Report of the Virginia Veteran and Family Support (VVFS) Program Working Group

To the

Joint Legislative Audit and Review Commission

November 14, 2016

To: The Honorable Robert D. Orrock, Sr.
Chairman
Joint Legislative Audit and Review Commission

The attached report of the Virginia Veteran and Family Support (VVFS) Program Working Group is submitted pursuant to Chapter 780, 2016 Acts of Assembly, Item 466.

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Executive Summary

- The Virginia Veteran and Family Support (VVFS) program was created in 2008 as the Virginia Wounded Warrior Program (VWWP). It was the first comprehensive state-level program of its kind in the nation, designed to address shortcomings in access to veterans' behavioral health and rehabilitative services provided by the U.S. Department of Veterans Affairs (USDVA, or "the VA").
- VVFS provides services throughout the Commonwealth and is operationally divided into five regional areas. The program is comprised of forty-five (45) staff members in total; thirty-four (34) staff employed by contracted Community Service Boards (CSB) and eleven (11) Department of Veteran Services (DVS) staff.
- In 2015 the Virginia General Assembly directed the Joint Legislative Audit and Review Commission (JLARC) to review DVS. The December 2015 JLARC report found a variety of problems with the VVFS program's design and implementation, and recommended a series of improvements, including a working group.
- The 2016 General Assembly directed the formation of a working group, comprised of the Secretary of Veterans and Defense Affairs, the Secretary of Health and Human Resources, and the Director, JLARC, to review the entire program and submit a report to the JLARC no later than November 15, 2016.
- The workgroup met five times between May and October 2016. Between workgroup meetings, DVS, Department of Behavioral Health and Developmental Services (DBHDS), and JLARC staff conducted research and analysis and held meetings to inform the workgroup deliberations.
- The working group agreed that the new goal of the VVFS program should be to:

  Conduct outreach to veterans and families; cost-effectively refer them to mental health, physical rehabilitative, and other services as needed; and periodically monitor their progress.
- The workgroup concluded there are two equally important aspects of this goal:
  - First, cost-effectiveness is essential because there are likely far more veterans that could benefit from these services than the current budgetary allocation will accommodate.
  - Second, referring veterans and monitoring their progress fulfills a needed role to help veterans navigate the complex service provider environment. The role of referring and monitoring---but not directly providing mental health or rehabilitative services—has the benefits of not asking program staff to provide services for which they lack sufficient expertise and qualifications, and not attempting to provide mental health, rehabilitative services, or other services that duplicate existing public and private programs.
- The workgroup concluded the program should achieve this goal by implementing a program that features four types of activities based on lessons learned from operating the current

VVFS program, issues identified during the 2015 JLARC review, a working group review of other states' programs, and working group deliberations: 1) Building program awareness; 2) Veteran intake to "triage" issues; 3) Developing a resource plan and referring the veteran to the appropriate resources; and 4) Monitoring veteran progress.

- The work group identified four structural options for how to achieve the goal of the VVFS program:

Option	Description	# Employees	Annual Service Capacity	Additional GF $ needed to implement
1	Current service model	11 state, 34 contract	2,500 – 3,000	$0
2	Change to all state employees – improved service delivery through program standardization	39 state	2,300 – 2,800	$0
3	Change to all state employees – improved service delivery through program standardization. Increased service capacity	45 state	2,800 – 3,300	$500,000
4	Change to all state employees – improved service delivery through program standardization. Increased service capacity. Would award grants to community organizations to provide additional services	45 state	3,000 - ?	$800K - $1.7M

- Partnerships with CSBs would continue to be a top priority for VVFS staff in a state-run model. Program staff would continue to work with CSBs regularly to ensure access to community behavioral health services for service members, veterans, and families (SMVF) that lack timely and accessible services in the VA system. VVFS staff would also continue to partner with DBHDS and CSBs to increase military cultural competency among community behavioral health providers and conduct ongoing analysis of CSB demographic and services data to facilitate resource planning for SMVF.

