25;
  - ii. Involving families, adolescents, and transitional aged youth at the state/territorial/tribal/local levels to inform policy, program, and effective practice;
  - iii. Expanding the qualified workforce;
  - iv. Disseminating Evidence-Based Practices (EBPs);
  - v. Developing funding and payment strategies that support EBPs in the current funding environment; and
  - vi. Improving interagency collaboration.
2. Subrecipient must address each of the following required activities:
  - i. Provide outreach and other engagement strategies to increase participation in, and provide access to, treatment for diverse populations (i.e. ethnic, racial, sexual orientation, gender identity, etc.).
  - ii. Provide direct treatment including screening, assessment, care management, and recovery support for diverse populations at risk. Treatment must be provided in outpatient, intensive outpatient, or day treatment settings. Clients must be screened and assessed for the presence of substance use disorders and/or co-occurring mental and substance use disorders, using an assessment instrument(s) that is evidence-based, and use the information obtained from the screening and assessment to develop appropriate treatment approaches for the persons identified as having such disorders.
  - iii. Provide youth recovery support services and supports (e.g. recovery coaching, vocational, educational, and transportation services) designed to support recovery and improve access and retention.
  - iv. Provide the EBPs in assessment(s) and treatment intervention(s), selected in consultation with DBHDS for the population of focus.
  - v. Participate in a provider collaborative, managed by DBHDS, that, at a minimum, provides the following:
    1. Direct treatment for SUD and/or co-occurring substance use and mental disorders and recovery support services to the population of focus;
    2. Identifies and addresses common provider-level administrative challenges in providing substance abuse treatment and recovery support services to the population of focus;
    3. Develops and implements a common continuous quality improvement/quality assurance plan across the providers in the collaborative to improve the services provided;

## Exhibit F: FY22-23 Federal Grant Compliance Requirements

4. Identifies and addresses common barriers faced by the population of focus in accessing services; and
  5. Promotes coordination and collaboration with family support organizations to assist in the development of peer support services and strengthen services for the population of focus who have, or are at risk of SUD and/or co-occurring substance use and mental disorders.
3. Subrecipient must screen and assess clients for the presence of SUD and/or co-occurring mental and substance use disorders 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.
  4. Subrecipient must utilize third party and other revenue realized from the provision of services to the extent possible and use Youth Treatment Implementation Grant funds only for services to individuals who are not covered by public or commercial eHealth 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. Subrecipient are also expected to facilitate the health insurance application and enrollment process for eligible uninsured clients. Subrecipient should also consider other systems from which a potential service recipient may be eligible for services if appropriate for and desired by that individual to meet his/her needs. In addition, Subrecipient are required to implement policies and procedures that ensure other sources of funding are utilized first when available for that individual.
- 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, 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.

- d. **Closeout:** Final payment request(s) under this 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. 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 as defined in this agreement

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 75<sup>th</sup> 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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## Exhibit F: FY22-23 Federal Grant Compliance Requirements

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 this agreement. Subrecipient's obligations to DBHDS under this agreement 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 this 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, 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.

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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 75<sup>th</sup> 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:

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C/O

**Exhibit F: FY22-23 Federal Grant Compliance Requirements**

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**IV. List of Federal Grants**

Provided in the chart below is a current list of the federal grants that DBHDS passes-through to CSBs and the required identifying information that should be used to categorize and track these funds.

<b>SAMHSA GRANTS</b>
<b>GRANT NAME: State Opioid Response Grant (SUD Federal Opioid Response)</b>
<b>GRANT NAME:</b> State Opioid Response Grant (SUD Federal Opioid Response) <b>FEDERAL AWARD IDENTIFICATION NUMBER (FAIN):</b> H79TI081682 <b>FEDERAL AWARD DATE:</b> 2/19/2018 <b>FEDERAL AWARING AGENCY:</b> Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) <b>FEDERAL AWARD PASS-THROUGH ENTITY:</b> Virginia Department of Behavioral Health and Developmental Services <b>CFDA NUMBER:</b> 93.788 <b>RESEARCH AND DEVELOPMENT AWARD:</b> ___ YES OR <input checked="" type="checkbox"/> NO <b>FEDERAL GRANT AWARD YEAR:</b> FFY 2020 <b>AWARD PERIOD:</b> 9/30/2019 – 9/29/2021
<b>GRANT NAME: Substance Abuse Prevention and Treatment Block Grant (SUD FBG)</b>
<b>GRANT NAME:</b> Substance Abuse Prevention and Treatment Block Grant (SUD FBG) <b>FEDERAL AWARD IDENTIFICATION NUMBER (FAIN):</b> B08TI083056-01 <b>FEDERAL AWARD DATE:</b> 5/15/2020 <b>FEDERAL AWARING AGENCY:</b> Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) <b>FEDERAL AWARD PASS-THROUGH ENTITY:</b> Virginia Department of Behavioral Health and Developmental Services <b>CFDA NUMBER:</b> 93.959 <b>RESEARCH AND DEVELOPMENT AWARD:</b> ___ YES OR <input checked="" type="checkbox"/> NO <b>FEDERAL GRANT AWARD YEAR:</b> FFY 2020 <b>AWARD PERIOD:</b> 10/1/2019 – 9/30/2021
<b>GRANT NAME: Community Mental Health Services Block Grant (MH FBG)</b>



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**GRANT NAME:** Community Mental Health Services Block Grant (MH FBG)  
**FEDERAL AWARD IDENTIFICATION NUMBER (FAIN):** B09SM082636-01  
**FEDERAL AWARD DATE:** 12/31/2019  
**FEDERAL AWARDDING 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 2020  
**AWARD PERIOD:** 10/1/2019 – 9/30/2021

**GRANT NAME: Projects for Assistance in Transition from Homelessness (PATH)**

**GRANT NAME:** Projects for Assistance in Transition from Homelessness (PATH)  
**FEDERAL AWARD IDENTIFICATION NUMBER (FAIN):** X06SM083701-01  
**FEDERAL AWARD DATE:** 8/24/2020  
**FEDERAL AWARDDING 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:** 93.15  
**RESEARCH AND DEVELOPMENT AWARD:** \_\_\_ YES OR \_\_\_ X \_\_\_ NO  
**FEDERAL GRANT AWARD YEAR:** FFY 2020  
**AWARD PERIOD:** 9/1/2020 – 8/31/2021

**GRANT NAME:** Projects for Assistance in Transition from Homelessness (PATH)  
**FEDERAL AWARD IDENTIFICATION NUMBER (FAIN):** X06SM083701-02  
**FEDERAL AWARD DATE:** TBD  
**FEDERAL AWARDDING 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:** 93.15  
**RESEARCH AND DEVELOPMENT AWARD:** \_\_\_ YES OR \_\_\_ X \_\_\_ NO  
**FEDERAL GRANT AWARD YEAR:** FFY 2021  
**AWARD PERIOD:** 9/1/2021 – 8/31/2022

**GRANT NAME: Young Adult Substance Abuse Treatment Implementation Grant (YSAT)**

**GRANT NAME:** Young Adult Substance Abuse Treatment Implementation Grant (YSAT)  
**FEDERAL AWARD IDENTIFICATION NUMBER (FAIN):** H79TI080197  
**FEDERAL AWARD DATE:** 5/15/2020  
**FEDERAL AWARDDING 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:** 93.243  
**RESEARCH AND DEVELOPMENT AWARD:** \_\_\_ YES OR \_\_\_ X \_\_\_ NO  
**FEDERAL GRANT AWARD YEAR:** FFY 2021  
**AWARD PERIOD:** 9/30/2020 – 9/29/2021

**GRANT NAME: State Opioid Response Grant (SUD Federal Opioid Response)**

**Exhibit F: FY22-23 Federal Grant Compliance Requirements**

<p><b>GRANT NAME:</b> State Opioid Response Grant (SUD Federal Opioid Response)  <b>FEDERAL AWARD IDENTIFICATION NUMBER (FAIN):</b> H79TI081682  <b>FEDERAL AWARD DATE:</b> 2/19/2018  <b>FEDERAL AWARDDING AGENCY:</b> Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA)  <b>FEDERAL AWARD PASS-THROUGH ENTITY:</b> Virginia Department of Behavioral Health and Developmental Services  <b>CFDA NUMBER:</b> 93.788  <b>RESEARCH AND DEVELOPMENT AWARD:</b> <u>    </u> YES OR <u>  X  </u> NO  <b>FEDERAL GRANT AWARD YEAR:</b> FFY 2020  <b>AWARD PERIOD:</b> 9/30/2019 – 9/29/2021</p>	<p><b>GRANT NAME:</b> State Opioid Response Grant (SUD Federal Opioid Response)  <b>FEDERAL AWARD IDENTIFICATION NUMBER (FAIN):</b> H79TI083296  <b>FEDERAL AWARD DATE:</b> 8/27/2020  <b>FEDERAL AWARDDING AGENCY:</b> Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA)  <b>FEDERAL AWARD PASS-THROUGH ENTITY:</b> Virginia Department of Behavioral Health and Developmental Services  <b>CFDA NUMBER:</b> 93.788  <b>RESEARCH AND DEVELOPMENT AWARD:</b> <u>    </u> YES OR <u>  X  </u> NO  <b>FEDERAL GRANT AWARD YEAR:</b> FFY 2021  <b>AWARD PERIOD:</b> 9/30/2020 – 9/29/2021</p>
<p align="center"><b>GRANT NAME: Substance Abuse Prevention and Treatment Block Grant (SUD FBG)</b></p>	
<p><b>GRANT NAME:</b> Substance Abuse Prevention and Treatment Block Grant (SUD FBG)  <b>FEDERAL AWARD IDENTIFICATION NUMBER (FAIN):</b> B08TI083481  <b>FEDERAL AWARD DATE:</b> 2/1/2021  <b>FEDERAL AWARDDING AGENCY:</b> Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA)  <b>FEDERAL AWARD PASS-THROUGH ENTITY:</b> Virginia Department of Behavioral Health and Developmental Services  <b>CFDA NUMBER:</b> 93.959  <b>RESEARCH AND DEVELOPMENT AWARD:</b> <u>    </u> YES OR <u>  X  </u> NO  <b>FEDERAL GRANT AWARD YEAR:</b> FFY 2021  <b>AWARD PERIOD:</b> 10/1/2020 – 9/30/2022</p>	<p><b>GRANT NAME:</b> Substance Abuse Prevention and Treatment Block Grant (SUD FBG)  <b>FEDERAL AWARD IDENTIFICATION NUMBER (FAIN):</b> B08TI083547  <b>FEDERAL AWARD DATE:</b> 3/11/2021  <b>FEDERAL AWARDDING AGENCY:</b> Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA)  <b>FEDERAL AWARD PASS-THROUGH ENTITY:</b> Virginia Department of Behavioral Health and Developmental Services  <b>CFDA NUMBER:</b> 93.959  <b>RESEARCH AND DEVELOPMENT AWARD:</b> <u>    </u> YES OR <u>  X  </u> NO  <b>FEDERAL GRANT AWARD YEAR:</b> FFY 2022  <b>AWARD PERIOD:</b> 3/15/2021 – 3/14/2023</p>
<p align="center"><b>GRANT NAME: Community Mental Health Services Block Grant (MH FBG)</b></p>	
<p><b>GRANT NAME:</b> Community Mental Health Services Block Grant (MH FBG)  <b>FEDERAL AWARD IDENTIFICATION NUMBER (FAIN):</b> B09SM083794  <b>FEDERAL AWARD DATE:</b> 11/17/2020  <b>FEDERAL AWARDDING AGENCY:</b> Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA)  <b>FEDERAL AWARD PASS-THROUGH ENTITY:</b> Virginia Department of Behavioral Health and Developmental Services  <b>CFDA NUMBER:</b> 93.958  <b>RESEARCH AND DEVELOPMENT AWARD:</b> <u>    </u> YES OR <u>  X  </u> NO  <b>FEDERAL GRANT AWARD YEAR:</b> FFY 2021  <b>AWARD PERIOD:</b> 10/1/2020 – 9/30/2022</p>	<p><b>GRANT NAME:</b> Community Mental Health Services Block Grant (MH FBG)  <b>FEDERAL AWARD IDENTIFICATION NUMBER (FAIN):</b> B09SM083950  <b>FEDERAL AWARD DATE:</b> 3/11/2021  <b>FEDERAL AWARDDING AGENCY:</b> Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA)  <b>FEDERAL AWARD PASS-THROUGH ENTITY:</b> Virginia Department of Behavioral Health and Developmental Services  <b>CFDA NUMBER:</b> 93.958  <b>RESEARCH AND DEVELOPMENT AWARD:</b> <u>    </u> YES OR <u>  X  </u> NO  <b>FEDERAL GRANT AWARD YEAR:</b> FFY 2022  <b>AWARD PERIOD:</b> 3/15/2021 – 3/14/2023</p>

**Exhibit F: FY22-23 Federal Grant Compliance Requirements**

<b>GRANT NAME: Emergency Grants to Address Mental &amp; Substance Use Disorders During COVID-19 (MH &amp; SUD Federal COVID Emergency Grant)</b>	
<p><b>GRANT NAME:</b> Emergency Grants to Address Mental &amp; Substance Use Disorders During COVID-19 (MH &amp; SUD Federal COVID Emergency Grant)</p> <p><b>FEDERAL AWARD IDENTIFICATION NUMBER (FAIN):</b> H79FG000285</p> <p><b>FEDERAL AWARD DATE:</b> 4/16/2020</p> <p><b>FEDERAL AWARDDING AGENCY:</b> Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA)</p> <p><b>FEDERAL AWARD PASS-THROUGH ENTITY:</b> Virginia Department of Behavioral Health and Developmental Services</p> <p><b>CFDA NUMBER:</b> 93.665</p> <p><b>RESEARCH AND DEVELOPMENT AWARD:</b> <input type="checkbox"/> YES OR <input checked="" type="checkbox"/> NO</p> <p><b>FEDERAL GRANT AWARD YEAR:</b> FFY 2021</p> <p><b>AWARD PERIOD:</b> 4/20/2020 – 8/19/2021</p>	<p><b>GRANT NAME:</b> Emergency Grants to Address Mental &amp; Substance Use Disorders During COVID-19 (MH &amp; SUD Federal COVID Emergency Grant)</p> <p><b>FEDERAL AWARD IDENTIFICATION NUMBER (FAIN):</b> H79FG000712</p> <p><b>FEDERAL AWARD DATE:</b> 1/15/2021</p> <p><b>FEDERAL AWARDDING AGENCY:</b> Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA)</p> <p><b>FEDERAL AWARD PASS-THROUGH ENTITY:</b> Virginia Department of Behavioral Health and Developmental Services</p> <p><b>CFDA NUMBER:</b> 93.665</p> <p><b>RESEARCH AND DEVELOPMENT AWARD:</b> <input type="checkbox"/> YES OR <input checked="" type="checkbox"/> NO</p> <p><b>FEDERAL GRANT AWARD YEAR:</b> FFY 2021</p> <p><b>AWARD PERIOD:</b> 2/1/2021 – 5/31/2022</p>

## 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:**

<u>Agency Name and Address</u>		<u>FEIN(s)</u>	<u>Fiscal Year End Date</u>
<u>Agency Representative</u>		<u>Title</u>	
<u>Telephone</u>	<u>Fax</u>	<u>Email</u>	

**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.**

<u>Agency Representative's Signature</u>	<u>Date</u>
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**Independent Auditor Information:**

<u>Firm Name and Address</u>		
<u>CPA Name</u>		<u>Virginia State License Number</u>
<u>Telephone</u>	<u>Fax</u>	<u>Email</u>



**Exhibit G: FY22 – Core Mandated Services**

Core mandated services a CSB shall be responsible for providing.

Services	Mandated	Description
<b>Virginia Psychiatric Bed Registry</b>	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.
<b>Preadmission Screening</b>	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.
<b>Discharge Planning</b>	VA Code Mandated	Section 37.2-500 of the Code of Virginia requires that CSBs must provide emergency services.
<b>Emergency Services Availability</b>	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.
<b>Preadmission Screening Evaluations</b>	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.
<b>Certification of Preadmission Screening Clinicians</b>	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.
<b>STEP-VA</b>	VA Code Mandated and Appropriations Act MM.1	Pursuant to 37.2-500 and 37.2-601 of the Code, all CSBs shall provide the following services as described in the Taxonomy and report data through CCS 3 and CARS as required by the Department. <ul style="list-style-type: none"> <li>a. Same Day Mental Health Assessment Services (SDA or Same Day Access)</li> <li>b. Outpatient Primary Care Screening Services</li> </ul>

**Exhibit G: FY22 – Core Mandated Services**

		<ul style="list-style-type: none"> <li>c. Outpatient Behavioral Health and Substance Use Disorder Services</li> <li>d. Peer Support and Family Support Services</li> <li>e. Mental Health Services for Military Service Members, Veterans, and Families (SMVF)</li> </ul>
<p><b>Department of Justice Settlement Agreement (DOJ SA)</b></p>	<p>Compliance with DOJ SA</p>	<p>See Exhibit M</p>

## COMMUNITY SERVICES PERFORMANCE CONTRACT

### 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



## COMMUNITY SERVICES PERFORMANCE CONTRACT

### Exhibit H FY22-23: Regional Local Inpatient Purchase of Services (LIPOS) Requirements

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).

## Exhibit I FY2022-2023: Behavioral Health Wellness/Prevention Services

### I. Behavioral Health Wellness/Prevention Services

#### 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 and Mental Health First Aid 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 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.

#### B. DBHDS Behavioral Health Wellness Priorities

## **Exhibit I FY2022-2023: Behavioral Health Wellness/Prevention Services**

- 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.

