BOARD OF DIRECTORS MEETING MINUTES

January 5, 2021

This meeting of the Richmond Behavioral Health Authority (RBHA) Board was held through electronic communication means due to the current State of Emergency and due to safety concerns stemming from the coronavirus pandemic. Board members, staff, and the general public were able to participate by teleconference/videoconference via Zoom.

RBHA Board members present were: Scott Cannady; Irvin Dallas, **Vice Chair;** Dr. Cynthia Newbille; Melodie Patterson; Eduardo Vidal; Denise Dickerson, **Secretary/Treasurer**; Dr. Cheryl Ivey Green, **Chair**; Sabrina Gross; Karah Gunther; and Dr. Andrew Ramsey.

RBHA Board members absent: Dr. Joy Bressler; Chelsea Higgs-Wise; Colleen Howarth; and Malesia "Nikki" Taylor.

Staff present: Dr. John Lindstrom, **CEO**; Amy Erb; Bill Fellows; Susan Hoover; Dr. Jim May; Shenée McCray; Carolyn Seaman; Michael Tutt; Cristi Zedd and Meleese Evans.

RBHA's Legal Counsel: Jon Joseph of Christian & Barton, LLP.

Guests: None.

Proceedings:

- The meeting was called to order at 3:03 p.m. by Dr. Cheryl Ivey Green.
- The Board meeting minutes for October 6, 2020 and November 10, 2020 were approved with a motion by Denise Dickerson and seconded by Scott Cannady. The minutes were unanimously approved.
- **Public Comment**: None.

Presentation: FY 2020 Audit Report was presented by Chris Murray, CPA of Brown, Edwards & Company, L.L.P. The reports were sent electronically to board members.
Motion: Denise Dickerson moved that the Board accept the FY 2020 Audit Report as presented; seconded by Irvin Dallas and unanimously approved.

Board Chair Report- Dr. Cheryl Ivey Green

- Dr. Green welcomed Dr. Andrew Ramsey to the RBHA Board.
- Dr. Green encouraged the Richmond Behavioral Health (RBH) team and thanked them for all they are doing during the pandemic. Please let the Board know if there is anything they can do to help.

Chief Executive Officer's Report- Dr. John Lindstrom

- The CEO Report was discussed and is included in today's board meeting packet and with today's meeting minutes.

RBH Foundation Report – Carolyn Seaman

- The Foundation Development Report was discussed and is included in today's board meeting packet and with today's meeting minutes.
- Carolyn also discussed a few questions that arose from the Staff Roll-Out of RBH's new branding and marketing efforts. One of the next steps is to strategize around more effectively utilizing social media and around employment outreach with the goal of filling many vacant positions that we currently have across programs.

Committee Reports:

***Access & Service Delivery Committee* - Scott Cannady**

- The Access and Service Delivery Committee reviewed and discussed the RBHA Service Data Report for 1st Quarter FY-21, the Crisis Intervention Triage Referrals Report, and Human Rights Report.

- The Human Rights reports noted 44 complaints throughout the 1st Quarter. Two were potential Human Rights Violations and zero were found to be a Human rights violation.
- Discussed upcoming Board Education Presentations through April 2021.
- The RICH Recovery Clinic continues to provide telemedicine to RBHA clients during the pandemic.
- The Access & Service Delivery Committee is in need of a new Chair, as Dr. Michelle Whitehurst-Cook recently completed her terms on the RBHA Board.
- A draft report of the Access and Service Delivery Committee meeting is included in today's board meeting packet.

Advocacy & Community Education Committee **– Scott Cannady**

- The Advocacy and Community Education Committee has not met since the last board meeting.

Executive Committee **– Dr. Cheryl Ivey Green**

- The Executive Committee reviewed and discussed nominations for the Wayne Hamilton Blanks Service in Recovery Award. The committee unanimously agreed that Richard Schellenberg will receive the award as a community member and Michael Branch will receive the award as an RBH employee. The award recipients will be recognized at the February 2, 2021 RBHA Board of Directors meeting.

Finance Committee **– Denise Dickerson**

- Total cash in the bank at October 31st was $22.5 million, and RBHA's share of that cash is $5.7 million.
- RBHA's current operating reserve ratio is at 0.93 or just under 2 months of expenses. RBHA is reporting monthly to DBHDS on COVID-19 issues including cash flows.
- Gross Accounts Receivable of October was 7.9 million and 4.8 after allowances for bad debt.
- The note payable balance at October 31st is $3.1 million and has been recorded in the liabilities section of the balance sheet.

Human Resources Committee **– Irvin Dallas**

- The Human Resources Committee has not met since the last board meeting.

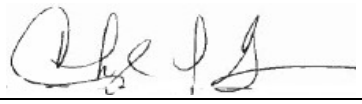
Nominating & By-Laws Committee **– Dr. Joy Bressler**

- The Nominating and By-Laws Committee has not met since the last board meeting.

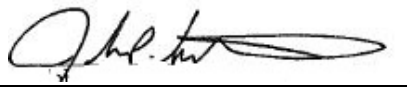
The meeting adjourned at 4:14 p.m.

The next Board of Director's meeting will take place on **Tuesday, February 2, 2021 at 3:00 p.m. by teleconference/videoconference via Zoom.**

Respectfully Submitted:



Dr. Cheryl Ivey Green
RBHA Board Chair



Dr. John P. Lindstrom
Chief Executive Officer

Richmond Behavioral Health Authority
Board of Directors
Chief Executive Officer's Report
January 5, 2021

Welcome to 2021! I hope you had a healthy, happy, and hopeful holiday. I do not remember a year in which I anticipated and celebrated the ending such as 2020. Similarly, I have such hopes for 2021. We have many steep challenges ahead, but with what appear to be effective vaccines in the public health pipeline, there is good reason for hope. RBHA reacted effectively to the public health crisis presented by COVID-19, yet we were not immune from the associated threat of infection, staffing challenges, operating barriers, and revenue shortfalls. Thus far, due to the dedication and rapid action of the Executive Leadership Team and the heroic response of our staff, we have survived the most difficult 10 months of my professional life. Now we must press forward, reaching a thriving status in 2021.

As you are probably aware, the COVID-19 positivity rate is now in excess of 15 percent having steadily grown since the Thanksgiving holidays. In the same manner, positive tests among those we serve and that of RBHA staff continues to climb. To date, 121 consumers and 38 staff have tested positive. Outbreaks associated with Assisted Living Facilities and some of our own residential programs have posed serious staffing challenges and several episodes of halting and restarting admissions. Our service areas and HR have worked commendably with the Richmond Health District, assuring that we continue on the best footing for infection control and any necessary service and/or environmental modifications.

It is ever so clear that RBHA will be operating under significantly modified service structures and practices well into the spring and summer. Flexibilities afforded by DMAS and DBHDS are likely to continue, thus making it possible for us to sustain services, even if different from what we would choose as more ideal. I wish to thank you, the RBHA Board of Directors, for the support and encouragement provided throughout the pandemic. You have demonstrated the interest, confidence, and trust necessary for us to navigate these difficult times.

RBHA Board Membership

We welcome Dr. Andrew Ramsey, practicing Emergency Medicine at Henrico Doctors Hospital, as the newest member of the RBHA Board of Directors. We also celebrate the reappointment of Malesia Taylor to her second term. Two seats remain open, one at large member and one seat filled through appointment by the Mayor.

Growing Caseloads

The number of individuals seeking services have dramatically increased, stressing caseloads and other resources. We are in the process of adding staff, particularly in the Case Management

and Outpatient areas; however, staff recruitment and retention is proving to be problematic, at least partly due to the pandemic.

Marcus Alert

Planning continues at both the local and state levels. Attached you will find slides from a briefing to local government held just prior to the holidays. The Marcus Alert will focus primary on law enforcement response. On a parallel track, DBHDS and regional planning is underway for expansion of Mobile Crisis services and a Regional/State Call System, interfacing with law enforcement when necessary. RBHA is likely be one of the five regional hubs and it is equally likely that the City of Richmond will be in the mix of initial Marcus Alert implementation sites.

Behavioral Health Enhancement (formerly Behavioral Health Redesign)

Also attached is a presentation on the restart/status of Behavioral Health Enhancement. BHE is largely driven by DMAS, but in collaboration with DBHDS, and is intended to bring about significant changes in Medicaid funded behavioral health services. We can expect improvements to service access, the redesign of some services, service expansion in gap areas, and overall improvement in rates.

Performance Contract

The PC extension that was to expire on December 30, 2020 has now been extended through FY 2021. So far, we have not received any agreement for signature and it is not clear how the Department intends to formalize the extension. We can anticipate a restructured PC for FY 22. In response to recommendations provided by JLARC during a study of the Department's fiscal accountability, we are receiving many new Exhibit D documents along the way. These are highly specific agreements for any funding item in excess of $5,000.

Wayne H. Blanks Service in Recovery Award

The Executive Committee approved two candidates for this annual award, one internal (employee) and one external (community member). We are planning a virtual presentation of the awards in association with the February board meeting.

Governor's Budget

I have attached, in its entirety, an email from Jennifer Faison, VACSB Executive Director, summarizing those elements in the Governor's budget that may/will affect us in some way. More comments to come.