- None of the four options would change the continuity of referrals to the CSBs for clinical treatment, and, as at present, VVFS would continue to contract for clinical services based on availability of non-general fund dollars.

Recommendations:

1. Option 3 represents the best near-term way to achieve the VVFS program goal: the VVFS Working Group recommends Option 3. The proposed program structure, in a totally converted state model, would allow VVFS to meet the needs of its target population by establishing and putting into effect uniform operational and hiring policies to guide program operations and prioritize the work of VVFS staff and services. Additionally, an all-state employee model will create permanence and standardization in VVFS service-delivery which will permit the uniform development and implementation of new metrics to measure the impact and success of VVFS program services.
2. FY17 Funding should be used for one-time costs: Chapter 780, 2016 Acts of Assembly, Item 466, set aside $393,494 from the general fund "*for the purpose of implementing the recommendations of the working group for the Virginia Veteran and Family Support program*."

   The VVFS Working Group recommends that $300,000 be transferred to DVS in FY17 for one-time expenditures associated with implementing Option 3, including costs to co-locate VVFS staff in up to 15 DVS Benefits Services offices and the purchase of new IT equipment and furniture. The balance should be applied to other veterans programs or returned to the Treasury.
3. Revisions should be made to §2.2-2001.1 of the Code of Virginia: the VVFS Working Group recommends revising the Code of Virginia to update the statute that established the VVFS program. The working group has concluded a revision is important to provide updated guidance to program staff about the program's purpose and primary activities. The working group has also concluded that new statutory language can be drafted that reflects lessons learned since 2008 when the program was established, and the evolving nature of veterans needs and services.

   The language would codify the program's goal and specify the key program activities related to awareness, intake, planning and referral, and monitoring.
4. The VVFS Working Group should continue to meet periodically: the VVFS Working Group recommends it continues to meet periodically to ensure that the recommendations of this report, as approved by JLARC, are efficiently and effectively implemented. The working group further recommends that the Secretaries of Veterans and Defense Affairs and Health and Human Resources continue their close collaboration on VVFS and on other issues related to the CSBs and behavioral health care for veterans and families.

1. VVFS program purpose and history

The Virginia Veteran and Family Support (VVFS) program was created in 2008 as the Virginia Wounded Warrior Program (VWWP). It was the first comprehensive state-level program of its kind in the nation, designed to address shortcomings in access to veterans' behavioral health and rehabilitative services provided by the U.S. Department of Veterans Affairs (USDVA, or "the VA").

Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) have been called the "signature wounds" of the conflicts in Iraq and Afghanistan and the ongoing Global War on Terrorism. These "invisible wounds," if unaddressed, can be crippling for some veterans and their families, impeding their successful reintegration into society, impacting their health and well-being, destroying family integrity and happiness, and robbing society of the potential contributions of a generation of Americans recognized for their leadership, drive, energy, and selfless-service.

Leaders in the Executive and Legislative branches of state government, as well as in the veterans community, have long recognized that the Commonwealth of Virginia had a moral obligation to help those who had served in the Armed Forces of the United States of America, and their families, make the successful transition from military to civilian life. The notion that "they have served us, now we must serve them" has been the guidepost in fulfilling this obligation.

But Virginia's leaders, noted for their fiscal discipline, have also long recognized that spending state dollars on services for veterans and their families is a prudent investment in both the veteran's future and that of the Commonwealth, an investment that pays a significant return across a wide spectrum, from direct federal spending on veterans services ($5.4 Billion by the USDVA and $5.2 Billion in Department of Defense retirement pay in FFY15) to the leadership roles veterans play in business and in civil society, from enriching our college classrooms to helping grow and diversify the Virginia economy.