### **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:*

## Exhibit I FY2022-2023: Behavioral Health Wellness/Prevention Services

Priority Strategy	Proposed FY21 and FY22 Performance Contract Measures
<b>General Capacity Requirements</b>	<ul style="list-style-type: none"> <li>• Each CSB must complete an evaluation plan which is revised and approved annually and includes:               <ul style="list-style-type: none"> <li>○ 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.</li> <li>○ A measurement plan documenting how all required metrics will be tracked and reported.</li> </ul> </li> <li>• 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.</li> <li>• Each CSB must maintain a license for the Performance-Based Prevention System (PBPS) and record all implemented strategies in the PBPS.</li> <li>• 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.</li> <li>• 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.</li> </ul>
<b>Community Coalition Development</b>	<ol style="list-style-type: none"> <li>1. The CSB shall be involved in a minimum of 6-10 coalition meetings a year.</li> <li>2. The CSB should maintain membership in CADCA and/or CCoVA each year.</li> <li>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.</li> <li>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.</li> <li>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.</li> </ol>
<b>SYNAR: Merchant Education and Counter Tools</b>	<ol style="list-style-type: none"> <li>1. 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.</li> <li>2. The CSB also must maintain and update a list of tobacco/nicotine retailers in its catchment area over the two-year period.</li> <li>3. Data must be entered into the Counter Tools and PBPS systems.</li> <li>4. Tobacco education programs for youth with the goal of reducing prevalence of use are not to be identified as SYNAR activities.</li> </ol>
<b>ACEs Self-Healing Communities</b>	<ol style="list-style-type: none"> <li>1. All CSBs should ensure there are at least 2 ACEs master trainers in their catchment area at all times.</li> <li>2. All CSBs must conduct at least 12 ACEs trainings annually.</li> <li>3. All ACEs training data (including number of trainings held and number of people trained) must be reported in PBPS.</li> <li>4. CSBs which are designated as Self-Healing Communities and are receiving additional funding to address ACEs must complete all items noted above <i>and</i> the following:</li> <li>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.</li> </ol>

## Exhibit I FY2022-2023: Behavioral Health Wellness/Prevention Services

Priority Strategy	Proposed FY21 and FY22 Performance Contract Measures
	<ol style="list-style-type: none"> <li>6. Create a logic model specific to the ACEs work that is planned and implemented in the community.</li> <li>7. Submit a quarterly report on all ACEs strategies and measures.</li> <li>8. Engage in a local Trauma-Informed Community Network (TICN) or other trauma-centered coalition.</li> </ol>
<b>MHFA/Suicide Prevention Planning and Trainings</b>	<ol style="list-style-type: none"> <li>1. 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.</li> <li>2. 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.</li> <li>3. Each MHFA trainer must provide a minimum of 3 Youth and/or Adult MHFA trainings annually.</li> <li>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).</li> <li>5. In addition to the required MHFA trainings, a minimum of 3 suicide prevention trainings <i>per trainer</i> must be provided annually. These 3 trainings may be a combination of any of the approved trainings below:               <ol style="list-style-type: none"> <li>a. ASIST</li> <li>b. safeTALK</li> <li>c. suicideTALK</li> <li>d. QPR</li> </ol> </li> <li>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.</li> </ol>
<b>Lock &amp; Talk</b>	<ol style="list-style-type: none"> <li>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 &amp; 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.</li> <li>2. Lock and Talk Components:               <ol style="list-style-type: none"> <li>a) Media Campaign Materials (bus ads, posters, billboards, PSA, etc.)</li> <li>b) Medication Lock Box/Cable Lock/Trigger Lock Distribution at Event</li> <li>c) Gun Shop Project</li> </ol> </li> </ol>

## **FY 22-23 Exhibit K**

### **Collaborative Discharge Requirements for Community Services Boards and State Hospitals**

#### **Adult & Geriatric**

##### **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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Appendix B: Memo Regarding Patient Choice at Discharge

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**General Requirements**

Regional responsibility	Responsible entity	Timeframe
<p>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.</p>	<p>CSB emergency services</p>	<p><i>Upon admission request to state hospital</i></p>
<p>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.</p> <p>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.</p>	<p>CSBs</p> <p>DBHDS Office of Community Integration</p>	<p><i>At least quarterly, or whenever changes occur</i></p> <p><i>At least quarterly</i></p>
<p>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.</p>	<p>CSB regions</p>	<p><i>Updated at least quarterly</i></p>
<p>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</p>	<p>CSB regions</p>	<p><i>Updated as needed</i></p>



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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.		
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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	<i>Within 24 hours of the issuance of the TDO</i>		
CSB staff shall participate in discussions to determine whether the state hospital is the most appropriate treatment site	<i>Immediately upon admission and ongoing</i>	State hospital staff shall assess each individual to determine whether the state hospital is the most appropriate treatment site	<i>Immediately upon admission and ongoing</i>
<p>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).</p> <ol style="list-style-type: none"> <li>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.</li> <li>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.</li> </ol>	<i>Upon admission</i>	<p>State hospital staff shall contact the CSB to notify them of the new admission</p> <p>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</p> <p>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.</p>	<p><i>Within one business day</i></p> <p><i>Within one business day</i></p>

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<p>3. CSB staff shall establish a personal contact (preferably in person) with the hospitalized individual in order to initiate collaborative discharge planning.</p>	<p><i>Within seven calendar days of admission</i></p>		
<p>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.</p> <p>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.</p> <p>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.</p> <p>Note: While it may not be possible for the CSB to attend every treatment planning meeting,</p>	<p><i>Ongoing</i></p> <p><i>Ongoing</i></p> <p><i>Within two business days of</i></p>	<p>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.</p> <p>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</p> <p>The CTP meeting shall be held within seven calendar days of admission.</p> <p>Note: It is expected that the state hospital will make every effort to include CSBs in CTP and TPRs, including providing alternative accommodations (such as phone or video) and scheduling meetings so that liaisons can</p>	<p><i>At least two business days prior to the scheduled meeting</i></p> <p><i>Within seven calendar days of admission</i></p>

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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.	<i>the missed meeting</i>	participate in as many treatment team meetings as possible	
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becomes available, the CSB staff shall update the discharge plan accordingly		progress notes and through communications/meetings with the CSB.	
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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)	<i>Ongoing</i>
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<p>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.</p> <p>The CSB NGRI Coordinator shall review, edit, sign, and return the risk management plan (RMP) for individuals adjudicated as NGRI</p> <p>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</p> <p>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.</p>	<p><i>to DBHDS Central Office Forensics staff</i></p> <p align="center"><i>Ongoing</i></p> <p><i>Within 10 business days of receiving notice from the state hospital</i></p> <p><i>Within 10 business day of being notified that the individual has been recommended for release</i></p>	<p>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</p> <p>The state hospital shall complete the packet requesting an increase in privilege level or release</p>	<p align="center"><i>Within one business day of the treatment team identifying the individual as being eligible for a privilege increase or release</i></p> <p align="center"><i>Within 10 business days of the treatment team identifying the individual as being eligible for a privilege increase</i></p>
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<p><b>Guardianship:</b></p> <p>Upon being notified of the need for a guardian, the CSB shall explore potential individuals/agencies to serve in that capacity.</p> <p>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.</p>	<p><i>Within two business days of notification</i></p> <p><i>Within 10 business days of notification of need for a guardian</i></p>	<p><b>Guardianship:</b></p> <p>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.</p> <p>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.</p> <p>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.</p>	<p><i>Within two business days of determination</i></p> <p><i>Immediately upon notification by the CSB of the need for a DBHDS guardianship slot</i></p>

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<p><b>Assisted Living (ALF) referrals:</b></p> <p>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.</p> <p>The CSB shall obtain required documentation and send referral packets to multiple potential placements. The referrals are to be sent simultaneously.</p> <p>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.</p>	<p><i>As soon as an ALF is being considered, and prior to the individual being determined to be RFD</i></p> <p><i>Within one business day after the individual is rated as RFD</i></p> <p><i>Within five business days of sending the referral</i></p>	<p><b>Assisted Living referrals:</b></p> <p>The state hospital shall complete the UAI.</p> <p>The state hospital shall transmit the UAI to the CSB</p> <p>The state hospital shall assist in the facilitation of interviews/assessments required by potential ALF providers</p>	<p><i>Within five business days of the individual being found discharge ready level 2</i></p> <p><i>Immediately upon completion of the UAI</i></p> <p><i>As requested</i></p>

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<p>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.</p>	<p align="center"><i>Prior to referring to private pay Memory Care units</i></p>		
<p><b>Nursing home (NH) referrals:</b></p> <p>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.</p> <p>The CSB shall obtain required documentation and send referral packets to multiple potential placements. The referrals are to be sent simultaneously.</p> <p>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</p>	<p align="center"><i>As soon as an NH is being considered, and prior to the individual being determined to be RFD</i></p> <p align="center"><i>Within one business day after the individual is rated as RFD</i></p>	<p><b>Nursing home referrals:</b></p> <p>The state hospital shall complete the UAI</p> <p>For individuals who require PASRR screening, the state hospital shall send the referral packet to Ascend</p> <p>The results of the level 2 PASRR screening shall be transmitted to the CSB</p> <p>The state hospital shall assist in the facilitation of interviews/assessments required by potential nursing home providers</p>	<p align="center"><i>Within five business days of the individual being found discharge ready level 2</i></p> <p align="center"><i>Within one business day of the individual being found clinically ready for discharge</i></p> <p align="center"><i>Immediately upon receipt of the screening results</i></p>

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<p>or the patient discharges to a different placement.</p>	<p><i>Within five business days of sending the referral</i></p>		<p><i>As requested</i></p>
<p><b>Shelter placements:</b></p> <p>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.</p>		<p><b>Shelter placements:</b></p> <p>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</p>	

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		<p>endorsement of the plan for discharge to a shelter in the individual's medical record.</p> <p>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.</p>	<i>Prior to discharge</i>
<p><b>Individuals with a developmental disability (DD) diagnosis:</b></p> <p>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</p> <p>When indicated based on the information above, the VIDES shall be completed</p> <p>The CSB shall initiate a referral to REACH for any individual who is not already being followed by REACH</p> <p>If applicable, the CSB shall ensure that the individual has been added to the DD Waiver waitlist.</p>	<p><i>Within two business days of admission</i></p> <p><i>Within ten business days of admission</i></p> <p><i>Within three calendar days of admission</i></p>	<p><b>Individuals with a developmental disability (DD) diagnosis:</b></p> <p>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).</p> <p>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.</p> <p>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</p>	<p><i>Immediately upon notification of diagnosis</i></p> <p><i>Ongoing</i></p> <p><i>As needed. Required</i></p>

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<p>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.</p> <p>The CSB shall contact and send referrals to potential providers, and assist in coordinating assessments with these providers.</p> <p>The CSB shall assist in scheduling tours/visits with potential providers for the individual and/or the individual’s surrogate decision maker.</p> <p>The CSB shall locate and secure needed specialists who will support the individual in the community at discharge.</p> <p>If required, the CSB shall facilitate the transfer of case management responsibilities to the receiving CSB according to the <i>Transferring Support Coordination/DD Waiver Slots</i> policy.</p> <p>The CSB shall request an emergency DD waiver slot if the individual is determined to be eligible for waiver, prior to requesting DAP funding.</p> <p>If it is anticipated that an individual with a DD diagnosis is going to require transitional</p>	<p><i>Immediately upon notification of need</i></p> <p><i>At admission and ongoing</i></p> <p><i>At the time that an individual is rated a discharge ready level 2</i></p> <p><i>Ongoing</i></p> <p><i>Prior to discharge</i></p> <p><i>According to timelines set forth</i></p>	<p>including conducting psychological testing and assessments as needed.</p> <p>The state hospital shall serve as a consultant to the DD case manager as needed.</p> <p>The state hospital shall assist with coordinating assessments with potential providers.</p> <p>The state hospital shall facilitate tours/visits with potential providers for the individual and/or the individual’s surrogate decision maker.</p> <p>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.</p>	<p><i>psychological testing and assessment shall be completed within 21 calendar days of referral</i></p> <p><i>At the time that the individual is rated a discharge ready level 2</i></p> <p><i>Ongoing</i></p>
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funding, the CSB shall completed an application for DD crisis funds.	<i>in the transfer procedure</i>  <i>Immediately upon notification of need</i>  <i>Immediately upon notification of need</i>		
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**Readiness for Discharge**

CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
<p>Once the CSB has received notification of an individual's readiness for discharge, they shall take immediate steps to implement the discharge plan</p>	<p><i>Immediately upon notification</i></p>	<p>The treatment team shall assess and rate the clinical readiness for discharge for all individuals</p> <p>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.</p>	<p><i>A minimum of weekly</i></p> <p><i>Within one business day</i></p>
<p>In response to the state hospital's weekly email including all patients who are RFD, the CSB shall "reply all" with discharge planning updates.</p> <p>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.</p>	<p><i>Within two business days</i></p>	<p>On weeks in which CSB and state hospital census/barriers meetings do not occur, the state 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.</p>	<p><i>Weekly</i></p>



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		Note: These notifications and responses shall occur for all individuals, including individuals who were diverted from other state hospitals.	
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Collaborative Discharge Requirements for Community Services Boards and 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 approval to begin 48 hour passes\*
- NGRI patient for whom at least one forensic evaluator has recommended conditional or unconditional release and there is a pending court date\*
- NGRI on revocation status and treatment team and CSB recommend conditional or unconditional release and there is a pending court date\*
- Any civil patient for which the barrier to discharge is not clinical stability
- Other forensic legal status (CST, restoration, etc.): clinically stable, evaluations completed and ready to be discharged back to jail\*

**2. Almost Clinically Ready for Discharge**

- Has made significant progress towards meeting 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, not overnight privilege level
- 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

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- Other forensic legal status: not psychiatrically stable or nearing psychiatric stability, evaluations not completed

*\*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).

**FY 22-23 Exhibit K**

**Collaborative Discharge Requirements for Community Services Boards and State Hospitals**

**Adult & Geriatric**

**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 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.	<i>Within seven (7) calendar days of determination that individual is clinically ready for discharge</i>		

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**Collaborative Discharge Requirements for Community Services Boards and State Hospitals**

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<p>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</p> <p>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.</p> <p>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</p>	<p><i>Prior to discharge</i></p>	<p>The state hospital shall collaborate and provide assistance in the development of safety and support plans</p> <p>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.</p> <p>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</p>	<p><i>Prior to discharge</i></p>
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Collaborative Discharge Requirements for Community Services Boards and State Hospitals

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<p><b>Benefit applications:</b> 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.</p> <p>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.</p> <p>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.</p>	<p><i>As soon as a discharge date is finalized</i></p> <p><i>30 days post-discharge, and every 15 days thereafter until benefits are active</i></p>	<p><b>Benefit applications:</b> 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 <i>*Note: For patients whose hospital stay is less than 30 days, the CSB will be responsible for Social Security applications</i></p> <p>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</p>	<p><i>Prior to discharge and per federal and state regulations</i></p>
<p><b>Discharge Transportation:</b></p> <p>The CSB shall ensure that discharge transportation is arranged for individuals discharging from state hospitals.</p> <p>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.</p>	<p><i>Prior to scheduled discharge date</i></p>	<p>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.</p>	

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Collaborative Discharge Requirements for Community Services Boards and State Hospitals

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		<p><b>Discharge Instructions:</b> 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.</p> <p>Distribution of the DIIF shall be provided to all next level of care providers, including the CSB.</p> <p>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)</p>	<p><i>Prior to discharge</i></p> <p><i>No later than one calendar day post-discharge</i></p> <p><i>As soon as possible post-discharge</i></p>
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**Collaborative Discharge Requirements for Community Services Boards and State Hospitals**

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<p>permanently unavailable, resulting in increased risk to the community or to the NGRI acquttee.</p> <p>For individuals who are enrolled in CSB DD services, please follow the <i>Transferring Support Coordination/DD Waiver Slots</i> policy.</p>			
<p>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.</p> <p>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 involvement are to be documented in the</p>	<p><i>Prior to discharge</i></p>		

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**Collaborative Discharge Requirements for Community Services Boards and State Hospitals**

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<p>discharge plan and the individual’s medical record.</p> <p>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.</p>	<p align="center"><i>Prior to discharge</i></p>		
<p>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</p>	<p align="center"><i>Within three calendar days of notification of intent to transfer</i></p>		

## FY 22-23 Exhibit K

### Collaborative Discharge Requirements for Community Services Boards and State Hospitals

#### Adult & Geriatric

#### 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.

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### Collaborative Discharge Requirements for Community Services Boards and State Hospitals

#### Adult & Geriatric

**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.

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

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### Collaborative Discharge Requirements for Community Services Boards and State Hospitals

#### Adult & Geriatric

- 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 acquttees to the state hospital when necessary
  - i. Represent the CSB in court hearings regarding insanity acquttees
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 acquttees, 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.

**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.

## FY 22-23 Exhibit K

### Collaborative Discharge Requirements for Community Services Boards and State Hospitals

#### Adult & Geriatric

**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.

**FY 22-23 Exhibit K**

**Collaborative Discharge Requirements for Community Services Boards and State Hospitals**

**Adult & Geriatric**

**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.**





# COMMONWEALTH of VIRGINIA

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COMMISSIONER

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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:
  - o 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;
  - o 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
  - o 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 overcrowding 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.

## Exhibit M - FY2022

### 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.

## Exhibit M - FY2022

### Department of Justice Settlement Agreement Requirements

- 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 to assess at whether or not each person receiving targeted case management 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.

## Exhibit M - FY2022

### Department of Justice Settlement Agreement Requirements

- 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.

## Exhibit M - FY2022

### Department of Justice Settlement Agreement Requirements

- 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 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 individual's 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,

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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.

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### Department of Justice Settlement Agreement Requirements

- 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, 24.) 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].
- 25.) 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.
- 26.) 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].



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- 27.) 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].
- 28.) 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]
- 29.) 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].
- 30.) 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]
- 31.) 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.
- 32.) 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].
- 33.) DBHDS shall provide data to CSBs on their compliance with the RST referral and implementation process.

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### Department of Justice Settlement Agreement Requirements

- 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.
- 34.) 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].