Respectfully submitted,

John P. Lindstrom, Ph.D., LCP
Chief Executive Officer

Marcus Alert: Initial Implementation Planning and Preparation

Local Government Informational Call

December 21, 2020

Purpose of the Call

- Brief overview of legislation
- Readiness assessment for localities
- Initial area vs. non initial area responsibilities in year 1
- Q&A

What is the Marcus Alert?

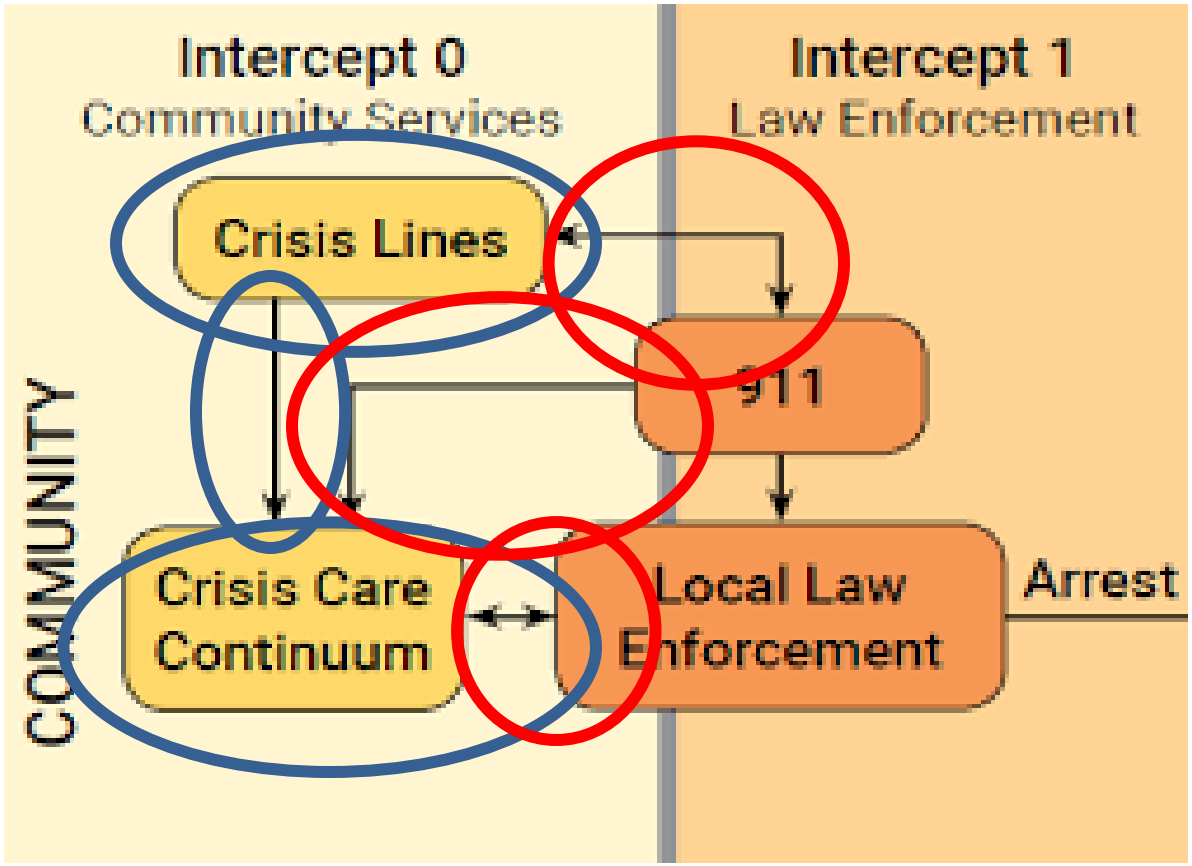
- A reform of the governmental response to Virginians in behavioral health crisis
- Set of protocols, procedures, and response teams to ensure that Virginia provides a behavioral health response (no force first) to a behavioral health crisis
- Named for Marcus-David Peters who was shot and killed by Richmond police in 2018 in the midst of a behavioral health crisis

Shared Responsibility Between DBHDS and DCJS

- DBHDS is lead agency for most of the plan/report; DCJS with specific components
- Both agencies have role in monitoring upon implementation (DCJS in monitoring LE progress towards goals, DBHDS in monitoring crisis system progress towards goals)
- DCJS lead on voluntary database component
- DBHDS lead on public service campaign

Where do the Marcus Alert and STEP-VA Overlap?

Blue = STEP-VA/Crisis Care
Red = Marcus Alert



Key overlap = **bidirectional arrows**. The Crisis Call Center will include a triage for when they need to involve 911 or Law Enforcement in a response. Situations such as need for an active rescue or presence of a weapon would lead to calling for Law Enforcement to join mobile crisis (for active rescue, Emergency Response would proceed with or without mobile crisis)

Crisis Now Model

HIGH-TECH CRISIS CALL CENTERS

These programs use technology for real-time coordination across a system of care and leverage big data for performance improvement and accountability across systems. At the same time, they provide high-touch support to individuals and families in crisis.

24/7 MOBILE CRISIS

Mobile crisis offers outreach and support where people in crisis are. Programs should include contractually required response times and medical backup.

CRISIS STABILIZATION PROGRAMS

These programs offer short-term "sub-acute" care for individuals who need support and observation, but not ED holds or medical inpatient stay, at lower costs and without the overhead of hospital-based acute care.

ESSENTIAL PRINCIPLES & PRACTICES

These must include a recovery orientation, trauma-informed care, significant use of peer staff, a commitment to Zero Suicide/Suicide Safer Care, strong commitments to safety for consumers and staff, and collaboration with law enforcement.

Approach to the Work

1. Rooted in comprehensive crisis system framework with essential elements based on national best practice models;
2. Supports the rights of all Virginians, regardless of area of residence and race/ethnicity to access behavioral health care safely, in a timely fashion, and in the least restrictive environment
3. Decreases Virginia's reliance on law enforcement as the *de facto* response to behavioral health crises, and
4. Ensures that Virginians with disabilities receive appropriate accommodations to include a safe, compassionate, trauma-informed response when law enforcement is involved during a behavioral health crisis

Levels of Complexity

Comprehensive Crisis System	Marcus Alert
State: air traffic control and standardized measurements	*State:* protections for individuals and standardized measurements
Regional: mobile crisis hubs, Crisis Stabilization Units, CITACs (regional/local), mobile crisis teams (co-located locally when appropriate)	*Regional:* agreements between hub and PSAPs, local law enforcement for back-up
Local: Emergency services, community crisis stabilization supports	*Local:* local protocols for no-force-first approach, warm hand off procedures, local co-response teams when sustainable

High Level Timeline

July 1, 2021: Plan, with diverse stakeholder input, due to general assembly. Will include requirements for protocol development, clarity on what protocols are state-standard vs. individualized, and process for review and approval

December 1, 2021: 5 initial areas covered by all components of Marcus Alert (protocols and response teams)

July 1, 2022: all localities covered by Marcus Alert protocols; 5 more areas covered by all components (including response teams)

Response teams built out over following years until statewide coverage of all components

Marcus Alert Definition

***M**ental health **a**wareness **r**esponse and **c**ommunity **u**nderstanding **s**ervices alert system = Marcus Alert system*

Marcus alert is a **series of protocols** aimed to **divert to the behavioral health system** or respond with a **specialized law enforcement response**, including:

1. Protocols to divert from 911 to crisis call center
2. MOUs for law enforcement backup to a crisis response
3. Minimum standards/best practices for law enforcement response

Local Readiness to be an Initial Area

- We have broad buy-in across sectors and are ready to form a group of champions
- We acknowledge the role of systemic racism in behavioral health disparities and disproportionate impact of policing
- At least some of our community members called for reform during the Summer 2020 protests and demonstrations
- We are willing to evaluate our current laws, regulations, and designation of policies and critically assess them
- We are willing to share internal policies and workforce data and budget information across agencies to support the dialogue as it relates to responsibilities and resources

Local Readiness (Cont'd).