Ideally, veterans' transition journeys would be relatively simple and short. They would know what they want to do before they leave the military and would begin preparing for separation a year in advance. All health care issues would be addressed (whether physical or invisible), their finances would be in order, and their school or job applications completed, submitted, and accepted. This would enable them to simply walk right off their base "free and clear" and directly into a classroom or work place (be they employee or entrepreneur). Finances would not be an issue and the family unit would be strong and healthy.

Unfortunately, this ideal situation is not the norm for many veterans, and this is where the Commonwealth's investment in her veterans comes into play. This investment is a multi-pronged, cross-discipline effort involving multiple state agencies and focused on the areas of financial stability and access to health care; education, employment, and entrepreneurship; and behavioral, rehabilitative, and supportive services. Whether helping them file for VA disability compensation benefits (which provides both a monthly payment based on the level of service-connected disability and number of dependents and enables priority access to VA healthcare), helping them achieve their education or training goals, working with Virginia employers to create meaningful and well-paying employment opportunities, or helping them on the road to resilience and recovery, the

Commonwealth is committed to helping its veterans succeed. This commitment is especially evident in the Virginia Veteran and Family Support (VVFS) program.

The VVFS is a Code-mandated partnership between the Department of Veterans Services (DVS), the Department of Behavioral Health and Developmental Services (DBHDS), and the Department for Aging and Rehabilitative Services (DARS), with DVS exercising the primary leadership and management roles, as well as controlling fiscal and personnel assets directly authorized for the program. The mission and purpose of VVFS has been, since the beginning, to monitor and coordinate behavioral health care and rehabilitative services for veterans, Guardsmen and Reservists not in active federal service, and their families. As noted above, VVFS was the first of its kind in the nation both in what it was intended to achieve and also in who it was intended to serve. The program's charter has, from the start, included a mandate to help Virginia's citizen-soldiers.

Before the program was stood up in 2008, various organizational options were reviewed, including an all-state employee model and a hybrid model with both state and contract employees. The contract employees are in fact employed by local Community Service Boards (CSBs) and have a dual reporting chain to a VVFS Regional Director and a CSB supervisor. The CSB-contract model was chosen primarily for two reasons: 1) to integrate the then new program into the state's community-based mental health care system (as an alternative to or backstop for the VA) and 2) for fiscal reasons – with a lower pay scale and benefits, a CSB employee was generally less expensive to employee than a state worker, even if that meant accepting challenges in management and operation (the state is responsible for program outcomes but operations are outsourced and decentralized, leading to differences in program execution). The hybrid contract model has meant that there is limited upward or lateral mobility for VVFS contract employees, as they were, at one time, employed by no fewer than 11 CSBs.

VVFS has been organized from the beginning into five regions, to match Virginia's health planning regions, and these regional boundaries remain unchanged today. One CSB in each region serves as a "fiscal agent" for the region. Some regions have had the same fiscal agent from the program's inception, while others have changed at least once, necessitating the establishment of new working relationships, the teaching of VVFS fiscal and management procedures and policies, new employee salary and benefit packages, and the acceptance of the risk that the fiscal agent may change when the contract comes up for renewal the next fiscal year.

At the end of each state fiscal year, DVS negotiates new contracts with the five regional fiscal agents for the next fiscal year. The amount of each contract is based on expected service levels and available resources. Because of the "front loading" of the VVFS budget when it was first stood up, VVFS has employed a "cross-year, forward-funding" model with the CSBs, in which contract funding for part of the next state fiscal year (FY) is allocated in the current FY. The last year this model was an option was in FY16 (for FY17 operations). When the FY17 contracts with the CSBs were signed, all FY16 and FY17 funds were allocated to FY17 operations in order to make the program and service improvements discussed below.