#### 35.) 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
  - ii. social security number
  - iii. Medicaid number
  - iv. CSB unique identifier
  - v. current physical residence address
  - vi. living situation (e.g., group home
  - vii. family home, or own home)
  - viii. level of care information
  - ix. change in status
  - x. terminations
  - xi. transfers
  - xii. waiting list information
  - xiii. bed capacity of the group home if that is chosen
  - xiv. Current support coordinator's name
- f. Case managers or support coordinators and other CSB staff shall comply with the SIS<sup>®</sup> 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.

**Department of Justice Settlement Agreement Requirements**

- 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.

36.) 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.

37.) 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.

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**Department of Justice Settlement Agreement Requirements**

PLAN TO MEET COMPLIANCE BY JUNE 30, 2021					PERIOD:													
	MILESTONES	PLAN START	PLAN DURATION	COMPLETE DATE	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
					<b>Phase 1</b>	Vendor Contract	4/1/2020	1 Month	4/27/2020	█								
Tools/Definitions/ Methodology Refined and Delivered to IR/Consultant Review and Approval	5/1/2020	1 Month	5/22/2020			█												
Finalize Tools and Train Reviewers	5/22/2020	2 Weeks	6/5/2020				█											
Group 1 Reviews Begin (290)	6/5/2020	4 Weeks	6/30/2020					█										
Group 2 Reviews (290)	7/1/2020	45 Days	8/15/2020						█									
Group 2 Reviews (290)	8/15/2020	45 Days	9/30/2020							█								
<b>Phase 2</b>	Group 1 Data Analysis and Reports Developed and Delivered	8/16/2020	1 Month	9/15/2020	█	█	█	█	█	█	█	█	█	█	█	█	█	█
	Group 1 Technical Assistance Developed and Delivered	7/1/2020	1 Month/ Ongoing	9/15/2020	█	█	█	█	█	█	█	█	█	█	█	█	█	█
	Group 2 Data Analysis and Reports Developed and Delivered	10/1/2020	1 Month	10/31/2020							█	█	█	█	█	█	█	█
	Group 2 Technical Assistance Developed and Delivered	9/16/2020	45 Days/ Ongoing	10/31/2020	█	█	█	█	█	█	█	█	█	█	█	█	█	█
<b>Phase 3</b>	Group 1 Improvements Implemented	9/16/2020	2 Months	11/15/2020							█	█	█	█	█	█	█	█
	Group 2 Improvements Implemented	11/1/2020	2 Months	12/31/2020								█	█	█	█	█	█	█
<b>Phase 4</b>	Group 1 Re-Review	11/15/2020	45 Days	12/31/2020								█	█	█	█	█	█	█
	Group 2 Re-Review	1/1/2021	45 Days	2/15/2021										█	█	█	█	█
	Group 1 Data Analysis and Report Generation to Evaluate Impact	1/1/2021	1 Month	1/31/2021											█	█	█	█
	Group 2 Data Analysis and Report Generation to Evaluate Impact	2/16/2021	1 Month	3/15/2021												█	█	█
	Group 1 Report Delivered to IR	2/1/2021	N/A	2/1/2021													█	█
	Group 2 Report Delivered to IR	3/16/2021	N/A	3/16/2021														█
	Specific Activity																	
	Ongoing Activity																	

**Department of Behavioral and Developmental Services and Community Services Board**

**Addendum I**

**FY2022 and FY2023: Administrative Requirements and Processes and Procedures**

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Addendum I

FY2022 and FY2023: 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.

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FY2022 and FY2023: Administrative Requirements and Processes and Procedures

- 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.

Addendum I

**FY2022 and FY2023: Administrative Requirements and Processes and Procedures**

- 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.



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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.

#### 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.
  - i. 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:

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- 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

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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.

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Appendix A: CSB and Board of Directors Organization and Operations

I. 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.

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**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

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#### FY2022 and FY2023: Administrative Requirements and Processes and Procedures

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.

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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.



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**Appendix C: Unspent Balances Principles and Procedures**

**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; and
  - 4.
- 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.

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Appendix C: Unspent Balances Principles and Procedures

1. Unspent Balances Principles and Procedures

- a. **Unspent balances:** Means amounts of unexpended federal funds, unrestricted and restricted state general funds, hereafter referred to as state funds unless clarity requires more specificity, disbursed to CSBs that remain unexpended after the end of the fiscal year in which they were disbursed to the CSB by the Department.

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 and reflected in its financial management system and independent CPA audit.

- 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 at the end of the appropriate period of performance identified in Exhibit F. Exhibit F provides explicit instructions for the expenditure of funds for unliquidated obligations and the procedures and dates by which unexpended federal funds must be returned to DBHDS.

- 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 for the preceding state fiscal year. The Department shall continue to communicate information about individual balances to each CSB.
- ii. In calculating amounts of unspent state funds, the Department shall prorate balances of unexpended unrestricted funds after the close of the fiscal year among unrestricted state funds, local matching funds, and fees, based on the relative proportions of those funds received by the CSB. This normally will produce identified balances of unrestricted state funds, local matching funds, and fees, rather than just balances of unrestricted state funds. Restricted state funds shall be accounted for separately, given their restricted status, and the Department shall identify balances of unexpended restricted state funds separately.

- 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. All participating CSBs must review and approve how these balances are handled. 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.

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Appendix C: Unspent Balances Principles and Procedures

- 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. 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 earmarked or restricted by funding sources such as the General Assembly, since these funds cannot be used for another purpose during the biennium in which they are appropriated. 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**

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**FY2022 – FY2023: Administrative Requirements and Processes and Procedures**

**Appendix C: Unspent Balances Principles and Procedures**

- 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 purpose. CSB must obtain approval from the Department to use these funds for other purposes.
- b. Allowable uses of state funds appropriated in the Grants to Localities item of the Appropriation Act for identified purposes (restricted funds) remain in effect for each fiscal year through the end of the biennium in which those restricted funds were originally appropriated. After the end of the biennium in which the restricted funds were disbursed to CSBs, any unexpended balances of these those state funds shall be identified as unrestricted state funds.
- c. From time to time, the Department may deem it necessary to maintain the restricted purpose beyond the biennium during which the funds were allocated. The Department will provide 60 days advance notification to the CSB of its intent to maintain restrictions on funds during subsequent bienniums.
- d. 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 on pages AF 1 and AF-3 through AF-8 as applicable but shall not be included in the service costs shown on Forms 11, 21, 31, or 01 of 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 funds shown on pages AF-1 through AF-8 related to the inclusion of unspent balances as retained earnings for major capital expenses and the costs shown on Forms 11 through 01 shall be explained on Form AF-10 Supplemental Information: Reconciliation of Projected Resources and Core Services Costs by Program Area. However, depreciation of those capital assets can be included in service costs shown on Forms 11 through 01.
- 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 performance contract, if the expenditure was planned at the beginning of the contract term, and in the end of the fiscal year 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

**Addendum I**

**FY2022 – FY2023: Administrative Requirements and Processes and Procedures**

**Appendix C: Unspent Balances Principles and Procedures**

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.

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**FY2022 AND 2023: Administrative Requirements and Processes and Procedures**

**Appendix D: User Acceptance Testing Process**

**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 of Behavioral and Developmental Services and Community Services Board**

**Addendum I**

**FY2022 AND 2023: Administrative Requirements and Processes and Procedures**

**Appendix D: User Acceptance Testing Process**

<b>Department and CSB User Acceptance Testing Process</b>	
<b>Time Frame</b>	<b>Action</b>
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*

<b>Department and CSB User Acceptance Testing Process</b>	
<b>Time Frame</b>	<b>Action</b>
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).

**Department of Behavioral and Developmental Services and Community Services Board**

**Addendum I**

**FY2022 and FY2023: Administrative Requirements and Processes and Procedures**

**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

## **Addendum II FY2022-23: Central Office, State Facility, and Community Services Board Partnership Agreement**

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

## **Addendum II FY2022-23: Central Office, State Facility, and Community Services Board Partnership Agreement**

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.

## **Addendum II FY2022-23: Central Office, State Facility, and Community Services Board Partnership Agreement**

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.

## **Addendum II FY2022-23: Central Office, State Facility, and Community Services Board Partnership Agreement**

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.

## **Addendum II FY2022-23: Central Office, State Facility, and Community Services Board Partnership Agreement**

### **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.

## Core Services Taxonomy 7.3

### Core Services Definitions: Categories and Subcategories of 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.

### Core Services Taxonomy 7.3

- 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 waiver 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.

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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,

### Core Services Taxonomy 7.3

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.



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- 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.

### Core Services Taxonomy 7.3

- 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;
    - individual-related staff travel; and
    - phone consultation with individual;
    - discharge planning, individual not present.
    - report writing re: individual;
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.

## Core Services Taxonomy 7.3

- 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. Ongoing 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.

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- 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<sup>1</sup>, 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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<sup>1</sup> 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.

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*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

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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

### Core Services Taxonomy 7.3

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 through 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.

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### 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.



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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.

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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.

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**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 out 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. <b>Emergency Services (100)</b>	Service Hour	NA
2. <b>Ancillary Services</b>		
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. <b>Consumer-Run Services (730)</b>	NA	NA

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### Core Services Category and Subcategory Matrix

#### Services Available at Admission to a Program Area

	MH	DV	SA	Unit of Service	Capacity
<b>4. Inpatient Services</b>					
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
<b>5. Outpatient Services</b>					
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
<b>6. Case Management Services (320)</b>	x	x	x	Service Hour	NA
<b>7. Day Support Services</b>					
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
<b>8. Employment Services</b>					
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
<b>9. Residential Services</b>					
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
<b>10. Prevention Services (610)</b>	x	x	x	Service Hour	NA

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### 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.

<i>Examples of Service Hour Activities</i>	
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.

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**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.

<i>Examples of Z-Consumer Activities for Service Hours</i>	
Case-specific clinical supervision	Employee, student, or peer assistance
Record charting	Staff preparation for individual, group, family, or marital counseling or therapy
Case consultation	Healthy pregnancies and fetal alcohol syndrome education
Treatment planning conference	Child abuse and neglect prevention and positive parenting programs
Phone Calls in emergency services	Neighborhood-based high risk youth programs
Participation in FAPT	Competency building programs
Coordination of multidisciplinary teams	Skill-building group training
Consultation to service providers	
Application for admission to facility	
Preparing for workshops and 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  $\frac{1}{4}$  bed day, six to 12 hours would equal  $\frac{1}{2}$  bed day, 12 to 18 hours would equal  $\frac{3}{4}$  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.

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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.

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### 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.

<b>Core Service and State Facility Cost Accounting Crosswalk</b>		
<b>4.</b>	<b>Inpatient Services (Core Service)</b>	
	<b>State Facility Cost Center</b>	<b>Code</b>
a.	<b>Medical/Surgical</b>	
	Acute Medical/Surgical (Certified)	411
b.	<b>Skilled Nursing</b>	
	Skilled Nursing - ID (Certified)	421
	Skilled Nursing - General (Certified)	423
c.	<b>Intermediate Care Facility/Intellectual Disability (ID)</b>	
	ICF/ID Certified (General)	529
d.	<b>Intermediate Care Facility/Geriatric</b>	
	ICF (Certified)	441
	Chronic Disease (Certified)	443
e.	<b>Acute Intensive Psychiatric</b>	
	Acute Admissions (Certified)	457
g.	<b>Extended Rehabilitation</b>	
	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



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### **Performance Contract Definitions**

**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.

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**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 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.

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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 90<sup>th</sup> 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

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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.

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- 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 18<sup>th</sup> 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

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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 intoxication 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);

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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 intoxication, physical fights).

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### Appendix A: Diagnostic Criteria Checklists

Serious Mental Illness Criteria Checklist		
Yes	No	Criteria
		<b>1. Age:</b> The individual is 18 years of age or older.
		<b>2. DIAGNOSIS:</b> The individual has a major mental disorder diagnosed using the DSM IV. <b>At least one of the following diagnoses must be present.</b> 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
		<b>3. Level Of Disability:</b> There must be evidence of severe and recurrent disability resulting from mental illness. The disability must result in functional limitations in major life activities. <b>The individual must meet at least two of these criteria on a continuing or intermittent basis.</b> 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.
		<b>4. Duration Of Illness: The individual's treatment history must meet at least one of these criteria.</b> 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.
<p><b>NOTE:</b> 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.</p>		



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### Appendix A: Diagnostic Criteria Checklists

<b>Serious Emotional Disturbance Criteria Checklist</b>		
<b>Yes</b>	<b>No</b>	<b>Criteria</b>
		<b>1. Age:</b> The individual is a child, age birth through 17 (until the 18 <sup>th</sup> birthday).
		<b>2. Diagnosis:</b> The child has a serious mental health problem that can be diagnosed under the DSM IV. Specify the diagnosis: _____
		<b>3. Problems And Needs: The child must exhibit all of the following:</b>
		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 <b>OR</b> for all four responses in criterion 3, then check Yes here to indicate that the child has serious emotional disturbance.
<p><b>NOTE:</b> 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.</p>		

<b>At Risk Of Serious Emotional Disturbance Criteria Checklist</b>		
<b>Yes</b>	<b>No</b>	<b>Criteria</b>
		<b>1. Age:</b> The person is a child, age birth through 7.
		<b>2. Problems: The child must meet at least one of the following criteria.</b>
		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.
<p><b>NOTES:</b> 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.</p>		

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### 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 <sup>1</sup>
Inpatient Services	None
Outpatient Services	Skilled Nursing Services <sup>2</sup> Therapeutic Consultation <sup>3</sup>
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 <sup>5</sup>
Supervised Residential Services	Congregate Residential Support Services <sup>5</sup>
Supportive Residential Services	Supported Living/In-Home Residential Supports Agency and Consumer-Directed Respite Services, Personal Assistance Services <sup>4</sup> , 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>

<sup>1</sup> **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.

<sup>2</sup> **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.

<sup>3</sup> **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

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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.

<sup>4</sup> **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.

<sup>5</sup> **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).

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### 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.

<b>Retired Core Services Service Codes</b>		
<b>Core Service Category</b>	<b>Former Core Services Subcategory</b>	<b>Service Code</b>
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

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### 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.

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- 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.

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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

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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



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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

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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

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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.

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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

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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.

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### 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 establish 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:

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- 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

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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.



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- 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,

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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

## Core Services Taxonomy 7.3

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.

## Core Services Taxonomy 7.3

### 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.

## Core Services Taxonomy 7.3

### 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,

### **Core Services Taxonomy 7.3**

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.

## **Exhibit D: Richmond Behavioral Health Authority Performance Measures for the Adult Residential Crisis Stabilization Units**

The Agreement is between the Department of Behavioral Health and Developmental Services (“DBHDS” or “Department”) and the Richmond Behavioral Health Authority (“CSB”), collectively hereinafter referred to as “the Parties”, entered into this Agreement to govern certain activities and responsibilities required for operating or contracting to provide Adult Residential Crisis Stabilization Units (ARCSU). This Agreement is attached to and made part of the performance contract by reference.

**Purpose:** Adult Residential Crisis Stabilization Units (ARCSU) are an essential component of the community based crisis services continuum of care in Virginia. The expectations of this document support the strategic vision of DBHDS provide access to quality, person-centered services and supports that exemplify clinical and management best practices for ARCSUs. It is imperative that ARCSUs demonstrate consistent utilization, evidenced-based clinical programming, and efficient operations. ARCSUs provide treatment for individuals requiring crisis stabilization and support in their community and also serve as a step-down for individuals admitted to inpatient units if clinical necessity is met.

**A. Term:** This Agreement shall govern the performance of the Parties for the period of February 1, 2021 through June 30, 2022. It is understood by the Department and the CSB that this performance period spans the remaining months of FY 2021 and the upcoming FY2022, the period from February 1, 2021 through June 30, 2021 will serve as the implementation time period for the ARCSUs to develop and implement the requirements as outlined in this Exhibit D.

### **B. Scope of Services**

1. Staffing – The ARCSU staffing patterns will be reviewed at least quarterly by the ARCSU Leadership to evaluate changing staffing needs and to ensure the staffing patterns meet the needs of the individuals served.
  - a. Reviews are to ensure staffing patterns maximize the unit’s ability to take 24 hours a day, seven (7) days a week admissions and provide services to the individuals as needed for therapeutic counseling and support services 24 hours a day. The ARCSU will follow the service description and staffing as defined in Article I of Part IV in Chapter 105 Rules and Regulations for licensing providers by the Department.
  - b. The ARCSU will have well-defined written plan for psychiatric prescriber coverage that meets the needs of the individuals admitted to the program. The plan must address contingency plans for vacations, vacancies and illnesses and other extended staff absences of the primary psychiatric provider. Plans will be reviewed annually and updated as needed by the ARCSU and as needed by DBHDS
  - c. The ARCSU will have a well-defined written plan for nursing coverage that meets the needs of the individuals admitted to the program. The plan must address contingency plans for vacation, vacancies and other extended staff absence as well as plans for sustaining adequate nursing coverage for the individuals being served on the unit. Plans will be reviewed and updated at least annually by the ARCSU and as needed by DBHDS. The plan will address having access to nursing consultation if a nurse is not on duty.
  - d. The ARCSUs will provide peer support services for individuals admitted to the program. The ARCSU will have a well-defined written plan for staffing peer support services to address hours of coverage, sustainability plans for recruiting and training peers to provide these services, and a description of the services peers will provide. Plans are to be reviewed by the ARCSU at least annually and updated as needed to meet the needs of the individuals being served in the program.
  - e. The ARCSU will have a well-defined written plan for staffing all provider coverage during weather related, other natural and man-made disasters and pandemics. The plans will address the continuation of services for individuals in their care at the time of these events and those

## **Exhibit D: Richmond Behavioral Health Authority Performance Measures for the Adult Residential Crisis Stabilization Units**

who may need admission. Plans will be reviewed and updated annually by the ARCSU and as needed by DBHDS.