- We can have someone on the team whose purview and responsibility crosses law enforcement and behavioral health
- We support the regional model of behavioral health mobile crisis through STEP-VA, including regional call center and shared dispatch infrastructure. We know local policies and procedures may change in order to align with both the Marcus Alert requirements and the broader crisis system to form a statewide "safety net to the safety net."
- Law enforcement in initial area is willing to evaluate use of force protocols and other details of police presentation like uniforms and vehicles as part of this process, and acknowledges that a behavioral health response is a no-force-first response
- We see the importance of working as a region, even as we design our local implementation

Responsibilities as an Initial Area

- If selected, form area group by March
- Send a rep to the statewide group beginning in March
- Work with region to ensure coordination with mobile crisis hub
- Work through state-provided “work plan” to develop implementation plan
- Submit budget and plan, approximately August, 2021
- Stand up plan in December, 2021, with dispatch integrated with mobile crisis call center

Responsibilities as a non-Initial Area

- Take steps toward readiness
- Seek representation on state group, stay engaged and attend forums, calls for comments, etc.
- Form local group following release of state requirements (July 1, 2021)
- Focus of first year will be on protocols for diversion from PSAPs, protocols to serve as back up to regional mobile crisis, and changes to police presentation when responding
- During first year, may determine plan for team coverage (mobile crisis vs. community care vs. co-responder)
- Submit plans for approval to implement by July 1, 2022

State Stakeholder Group (Nominations closed)

20 stakeholder members across 8 areas

- + approximately 5 DBHDS reps (Heather, Mira, Alex, Stephen Craver, Finance Rep), DCJS reps
- new staff position, Lisa, and DCJS staff will facilitate
- + approximately 5 regional CSB reps from initial areas
- Will be process- heavy and structured

Example breakdown:

- Behavioral health- mental health (2), SUD (2) (include peer support for some)
- Law enforcement and CIT (4; at least 2 CIT, 1 leadership)
- Developmental services, brain injury (2)
- Social justice and racial equity (4)
- 9-1-1/PSAP (2)
- Peer support specialist specifically (1)
- EMS, fire, EMTs (2)
- 1 not categorized (based on other priority areas and applicant pool)

Across the types: prioritize lived experiences, ensure statewide representation, and ensure various orientations (e.g., advocacy, local, state, government) and reasons for participating

Broader Engagement

- Stakeholder meetings will be open meetings
  - Public comments will be limited at most meetings (i.e., 10 minutes at the end)
- Three meetings (in addition to the ~10 stakeholder group meetings) will be *focused* on public comment and input

Long Term Expected Outcomes

- See more about Crisis Now Model at www.crisisnow.com
- Coordinated crisis response between state, regional, and local work at Intercept 0 and Intercept 1 (Sequential Intercept Model)
- Increased diversion to the behavioral health system for individuals in crisis, decreased police involvement in behavioral health/developmental disability crisis
- Improved safety and better outcomes for individuals experiencing a behavioral health crises at risk of law enforcement involvement
- Health centered approach for individuals in behavioral health crisis, whether response is by mobile crisis, community care, or law enforcement/specialized responses

Thank you, Question and Comments?

"*With non-existent or inadequate crisis care, costs escalate due to an overdependence on restrictive, longer-term hospital stays, hospital readmissions, overuse of law enforcement and human tragedies that result from a lack of access to care…In too many communities, the "crisis system" has been unofficially handed over to law enforcement; sometimes with devastating outcomes. The current approach to crisis care is patchwork and delivers minimal treatment for some people while others, often those who have not been engaged in care, fall through the cracks; resulting in multiple hospital readmissions, life in the criminal justice system, homelessness, early death and suicide...*

*...**A comprehensive and integrated crisis network is the first line of defense in preventing tragedies of public and patient safety, civil rights, extraordinary and unacceptable loss of lives, and the waste of resources. There is a better way. Effective crisis care that saves lives and dollars requires a systemic approach."***

February 2020, SAMHSA Toolkit, National Guidelines for Behavioral Health Crisis Care

ENHANCEMENT OF MEDICAID BEHAVIORAL HEALTH SERVICES: STAKEHOLDER UPDATE

Advancing Proactive, Evidence-Based Solutions

December 11th, 2020

PRESENTERS TODAY

Alyssa M. Ward, Ph.D.
Behavioral Health Clinical Director, DMAS
Laura Reed, LCSW
Acting Behavioral Health Senior Advisor, DMAS
Alexis Aplasca, M.D.
Chief Clinical Officer, DBHDS
Lisa Jobe-Shields, Ph.D.
Deputy Director of Community Based Services, DBHDS

Agenda Today

- Overview: Vision and Scope of BH Enhancement
- Timeline: What has been accomplished?
- Funding Update: Results of Special Session 2020
- Contextual Factors for DMAS/DBHDS
- Revised Implementation Plan
- High Level Service-Specific Updates
- Immediate Next Steps

Enhanced Behavioral Health Services for Virginia

Vision

Implement fully-integrated behavioral health services that provide a full continuum of care to Medicaid members. This comprehensive system will focus on access to services that are:

High Quality

Quality care from quality providers in community settings such as home, schools and primary care

Evidence-Based

Proven practices that are preventive and offered in the least restrictive environment