DVS, an agency under the Secretariat of Veterans and Defense Affairs (VADA), is the lead agent for VVFS operations. DVS and VADA work in partnership with the Secretariat of Health and Human Resources; DBHDS; DARS; the Virginia National Guard; the leaders of the VA Medical Centers

and associated treatment facilities in Virginia, West Virginia, North Carolina, Tennessee, and the District of Columbia; the Director of the VA Health System in Virginia and North Carolina; and CSB leaders to set the program's direction, ensure close cooperation between agencies, and prioritize activities. This leadership body is known as the Interagency Executive Strategy Committee (IESC).

The work of the IESC became increasingly important as VWWP began to address a wider spectrum of issues affecting behavioral health for veterans and families. This was noted in the VVWP 2012 Annual Report:

> *VWWP is becoming known for not only its ability to connect military service members, veterans and families to treatment and support for behavioral healthcare, but a trusted connection to primary healthcare services, financial assistance, employment, housing and other community support. In addition, the program has provided numerous opportunities for professional training in military culture, evidence-based practices for treatment of combat related stress disorders, healthcare issues, marital and family support, and for addressing the needs of military service members and veterans involved in the criminal justice services system.*

It must also be noted that in 2014 VVFS played a key leadership and coordinating role in the state's fight to end veterans homelessness. Over 2,000 veterans were housed in an 18-month period, and on Veterans Day 2015, Virginia was recognized by the U.S. Department of Housing and Urban Development and the U.S. Interagency Council on Homelessness as the first state in the nation to functionally end veterans homelessness.

Currently, VVFS provides services throughout the Commonwealth and is operationally divided into five regional areas: Northwestern (Region 1); Northern (Region 2); Southwestern (Region3); Central (Region 4); and Hampton Roads/Norfolk (Region 5). The program is comprised of forty-five (45) staff members in total; thirty-four (34) staff employed by contracted CSBs and eleven (11) DVS staff employed by the Commonwealth of Virginia. In FY 16-17, VVFS manages five regionally based contracts between area CSBs and DVS for the delivery of program services.

2. JLARC Study and formation of the VVFS Working Group

In 2015 the Virginia General Assembly directed the Joint Legislative Audit and Review Commission (JLARC) to review the Department of Veterans Services (DVS). The December 2015 JLARC report found a variety of problems with the VVFS program's design and implementation, and recommended a series of improvements and the creation of a working group.

The 2016 General Assembly directed the formation of a working group, comprised of the Secretary of Veterans and Defense Affairs, the Secretary of Health and Human Resources, and the Director, Joint Legislative Audit and Review Commission, or their designees, to review the entire program. The working group's charter is presented in Appendix A.

Though additional funding was appropriated in FY17 and FY18, the FY17 funding can only be released by the Director of the Department of Planning & Budget (DPB) based on the unanimous request of the workgroup members.

3. VVFS program improvements in 2016

In order to maintain current service levels, DVS and VVFS leadership, in conjunction with CSB partners, agreed to keep the current program structure in place through FY17, with any program changes being made in FY18 based on the report of the VVFS Working Group.

To address the issues identified in the JLARC report, DVS and partner CSBs took steps to standardize VVFS operations through the five CSB contracts for FY17, including standardized position descriptions approved by the state's Department of Human Resource Management (DHRM), more uniform performance standards, and consolidation from 11 to five hiring CSBs to reduce variability in staff salaries and benefits, and other programmatic improvements.

To improve implementation and oversight of the program, DVS developed a Clinical and Quality Assurance Director (CQAD) position to administer centralized staff training and evaluation, and quality control measures in services delivery. The CQAD has concentrated on developing VVFS policies related to program philosophy, operational standards and procedures, staff training and program services evaluation.

To date, standardized operating policies and procedures (SOP) have been developed and are being implemented at the regional and central office areas. These SOPs clearly outline the provision of the resources; coordination and supportive services offered; and the established functions, procedures and specified time frames for those services to be delivered. Staff training on the SOPs has occurred and will systematically continue to best promote the delivery of high quality supportive services to veterans, service members, families, and caregivers.