- f. The ARCSU will have access to a Licensed Mental Health Professional, Licensed Mental Health Professional–E, or Licensed Mental Health Professional–R. 24 hours a day.
- g. The ARCSU will have a written plan for appropriate staffing coverage at all times and be flexible to address the needs of the individuals being served and for changes in the unit census. The plan should be reviewed at least annually by the ARCSU to determine that it continues to meet the staffing needs of the unit. Plan may be reviewed by DBHDS as needed.

### **2. Admission and Discharge Processes**

- a. The CSB will provide 16 licensed beds in the ARCSU. The CSB shall notify the Department should it be unable to operate the number of beds licensed by the Department and the reason for the reduction. This notification will be made to the Office of Licensing and to the Crisis Service Coordinator. Once the Department approves the number of beds the CSB can operate, that number will become the service capacity. The Department will expect the CSB to comply with the local Health Department’s permission to operate 16 beds due to any public health emergency.
- b. The ARCSU will develop a well-defined written policy and procedures for the review of referrals and respond to referral sources within one hour after receiving information necessary to determine admission. The policy will address the unit’s information requirements for admission and focus on inclusion and not, exclusion of all referrals. Information required for admission decision should not automatically include medical assessment prior to admission unless there are medical concerns that need to be addressed. The policy and procedures should be prescriptive for all information required so that referral sources know what will be required for an admission decision. Plan should include how referrals for admission will be addressed (i.e., decision makers for the unit regarding admission, medical review if needed by either nursing or physician, when the unit can exclude a referral, etc...)
- c. The ARCSU will review and streamline their actual admission/intake policy and procedures to provide admissions 24 hours a day seven (7) days a week. A well-defined plan will be developed to reduce the admission/intake process for individuals. Plans will be reviewed at least semi-annually by the ARCSU and submitted annually to DBHDS for review and technical assistance, if needed, in meeting this requirement.
- d. The ARCSU will develop well-defined written policies and procedures for accepting individuals under a Temporary Detention Order (TDO). The plan will include inclusion of individuals under a TDO and will contain a plan for managing the individual’s needs, court processes and integration in the ARCSU without discrimination.
- e. The ARCSU will develop a well-defined written policy for accepting individuals with medically monitored detoxification needs and maintain the appropriate license to provide this service as cited in the DBHDS licensing regulations
- f. The ARCSU will develop well-defined written policies and procedures for the timely review of requests for admission and responding to referral sources within one hour. The ARCSU’s plan will focus on inclusion and not exclusion of potential referrals.
  - i. The CSU will maintain a record of documentation of all requests for admission that includes basic clinical information used for decision for admission.
  - ii. The CSU will maintain a record of documentation of all denials that includes basic clinical information used for the denial of admission.



## **Exhibit D: Richmond Behavioral Health Authority Performance Measures for the Adult Residential Crisis Stabilization Units**

- iii. Admission denials must be reviewed by the LMHP and other appropriately designated staff within 72 hours of the denial decision. Written documentation of all referrals and denials must be available for review by DBHDS upon request.
  - iv. Records of exclusion must contain an identifier for the individual, ARCSU staff making decision to admit or not, date of request, time of request, time of denial or acceptance, and reason for exclusion, if applicable.
  - g. The ARCSU will follow discharge planning requirements as cited in the DBHDS licensing regulations (12VA35-105-693).
  - h. ARCSUs will assess the integrated care needs of individuals upon admission and establish a discharge plan that addresses the individual's specialized care needs.
3. **Programming**
- a. The ARCSU will have a well-defined written schedule of clinical programming that covers at least eight (8) hours of active services per day (exclusive of meals and breaks), seven (7) days a week. Programming will be appropriate to individuals receiving crisis services and whenever possible will incorporate evidence-based and best practices. The ARCSU will annually submit the written schedule of programming to DBHDS.
  - b. 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.
  - c. ARCSUs will have a well-defined written policy and procedures for recognizing, responding and supporting individuals utilizing practices that are consistent with trauma informed care.
  - d. The ARCSU will involve family members, life partners and other supports as identified by the individual receiving service when clinically appropriate and consent is obtained by the individual. Involvement may include family therapy, marriage/life partner counseling, and group therapy.
  - e. The ARCSU 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). A record of these reviews will be maintained and available to DBHDS upon request.
  - f. Programming will contain a mix of services to include but not limited to: clinical, psycho-educational, psychosocial, relaxation, case management and physical health.
  - g. Alternate programming must be available for individuals unable or unwilling to participate in the scheduled programming due to their emotional or behavioral dysregulation. A written plan for alternate programming ideas and plans must be available for all staff to access. When an individual is not able or willing to participate in scheduled programming or alternate programming should staff should record the reasons and attempts to engage the individual in the clinical record.
  - h. The ARCSU 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 CSU will provide scheduled recreational which may include but is not limited to: art, music, pet therapy, meditation, exercise, and yoga, acupuncture, etc.
4. **Resources**
- a. The CSU will develop a well-defined written policy and process for building and sustaining collaborative relationships with private and state facilities, emergency services staff, and local emergency departments in their region. Ideally, these collaborative relationships will facilitate the flow of referrals to the CSU for diversion and step down from a hospital setting and to transition an individual from a CSU to a higher level of care. This process will be documented in the CSUs policies and procedures.

**Exhibit D: Richmond Behavioral Health Authority Performance Measures for the  
Adult Residential Crisis Stabilization Units**

- b. The CSU will participate in regional collaboration with other CSUs at least quarterly to share successes and resources in order to optimize individual program functioning and to increase inter-program consistency.
- C. The CSB Responsibilities:** In order to operate or contract for the ARCSU the CSB agrees to comply with the following requirements.
1. The ARCSU will comply with all DBHDS licensing requirements.
  2. ARCSUs shall be considered regional programs and is not specific to the physical location of the program. The CSBs in Region 4 will revise the Memorandum of Understanding (MOU) governing the Regional ARCSU and provide this to the Department upon request.
  3. The ARCSU 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.
  4. The ARCSU shall develop a written plan to maintain utilization at 75% averaged over a year and submit to DBHDS annually, Crisis Services Coordinator with ongoing revisions as needed.
  5. The ARCSU will develop a written plan to ensure the ARCSUs remain open, accessible, and available at all times as an integral part of DBHDSs community based crisis services.
  6. The ARCSU will develop a written plan to accept individuals subject to Temporary Detention Orders (TDO) and submit to DBHDS annually with revisions as needed.
- D.** The ARCSU will develop written plans for seeking reimbursement for services from all payor sources including the billing for TDOs. No one is to be denied access to the CSU for inability to pay.
- E. The Department Responsibilities:** The Department agrees to comply with the following requirements.
1. The Department shall technical assistance to include but not limited to: networking meetings, trainings and annual site visits to the ARCSU and upon request,
  2. DBHDS staff shall determine need for site visits based on monitoring that the ARCSU is not accomplishing its mission or meeting its goals as described in this document. The ARCSU will construct a corrective action plan for units not meeting their goals and collaborate with the ARCSU to implement the plan.
  3. The Department shall monitor data received through CCS monthly reports and CARS semi-annual reports. The Department will collaborate with the ARCSU to ensure data submitted through these reports meets the expectations as outlined in this document and in the ARCU's written plans. The Department will provide each ARCSU monthly reports on the data submission to review for accuracy.
- F. Payment Terms:** The Department shall provide the CSB with the amount still remaining of \$1,785,195 of Restricted Mental Health State General Funds originally allocated in FY 2021, to be paid in twice a month payments for the balance of the Period of Performance noted in the Term of the Agreement. The Department may, at its reasonable discretion, modify payment dates or amounts, or terminate this Agreement and will notify the CSB of any such changes in writing.

Though the performance period spans the remainder of fiscal year FY 2021 and the entirety of FY 2022, it is understood by the CSB and the Department that the funding included in this Exhibit D is only for operation of the ARCSU during the current fiscal year, FY 2021.

It is the intent of the Department, at its discretion, to provide funding for the ARCSU effective July 1, 2021 in accordance with those appropriations provided in the FY 2021 Appropriation Act. The

## **Exhibit D: Richmond Behavioral Health Authority Performance Measures for the Adult Residential Crisis Stabilization Units**

Department reserves the right to make changes to the requirements included in this Exhibit D to the revised Exhibit D for FY 2022.

**G. Use of Funds:** The CBS may not use the funds provided under this Agreement for any purpose other than as described herein and allowable to carry out the purposes and activities of the Program. The CSB agrees that if it does not fully implement this program as approved or as subsequently modified by agreement of the Parties, the Department shall be able to recover part or all of the disbursed funds. Funds provided under this agreement remain restricted to the provision of this services at this ARCSU.

**H. Performance Requirements:** The ARCSU will:

1. Maintain a 75% utilization averaged over the year. If circumstances arise prohibiting the unit from utilizing all of their licensed beds, the ARCSU must inform DBHDS through the licensing office and notification to the Crisis Services Coordinator. For non-emergent issues, the ARCSU will notify DBHDS prior to decreasing beds.
2. Develop a well-written stream lined process for reviewing requests for admission and provide the referral source a response after receiving the necessary paperwork to make an admission decision, within one hour, 90% of the time, .
3. Function as a regional resource by accepting referrals from any CSB within the ARCSUs region.
4. Consistently demonstrate flexibility with admissions by accepting admissions 24/7, seven days a week.

**I. Reporting Requirements:** The ARCSU shall:

1. Annually submit a plan to DBHDS to streamline the admission process to allow for 24 hours a day, 7 day a week admissions.
2. Quarterly submit a report DBHDS on the ARCSUs admission referral review with a response within one hour of receiving the response 90% of the time. Report shall be submitted to DBHDS quarterly with a corrective action plan if the unit does not meet the 90% benchmark.
3. Quarterly submit a report on the number of TDOs accepted.
4. Annually submit a programming schedule demonstrating the use of evidence based and best practices as well as alternate option for individuals unable to participate in the standard programming.
5. The ARCSU shall comply with the reporting requirements for the services provided as determined by the Department. This includes reporting financial information in its CARS mid-year and end of the year report and in its monthly CCS 3 extracts as required in the current performance contract.

**J. Monitoring, Review, and Audit:** The Department may monitor and review use of the funds, performance of the Program, 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.

**K. Entire Agreement:** This Agreement and any additional or supplementary document or documents incorporated herein by specific reference contain all the terms and conditions agreed upon by the Parties hereto, and no other contracts, oral or otherwise, regarding the subject matter of this Agreement or any part thereof shall have any validity or bind any of the Parties hereto.

**Exhibit D: Richmond Behavioral Health Authority Performance Measures for the  
Adult Residential Crisis Stabilization Units**

**L. 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.

**Signatures:** In witness thereof, the Department and the CSB have caused this Agreement to be executed by the following duly authorized Parties.

**Virginia Department of Behavioral  
Health and Developmental Services**

**Richmond Behavioral Health Authority**

By: \_\_\_\_\_

By: \_\_\_\_\_

Name: Alison G. Land, FACHE

Name: Cheryl Ivey Green, D. Min.

Title: Commissioner

Title: Chairperson

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Office of Community Integration

By: \_\_\_\_\_

By: John P. Lindstrom

Name: Suzanne Mayo

Name: John Lindstrom, Ph.D.

Title: Program Director

Title: Chief Executive Officer

Date: \_\_\_\_\_

Date: 3/5/2021

**Exhibit D: RICHMOND BEHAVIORAL HEALTH AUTHORITY****Performance Measures for the SUPPLEMENTAL EMERGENCY COVID-19 GRANT FUNDING**

This Agreement is between the Department of Behavioral Health and Developmental Services (“DBHDS” or “Department”) and the **RICHMOND BEHAVIORAL HEALTH AUTHORITY** (“CSB” or “Subrecipient”), collectively hereinafter referred to as “the Parties”, entered into this Agreement to govern certain activities and responsibilities required for operating or contracting the **Supplemental Emergency COVID-19 Grant Funding**. This Agreement is attached to and made part of the performance contract by reference.

<b>SELECT GRANT (ONLY ONE GRANT PER EXHIBIT)</b>	<b>SAMHSA GRANTS</b>
<b>I.</b> <input checked="" type="checkbox"/>	<p><b>GRANT NAME:</b> Supplemental Emergency Grants to Address Mental and Substance Use Disorders During COVID-19  <b>FEDERAL AWARD IDENTIFICATION NUMBER (FAIN):</b> H79FG000712  <b>FEDERAL AWARD DATE:</b> 1/15/2021  <b>FEDERAL AWARING AGENCY:</b> Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA)  <b>FEDERAL AWARD PASS-THROUGH ENTITY:</b> Virginia Department of Behavioral Health and Developmental Services  <b>CFDA NUMBER:</b> 93.665  <b>RESEARCH AND DEVELOPMENT AWARD:</b> ___ YES OR ___ X ___ NO  <b>FEDERAL GRANT AWARD YEAR:</b> FFY 2021 and FFY 2022  <b>AWARD PERIOD:</b> 2/1/2021 – 5/31/2022</p>

**Term:** This Agreement shall govern the performance of the Parties for the period of **April 1, 2021** through **May 31, 2022** (“Period of Performance”).

**A. Scope of Services:**

1. Provide direct treatment services and/or good as outlined in the approved proposal.
2. To continue approved activities based on the current grant application, to address the increased need due to COVID-19. This funding must be in line with your current scope of activities approved .
3. Treatment for individuals working toward application for Medicaid. The awarded funds should be of last resort.

**B. The CSB Responsibilities:** In order to implement the **Supplemental Emergency COVID-19 Grant**, the Sub recipient agrees to comply with the following requirements.

1. Subrecipient will utilize the funds to primarily support direct treatment services for individuals impacted by the COVID-19 pandemic.
2. Comply with the Government Performance and Results Act (GPRA) requirements that include the collection and periodic reporting of performance data as specified in the FOA or by the Grant Program Official (GPO).

**C. The Department Responsibilities:** In order to implement the **Supplemental Emergency COVID-19 Grant**, the Department agrees to comply with the following requirements.

1. Monitor use of these funds to assure that they are being used to support evidence-based treatment/recovery supports and will not permit use of these funds for non-evidence-based approaches.
2. The Department shall monitor the CSBs’ implementation progress through the bi-annual reports on the dates that are outlined below in the Reporting Requirements section below.

**D. Payment Terms:** Pursuant to the Notice of Award received by DBHDS and the Funding Opportunity associated with the **Supplemental** Emergency COVID-19 Grant, the following are requirements of the funding distributed to the Sub-recipient as a result of this agreement.

1. The Department shall provide **\$80,000** of the **SAMHSA Supplemental Emergency COVID-19 Grant** in a one-time disbursement to **RICHMOND BEHAVIORAL HEALTH AUTHORITY** by **May 3, 2021**. You will also be receiving **\$2,250** in one-time funding for client incentives for completion of the GPRA. The Department may provide additional funding to CSB based upon availability and approval

**Exhibit D: RICHMOND BEHAVIORAL HEALTH AUTHORITY**

**Performance Measures for the SUPPLEMENTAL EMERGENCY COVID-19 GRANT FUNDING**

2. **Restrictions on Expenditures:** Supplemental Emergency COVID-19 funds may not be used to:
- a) Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana.
  - b) For services that can be supported through other accessible sources of funding such as Medicaid, 3rd party insurance, and sliding scale self-pay among others.
  - c) The purchase of PPE is an allowable cost and can only be provided for staff working directly on the SAMHSA grant. The purchase of PPE for clients is not an allowable cost.
  - d) 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.

**E. Limitations on Reimbursements:** Subrecipient shall not be reimbursed or otherwise compensated for any expenditures incurred or services provided following the end of the Period of Performance.

**F. Closeout Disclosure.**

Final payment request(s) under this Agreement must be received by DBHDS no later than thirty (30) days from the end of the Period of Performance. 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 as defined in this agreement

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 Ramona Howell

Failure to return unexpended funds in a prompt manner may result in a denial of future federal Subrecipient awards from DBHDS.

In consideration of the execution of this agreement by 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 this agreement. Sub recipient's obligations to DBHDS under this agreement 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 this agreement.

**G. Use of Funds:** The Sub recipient may not use the funds provided under this Agreement for any purpose other than as described herein and allowable to carry out the purposes and activities of the Program or Service. The Subrecipient agrees that if it does not fully implement this funding as approved or as subsequently modified by agreement of the Parties, the Department shall be able to recover part or all of the disbursed funds.

**Exhibit D: RICHMOND BEHAVIORAL HEALTH AUTHORITY****Performance Measures for the SUPPLEMENTAL EMERGENCY COVID-19 GRANT FUNDING**

- H. Performance Outcome Measures:** The Programmatic Report is required at the midpoint of the grant period and at the end of the grant period. The Department will provide a template for the report, which will be submitted by each Subrecipient.
1. A summary of key program accomplishments to-date.
  2. Description of any difficulties and/or problems encountered in achieving planned goals and objectives including barriers to accomplishing program objectives, and actions to overcome barriers or difficulties.
  3. Detailed summary of progress for performance measures as reflected in your application regarding goals and evaluation of activities.
- I. Reporting Requirements:** Any reporting requirements outlined in this Section will be in addition to those reporting requirements in the current performance contract.

Provide (DBHDS) with a bi-annual report on the progress of the advertisement in addition to an updated budget report. Each Subrecipient will report bi-annually on the grant status and provide a final report with numbers reached, demographics (age, race, gender, and ethnicity).