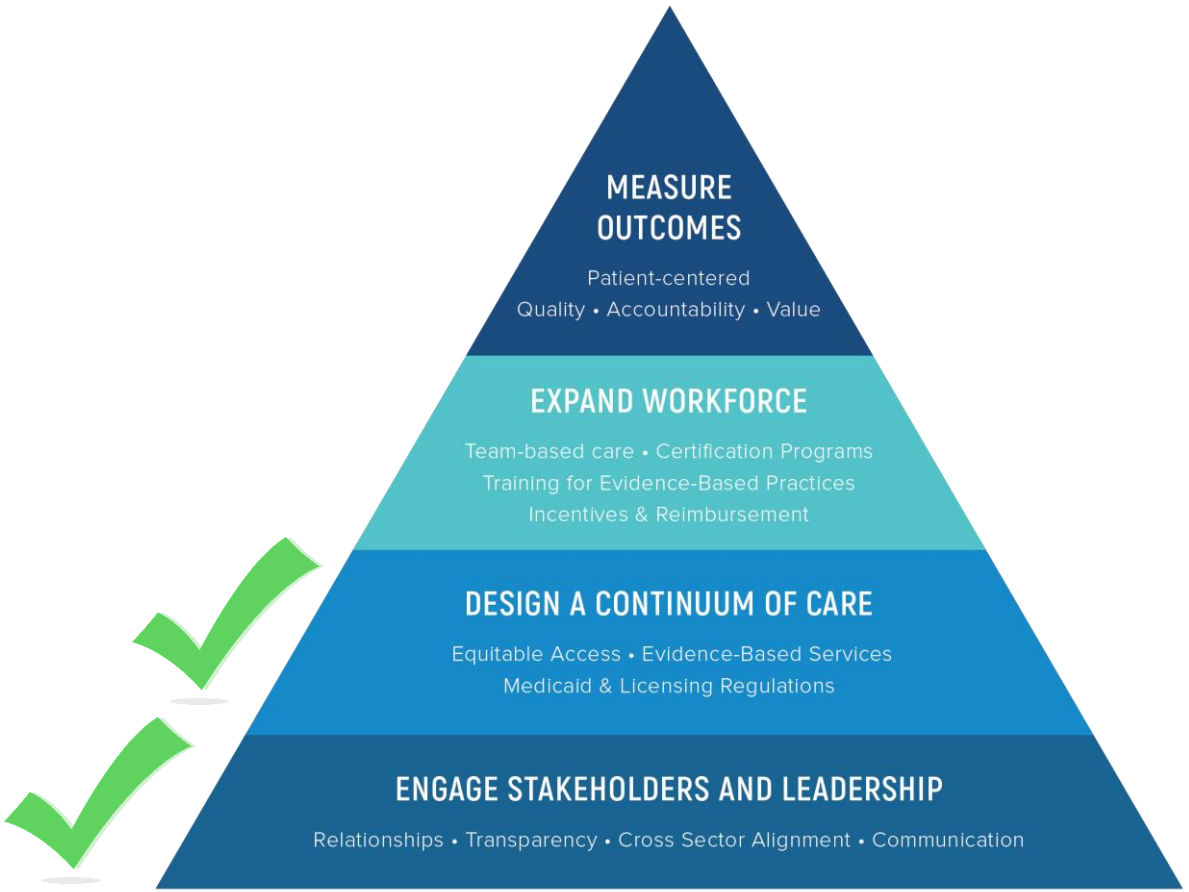
Trauma-Informed

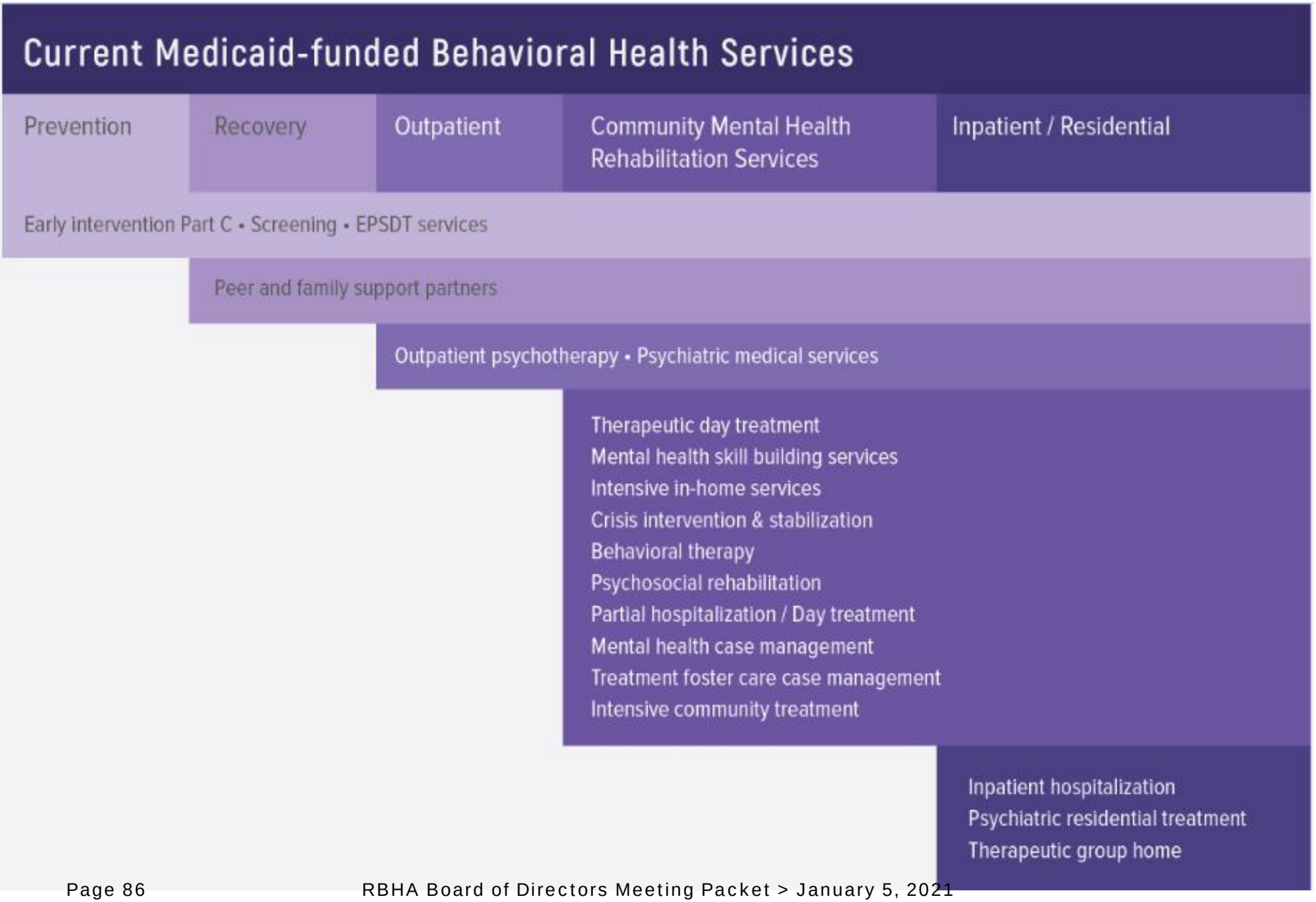
Better outcomes from best-practice services that acknowledge and address the impact of trauma for individuals

Cost-Effective

Encourages use of services and delivery mechanism that have been shown to reduce cost of care for system

Medicaid System Enhancement Fundamentals




Current Medicaid-funded Behavioral Health Services
Prevention
Recovery
Outpatient
Community Mental Health Rehabilitation Services
Inpatient / Residential
Early intervention Part C • Screening • EPSDT services
Peer and family support partners
Outpatient psychotherapy • Psychiatric medical services
Therapeutic day treatment
Mental health skill building services
Intensive in-home services
Crisis intervention & stabilization
Behavioral therapy
Psychosocial rehabilitation
Partial hospitalization / Day treatment
Mental health case management
Treatment foster care case management
Intensive community treatment
Inpatient hospitalization
Psychiatric residential treatment
Therapeutic group home

Continuum of Behavioral Health Services Across the Life Span

Promotion & Prevention	Recovery Services	Outpatient & Integrated Care	Intensive Community Based Support	Intensive Clinic-Facility Based Support	Comprehensive Crisis Services	Group Home & Residential Services	Inpatient Hospitalization

Behavioral Therapy Supports >>>> <<<< **Case Management*** >>>> <<<< **Recovery & Rehabilitation Support Services***

Home visitation • Comprehensive family programs • Early childhood education
Screening & assessment* • Early intervention Part C

Permanent supportive housing • Supported employment • Psychosocial rehabilitation*
Peer and family support services* • Independent living and recovery/resiliency services

Outpatient psychotherapy* • Tiered school-based behavioral health services
Integrated physical & behavioral health* • Psychiatric medical services*

Intermediate/ancillary home-based services • Multisystemic therapy • Functional family therapy
High fidelity wraparound • Intensive community treatment • Assertive community treatment

Intensive outpatient programs • Partial hospitalization programs

Mobile crisis* • Crisis intervention*
Crisis stabilization* • Peer crisis support*

Therapeutic group homes
Psychiatric residential treatment

Psychiatric inpatient hospitalization

INTEGRATED PRINCIPLES/MODALITIES

- Trauma informed care
- Universal prevention / early intervention
- Seamless care transitions
- Telemental health

*Key STEP-VA service alignment

Reminder that this is our NORTH STAR Vision for Enhancement

Enhancement Brings Alignment Across Initiatives

BH Enhancement Leverages Medicaid Dollars to Support Cross-Secretariat Priorities

Enhancement & Family First Prevention Services Act

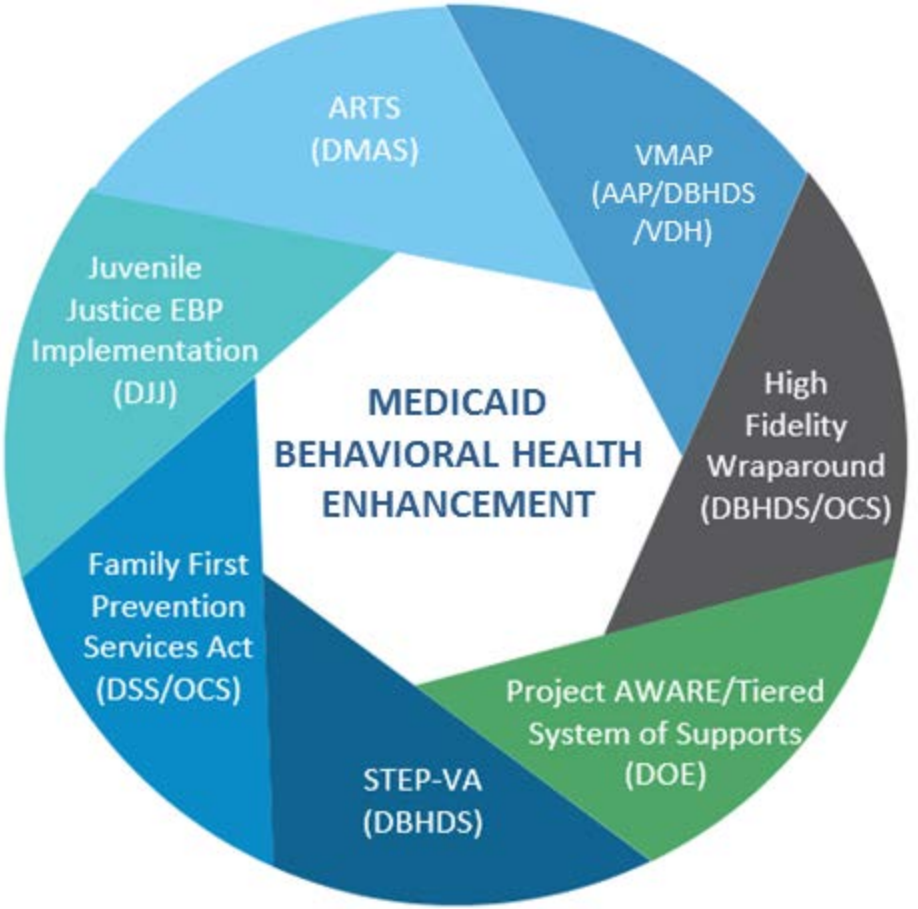
Focused on workforce development, evidence-based programs, prevention-focused investment, improving outcomes, and trauma informed principles

Enhancement & Juvenile Justice Transformation

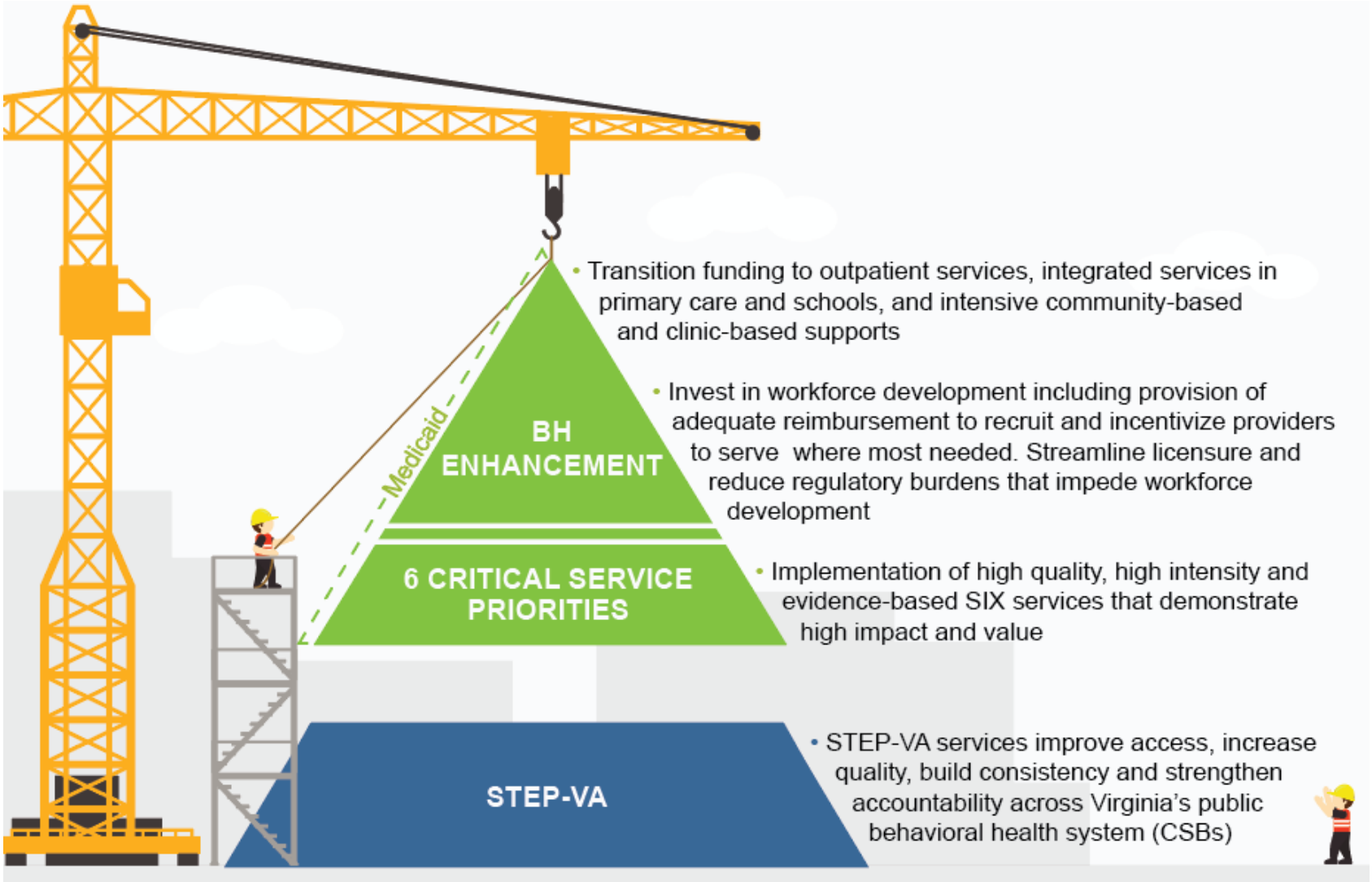
Supports sustainability of these services for the provider community, particularly in rural settings who have struggled with maintaining caseloads and business models when dependent on DJJ or CSA