In order to make these improvements, DVS increased the contract funding awarded to the five regional fiscal agents to begin to address higher salary and operating costs identified by VVFS leadership and the CSB fiscal agents. This meant that FY17 funds that would previously have been "set aside" for FY18 forward-funding were instead allocated for FY17 operations.

While significant improvements have been made, there are opportunities for additional improvements. For example, even stronger program metrics could be implemented. These continued improvements are also dependent on full utilization of appropriated FY18 funds in order to sustain and build upon FY17 improvements.

4. Workgroup activities

As directed in the 2016 Appropriation Act (Item 466), the Secretary of Veterans Affairs convened a workgroup to review the VVFS program as recommended in the December 2015 JLARC report. The workgroup comprised the Secretary of Veterans Affairs, Secretary of Health and Human Resources, and the Director of JLARC. The workgroup met five times between May and October 2016. Between workgroup meetings, DVS, DBHDS, and JLARC staff conducted research and analysis and held meetings to inform the workgroup deliberations.

5. Redesign of the VVFS program goal and key activities

The working group agreed that the new goal of the VVFS program should be to

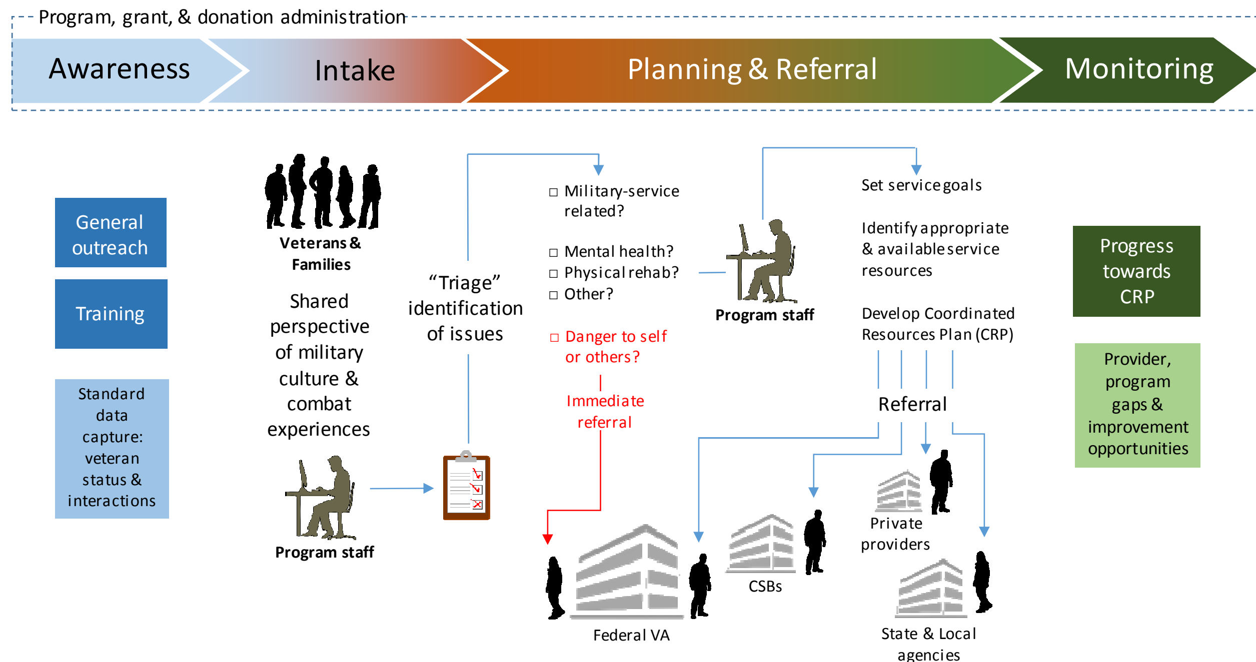
> *Conduct outreach to veterans and families; cost-effectively refer them to mental health, physical rehabilitative, and other services as needed; and periodically monitor their progress.*

The workgroup has concluded there are two equally important aspects of this goal. First, cost-effectiveness is essential because there are likely far more veterans that could benefit from these services than the current budgetary allocation will accommodate. Second, referring veterans and monitoring their progress fulfills a needed role to help veterans navigate the complex service provider environment. The role of referring and monitoring---but not directly providing mental health or rehabilitative services—has the benefits of not asking program staff to provide services for which they lack sufficient expertise and qualifications, and not attempting to provide mental health, rehabilitative services, or other services that duplicate existing public and private programs.