*Submission of a Programmatic Bi-Annual Report is due no later than the dates as follows:*

<i>1st Progress Report (Email)</i>	<i>December 31, 2021 (Reporting period: 4/1/21 – 9/30/21)</i>
<i>2nd Progress Report (Email)</i>	<i>August 31, 2022 (Reporting period: 2/1/21 – 5/31/22)</i>

***Please submit your Programmatic Bi-Annual Report to Ervina Baskerville-Allen @ [ervina.baskerville-allen@dbhds.virginia.gov](mailto:ervina.baskerville-allen@dbhds.virginia.gov), and copy Tara Belfast-Hurd @ [tara.belfast-hurd@dbhds.virginia.gov](mailto:tara.belfast-hurd@dbhds.virginia.gov). (HARD COPIES SUBMISSION IS NOT REQUIRED)***

- J. Monitoring, Review, and Audit:** The Department may monitor and review use of the funds, performance of the Program, and compliance with this Agreement, which may include onsite visits to assess the Sub recipient'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.
- K. Entire Agreement:** This Agreement and any additional or supplementary document(s) incorporated herein by specific reference contain all the terms and conditions agreed upon by the Parties hereto, and no other contracts, oral or otherwise, regarding the subject matter of this Agreement or any part thereof shall have any validity or bind any of the Parties hereto.
- L. 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.
- M. Conflicts:** In the event of any conflict between this Agreement (or any portion thereof) and any other agreement now existing or hereafter entered into, the terms of this Agreement shall prevail.

**Exhibit D: RICHMOND BEHAVIORAL HEALTH AUTHORITY  
Performance Measures for the SUPPLEMENTAL EMERGENCY COVID-19 GRANT FUNDING**

**Signatures:** In witness thereof, the Department and the CSB have caused this Agreement to be executed by the following duly authorized Parties.

**Virginia Department of Behavioral  
Health and Developmental Services**

By:   
648C7B1925394F8...

Name: Alison G. Land, FACHE

Title: Commissioner

Date: 5/14/2021 | 9:11 AM EDT

**Office of Adult Community Behavioral  
Health Services**

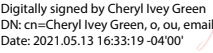
By:   
C2A615C6B51B4A4...

Name: Margaret Steele

Title: Program Director

Date: 5/14/2021 | 9:13 AM EDT

**RICHMOND BEHAVIORAL HEALTH  
AUTHORITY**

By:   
Digitally signed by Cheryl Ivey Green  
DN: cn=Cheryl Ivey Green, o, ou, email=execministries@fbctoday.org, c=US  
Date: 2021.05.13 16:33:19 -04'00'

Name: Cheryl Ivey Green, D. Min.

Title: Chairperson

Date: \_\_\_\_\_

By: 

Name: John Lindstrom, Ph.D., LCP

Title: Executive Director

Date: April 28, 2021



**Exhibit D. Richmond Behavioral Health Authority  
PERFORMANCE MEASURES FOR THE  
State General Funds cc 848 MH PACT**

This Agreement is between the Department of Behavioral Health and Developmental Services (the Department” or “DBHDS”) and the **Richmond Behavioral Health Authority (RBHA)**, collectively hereinafter referred to as “the Parties”, entered into this Agreement to govern certain activities and responsibilities required for operating or contracting the State General Funds cc 848 MH PACT General funds. This Agreement is attached to and made part of the performance contract by reference.

**Purpose:**

The Department shall award FY 2021 in Restricted Mental Health State General Funds for Programs of Assertive Community Treatment in the amount of \$103, 898 to the Behavioral Health Authority to be held for future use by the Department to fund The Tool Of Measurement of ACT (TMACT) reviews required for fidelity monitoring of the Assertive Community Treatment (ACT) programs.

**Term:** This Agreement shall govern the performance of the Parties for the period of **June 2021 through September 30, 2021** (“Period of Performance”).

**A. Scope of Services:**

1. State General Funds cc 848 MH PACT general fund dollars are to be held in reserve by RBHA until such time DBHDS uses the funding to renew the TMACT contract with UNC.

**B. The BHA Responsibilities:** In order to implement the Exhibit D, the BHA agrees to comply with the following requirements:

1. The BHA agrees to hold in reserve the FY 2021 Restricted State Mental Health General Funds in the amount of \$103, 898 until such a time that DBHDS requests return of the funding to renew the UNC TMACT evaluation contract.
2. The BHA is required to include any required financial information in its annual CARS Reports for FY 2021.

**C. The Department Responsibilities:** In order to implement the State General Funds cc 848 MH PACT funds, the Department agrees to comply with the following requirements.

1. DBHDS agrees to communicate in a timely fashion with Richmond Behavioral Health Authority when the funds need to be utilized by DBHDS.

**D. Payment Terms:** Pursuant to the Notice of Award received by DBHDS the following are requirements of the funding distributed to the Subrecipient as a result of this agreement.

1. The Department of Behavioral Health and Developmental Services shall provide the CSB Restricted State Mental Health General PACT Funds cc 848 MH PACT in the amount of \$103, 898. These funds shall be disbursed in the normal twice a month equal payments.
2. **Restrictions on Expenditures:** State General Funds cc 848 MH PACT may not be used to:
  - a) Funds may not be used for any purpose other than Tool for Measurement of ACT(TMACT) evaluations contract renewal with UNC by DBHDS. Any other request for use of the funding must be approved by DBHDS prior to access.

**E. Use of Funds:** The BHA may not use the funds provided under this Agreement for any purpose other than as described herein and allowable to carry out the purposes and activities of the Program or Service. The BHA agrees that if it does not fully implement this agreement as approved or as subsequently modified by agreement of the Parties, the Department shall be able to recover part or all of the disbursed funds.

In consideration of the execution of this agreement by 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,

**Exhibit D. Richmond Behavioral Health Authority  
PERFORMANCE MEASURES FOR THE  
State General Funds cc 848 MH PACT**

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 this agreement. Subrecipient's obligations to DBHDS under this agreement 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 this agreement.

**F. Monitoring, Review, and Audit:** The Department may monitor and review use of the funds, performance of the Program, 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.

**G. Entire Agreement:** This Agreement and any additional or supplementary document(s) incorporated herein by specific reference contain all the terms and conditions agreed upon by the Parties hereto, and no other contracts, oral or otherwise, regarding the subject matter of this Agreement or any part thereof shall have any validity or bind any of the Parties hereto.

**H. 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.

**I. Conflicts:** In the event of any conflict between this Agreement (or any portion thereof) and any other agreement now existing or hereafter entered into, the terms of this Agreement shall prevail.

**Signatures:** In witness thereof, the Department and the CSB have caused this Agreement to be executed by the following duly authorized Parties.


**Virginia Department of Behavioral  
Health and Developmental Services**

DocuSigned by:  
  
By: \_\_\_\_\_  
648C7B1925394F8...

Name: Alison G. Land, FACHE

Title: Commissioner

Date: 6/23/2021 | 10:48 AM EDT

DocuSigned by:  
  
By: \_\_\_\_\_  
C2A619C6B51B4A4...

Name: Margaret Steele

Title: Director of Adult Community Behavioral Health

Date: 6/23/2021 | 10:53 AM EDT

**Richmond Behavioral Health Authority**

By: 

**Exhibit D. Richmond Behavioral Health Authority  
PERFORMANCE MEASURES FOR THE  
State General Funds cc 848 MH PACT**

Name: Cheryl Ivey Green, D. Min.

Title: Chairperson

Date: 6-22-21

By: John P. Lindstrom

Name: John Lindstrom, Ph.D., LCP

Title: Chief Executive Officer

Date: June, 17, 2021

**Exhibit D: RICHMOND BEHAVIORAL HEALTH AUTHORITY (RBHA)**  
**Performance Measures for the Children's Residential Crisis Stabilization Units**

This Agreement is between the Department of Behavioral Health and Developmental Services (“DBHDS” or “Department”) and the [THE Richmond Behavioral Health Authority (RBHA (BHA or “Subrecipient”), collectively hereinafter referred to as “the Parties”, entered into this Agreement to govern certain activities and responsibilities required for operating or contracting the Children's Residential Crisis Stabilization Units-CRCSU (the “Program” or “Service”). This Agreement is attached to and made part of the performance contract by reference.

**Purpose:**

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 that exemplify clinical and management best practices for CRCSUs. It is imperative that CRCSUs 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.

**Term:** This Agreement shall govern the performance of the Parties for the period of 7/1/21 through 6/30/23 (“Period of Performance”).

**A. Scope of Services:**

**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.
  - a. 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.
2. 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.
3. 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.
4. 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.
5. 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.
6. The 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 by phone after business hours.

**B. Admission and Discharge Process:**

**Exhibit D: RICHMOND BEHAVIORAL HEALTH AUTHORITY (RBHA)  
Performance Measures for the Children's Residential Crisis Stabilization Units**

1. Individuals considered for admission should not have reached their 18<sup>th</sup> 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 RBHA shall agree to the following exclusionary criteria:
  - a. Individuals with medical needs that exceed the capacity of the program
  - b. Individuals unable or unwilling to participate in the programmatic requirements to ensure safety of staff and residents of the program
  - c. Individuals unable or unwilling to participate with the goals set out in individualized service plan (ISP)
  - d. Individuals demonstrating evidence of current assaultive or violent behavior that poses a risk to peers or CSU staff
  - e. Individuals demonstrating evidence of active suicidal behavior
  - f. Individuals with current violent felony charges pending
  - g. 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
  - h. Repetitive fire starter within the last 12 months
  - i. Individuals with a primary diagnosis of substance use disorder demonstrating active substance use disorder with current active use
  - j. Individuals who demonstrate or report inability to function in a group setting without causing significant disruption to others
  - k. Other reasons for denial would need to be thoroughly discussed with DBHDS Office of Child and Family Services
- l. 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 RBHA shall accept and admit at least 50% of referrals made.
  6. The CRCSU shall develop well-defined written policies and procedures for accepting step-downs from Commonwealth Center for Children and Adolescents.
  7. The CRCSU will follow discharge planning requirements as cited in the DBHDS licensing regulations (12VA35-105-693).
  8. CRCSUs will assess the integrated care needs of individuals upon admission and establish a discharge plan that addresses the individual's specialized care needs.

**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

**Exhibit D: RICHMOND BEHAVIORAL HEALTH AUTHORITY (RBHA)  
Performance Measures for the Children's Residential Crisis Stabilization Units**

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, RBHA 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

**B. The CSB Responsibilities:** In order to implement the **CRCSU RBHA** agrees to comply with the following requirements.

1. The CRCSU will comply with all DBHDS licensing requirements.
2. The CRCSU will provide additional reporting data as requested to DBHDS.
3. CRCSUs shall be considered regional programs and is not specific to the physical location of the program. RBHA in Region 4-will revise the Memorandum of Understanding (MOU) governing the Regional CRCSU and provide this to the Department upon request.
4. 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.
5. 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.
6. 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.

**C. The Department Responsibilities:** In order to implement the **CRCSU** the Department agrees to comply with the following requirements.

1. The Department shall shall provide Technical Assistance (TA), to include but not limited to: networking meetings, training, and site visits to RBHA 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.

**Exhibit D: RICHMOND BEHAVIORAL HEALTH AUTHORITY (RBHA)  
Performance Measures for the Children's Residential Crisis Stabilization Units**

2. The Department will initiate Quality Improvement Plans (QIP) after Technical Assistance has been provided and a CSU 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 will 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 Department 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 ensure data submitted through reports meets the expectations as outlined in this document and in the CRCSU written plans.

**D. Payment Terms:**

1. The Department shall provide RBHA \$727,816 in Restricted Mental Health State General Funds to be paid in twice a month payments. These funds are the result of a reduction in the amount currently allocated MH Crisis Response and Child Psychiatry currently allocated. There will not be any increase in funding for the provision of Children's Crisis Stabilization Services. The Department may, at its reasonable discretion, modify payment dates or amounts, or terminate this Agreement and will notify RBHA of any such changes in writing.
2. Because these funds are from the current funding allocation for the MH Crisis Response and Child Psychiatry (Fiscal Agent) allocation and included in the MH Crisis Stabilization (Fiscal Agent) allocation, they are to be used solely for the CRCSU. Any changes to the amount of the funds for the CRCSU must first be submitted in writing to the Department's Office of Child and Family Services for its review and approval.

**E. Limitations on Reimbursements:** RBHA shall not be reimbursed or otherwise compensated for any expenditures incurred or services provided following the end of the Period of Performance.

1. **Use of Funds:** RBHA may not use the funds provided under this Agreement for any purpose other than as described herein and allowable to carry out the purposes and activities of the CRCSU Program or Service. RBHA agrees that if it does not fully implement this Program as approved or as subsequently modified by agreement of the Parties, the Department shall be able to recover part or all of the disbursed funds.
2. **Performance Outcome Measures:**
  1. The CRCSU will maintain an average annual utilization of 65%.
  2. The CRCSU will accept 50% of referrals made to program based on agreed upon exclusionary criteria.
3. **Reporting Requirements:**
  1. The CRCSU will develop and provide procedures for accepting admissions 24/7- these procedures will be sent to DBHDS no later than July 15, 2021.
  2. The CRCSU will document in EHR all required elements for service and CCS.
  3. The CSB shall provide data and finance reports of funds provided by the Department and all expenditures to the consistent with Section 12 Reporting and Data Quality Requirements of the FY 2022 and FY 2023 Community Services Performance Contract
  4. Monthly CRCSU will provide additional data points as requested to DBHDS office of child and family services, no later than 5<sup>th</sup> of the month following the reporting month.

**Exhibit D: RICHMOND BEHAVIORAL HEALTH AUTHORITY (RBHA)  
Performance Measures for the Children's Residential Crisis Stabilization Units**

- 5. **Monitoring, Review, and Audit:** The Department may monitor and review use of the funds, performance of the Program, and compliance with this Agreement, which may include onsite visits to assess RBHA'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.
- 6. **Entire Agreement:** This Agreement and any additional or supplementary document(s) incorporated herein by specific reference contain all the terms and conditions agreed upon by the Parties hereto, and no other contracts, oral or otherwise, regarding the subject matter of this Agreement or any part thereof shall have any validity or bind any of the Parties hereto.
- 7. **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.
- 8. **Conflicts:** In the event of any conflict between this Agreement (or any portion thereof) and any other agreement now existing or hereafter entered into, the terms of this Agreement shall prevail.

**Signatures:** In witness thereof, the Department and the CSB have caused this Agreement to be executed by the following duly authorized Parties.

**Virginia Department of Behavioral  
Health and Developmental Services**

By:   
648C7B1926394F8...

Name: Alison G. Land, FACHE

Title: Commissioner

Date: 6/30/2021 | 11:38 AM EDT

**Office of Child and Family Services**

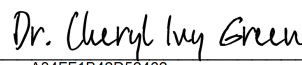
By:   
B33F7524C139478...

Name: Nina Marino

Title: Program Director

Date: 7/6/2021 | 3:27 PM EDT

**Richmond Behavioral Health Authority**

By:   
A34FF1B42D52462...

Name: Dr. Cheryl Ivy Green

Title: Chairperson

Date: 6/30/2021 | 5:37 PM EDT

By:   
C0B807EDDA664E9...

Name: John P. Lindstrom, Ph.D.

Title: Chief Executive Officer

Date: 6/30/2021 | 5:33 PM EDT



**EXHIBIT D: RICHMOND BEHAVIORAL HEALTH AUTHORITY****PERFORMANCE MEASURES FOR THE REGIONAL STEP-VA SERVICES FOR PEER AND FAMILY SUPPORTS (PFS), OUTPATIENT SERVICES & SERVICE MEMBERS, VETERANS AND THEIR FAMILIES (SMVF)**

This Agreement is between the Department of Behavioral Health and Developmental Services (“DBHDS” or “Department”) and the **Richmond Behavioral Health Authority** (“CSB/BHA” or “Subrecipient”), collectively hereinafter referred to as “the Parties”, entered into this Agreement to govern certain activities and responsibilities required for operating or contracting the **Regional STEP VA Services for Peer and Family Supports (PFS), Outpatient and Service Members, Veterans and Families (SMVF)** (the “Program” or “Service”). This Agreement is attached to and made part of the performance contract by reference.

**Purpose:** The purpose of Virginia's Behavioral Health System System Transformation Excellence and Performance (STEP-VA) is to reform the public mental health system by improving access, quality, consistency, and accountability in public mental health services across the Commonwealth. STEP-VA is a code-mandated long-term initiative that requires that all 40 Community Services Boards (CSBs) and Behavioral Health Authorities (BHAs) to implement nine essential services, referred to as steps, and requires consistent quality measures and oversight. Over time, after full implementation of STEP-VA, DBHDS 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. As one of the required services for STEP-VA, the purpose of Peer and Family Support Services is to ensure adequate capacity of this best practice and support the ability of the delivery system to empower people receiving services to make the best decisions for them and to strive towards their goals in their communities. Peers are an essential component of recovery-focused systems and are key across settings and stages of recovery. As another 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 component of Outpatient Services is the provision of regional training opportunities for clinical and quality improvement for outpatient behavioral health services such as evidence based practices in behavioral health. Services to Service Members, Veterans and Families (SMVF) is one of the nine required services for STEP-VA. The purpose of the Service Members, Veterans and Families (SMVF) step is to ensure SMVF receive needed mental health and supportive services in the most efficient and effective manner available. Services shall be high quality, evidence-based, trauma-informed, culturally-competent, and accessible. A critical component of the implementation of the aforementioned step is regional capacity building to build a system that is high quality, coordinated across communities and sectors, and has a skilled and highly trained workforce.

**Term:** This Agreement shall govern the performance of the Parties for the period of July 1, 2021 through June 30, 2022 (“Period of Performance”).

**A. Scope of Services:**

The CSB/BHA shall provide capacity and infrastructure to support regional capacity building, coalition building, training, workforce development efforts, and support for implementation and sustainability related to Services for Peer and Family Supports, Outpatient & Service Members, Veterans & Families steps of STEP-VA, as outlined in the approved proposal.

**B. The CSB/BHA Responsibilities:** In order to implement the Regional STEP-VA Services for Peer and Family Supports Program, Outpatient & Service Members, Veterans and Families for Region 4, the CSB/BHA agrees to comply with the following requirements:

1. The CSB/BHA shall ensure that the Services are implemented as regional program and is not specific to the physical location of the program.
2. The CSB/BHA shall coordinate the development of written plans to articulate the vision, goals, and activities of the Services, and provide them to the Department upon request.