Enhancement & Governor's Children's Cabinet on Trauma Informed Care

BH Enhancement continuum is built on trauma-informed principles of prevention and early intervention to address adverse childhood experiences



Enhancement of Behavioral Health and STEP-VA



Enhancement of Behavioral Health Services: *Current Priorities Explained*

What are our top priorities at this time?

Implementation of ***SIX*** high quality, high intensity and evidence-based services that have demonstrated impact and value to patients

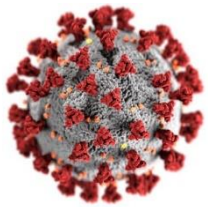
Services that currently exist and are licensed in Virginia ***BUT*** **are not covered by Medicaid** ***or the service is not adequately funded through Medicaid***

- Partial Hospitalization Program (PHP)
- Assertive Community Treatment (ACT)
- Multi-Systemic Therapy (MST)
- Intensive Outpatient Program (IOP)
- Comprehensive Crisis Services (Mobile Crisis, Intervention, Community-Based, Residential, 23Hr Observation)
- Functional Family Therapy (FFT)

Why Enhancement of BH for Virginia?

- ✓ Provides alternatives to state psychiatric admissions and offers step-down resources not currently available in the continuum of care, which will assist with the psychiatric bed crisis
- ✓ Demonstrated cost-efficiency and value in other states

BH Enhancement Timeline May 2019-Nov 2020



Stakeholder Implementation Workgroups	Mercer Rate Study & Fiscal Impact Analysis	Interagency Prioritization and Alignment Efforts	CORONAVIRUS	IMPLEMENTATION REVISION
20+ meetings 100+ stakeholders 5 workgroups (4 service specific) to inform rate study	Assumptions for Rate Development/Fiscal impact with stakeholder workgroup input: Report Publicly available Jan 2020 Presentation of rates and assumptions to stakeholders: December 3, 2019	Made it into Budget following 2020 GA Workforce needs analysis Alignment with other key initiatives Licensing analysis	Un-Allotment of Funding Pivot to COVID-19 Response and Service Flexibilities	Considered Feasibility Factors: • Resources • Staffing • Timeline

Enhancement of Behavioral Health Services

ORIGINAL *Governor's Budget 2020 Funding Summary: DMAS*

	FY2021	FY2022
General Fund	$3,028,038	$10,273,553
Non-General Funds	$4,127,378	$14,070,322
TOTAL FUNDS	$7,155,416	$24,343,875

Implementation January 2021
Multi-Systemic Therapy
Functional Family Therapy
Assertive Community Treatment

Implementation July 2021
Comprehensive Crisis Services
Partial Hospitalization
Intensive Outpatient

Enhancement of Behavioral Health Services

Special Session 2020: REVISED FUNDING

	[illegible] Year	Fiscal Year 21-22
General Fund	[illegible]8,038	$10,273,553
Non-General Funds	$4,12[illegible]	$14,070,322
TOTAL FUNDS		$24,343,875

Enhancement of Behavioral Health Services

Special Session 2020: Revised Implementation

	Fiscal Year 21-22
General Fund	$10,273,553
Non-General Funds	$14,070,322
TOTAL FUNDS	$24,343,875

*This does include funding for ALL of the services, just for what was estimated for the second year of implementation (which reflected a ramp up over time)

Enhancement of Behavioral Health Services

Governor's Budget Funding Summary: DBHDS

UN-ALLOTTED, NOT RE-INSTATED AT THIS TIME

	FY 2021 GF	FY 2022 GF
Train workforce in preparation for behavioral health enhancement - Provides $1.0 million general fund in FY 2021 and $1.2 million general fund in FY 2022 to conduct a behavioral health workforce study, create infrastructure for evidence based practice in behavioral health, and to educate the behavioral health workforce regarding changes in the behavioral health delivery system.	$1,025,815	$1,215,315
Align DBHDS licensing with Medicaid behavioral health services (Language Only) - Permits DBHDS to promulgate emergency regulations related to the licensing of services impacted by the enhancement of Medicaid behavioral health services included in the introduced budget**.**	$0	$0

Contextual Factors at DMAS & DBHDS

DMAS

- COVID-19 Response
- MES Implementation
- DOJ Settlement
- Changes in Leadership and Staff
- MCO Resolutions Panel
- Telehealth
- Workforce Support Efforts

DBHDS

- COVID-19 Response
- STEP-VA
- DOJ Settlement
- Changes in Leadership
- State Hospital Crisis
- Marcus Alert
- Workforce Support Efforts
- ASAM Alignment

Enhancement of Behavioral Health Services

Special Session 2020: Revised Implementation VERSION 2

	Fiscal Year 21-22
General Fund	$10,273,553
Non-General Funds	$14,070,322
TOTAL FUNDS	$24,343,875

Implementation *July 2021*
Assertive Community Treatment
Partial Hospitalization
Intensive Outpatient Programs

Implementation *December 2021*
Multi-Systemic Therapy
Functional Family Therapy
Comprehensive Crisis Services
(23 hour beds, Residential Crisis, Community Based Stabilization, Mobile Crisis Intervention)

DBHDS EBH Regulatory Actions

Three emergency actions per Item 318.B. of the 2020 Appropriation Act

i. *Ensure that licensing regulations support high quality community-based mental health services and align with the changes being made to the Medicaid behavioral health regulations for the services funded in this Act that support evidence-based, trauma-informed, prevention-focused and cost-effective services for members across the lifespan; and*

ii. *Amend the licensing regulations to align with the American Society of Addiction Medicine Levels of Care Criteria (ASAM) or an equivalent set of criteria into substance use licensing regulations to ensure the provision of outcome-oriented and strengths-based care in the treatment of addiction. The department shall seek input from *DMAS and other stakeholders to align with the implementation plan for changes being made to the Medicaid behavioral health regulations*

*[*within *Item 313 *(by Jan 1) assertive community treatment, multisystemic therapy and family functional therapy. (by July 1) intensive outpatient services, partial hospitalization programs, mobile crisis intervention services, 23 hour temporary observatio/n services, crisis stabilization services and residential crisis stabilization unit service].*

DBHDS Emergency Regulatory Actions

Children's Residential Regulations [12 VAC35-46]

- Amendments to align with ASAM criteria
  Secretary of Health and Human Resources review in progress.

Rules and Regulations For Licensing Providers by the Department of Behavioral Health and Developmental Services [12 VAC 35 - 105]

- Amendments to align with ASAM criteria
  Governor's Office review in progress.
- Amendments to align with enhanced behavioral health services
  Secretary of Health and Human Resources review in progress.

(→ Flow charts of the emergency and standard adoption processes.)

DBHDS Licensing Crosswalk: BHE Services

Licensed Service	Implementation Date	Current DBHDS License	DBHDS License Number
Multi-Systemic Therapy (MST)	12/2021	Intensive-In-Home Services	05-001
Functional Family Therapy (FFT)	12/2021	Outpatient Services	07-003 07-004 07-005
Mental Health Intensive Outpatient	7/2021	New License: MHIOP	OL will create new license numbers for: • MH IOP for adults; and • MH IOP for children & adolescents.
Partial Hospitalization	7/2021	Partial Hospitalization	02-019 02-021 02-023
Assertive Community Treatment (ACT)	7/2021	New License: ACT	OL will create new license numbers for ACT.
Crisis Intervention (Mobile)	12/2021	Crisis Stabilization	OL will create new license numbers for Crisis Intervention (separate from existing emergency services license numbers)

DBHDS Licensing Crosswalk: BHE Services

Licensed Service	Implementation Date	Current DBHDS License	DBHDS License Number
23-Hour Crisis Stabilization	12/2021	Crisis Stabilization Services	OL will create new license numbers for 23-Hour Crisis Stabilization.
Community-Based Crisis Stabilization	12/2021	Crisis Stabilization Services (Non-residential)	OL will create new license numbers for community-based crisis stabilization.
Crisis Stabilization Unit	12/2021	Crisis Stabilization Service (Residential)	01-019 01-020 01-023

Enhancement Implementation Steps: High Level

AUTHORITY GRANTED

Reconvene regular stakeholder workgroups for installation planning

INSTALLATION PLANNING

- Systems changes
- SPA, Regulations and Manual Updates
- Launch statewide workforce training

ACCOUNTABILITY

Develop metrics and dashboards with stakeholder input to report out on implementation progress and outcomes

1115 SMI WAIVER

Once installation plan is clear, engage Federal Government for 1115 SMI Waiver application

Throughout this process, we commit to continued interagency partnership with DBHDS as well as continued alignment efforts with DSS-DOE-DJJ-DOC

Enhancement Implementation Steps: Revised

If Funding is Re-Allotted through Special Session

Reconvene stakeholder workgroups for installation planning

+

Racial Equity Workgroup & MCO Resolutions Panel

INSTALLATION PLANNING

- Systems changes
- SPA, Regulations and Manual Updates
- Launch statewide workforce training

ACCOUNTABILITY

Develop metrics and dashboards with stakeholder input to report out on implementation progress and outcomes

1115 SMI WAIVER

Once installation plan is clear, engage Federal Government for 1115 SMI Waiver application

Throughout this process, we commit to continued interagency partnership with DBHDS as well as continued alignment efforts with DSS-DOE-DJJ-DOC

Enhancement In the Time of Covid-19

Establishment of BH Enhancement as Agency Priority

Evidenced-Based Practice Center Efforts

INSTALLATION PLANNING

Medical Necessity Criteria

State Plan Amendments

Unfunded Training Planning

BHE Advisory Meeting GA Mandate

Licensing Analysis

ACCOUNTABILITY

SMI Innovation Accelerator Program Dashboards

Internal Dashboard Template Development

MCO Resolutions Panel Formation

1115 SMI WAIVER

GA Report Preparation

Throughout this process, we commit to continued interagency partnership with DBHDS as well as continued alignment efforts with DSS-DOE-DJJ-DOC

EBP Center Update

BH Enhancement Timeline:

December 2020

- Reconvene Original Stakeholders
- Formal SPA Submissions (pending budget)
- System Changes Initiation
- MCO Panel Begins

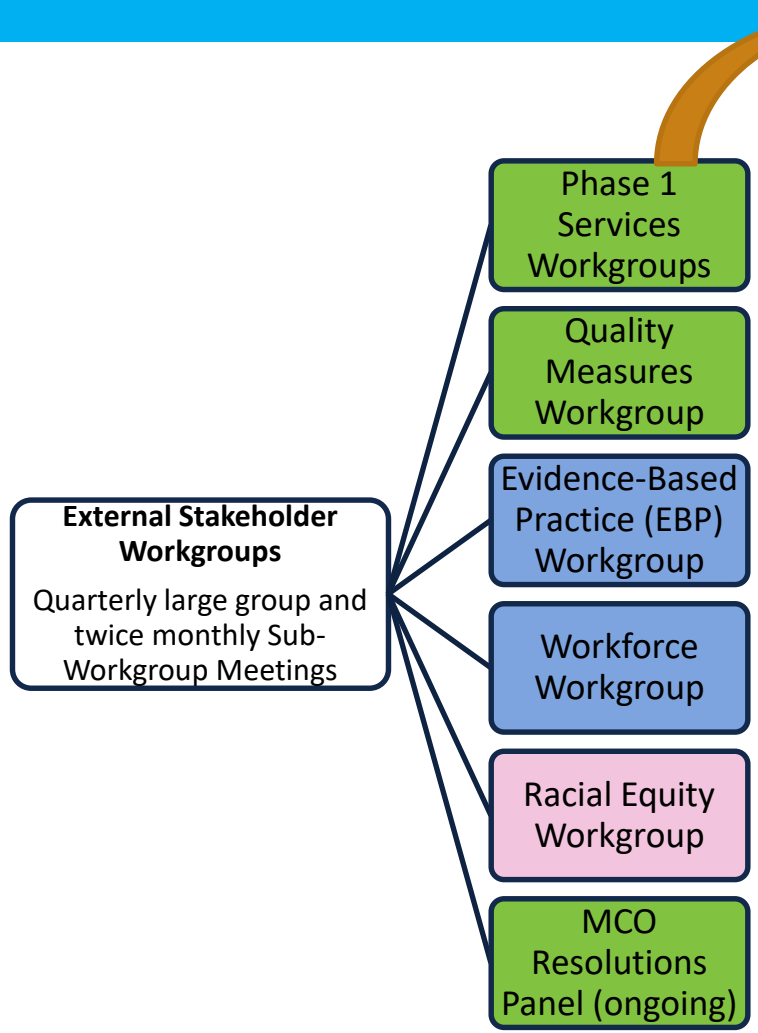
January-February 2021

- General Assembly
- Systems Changes Begin
- Manual & Regulation Work Begins
- MNC completion

March 2021

- MCO Readiness Reviews Begin
- Stakeholder Re-Engagement (Bi-Weekly to Monthly)
- Project Teams Fully Engaged
- Training Planning

BEHAVIORAL HEALTH ENHANCEMENT EXTERNAL WORKGROUP STRUCTURE



Green: Launching Now or in Next 3 Months
Pink: Will be seeking nominations
Blue: Need to consider how to use

Purpose

- Provide external stakeholder input on: service definitions, licensing and regulatory considerations, outcome/metrics, workforce credentials/considerations
- Serve as a means to disseminate widespread updates to all involved providers and or service recipients
- Provide feedback to internal agency work products

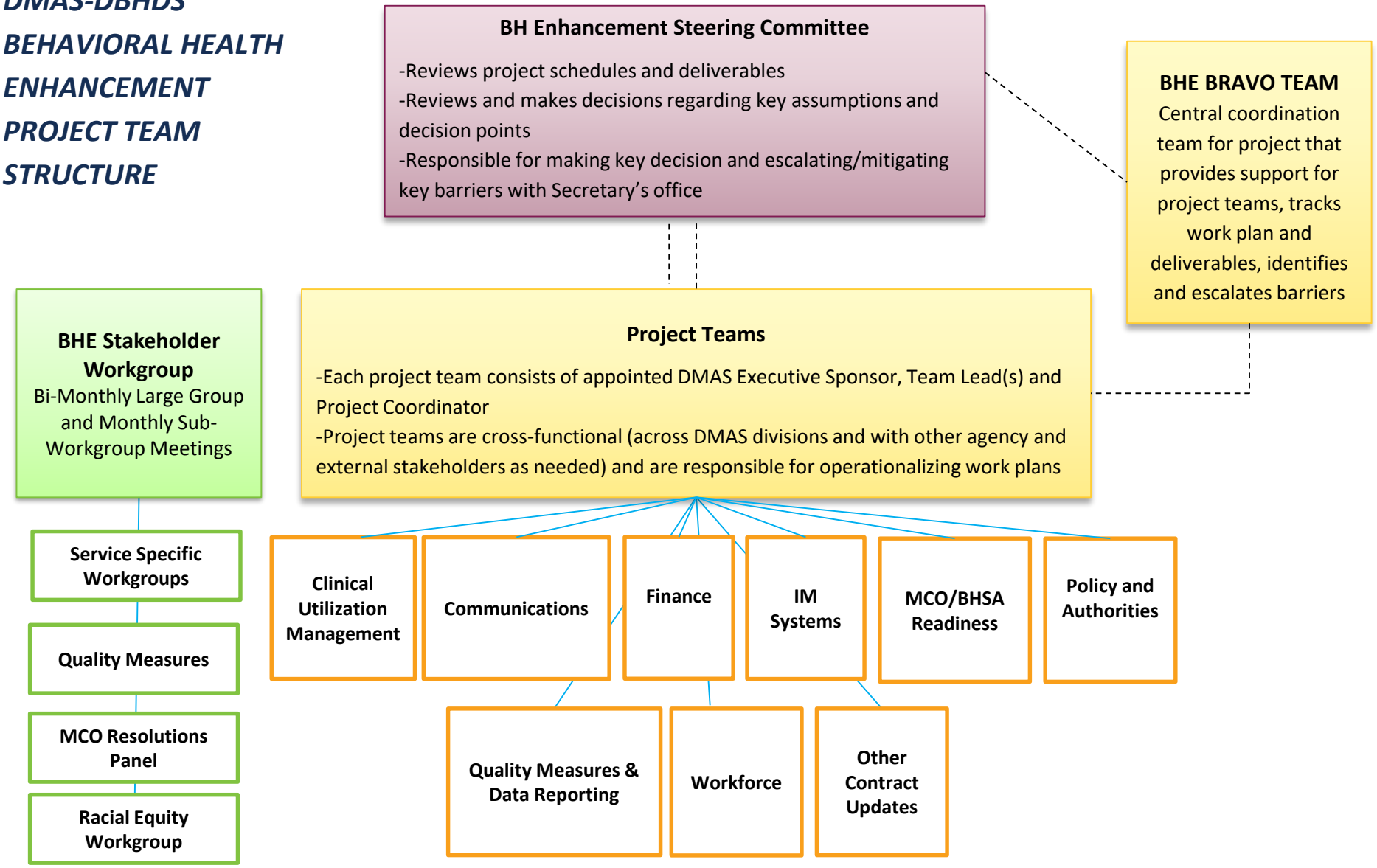
Who

- Each sub-workgroup will be composed of individuals for a respective service category: organizational representatives, subject matter experts.
- Ad hoc members may be included in the sub-workgroups as needed