**EXHIBIT D: RICHMOND BEHAVIORAL HEALTH AUTHORITY****PERFORMANCE MEASURES FOR THE REGIONAL STEP-VA SERVICES FOR PEER AND FAMILY SUPPORTS (PFS), OUTPATIENT SERVICES & SERVICE MEMBERS, VETERANS AND THEIR FAMILIES (SMVF)**

- a. For Outpatient services, the CSB/BHA will ensure that the regional program includes trauma focused training specifically, including evidence based practices for the treatment of traumatic stress for children, families, and adults, as well as trauma informed care more generally.
3. The CSB/BHA shall ensure the CSB/BHA s in the region develop a Memorandum of Understanding (MOU) outlining regional partnerships to support the Services and provide them to the Department upon request.
4. The CSB/BHA will offer evidence based and best practices as part of their programming and implementation of all aforementioned Services.
5. The CSB/BHA shall ensure that the regional programs for all services send training resources (e.g., trainers or training coordinators) whenever feasible to training programs and train-the-trainer programs relevant to core assessments and treatments, including but not limited to, DLA-20, Columbia Suicide Severity Scale, and ASAM; and then utilizes those trained resources to deliver support and trainings across the region for Outpatient services.
6. The CSB/BHA shall ensure that the regional program includes regional training infrastructure of at least 1.5 FTE across training coordination and training duties for STEP-VA services for children, families, and adults.
7. The CSB/BHA shall ensure that the regional program works collaboratively to identify Outpatient trainings and evidence based practices needed in the region for children, families, and adults.
8. The CSB/BHA shall collaborate with the Department's Office of Recovery Services to increase the capacity of Family Support Partner (FSP) role through concerted workforce development initiatives that align with system-wide priorities.
9. The CSB/BHA shall support 1.0 FTE to fund *either* a Peer Supporter or Family Support Partner.
10. Peer Supporter/Family Support Partners will obtain certification within one year of hire and Registered with the Virginia Board of Counseling within 15 months of hire.
11. The CSB/BHA shall support regional training and capacity building in the region in service to Peer and Family Supporters\*, specifically:
  - a. Ensuring access to appropriate training for CSB/BHA peer and family supporters to increase the availability for citizens to evidence-based, promising practices
  - b. Peer and family support workforce training (for CSB/BHA direct services staff) which improves knowledge, skills and abilities in recovery oriented services such as: crisis support; recovery community centers; peer specialist; peer recovery coaching; peer wellness coaching; peer health navigators; family navigators/parent support partners/providers; Peer-delivered motivational interviewing; peer-run respite services; peer-run crisis diversion services; telephone recovery checkups; warm lines; self-directed care; supportive housing models; evidenced-based supported employment; Action Planning Prevention and Recovery; Whole Health Action Management (WHAM); Personal Medicine training, shared decision-making; person-centered planning; self-care and wellness approaches; peer-run Seeking Safety groups; wellness-based community campaigns; corrections-based recovery programs, etc.

*\*20% must be used to address increasing the capacity of Family Support Partner (FSP) role.*
12. The CSB/BHA shall ensure that the Program is implemented as a regional program and is not specific to the physical location of the program.
13. The CSB/BHA shall ensure the participating CSBs/BHAs in the region develop a Memorandum of Understanding (MOU) outlining the mission, vision, and goals of the regional partnerships to support the Program and provide this to the Department upon request.
14. The CSB/BHA will offer evidence based and best practices as part of their programming and implementation.
15. The CSB/BHA shall support and hire at least 1.0 FTE Regional Navigator SMVF position by October 1, 2021, to provide dedicated capacity at the regional level to support regional and state level SMVF initiatives; support the connectedness of SMVF system needs across regional, state, and federal level; serve as a resource to CSBs/BHAs in the region in meeting SMVF metrics; oversee regional training and capacity-building funds, liaise with relevant partners at the state and federal levels, and participate

**EXHIBIT D: RICHMOND BEHAVIORAL HEALTH AUTHORITY****PERFORMANCE MEASURES FOR THE REGIONAL STEP-VA SERVICES FOR PEER AND FAMILY SUPPORTS (PFS), OUTPATIENT SERVICES & SERVICE MEMBERS, VETERANS AND THEIR FAMILIES (SMVF)**

in regional and state SMVF initiatives focused on suicide prevention at the intersection of SMVF populations.

16. The CSB/BHA shall support a Regional Navigator to form and support cross referral and training partnerships with regional Department of Veterans Services, Military Treatment Facilities, and Veterans Health Administration facilities and serve on SMVF work groups to enhance regional services and partnerships (e.g. Governor's Challenge teams, etc.) and support and grow best practices within the region and individual CSBs/BHAs in their region.
17. The CSB/BHA shall support regional goals to implement, enhance, and promote the goals of Lock and Talk at the intersection of the SMVF population including but not limited to regional planning and capacity building, lethal means safety, social media campaigns, and other activities.
18. The CSB/BHA shall support regional training and capacity building in the region in service to SMVF, specifically:
  - a. Ensuring access to clinical training for CSB/BHA providers to increase the availability for citizens to evidence-based, trauma-focused therapy such as prolonged exposure, cognitive processing therapy, and eye movement desensitization and reprocessing (EMDR).
  - b. Supporting workforce training (for CSB/BHA direct services staff) on military culture and resources available to Service Members and their Families (SMVF).
  - c. Providing educational materials and outreach activities to support clinical needs of SMVF, as needed.

**C. The Department Responsibilities:** In order to implement the Regional STEP-VA Services for Peer and Family Supports (PFS), Outpatient & Service Members and their Families (SMVF), 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/BHA 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. Provide training, master training, and/or train-the-trainer opportunities for regional training resources for Outpatient services for prioritized assessments and treatments.
3. 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.
4. Require the CSB/BHA uses the funds in a manner associated with the intended requirements, and the Department shall monitor accordingly.

**D. Payment Terms:** The Department shall provide the CSB/BHA \$100,000 in FY 2022 Restricted MH State General Funds for Training and Capacity Building for Peer and Family Supports Services; \$308,000 in FY 2022 Restricted MH State General Funds for Regional Training – Capacity & Enhancements for Outpatient Services; \$109,000 in FY 2022 Restricted MH State General Funds to support a Regional Navigator for SMVF services; \$25,000 in FY 2022 Restricted MH State General Funds for Lock and Talk; and \$25,000 for Training and Capacity Building for SMVF services, for a total of \$567,000 to implement STEP-VA requirements in normal twice a month payments. The Department may, at its reasonable discretion, modify payment dates or amounts, or terminate this Agreement and will notify the CSB/BHA of any such changes in writing.

The CSB/BHA, as the agency responsible for directly administering Regional STEP-VA Services for Peer and Family Supports, Outpatient & Service Members, Veterans and their Families and for the region, may retain administrative costs up to 10% of the gross amount of these funds for the administration of the Programs. These costs will be disclosed to DBHDS and to the CSBs/BHAs within the region. Any restricted funds for these Programs that remain unexpended at the end of the fiscal year shall be returned to the Department for reinvestment into STEP-VA regional services or carried over by the CSB/BHA to the following fiscal year to be used only for Regional STEP-VA Services for Peer and Family Supports, Outpatient & Service Members,

**EXHIBIT D: RICHMOND BEHAVIORAL HEALTH AUTHORITY****PERFORMANCE MEASURES FOR THE REGIONAL STEP-VA SERVICES FOR PEER AND FAMILY SUPPORTS (PFS), OUTPATIENT SERVICES & SERVICE MEMBERS, VETERANS AND THEIR FAMILIES (SMVF)**

Veterans and their Families authorized by the Department in consultation with the participating CSBs/BHAs. The CSB/BHA may retain administrative costs up to 5% of the gross amount of these funds for the administration of the Outpatient training Program.

- E. Limitations on Reimbursements:** CSB/BHA shall not be reimbursed or otherwise compensated for any expenditures incurred or services provided following the end of the Period of Performance.
- F. Use of Funds:** The CBS may not use the funds provided under this Agreement for any purpose other than as described herein and allowable to carry out the purposes and activities of the Programs or Services without explicitly contacting the Division of Community Services in writing and receiving written approval. The CSB/BHA agrees that if it does not fully implement this Program as approved or as subsequently modified by agreement of the Parties, the Department shall be able to recover part or all of the disbursed funds.
- G. Performance Outcome Measures:**
1. Evidence-based and trauma focused training will be offered to all CSB direct service workers in the region, for Peer and Family Supports, Outpatient Services & Service Members, Veterans and their Families.
  2. 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. Conduct military cultural competency training for 100% of Direct Services CSB staff.
  4. Track SMVF status for 90% of individuals presenting for services.
  5. Track referral destination to military/veteran resources. Of those served by the CSB who are SMVF, at least 70% will be referred to the Department of Veterans Services (DVS), Veterans Health Administration facilities and services (VHA), and/or Military Treatment Facilities and services (MTF).
  6. Conduct suicide risk screening using the Columbia Suicide Severity Rating Scale brief screen for 60% of Military Service Members and Veterans.
- H. Reporting Requirements:**
1. The CSBs/BHAs will comply with Section 12. Reporting and Data Quality Requirments in the FY 2022 and FY 2023 Performance Contract.
  2. The Department will work with the CSBs/BHAs to establish benchmark measures to address reporting requirements in Section 9. CSB Responsibilities, E. Reporting Requirements and Data Quality of the FY 2022 and FY 2023 Performance Contract.
  3. The CSB must also comply with any additional reporting for the STEP-VA requirements and other reporting requirements negotiated with the Department.
- J. Monitoring, Review, and Audit:** The Department may monitor and review use of the funds, performance of the Program, and compliance with this Agreement, which may include onsite visits to assess the CSB/BHA '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.
- K. Entire Agreement:** This Agreement and any additional or supplementary document(s) incorporated herein by specific reference contain all the terms and conditions agreed upon by the Parties hereto, and no other contracts,

**EXHIBIT D: RICHMOND BEHAVIORAL HEALTH AUTHORITY**

**PERFORMANCE MEASURES FOR THE REGIONAL STEP-VA SERVICES FOR PEER AND FAMILY SUPPORTS (PFS), OUTPATIENT SERVICES & SERVICE MEMBERS, VETERANS AND THEIR FAMILIES (SMVF)**

oral or otherwise, regarding the subject matter of this Agreement or any part thereof shall have any validity or bind any of the Parties hereto.


- L. 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.
- M. Conflicts:** In the event of any conflict between this Agreement (or any portion thereof) and any other agreement now existing or hereafter entered into, the terms of this Agreement shall prevail.

**EXHIBIT D: RICHMOND BEHAVIORAL HEALTH AUTHORITY**


**PERFORMANCE MEASURES FOR THE REGIONAL STEP-VA SERVICES FOR PEER AND FAMILY SUPPORTS (PFS), OUTPATIENT SERVICES & SERVICE MEMBERS, VETERANS AND THEIR FAMILIES (SMVF)**

**Signatures:** In witness thereof, the Department and the CSB/BHA have caused this Agreement to be executed by the following duly authorized Parties.


**Virginia Department of Behavioral Health and Developmental Services**

By:   
Name: Alison G. Land, FACHE  
Title: Commissioner  
Date: 7/7/2021 | 10:40 AM EDT

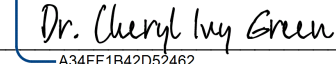
**Office of Recovery Services**


By:   
Name: Mark Blackwell  
Title: Program Director  
Date: 7/7/2021 | 6:59 AM PDT

**Office of Adult Community Behavioral Health Services**

By:   
Name: Tara Belfast-Hurd  
Title: Outpatient, Veterans, Co-occurring Manager  
Date: 7/2/2021 | 12:57 PM EDT

**Richmond Behavioral Health Authority**

By:   
Name: Dr. Cheryl Ivy Green  
Title: Chairperson  
Date: 7/2/2021 | 11:45 AM EDT

By:   
Name: John P. Lindstrom, Ph.D.  
Title: Chief Executive Officer  
Date: 7/2/2021 | 7:35 AM EDT

**Exhibit D: RICHMOND BEHAVIORAL HEALTH AUTHORITY (RBHA)  
Performance Measures for the Children's Residential Crisis Stabilization Units**

This Agreement is between the Department of Behavioral Health and Developmental Services (“DBHDS” or “Department”) and the [THE Richmond Behavioral Health Authority (RBHA (BHA or “Subrecipient”), collectively hereinafter referred to as “the Parties”, entered into this Agreement to govern certain activities and responsibilities required for operating or contracting the **Children's Residential Crisis Stabilization Units-CRCSU** (the “Program” or “Service”). This Agreement is attached to and made part of the performance contract by reference.

**Purpose:**

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 that exemplify clinical and management best practices for CRCSUs. It is imperative that CRCSUs 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.

**Term:** This Agreement shall govern the performance of the Parties for the period of **7/1/21** through **6/30/23** (“Period of Performance”).

**A. Scope of Services:**

**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.
  - a. 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.
2. 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.
3. 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.
4. 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.
5. 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.
6. The 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 by phone after business hours.

**B. Admission and Discharge Process:**

**Exhibit D: RICHMOND BEHAVIORAL HEALTH AUTHORITY (RBHA)  
Performance Measures for the Children's Residential Crisis Stabilization Units**

1. Individuals considered for admission should not have reached their 18<sup>th</sup> 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 RBHA shall agree to the following exclusionary criteria:
  - a. Individuals with medical needs that exceed the capacity of the program
  - b. Individuals unable or unwilling to participate in the programmatic requirements to ensure safety of staff and residents of the program
  - c. Individuals unable or unwilling to participate with the goals set out in individualized service plan (ISP)
  - d. Individuals demonstrating evidence of current assaultive or violent behavior that poses a risk to peers or CSU staff
  - e. Individuals demonstrating evidence of active suicidal behavior
  - f. Individuals with current violent felony charges pending
  - g. 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
  - h. Repetitive fire starter within the last 12 months
  - i. Individuals with a primary diagnosis of substance use disorder demonstrating active substance use disorder with current active use
  - j. Individuals who demonstrate or report inability to function in a group setting without causing significant disruption to others
  - k. Other reasons for denial would need to be thoroughly discussed with DBHDS Office of Child and Family Services
- l. 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 RBHA shall accept and admit at least 50% of referrals made.
  6. The CRCSU shall develop well-defined written policies and procedures for accepting step-downs from Commonwealth Center for Children and Adolescents.
  7. The CRCSU will follow discharge planning requirements as cited in the DBHDS licensing regulations (12VA35-105-693).
  8. CRCSUs will assess the integrated care needs of individuals upon admission and establish a discharge plan that addresses the individual's specialized care needs.

**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



**Exhibit D: RICHMOND BEHAVIORAL HEALTH AUTHORITY (RBHA)  
Performance Measures for the Children's Residential Crisis Stabilization Units**

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, RBHA 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

**B. The CSB Responsibilities:** In order to implement the **CRCSU RBHA** agrees to comply with the following requirements.

1. The CRCSU will comply with all DBHDS licensing requirements.
2. The CRCSU will provide additional reporting data as requested to DBHDS.
3. CRCSUs shall be considered regional programs and is not specific to the physical location of the program. RBHA in Region 4-will revise the Memorandum of Understanding (MOU) governing the Regional CRCSU and provide this to the Department upon request.
4. 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.
5. 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.
6. 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.

**C. The Department Responsibilities:** In order to implement the **CRCSU** the Department agrees to comply with the following requirements.

1. The Department shall shall provide Technical Assistance (TA), to include but not limited to: networking meetings, training, and site visits to RBHA 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.

**Exhibit D: RICHMOND BEHAVIORAL HEALTH AUTHORITY (RBHA)**  
**Performance Measures for the Children's Residential Crisis Stabilization Units**

2. The Department will initiate Quality Improvement Plans (QIP) after Technical Assistance has been provided and a CSU 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 will 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 Department 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 ensure data submitted through reports meets the expectations as outlined in this document and in the CRCSU written plans.

**D. Payment Terms:**

1. The Department shall provide RBHA \$766,122 in FY 2022 Restricted Mental Health State General Funds to be paid in twice a month payments. These funds are the result of a reduction in the amount currently allocated MH Crisis Response and Child Psychiatry currently allocated. There will not be any increase in funding for the provision of Children's Crisis Stabilization Services. The Department may, at its reasonable discretion, modify payment dates or amounts, or terminate this Agreement and will notify RBHA of any such changes in writing.
2. Because these funds are from the current funding allocation for the MH Crisis Response and Child Psychiatry (Fiscal Agent) allocation and included in the MH Crisis Stabilization (Fiscal Agent) allocation, they are to be used solely for the CRCSU. Any changes to the amount of the funds for the CRCSU must first be submitted in writing to the Department's Office of Child and Family Services for its review and approval.
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:
  - 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 Fiscal Agent may retain up to 2.5% of the allocation amount for Administrative Costs.
  - 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.
  - 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.

**E. Limitations on Reimbursements:** RBHA shall not be reimbursed or otherwise compensated for any expenditures incurred or services provided following the end of the Period of Performance.

1. **Use of Funds:** RBHA may not use the funds provided under this Agreement for any purpose other than as described herein and allowable to carry out the purposes and activities of the CRCSU Program or Service. RBHA agrees that if it does not fully implement this Program as approved or as subsequently modified by agreement of the Parties, the Department shall be able to recover part or all of the disbursed funds.
2. **Performance Outcome Measures:**
  1. The CRCSU will maintain an average annual utilization of 65%.
  2. The CRCSU will accept 50% of referrals made to program based on agreed upon exclusionary criteria.