Meeting Frequency

- Quarterly Large Group Meeting
  - Virtual, recorded and uploaded to website
- Twice Monthly Sub-Workgroup Meetings
  - MNC Review
  - Manual Review
  - Staggered based on BHE timeline

DMAS-DBHDS BEHAVIORAL HEALTH ENHANCEMENT PROJECT TEAM STRUCTURE



Next immediate steps

Stakeholder WebEx: December 11th, 2020

- Will be posted to website and youtube

MCO Resolutions Panel: December 17th, 2020

- Initial meeting of this panel that conforms to mandated budget language

General Assembly Session

- External workgroups will pause during this time

Instructions for Service Specific Break Outs

Original Stakeholder Workgroup Members may remain here in this Webex meeting and we will return after 15 minute break

Service Specific Stakeholders, please log out and join your Google Meets invitations for your break out meetings in 15 minutes

Service Specific Workgroups Meeting Info

Crisis Workgroup (Co-leads: Stefanie Pollay(DMAS) & Heather Norton (DBHDS))

- Meeting ID: meet.google.com/ssg-keeu-pcb
- Phone Numbers: (716) 800-3479
- PIN: 592 042 662#

ACT Workgroup (Co-leads: Jeffrey Vanarnam (DBHDS) and Brian Campbell (DMAS))

- Meeting ID: meet.google.com/ifo-nswd-hre
- Phone Numbers: (929) 324-9787
- PIN: 834 722 527#

PHP/IOP Workgroup (Co-Leads: Shamika Ward (DMAS) & Alexis Aplasca (DBHDS))

- Meeting ID: meet.google.com/hku-oncj-eht
- Phone Numbers: (910) 634-0294
- PIN: 839 321 430#

MST/FFT Workgroup (Co-Leads: Oketa Winn (DMAS) & Malcolm King (DBHDS))

- Meeting ID: meet.google.com/abg-yqvs-hzu
- Phone Numbers: (567) 855-1099
- PIN: 732 652 395#

15 Minute Break

1. Workgroup Members can log off and join their Google Meets meeting at 12:15pm.
2. Others may remain logged into this meeting if they would like to participate in the Q & A session.
3. Please turn off your video and make sure you are muted during the break.

Q&A Session

Thank you for your partnership, support and participation.

Additional Questions?

Please contact us at:
Enhancedbh@dmas.virginia.gov

From: Jennifer Faison <jfaison@vacsb.org>
Sent: Wednesday, December 16, 2020 2:21 PM
To: Aileen Smith <ALSmith@vbgov.com>; Allison Downey <adowney@vacsb.org>; Angelo Wider <widera5105@aol.com>; Angie Hicks (amhicks@vbgov.com) <amhicks@vbgov.com>; Beth Engelhorn <bengelhorn@sscsb.org>; Carol Layer <Carol.Layer@alexandriava.gov>; Damien Cabezas <damien.cabezas@horizonbh.org>; Daryl Washington <Daryl.Washington@fairfaxcounty.gov>; David Coe <DCoe@colonialbh.org>; Debbie Bonniwell <dbonniwell@brbh.org>; dwarren@arlingtonva.us; Demetrios Peratsakis <dperatsakis@wtcsb.org>; Ellen Harrison <eharrison@hrcsb.org>; Greg Preston <gpreston@piedmontcsb.org>; Hilary Piland <hpiland@vacsb.org>; Ingrid Barber <ibarber@ahcsb.org>; Ivy Sager <itsager@co.hanover.va.us>; James Pritchett <jpritchett@nrvcs.org>; Jane Yaun <jyaun@rappahannockareacsb.org>; Jennifer Faison <jfaison@vacsb.org>; Jennifer Tunstall <jtunstall@d19csb.com>; Jim Bebeau <jbebeau@dpcs.org>; Jim LaGraffe <jlagraffe@rrcsb.org>; jscislowicz@chesapeakeibh.net; John Lindstrom <lindstromj@rbha.org>; Kelly Fried (friedk@chesterfield.gov) <friedk@chesterfield.gov>; Kevin Mullins <kevin.mullins@dcbhs.com>; Kim Shaw <kshaw@racsb.org>; Kimberly McClanahan <kmcclanahan@vcsb.org>; Kristie Hammonds <khammond@frontierhealth.org>; tot05@henrico.us; Linda Hodges <Lhodges@mpnn.state.va.us>; Lisa "Mimi" Sedjat <lsedjat@escsb.org>; Lisa Beitz <lisa.beitz@regionten.org>; Lisa Madron <lmadron@pwcgov.org>; Margaret Graham <margaret.graham@loudoun.gov>; mcole@cmcsb.com; Mike Elwell <MElwell@nwcsb.com>; Natale Ward Christian <NWard@hnncsb.org>; Pamela Little Hill <littlehillp@portsmouthva.gov>; Rebecca Holmes <rholmes@highlandscsb.org>; Sandy Bryant - Mt. Rogers CSB (Sandy.Bryant@mountrogers.org) <Sandy.Bryant@mountrogers.org>; sodell@pd1bhs.org; Sarah Paige Fuller <sarah.fuller@norfolk.gov>; Stacy Gill <sgill@goochlandva.us>; Susan Baker <sbaker@crossroadscsb.org>; Valerie Long <vlong@vacsb.org>
Subject: Governor's Introduced Budget: Initial Review

Good afternoon,
As you may be aware, the Governor announced his budget for the 2021 session today. Below are some highlights from a cursory review of the document. I will continue to review for less obvious items that may impact our system and the Public Policy Committee will receive thoughts and impressions from our stakeholder partners.

Unfortunately, the DBHDS request to transfer LIPOS funding from Grants to Localities to the DBHDS operating budget made it into the document. The discharge planning positions at state facilities did not; however, DBHDS has been given permission to pursue a code change to 37.2-505 which would support DBHDS' desire to create basic discharge plans and have the CSBs flesh them out after the individual has already been discharged.

The new language will say something like:

"The discharge plan shall be completed withing 30 days of the individual's date of discharge from the state hospital or training center."

You will also see language regarding the creation of a mobile crisis pilot for individuals with a primary diagnosis of dementia in addition to funds to support contracts for the diversion and discharge of individuals with a primary diagnosis of dementia from state hospitals.

While the Commissioner has discussed the need to address this population at a high level, there has been no detailed discussion of how this population fits into the behavioral health system. I do not have any insight as to whether this pilot is supposed to be integrated into our plans for mobile crisis or if the intention is to contract with a private provider, but either way, we will address this as we continue to try and showcase our successes as a statewide community safety net and attempt to strengthen our partnership with DBHDS.

> *N.1. Out of this appropriation, $3,547,000 the second year from the general fund shall be used to support the diversion and discharge of individuals with a diagnosis of dementia. Priority shall be given to those individuals who would otherwise be served by state facilities.*

2. Of the amounts in N.1., $2,820,000 shall be used to establish contracts to support the diversion and discharge into private settings of individuals with a diagnosis of dementia.

3. Of the amounts in N.1., $727,000 shall be used for a pilot mobile crisis program targeted for individuals with a diagnosis of dementia.

4. The Secretary of Health and Human Resources shall convene a workgroup including the Department of Behavioral Health and Developmental Services, the Department of Social Services, the Department of Aging and Rehabilitative Services, providers, and other stakeholders, to identify existing services and make recommendations for the development, evaluation, implementation, and scaling-up of evidence-based and evidence-informed services for persons living with dementia in order to improve quality and availability of care and reduce preventable hospitalizations. The workgroup shall report to the Governor and the Chairmen of the House Appropriations and Senate Finance and Appropriations Committee by November 1, 2021.

The funding to support discharge assistance plans is less than what was requested by DBHDS, coming in at $2.5M.

Funding for STEP-VA as well as the other items that we are supportive of retaining from the special session budget such as the DD Waiver rate refresh, the behavioral health provider reimbursement rate increase and permanent supportive housing funds appear to have remain intact.

We will be making changes to our talking points on the budget priorities with these new developments.

Below please find links to some budget summary documents as well as the full budget.

DPB summary publication on HHR: https://dpb.virginia.gov/budget/buddoc21/partb/OfficeOfHealthAndHumanResources.pdf

DBHDS Details: http://publicreports.dpb.virginia.gov/rdPage.aspx?rdReport=BDoc2021_Agency&iptAgency=720&rdAgReset=True

DMAS Details: http://publicreports.dpb.virginia.gov/rdPage.aspx?rdReport=BDoc2021_Agency&iptAgency=602&rdAgReset=True

Full Budget Document: https://budget.lis.virginia.gov/bill/2021/1/HB1800/Introduced/

Please contact me with your questions.

Best,

Jennifer

RBHF RICHMOND BEHAVIORAL HEALTH FOUNDATION

RBHA Board Meeting
Development Report – January 5, 2021

Richmond Behavioral Health Foundation

YTD Income (minus grants) to RBHF: $7524.67 (as of December 31, 2020)
YTD grants awarded: $51,320 (as of December 31, 2020)
YTD gifts-in-kind: $57,816.40 (as of December 31, 2020)
YTD Total Revenue: $116,639.23

	Current Year (FY21)	Previous Year (FY20)	Two Years Ago (FY19)
	Total Grants/Requests Submitted in FY21 (July 1, 2020 – June 30, 2021)	**Total Grants/Requests Submitted in FY20 (July 1, 2019 – June 30, 2020)**	**Total Grants/Requests Submitted in FY19 (July 1, 2018 – June 30, 2019)**
Number of Submitted Grants/Requests	5 Total: $106,320	2 carryover from FY19 ($40,000) 10 (TOTAL: $151,000)	9 $418,500 and up to $500,000 (TOTAL: $918,500)
Number of Funded Grants/Requests	3	7	5
Dollar Value of Awarded Grants/Requests	$51,320	$142,000	$59,795
Number of Pending Grants/Requests	0	0	2
Dollar Value of Pending Grants/Requests	$0	0	$40,000
Number of Denied Grants/Requests/Postponed	2	2 - denied 3 – cancelled (COVID)	3
Dollar Value of Denied or Partially Funded Grants/Requests	$55,000	$59,000	$821,500.00
Gifts in Kind Monetary Value	$57, 816.40	$57,671.25	$9,342.00
Volunteer Hours	1362	863	200

Update on Grants and Gifts: See attached chart

RBHA Board Meeting
Development Report – January 5, 2021

Communications:

- Next Steps:
  - Brand Standards Manual to be completed
  - Print Collateral Strategic Plan to be finalized
  - Begin transition of internal documents and external facing communications
- Developing a Communications Plan
- Developing a Social Media Plan
- Beginning work on Employee Recruitment -

- Branding Roll Out to Staff took place October 29th via Zoom Webinar

  Key Metrics:

  - 414 Employees registered for the webinar; 352 attended
  - Direct feedback was received from 151 attendees, over 40% of all attendees
  - Despite the challenging COVID backdrop, 89% of feedback was extremely positive
  - Only 2% of attendees provided negative constructive feedback
  - 59 Employees volunteered to participate in upcoming aspects of the re-branding process (i.e., marketing, event planning, etc.)
- Logo Presentation to RBHA Board for vote to adopt – September 1, 2020 – ADOPTED
- RBH Brochure and RBHF Insert is complete

Volunteer Appeals/Events:

- DIY Volunteer Project Outcomes:
  - Volunteer Service Hours:
  - Painted Rocks for NC Walking Trail: 58
  - Nourishment Kits: 449
  - Hygiene Kits: 252
  - Cold Weather Item Kits: 1266
- DIY Volunteer Project Impact:
  - Items have been distributed to 17 RBHA programs for distribution to individuals and families in need
- Planning several Volunteer Appeals in partnership with Hands On Greater Richmond - primary goal is to connect with individuals in the community and establish new relationships
  - Painted Rocks – North Campus Walking Trail
  - Hygiene Kits – Marshall Center, MRTC, PACT, Homeless Services
  - Nourishment Kits – Homeless Services
  - Cold Weather Kits – to grow our Giving Tuesday Cold Weather Item Collection
- Walking Trail – North Campus – November 2020 – Work to begin this week – tentatively scheduling 2 small volunteer opportunities around the installation of the walking trail

RBHF RICHMOND BEHAVIORAL HEALTH FOUNDATION

RBHA Board Meeting
Development Report – January 5, 2021

Appeals:

- Annual Appeal Campaign begins this week
  - Mailing
  - Email
  - Social Media Campaign
- Annual Appeal to begin in late October – first wide distribution of the new RBH brochure
- Planning a campaign for the Children's Services Center at North Campus – Outdoor Needs – primary goal is to involve/reach community members and increase community awareness of RBHA – Spring 2021
- GIVING TUESDAY – December 1, 2020 – plans underway for securing cold weather clothing items
- United Way Employee Campaign – November 16, 2020

Email to RBHA Staff on 12/14/20:

As part of on-going communications around our branding and marketing efforts, I wanted to take the opportunity to answer a few questions that arose from the Staff Roll-Out (October 29th) of the new branding and marketing that we have committed to undertake. **I hope you will take a few minutes to read this.** Most of the responses were very supportive of this initiative and felt it captured the essence of the commitment and good works that happen every day at RBHA. Some asked good questions such as:

"How does this impact everyday operations?"
"How does marketing/branding pertain to front line workers?"
"What does this have to do with me?"
"Why market? Everyone knows who we are."

I will answer your question with another question and then I will connect the dots:

Does anyone/any program/any division need additional resources (i.e., increased staffing, tangible resources for individuals receiving services, funding for programs/projects, etc.)?

From my perspective, the answer to this question is, most certainly, YES.

CONNECTING THE DOTS:
Earlier this year, RBHA (Dr. Jim May and his team in Grants, Research, Evaluation, and Planning) conducted a Community Stakeholder Survey. The survey was targeted to individuals who live or work in the City of Richmond and surrounding areas. The first question was "How familiar are you with RBHA and the services provided?" **The answer: Almost 60% of respondents knew "almost nothing" (29.5%) or "very little" (28.7%) about RBHA.**

How do we bring in resources when most people in our community - who have no direct affiliation with RBHA - don't know who we are or what we do? We don't, is the answer.

How do we get people to know who we are and what we do? We create a dynamic brand based on our employees, our work, and our impact in the community and we begin to educate the community – AKA - We market ourselves.

Here is the most recent example of our marketing efforts:
In 2019, we began a campaign around Giving Tuesday to request donations of cold weather items for the individuals and families we serve. **In 2020, we did the same but we made intentional efforts to market RBHA services, employee commitment to serve the community (especially during COVID), and the needs of the people we serve.**
Here are the results:

2019 – We received:	2020 – We received:
78 pairs of socks	449 Nourishment Kits (non-perishable food and water)
16 scarves	252 Hygiene Kits (soap, deodorant, washcloths, toothbrushes, toothpaste, etc.)
30 pair of gloves	1266 Cold Weather Item Kits (socks, hat, and gloves)
57 hats	Many, many individual cold weather items and blankets
7 jackets	
19 blankets	
• Distributed items to Homeless Services	• So far, distributed items to 16 RBHA programs and locations for distribution to individuals receiving services.

<u>This is the impact of marketing.</u> While this is only one example, hopefully, you can all begin to see how this impacts your work on the front lines, what is has to do with you, and how it does and can impact daily operations.

While I have taken the lead for Marketing and Communications, in addition to my more specific work with RBHFoundation, I am very happy to have a team of RBHA employees working with me who are excited about and committed to doing the work to move our organization forward. I am also very happy that so many of you offered to be involved in upcoming projects and initiatives. We will be in touch!

For now, we are in the process of finishing up a **Brand Standards Manual** which outlines logos, graphics, messaging, when to use what, colors, etc. Hopefully in January, we will begin rolling out some of the new graphics via letterhead, business cards, email signature lines, etc.

Our next step is to strategize around more effectively utilizing **social media** and around **employment outreach** with the goal of filling the many vacant positions that we currently have across programs.

As always, I am happy to answer questions and provide additional information. Thanks for reading!

Carolyn B. Seaman | Director of Development | Richmond Behavioral Health Foundation | 107 S. 5th Street, Richmond, VA 23219 | 804-819-4097 | www.rbha.org

Richmond Behavioral Health Foundation (RBHF) is a nonprofit 501(c)(3) that works to support the essential services of the Richmond Behavioral Health Authority (RBHA) – Mental Health, Developmental Services, Substance Use Disorders, and Assessment, Emergency & Medical Services.

GRANT Applications FY21

	Application Date	Request	Requested	Funded	Not Funded	In Kind	Volunteer Hours	Volunteer Hours Value	NOTES
Altria - Give Together	7/16/2020	Homeless Services Outreach	$ 25,000.00	$ 25,000.00					Award Letter 07/27/20
Community Foundation	8/12/2020	Homeless Services COVID Relief	$ 25,000.00	$ 25,000.00					Community COVID-19 Relief Fund Award Letter 09/21/20
Women of St. Stephen's	8/14/2020	WRTC	$ 1,320.00	$ 1,320.00					Strollers and Car Seats
Richmond Christmas Mother	9/4/2020	Marshall Center Holiday Party	$ 5,000.00		$ 5,000.00				Holiday Party for 95 Marshall Center Members
Reynolds Foundation	10/30/2020	North Campus Reception Area	$ 50,000.00		$ 50,000.00				Reception Area Renovations - MRTC Building

		TOTALS:	**$ 106,320.00**	**$ 51,320.00**	**$ 55,000.00**	**$ -**			