**Exhibit D: RICHMOND BEHAVIORAL HEALTH AUTHORITY (RBHA)  
Performance Measures for the Children's Residential Crisis Stabilization Units**

**3. Reporting Requirements:**

1. The CRCSU will develop and provide procedures for accepting admissions 24/7- these procedures will be sent to DBHDS no later than July 15,2021.
2. The CRCSU will document in EHR all required elements for service and CCS.
3. The CSB shall provide data and finance reports of funds provided by the Department and all expenditures to the consistent with Section 12 Reporting and Data Quality Requirements of the FY 2022 and FY 2023 Community Services Performance Contract
4. Monthly CRCSU will provide additional data points as requested to DBHDS office of child and family services, no later than 5<sup>th</sup> of the month following the reporting month.
5. **Monitoring, Review, and Audit:** The Department may monitor and review use of the funds, performance of the Program, and compliance with this Agreement, which may include onsite visits to assess RBHA'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.
6. **Entire Agreement:** This Agreement and any additional or supplementary document(s) incorporated herein by specific reference contain all the terms and conditions agreed upon by the Parties hereto, and no other contracts, oral or otherwise, regarding the subject matter of this Agreement or any part thereof shall have any validity or bind any of the Parties hereto.
7. **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.
8. **Conflicts:** In the event of any conflict between this Agreement (or any portion thereof) and any other agreement now existing or hereafter entered into, the terms of this Agreement shall prevail.

**Signatures:** In witness thereof, the Department and the CSB have caused this Agreement to be executed by the following duly authorized Parties.

**Virginia Department of Behavioral Health and Developmental Services**

By: DocuSigned by:  
Alison Land

Name: Alison G. Land, FACHE

Title: Commissioner  
7/20/2021

Date: \_\_\_\_\_

**Office of Child and Family Services**

By: DocuSigned by:  
Nina Marino

Name: Nina Marino

Title: Program Director

Date: 7/20/2021

**Richmond Behavioral Health Authority**

By: DocuSigned by:  
Dr. Cheryl Ivy Green

Name: Dr. Cheryl Ivy Green

Title: Chairperson  
7/20/2021

Date: \_\_\_\_\_

By: DocuSigned by:  
John P. Lindstrom, Ph.D., ULP CEO

Name: John P. Lindstrom, Ph.D.

Title: Chief Executive Officer  
7/20/2021

Date: \_\_\_\_\_

**Exhibit D: RICHMOND BEHAVIORAL HEALTH AUTHORITY (RBHA)  
Performance Measures for the Children's Residential Crisis Stabilization Units**

**Exhibit D: Richmond Behavioral Health Authority**  
**Performance Measures for the Local Marcus Alert Planning and Implementation**

This Agreement is between the Department of Behavioral Health and Developmental Services (“DBHDS” or “Department”) and the Richmond Behavioral Health Authority (“BHA” or “Subrecipient”), collectively hereinafter referred to as “the Parties”, entered into this Agreement to govern certain activities and responsibilities required for operating or contracting the local Marcus Alert (the “Program” or “Service”). This Agreement is attached to and made part of the performance contract by reference.

**Purpose**

**Term:** This Agreement shall govern the performance of the Parties for the period of 7/1/2021 through 6/30/2022 (“Period of Performance”).

- A. Scope of Services:** These funds are to support the planning and implementation of the local components of the Marcus Alert.
- B. The CSB Responsibilities:** In order to implement the local Marcus Alert, the CSB agrees to comply with the following requirements.
1. The CSB shall convene a stakeholder group, or alternately, a mission group and an operations group, with diverse representation to plan for implementation of the Marcus Alert.
  2. The CSB shall ensure close collaboration between the local Marcus Alert development and the regional Call Center/mobile crisis hub development. The initial Marcus Alert implementation area should have representation on any regional development planning groups.
  3. The CSB shall hire a coordinator position who will serve a regional function as the Marcus Alert expands. This coordinator is expected to support the initial area’s local implementation and also play a key role in coordination between the call center/mobile crisis hubs and Protocol #2 (law enforcement back up). The initial area CSB should work with their regional partners to coordinate appropriate responsibilities for this position.
  4. The CSB shall submit the 10 required items for a local application to the Department by October 1, 2021.
  5. The CSB shall implement the initial plan to launch December 1, 2021.
  6. The CSB shall collect data for quality improvement processes when the implementation begins and ensure that data collection systems are being developed between January, 2022-June 2022.
  7. The CSB shall report any significant events to the Department during the initial implementation period (December 1, 2021-June, 2022).
  8. The CSB shall provide data reports as required in CCS 3 and finance reports on the funds provided by the Department as required in CARS pursuant to Section 12 Reporting and Data Quality Requirements of the FY 2022 and FY 2023 Community Services Performance Contract.
- C. The Department Responsibilities:** In order to implement the local Marcus Alert, the Department agrees to comply with the following requirements.
1. The Department shall provide \$600,000 in Restricted MH STEP-VA state general funds for the project.
  2. The Department shall share any information received regarding true costs of the project to support ongoing appropriate estimate of cost by key decision makers.
  3. The Department shall review completed local plans that are received by October 1, 2021 by October 22, 2021, if not sooner.
  4. The Department shall hold monthly technical assistance meetings.
  5. The Department shall ensure that the needs (timeline) of the initial Marcus Alert areas are taken into consideration to the highest extent possible in the development of the crisis call center platform.
  6. The Department shall support the initial area if needed in any regional discussions regarding timeline and need for mobile crisis coverage to implement the Marcus Alert.
  7. The Department shall use feedback received from the initial areas to inform the overall implementation plan.
- D. Payment Terms:** The Department shall provide the CSB \$600,000 in Restricted MH STEP-VA State General Funds in a one-time payment with Warrant Payment #1 for state fiscal year 2022.
- E. 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.

**Exhibit D: Richmond Behavioral Health Authority  
Performance Measures for the Local Marcus Alert Planning and Implementation**

**F. Use of Funds:** The CBS may not use the funds provided under this Agreement for any purpose other than as described herein and allowable to carry out the purposes and activities of the Program or Service. The CSB agrees that if it does not fully implement this Program as approved or as subsequently modified by agreement of the Parties, the Department shall be able to recover part or all of the disbursed funds.

**Performance Outcome Measures:**

**Planning:** All planning performance will be measured utilizing the 10 required local plan components to be received October 1, 2021

- o # of components completed of the 10; 10/10 required

**Implementation:** The current funding period is all during Phase 1 of implementation; and data collection begins in Phase 2 (July 1, 2022, with first quarter reporting due October, 2022).

- o # protocols (out of 3) implemented and date of implementation
- o # responses total during the funding period

**G. Reporting Requirements:**

Compliance will be monitored via components submitted October 1, 2021. Total number of responses at the end of the funding period will be requested via CSB internal data collection if they cannot be accessed through the call center data platform June, 2022. As described in #8 above, CSBs shall report all services provided with this funding and expenditures through CCS and CARS reporting procedures.

**H. Monitoring, Review, and Audit:** The Department may monitor and review use of the funds, performance of the Program, 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.

**I. Entire Agreement:** This Agreement and any additional or supplementary document(s) incorporated herein by specific reference contain all the terms and conditions agreed upon by the Parties hereto, and no other contracts, oral or otherwise, regarding the subject matter of this Agreement or any part thereof shall have any validity or bind any of the Parties hereto.

**J. 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.

**K. Conflicts:** In the event of any conflict between this Agreement (or any portion thereof) and any other agreement now existing or hereafter entered into, the terms of this Agreement shall prevail.

**Signatures:** In witness thereof, the Department and the CSB have caused this Agreement to be executed by the following duly authorized Parties.

**Virginia Department of Behavioral  
Health and Developmental Services**  
By: Alison Land  
648C7B1025394F8

Name: Alison G. Land, FACHE  
Title: Commissioner

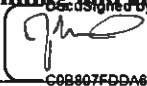
Date: 8/3/2021

**Marcus Alert** DocuSigned by:  
By: Lisa Jobe-Shields  
D4E9BAFF74DA488

Name: Lisa Jobe-Shields  
Title: Program Director

**Exhibit D: Richmond Behavioral Health Authority  
Performance Measures for the Local Marcus Alert Planning and Implementation**

Date: 8/3/2021

By:   
DocuSigned by:  
C0B807FDDA664E9...

DocuSigned by:  
**RICHMOND BEHAVIORAL HEALTH AUTHORITY**  
By:   
A34FF1842052402...

Name: John Lindstrom

Name: Dr. Cheryl Ivy Green

Title: CHIEF EXECUTIVE OFFICER

Title: Chairperson  
8/3/2021

Date: 7/8/2021 | 10:18 AM EDT

Date: \_\_\_\_\_

**Exhibit D: RICHMOND BEHAVIORAL HEALTH AUTHORITY****FY22 Performance Measures for the Substance Abuse Block Grant- Prevention Set- Aside**

This Agreement is between the Department of Behavioral Health and Developmental Services and the **Richmond Behavioral Health Authority (“CSB” or “Subrecipient”)**, collectively hereinafter referred to as “the Parties”, entered into this Agreement to govern certain activities and responsibilities required for operating or contracting the **Substance Abuse Block Grant (SABG) Prevention Set Aside Services, CAA Supplemental**. This Agreement is attached to and made part of the performance contract by reference.

**Purpose:** 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.

<b>SELECT GRANT (ONLY ONE GRANT PER EXHIBIT)</b>	<b>SAMHSA GRANTS</b>
<b>I.</b> <input checked="" type="checkbox"/>	<b>GRANT NAME:</b> Substance Abuse Prevention and Treatment Block Grant (SUD FBG) <b>FEDERAL AWARD IDENTIFICATION NUMBER (FAIN):</b> B08TI083547 <b>FEDERAL AWARD DATE:</b> 3/11/2021 <b>FEDERAL AWARDDING AGENCY:</b> Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) <b>FEDERAL AWARD PASS-THROUGH ENTITY:</b> Virginia Department of Behavioral Health and Developmental Services <b>CFDA NUMBER:</b> 93.959 <b>RESEARCH AND DEVELOPMENT AWARD:</b> ___ YES OR ___ X ___ NO <b>FEDERAL GRANT AWARD YEAR:</b> NA <b>AWARD PERIOD:</b> 3/15/2021 – 3/14/2023

**Term:** This Agreement shall govern the performance of the Parties for the period of **August 1, 2021** through **March 10, 2023** (“Period of Performance”).

- A. Scope of Services:** 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 CSB approved logic model and submitted plan.
- B. The CSB Responsibilities:** In order to implement and expand the SABG Prevention Set Aside, 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:
  - 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.
  - 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.



**Exhibit D: RICHMOND BEHAVIORAL HEALTH AUTHORITY****FY22 Performance Measures for the Substance Abuse Block Grant- Prevention Set- Aside**

- 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 CSBs should ensure there are at least 2 ACEs master trainers in their catchment area at all times.
- b. All CSBs 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. 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:
  - 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.
  - Submit a quarterly report on all ACEs strategies and measures.
  - 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).

**Exhibit D: RICHMOND BEHAVIORAL HEALTH AUTHORITY****FY22 Performance Measures for the Substance Abuse Block Grant- Prevention Set- Aside**

- 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:
  - ASIST
  - safeTALK
  - suicideTALK
  - 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. 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.)
- b. 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.

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

**C. The Department Responsibilities:** In order to implement and expand the **SABG Prevention Set Aside**, 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. The Parties will mutually agree on annual site visit dates.
- 3. 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. 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.
- 4. The Department will provide a budget template for annual budget submission.

**D. Payment Terms:** The Department shall provide the CSB SABG Prevention Set Aside payments of \$145,000 through the Department's warrant payment schedule. The Department may, at its reasonable discretion, modify payment dates or amounts, or terminate this Agreement and will notify the CSB of any such changes in writing.**E. 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.**F. Closeout Disclosure.**

**Closeout:** Final payment request(s) under this Agreement must be received by DBHDS no later than thirty (30) days prior to the end of the Period of Performance. No payment request will be accepted by DBHDS after this date without authorization from DBHDS. The CSB 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:

**Exhibit D: RICHMOND BEHAVIORAL HEALTH AUTHORITY****FY22 Performance Measures for the Substance Abuse Block Grant- Prevention Set- Aside**

DBHDS  
PO Box 1797  
Richmond, VA 23218-1797  
C/O Ramona Howell

Failure to return unexpended funds in a prompt manner may result in a denial of future federal Subrecipient awards from DBHDS.

In consideration of the execution of this agreement by 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 this agreement. Subrecipient's obligations to DBHDS under this agreement 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 this agreement.

- G. Use of Funds:** The CSB may not use the funds provided under this Agreement for any purpose other than as described herein and allowable to carry out the purposes and activities of the Program or Service. The CSB agrees that if it does not fully implement this Program as approved or as subsequently modified by agreement of the Parties, the Department shall be able to recover part or all of the disbursed funds.
- H. Performance Outcome Measures:**
1. Decrease in alcohol, tobacco and other drug (ATOD) misuse as measured by evaluation measures identified by OMNI
  2. Decrease in suicides as measured by the Office of the Chief Medical Examiner data (OCME)
  3. Increase in community capacity to address ATOD as measured by coalition readiness assessment
- I. Reporting Requirements:** All data is reported into the Prevention data system and must be submitted within 2 weeks of service delivery.
- J. Monitoring, Review, and Audit:** The Department may monitor and review use of the funds, performance of the Program, 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.
- K. Entire Agreement:** This Agreement and any additional or supplementary document(s) incorporated herein by specific reference contain all the terms and conditions agreed upon by the Parties hereto, and no other contracts, oral or otherwise, regarding the subject matter of this Agreement or any part thereof shall have any validity or bind any of the Parties hereto.
- L. 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.
- M. Conflicts:** In the event of any conflict between this Agreement (or any portion thereof) and any other agreement now existing or hereafter entered into, the terms of this Agreement shall prevail.

**Signatures:** In witness thereof, the Department and the CSB have caused this Agreement to be executed by the following duly authorized Parties.



**Exhibit D: Richmond Behavioral Health Authority**  
**FY22 Performance Measures for the Problem Gambling Prevention Services**

This Agreement is between the Department of Behavioral Health and Developmental Services (“DBHDS” or “Department”) and the **Richmond Behavioral Health Authority** (“CSB” or “Subrecipient”), collectively hereinafter referred to as “the Parties”, entered into this Agreement to govern certain activities and responsibilities required for operating or contracting the **Problem Gambling Prevention Services** (the “Program” or “Service”). This Agreement is attached to and made part of the performance contract by reference.

**Purpose:** 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.

**Term:** This Agreement shall govern the performance of the Parties for the period of **August 6, 2021 through August 6, 2022** (“Period of Performance”).

- A. Scope of Services:** 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.
- B. The CSB Responsibilities:** In order to implement the **Problem Gambling Prevention Services**, the CSB agrees to comply with the following requirements.
1. The CSB shall provide a proposed budget.
  2. 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.
  3. These funds shall be used only for the implementation of the Problem Gambling Prevention Services described herein.
  4. 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.
  5. 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.
  6. 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.
  7. Any restricted state FY 2022 Problem Gambling and Support funds that remain unexpended or unencumbered at the end of the fiscal year may be carried over (with approval by the Department) by the CSB to the following year to be used only for Problem Gambling Prevention strategy expenses authorized by the Department in consultation with the participating regional CSBs.
- C. The Department Responsibilities:** In order to implement the **Problem Gambling Prevention Services** 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

**Exhibit D: Richmond Behavioral Health Authority**  
**FY22 Performance Measures for the Problem Gambling Prevention Services**

3. The Department, will respond to inquiries in a timely fashion, 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 by DBHDS in partnership with OMNI Institute federal reporting contractor.
  4. The Department will provide a template for the plan and quarterly report for the CSB to use.
- D. Payment Terms:** The Department shall provide the CSB \$35,000 one-time restricted state general funds - Problem Gambling and Support Fund (code 9039). The Department may, at its reasonable discretion, modify payment dates or amounts, or terminate this Agreement and will notify the CSB of any such changes in writing.
- E. 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.
- F. Use of Funds:** The CSB may not use the funds provided under this Agreement for any purpose other than as described herein and allowable to carry out the purposes and activities of the Program or Service. The CSB agrees that if it does not fully implement this Program as approved or as subsequently modified by agreement of the Parties, the Department shall be able to recover part or all of the disbursed funds.
- G. Performance Outcome Measures:** The Department will work with the CSB to develop performance outcome measures through review of the needs assessment and data reporting.
- H. Reporting Requirements:**
1. Each CSB shall provide quarterly reports submitted by the Problem Gambling Prevention Service Lead.
  2. Each CSB shall report activities in the Prevention Database.
  3. The CSB shall provide data reports as required in CCS 3 and finance reports on the funds provided by the Department as required in CARS pursuant to the Reporting and Data Quality Requirements of the Community Services Performance Contract.
- I. Monitoring, Review, and Audit:** The Department may monitor and review use of the funds, performance of the Program, 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.
- J. Entire Agreement:** This Agreement and any additional or supplementary document(s) incorporated herein by specific reference contain all the terms and conditions agreed upon by the Parties hereto, and no other contracts, oral or otherwise, regarding the subject matter of this Agreement or any part thereof shall have any validity or bind any of the Parties hereto.
- K. 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.
- L. Conflicts:** In the event of any conflict between this Agreement (and any portion thereof) and any other agreement now existing or hereafter entered into, the terms of this Agreement shall prevail.

**Signatures:** In witness thereof, the Department and the CSB have caused this Agreement to be executed by the following duly authorized Parties.

**Exhibit D: Richmond Behavioral Health Authority  
FY22 Performance Measures for the Problem Gambling Prevention Services**

**Virginia Department of Behavioral Health  
and Developmental Services**

By: \_\_\_\_\_  
DocuSigned by:  
*Alison Land*  
Name: Alison G. Land, FACHE  
648C7B1925394F8C  
Title: Commissioner  
8/10/2021  
Date: \_\_\_\_\_

**Richmond Behavioral Health Authority**

By: \_\_\_\_\_  
DocuSigned by:  
*Dr. Cheryl Ivy Green*  
A34FF1B42D52462...  
Name: [CHAIRPERSON NAME]  
Dr. Cheryl Ivy Green  
Title: Chairperson  
8/10/2021  
Date: \_\_\_\_\_

**Office of Behavioral Health Wellness**

By: \_\_\_\_\_  
DocuSigned by:  
*Gail Taylor*  
Name: Gail Taylor  
BA947D658D2447E...  
Title: Program Director  
8/10/2021  
Date: \_\_\_\_\_

By: \_\_\_\_\_  
DocuSigned by:  
*John P. Lindstrom, Ph.D, UCP CEO*  
C0B807FDDA664E9...  
Name: **John Lindstrom**  
Title: Executive Director  
8/10/2021  
Date: \_\_\_\_\_

**Exhibit D: Richmond Behavioral Health Authority  
Performance Measures for the Crisis Receiving Center Grant Funding**

This Agreement is between the Department of Behavioral Health and Developmental Services (“DBHDS” or “Department”) and the **Richmond Behavioral Health Authority** (“CSB” or “Subrecipient”), collectively hereinafter referred to as “the Parties”, entered into this Agreement to govern certain activities and responsibilities required for operating or contracting the **Crisis Receiving Center Grant Funding** (the “Program” or “Service”). This Agreement is attached to and made part of the performance contract by reference.

**Purpose:**

The Commonwealth is seeing an increasing number of individuals seeking services for a crisis. A growing number of these individuals are being admitted to state hospitals which are not well suited to serve individuals who primarily need access to rapid assessment and crisis response within their community settings. Virginia is aligning a full continuum of crisis services after the evidence-based, best practice model, Crisis Now. The three main components of the Crisis Now model are a high-tech call center/dispatch, mobile crisis response available 24/7 for all populations and disabilities to the location of the individual and crisis receiving centers. The crisis receiving centers (CRCs) allow for individuals to walk in for service or be brought in by law enforcement, either voluntarily or involuntarily. At the CRCs, individuals have access to rapid assessment, intervention services, physical health assessment, substance use detoxification services and linkages to community resources as well as offering 23 hour observation areas and an attached residential crisis stabilization unit. The CRC should be designed to create the biggest impact on reducing the census at state hospitals and treating individuals in their community as well as be modeled after the Crisis Now model for CRCs.

<b>SELECT GRANT (ONLY ONE GRANT PER EXHIBIT)</b>	<b>SAMHSA GRANTS</b>
1. <input checked="" type="checkbox"/>	<b>GRANT NAME:</b> Substance Abuse Prevention and Treatment Block Grant (SUD FBG) <b>FEDERAL AWARD IDENTIFICATION NUMBER (FAIN):</b> B08TI083547 <b>FEDERAL AWARD DATE:</b> 3/11/2021 <b>FEDERAL AWARDDING AGENCY:</b> Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) <b>FEDERAL AWARD PASS-THROUGH ENTITY:</b> Virginia Department of Behavioral Health and Developmental Services <b>CFDA NUMBER:</b> 93.959 <b>RESEARCH AND DEVELOPMENT AWARD:</b> ___ YES OR ___ X ___ NO <b>FEDERAL GRANT AWARD YEAR:</b> NA <b>AWARD PERIOD:</b> 3/15/2021 – 3/14/2023
2. <input checked="" type="checkbox"/>	<b>GRANT NAME:</b> Community Mental Health Services Block Grant (MH FBG) <b>FEDERAL AWARD IDENTIFICATION NUMBER (FAIN):</b> B09SM083950 <b>FEDERAL AWARD DATE:</b> 3/11/2021 <b>FEDERAL AWARDDING AGENCY:</b> Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) <b>FEDERAL AWARD PASS-THROUGH ENTITY:</b> Virginia Department of Behavioral Health and Developmental Services <b>CFDA NUMBER:</b> 93.958 <b>RESEARCH AND DEVELOPMENT AWARD:</b> ___ YES OR ___ X ___ NO <b>FEDERAL GRANT AWARD YEAR:</b> NA <b>AWARD PERIOD:</b> 3/15/2021 – 3/14/2023

**Term:** This Agreement shall govern the performance of the Parties for the period of **August 1, 2021** through **March 14, 2023** (“Period of Performance”).

**A. Scope of Services**



**Exhibit D: Richmond Behavioral Health Authority**  
**Performance Measures for the Crisis Receiving Center Grant Funding**

1. By June 30, 2022, provide goods and furnishings as outlined in the approved proposal that would be of appropriate use for individuals in the CRC-Lite.
2. By June 30, 2022, provide staffing needs, to include but not limited to, salaries, fringe benefits, orientation and training as outlined in the approved proposal.
3. By June 30, 2022, provide individuals access to rapid assessment, intervention services, physical health assessments, substance use detoxification services and/or linkages to community resources, as well as offer urgent care, 23 hour observation areas. and an attached residential crisis stabilization unit.
4. By June 30, 2022, renovate and equip building for a Crisis Receiving Center to operate as an urgent care center and 23 hour observation for adults.. The CRC-Lite will have an office at a minimum for urgent care services for children and adolescents who may present at the center. The office will be separate from adult programming and be sufficient for assessment, linkage and referral to appropriate resources.
5. Provide a safe and therapeutic environment for services as outlined in your approved proposal. Provide urgent care services for adults as well as children and adolescents who may present to the building with a self-defined crisis in separate spaces. Services for children and adolescents may be rapid assessment and linkage with appropriate community referrals.
6. Align with the goals of CrisisNow model with a “No Wrong Door” and “No Force First” approaches.
7. Staffing – The CRC-Lite staffing patterns will be reviewed at least quarterly by the CRC-Lite Leadership to evaluate changing staffing needs and to ensure the staffing patterns meet the needs of the individuals served.
  - a. Reviews are to ensure staffing patterns maximize the program’s ability to function 24 hours a day, seven (7) days a week admissions and provide services to the individuals as needed for therapeutic counseling and support services 24 hours a day. The CRC-Lite will follow the service description and staffing as defined for licensing providers by the Department.
  - b. The CRC –Lite will have well-defined written plan for psychiatric prescriber coverage that meets the needs of the individuals admitted to the programs. The plan must address contingency plans for vacations, vacancies and illnesses and other extended staff absences of the primary psychiatric provider. Plans will be reviewed annually and updated as needed by the CRC-Lite and as needed by DBHDS
  - b. By June 30, 20222, the CRC–Lite will have a well-defined written plan for nursing coverage that meets the needs of the individuals admitted to the programs. The plan must address contingency plans for vacation, vacancies and other extended staff absence as well as plans for sustaining adequate nursing coverage for the individuals being served in the programs. Plans will be reviewed and updated at least annually by the CRC- Lite and as needed by DBHDS.
  - c. By June 30, 2022, the CRC–Lite will provide peer support services for individuals admitted to the program. The CRC-Lite will have a well-defined written plan for staffing peer support services to address hours of coverage, sustainability plans for recruiting and training peers to provide these services, and a description of the services peers will provide. Plans are to be reviewed by the CRC-Lite at least annually and updated as needed to meet the needs of the individuals being served in the program.
  - d. By June 30, 2022, the CRC-Lite will have a well-defined written plan for staffing all provider coverage during weather related, other natural and man-made disasters and pandemics. The plans will address the continuation of services for individuals in their care at the time of these events and those who may need admission. Plans will be reviewed and updated annually by the CRC-Lite and as needed by DBHDS.
  - e. By June 30, 2022, the CRC –Lite will have access to a Licensed Mental Health Professional, Licensed Mental Health Professional–E, or Licensed Mental Health Professional–R. 24 hours a day.
  - f. By June 30, 2022, the CRC-Lite will have a written plan for appropriate staffing coverage at all times and be flexible to address the needs of the individuals being served and for changes in the program

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census. The plan should be reviewed at least annually by the CRC-Lite to determine that it continues to meet the staffing needs of the unit.

- g. The Department retains the right to review and approve the CSB's responses to the requirements in Section 7 Staffing.

**8. Admission and Discharge Processes**

- a. By June 30, 2022, the CRC-Lite will provide 16 adult recliners in the 23 hour observation services, an area for walk-ins to receive urgent behavioral healthcare as well as adequate space for urgent BH care services. The CSB shall notify the Department should it be unable to operate the number of recliners licensed by the Department and the reason for the reduction. This notification will be made to the Crisis Service Coordinator. Once the Department approves the number of recliners the CSB can operate, that number will become the service capacity. The Department will expect the CSB to comply with the local Health Department's permission to operate 16 recliners due to any public health emergency.
- b. By June 30, 2022, the CRC-Lite will develop a well-defined plan for managing walk-ins, drop-offs, and phone calls seeking services in the CRC-Lite. This plan is to include a "no wrong door approach" and accept 90% of all individuals who self-refer, are referred by law enforcement, or brought to the program involuntarily. The plan will clearly outline exclusionary criteria.
- c. By December 31, 2021, the CRC-Lite will develop well-defined written policies and procedures for accepting individuals under an Emergency Custody Order (ECO). or Temporary Detention Order (TDO). The plan will include inclusion of individuals under an ECO or TDO and will contain a plan for managing the individual's needs, court processes and integration in the CRC-Lite without discrimination. The CRC-Lite will be expected to operate as a temporary location for TDOs that can safely be managed in the program until a transfer to a more secure location may be found.
- d. The CRC will follow discharge planning requirements as cited in the DBHDS licensing regulations.
- e. The CRC will assess the integrated care needs of individuals upon admission and establish a discharge plan that addresses the individual's specialized care needs.

**9. Programming**

- a. 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.
- b. By June 30, 2022, the CRC-Lite will have a well-defined written policy and procedures for recognizing, responding and supporting individuals utilizing practices that are consistent with trauma informed care.
- c. The CRC-Lite will involve family members, life partners and other supports as identified by the individual receiving service when clinically appropriate and consent is obtained by the individual. Involvement may include family therapy, marriage/life partner counseling, and group therapy.
- d. By June 30, 2022, The CRC-Lite director, manager or designee shall implement a review process to evaluate both current and closed records for completeness, accuracy, and timeliness of entries. A record of these reviews will be maintained and available to DBHDS upon request.
- e. Programming will contain a mix of services to include but not limited to: clinical, psycho-educational, psychosocial, relaxation, case management and physical health.
- f. By June 30, 2022, the CRC-Lite director, manager or designee shall outline how each service (urgent care, and 23 hour observation) 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.
- g. The Department retains the right to review and approve the CSB's responses to Section 9 Programming.

**10. Resources**

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- a. The CRC-Lite will develop a well-defined written policy and process for building and sustaining collaborative relationships with private and state facilities, emergency services staff, and local emergency departments in their region. Ideally, these collaborative relationships will facilitate the flow of referrals from the CITAC to the CRC-Lite for diversion from inpatient hospitalization.
- b. The CRC-Lite will participate in regional/statewide collaborations with other CRCs at least quarterly to share successes and resources in order to optimize individual program functioning and to increase inter-program consistency.

**B. The CSB Responsibilities:** In order to implement the Crisis Receiving Center, the CSB agrees to comply with the following requirements.

1. By June 30, 2022, the CSB shall ensure that the CRC-Lite Programs are implemented as a regional resource, and is not specific to the physical location of the unit.
2. By June 30, 2022, the CSB shall ensure the participating CSBs and stakeholders in the region develop a Memorandum of Understanding (MOU) outlining the mission, vision, and goals of the regional partnerships to support the Program and provide this to the Department upon request.
3. The CSB shall offer evidence-based and best practices as part of their programming and implementation.
4. By June 30, 2022, the CSB shall ensure that the CRC-Lite develops a written plan to ensure the Programs remain open, accessible, and available at all times as an integral part of DBHDSs community based crisis services.
5. By June 30, 2022,, the CRC will develop written plans for seeking reimbursement for services from all payer sources including the billing for TDOs and ECOs. No one is to be denied access to the CRC-Lite for inability to pay.
6. The CSB shall provide at least monthly check-ins via email until the program is implemented as outlined in the approved proposal.
7. The Department retains the right to review and approve the CSB's responses to Section B. CSB Responsibilities.
8. By May 31, 2022, the CRC-Lite will develop marketing resources for the programs offered at the center. All marketing materials must be approved by DBHDS prior to distribution. The CSB will develop a plan to distribute the materials to include making contacts with key community stakeholders (including neighboring CSBs and law enforcement departments) to inform them of the new services and options for crisis services at this site.

**C. The Department Responsibilities:** In order to implement the Crisis Receiving Center, 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 Program is not accomplishing its missions, and/or meeting its goals as described in this document.
3. The Department shall provide technical assistance to include but not limited to: networking meeting and trainings to the CRC-Lite and upon request.
4. The Department shall monitor data received through CCS monthly reports and CARS semi-annual reports. The Department will collaborate with the CRC to ensure data submitted through these reports meets the expectations as outlined in this document and in the CRC's written plans. The Department will provide the ARCSU with monthly reports on the data submission to review for accuracy.
5. The Department shall provide data reports for the CRC-Lite to complete as requested.
6. Require the CSB uses the funds in a manner associated with the intended requirements, and the Department shall monitor accordingly.
7. Monitor progress of CSB implementing the services as outlined in the approved proposal via a monthly check-in.

**Exhibit D: Richmond Behavioral Health Authority**  
**Performance Measures for the Crisis Receiving Center Grant Funding**

- D. Payment Terms:** The Department shall provide \$700,000 to Richmond Behavioral Health Authority in CAA Supplemental Substance Abuse Prevention and Treatment Block Grant (SUD FBG) Funds; and \$200,000 in CAA Supplemental Community Mental Health Services Block Grant (MH FBG) Funds, for a total of \$900,000 to implement Crisis Receiving Center - Lite requirements in a one-time disbursement by September 1, 2021. The Department may, at its reasonable discretion, terminate this Agreement and will notify the CSB of any such changes in writing.
- E. 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.

**1. Restrictions on Expenditures on the Crisis Receiving Center Grant funding:**

- a. Supplant existing positions and/or funding.
- b. No one item/purchase can exceed \$5,000.
- c. For services that can be supported through other accessible sources of funding such as Medicaid, 3rd party insurance, and sliding scale self-pay among others.
- d. Shall not exceed \$75,000 in construction, renovation and/or remodeling needs.
- e. Purchase of a vehicle is not an allowable expenditure.
- f. Purchase of Naloxone is not an allowable expenditure. The CSB shall coordinate with the Virginia Department of Health in order to acquire Naloxone.

**F. Closeout Disclosure.**

**Closeout:** Any funds remaining unexpended at the end of the Period of Performance shall be returned to DBHDS within 60 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:

DBHDS  
PO Box 1797  
Richmond, VA 23218-1797  
C/O Ramona Howell

Failure to return unexpended funds in a prompt manner may result in a denial of future federal Subrecipient awards from DBHDS.

In consideration of the execution of this agreement by 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 this agreement. Subrecipient's obligations to DBHDS under this agreement 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 this agreement.

- G. Use of Funds:** The CBS may not use the funds provided under this Agreement for any purpose other than as described herein and allowable to carry out the purposes and activities of the Program or Service as outlined in the approved proposal. The CSB agrees that if it does not fully implement this Program as approved or as subsequently modified by agreement of the Parties, the Department shall be able to recover part or all of the disbursed funds.

**Exhibit D: Richmond Behavioral Health Authority**  
**Performance Measures for the Crisis Receiving Center Grant Funding**

**H. Performance Outcome Measures:**

1. By June 30, 2022, Implement urgent BH care and 23-hour observation services to create a CRC-Lite for individuals experiencing a mental health or substance use crisis..
2. By June 30, 2022, utilize Peer Recovery Supports in order to further support the individuals by reducing traumatic experiences.
3. By June 30, 2022, Programs remain operational 24/7, 365 days a year, which would include the hiring and maintenance of the appropriate staff as prescribed by the Office of Licensing for the program.
4. Support walk-ins (including, but not limited to, children with families and adolescents).
5. The CSB will provide DBHDS with a monthly report on the progress of implementation of the program, as outlined in their approved proposal. Monthly reports will be submitted via email to Mary Begor *at mary.begor@dbhds.virginia.gov* by the 5<sup>th</sup> of each month for the previous month. Hard Copies Submission is not required. This monthly report will no longer be required when all components of the full CRC are implemented.

**I. Reporting Requirements:**

1. The Department will work with the CSB to establish benchmark measures to address reporting requirements.
2. The CSB must also comply with any additional reporting for the Crisis Receiving Center Grant Funding requirements and other reporting requirements negotiated with the Department.
6. The CSB shall provide data reports as required in CCS 3 and finance reports on the funds provided by the Department as required in CARS pursuant to the Reporting and Data Quality Requirements of the Community Services Performance Contract., co-locate and open- for services urgent BH care services and 23-hour observation to create a CRC-Lite.
7. By June 30, 2022, implement 23-hour observation and urgent BH care programs for individuals experiencing a mental health and/or substance use-related crisis.
8. By June 30, 2022, utilize Peer Recovery Supports in order to further support the individuals by reducing traumatic experiences.
9. The CSB will provide DBHDS with a monthly report on the progress of implementation of the program, as outlined in their approved proposal. Monthly reports will be submitted via email to Mary Begor *at mary.begor@dbhds.virginia.gov* by the 5<sup>th</sup> of each month for the previous month. Hard Copies Submission is not required. This monthly report will no longer be required when the CRC-Lite is operational.

**J. Monitoring, Review, and Audit:** The Department may monitor and review use of the funds, performance of the Program, 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.

**K. Entire Agreement:** This Agreement and any additional or supplementary document(s) incorporated herein by specific reference contain all the terms and conditions agreed upon by the Parties hereto, and no other contracts, oral or otherwise, regarding the subject matter of this Agreement or any part thereof shall have any validity or bind any of the Parties hereto.

**L. 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.

**M. Conflicts:** In the event of any conflict between this Agreement (or any portion thereof) and any other agreement now existing or hereafter entered into, the terms of this Agreement shall prevail.