The workgroup has also concluded the program should achieve this goal by implementing a program that features four types of activities (Figure 1). These activities were determined based on lessons learned from operating the current VVFS program, issues identified during the 2015 JLARC review, a working group review of other states' programs, and working group deliberations.

Figure 1

Proposed Key VVFS Program Activities



5.a – Building program awareness

Building awareness about state services for veterans is an ongoing challenge. Some veterans know they have mental health or physical rehabilitative needs related to their military service or combat experience, but are not aware of the VVFS program. Other veterans more fundamentally may not realize the full extent of their needs—or more likely how they combine to cause them difficulty maintaining employment, with substance abuse, or having healthy relationships with their families.

The working group concluded that the VVFS program should have three main types of activities designed to build awareness: marketing, training, and developing the capability to better identify veterans and families who may need services. The program should conduct marketing activities, such as regularly speaking at veterans' events and visiting military installations to educate active duty and veterans and families about the potential for them to need services and how the VVFS program can help. The program should also participate in training that is given to others who may routinely interact with veterans in need, including law enforcement, CSBs, and a myriad of not-for-profit organizations that address issues such as housing or hunger. Finally, over the longer-term, the program should work to develop a standardized outreach and assessment capability to identify veterans who may need services, and engage them early to prevent their needs from becoming greater or developing into crisis situations.

5.b – Veteran intake to "triage" issues

Once a veteran is aware the VVFS program exists and seeks help, program staff can use their shared understanding of military culture, service, combat, and transition to elicit from the veteran what they believe may be their major service needs. This initial intake function may not necessarily be consistent with what eventual service providers conclude, but it is important to determine on a preliminary basis (1) the severity of their need, (2) the nature of their need(s), and (3) whether their needs could be attributable to prior military service or combat. Effective veteran intake is essential to identify as quickly as possible veterans with a severe and immediate need, especially those who may be a danger to themselves or others, and immediately refer them to a qualified service provider, such as the VA or a local CSB. Intake is also important to begin to understand how complex the veterans service needs may be, and consequently, how comprehensive their eventual resource needs may need to be. Finally, there are some veterans who approach the program with needs that, at least based on an initial discussion, are not likely directly related to their prior military service or combat. This is important so that, to the extent there are constrained resources, program resources can be prioritized to those in immediate and severe need and for those whom it is more clear have needs directly related to prior military service or combat experience.

5.c – Developing a resource plan and referring the veteran to the appropriate resources

The primary purpose of the program is to refer veterans to appropriate and available resources. The groundwork for effective referral is laid well before a veteran approaches the program. VVFS program staff will need to maintain an update-to-date, comprehensive list of appropriate and available services providers—ideally in close geographic proximity. This list can then be used as the

basis from which to match each veteran's mental health or physical rehabilitative needs with appropriate service providers.

The end result of these activities will be the development of a coordinated resources plan (CRP) that serves as "roadmap" to guide the veteran through his or her various service providers. Importantly, the CRP is not a treatment plan, nor it is intended to replace the judgment and expertise of qualified service providers that eventually treat the veteran. Rather, the CRP should represent the beginning of the process and something that will be refined and tailored over time. The CRP, at a minimum, should specify which service provider(s) the veteran is being referred to, what the veteran is initially seeking service for, and when VVFS staff will check with the veteran on the progress they are making.

It is important to note that one of the referral sources is VVFS itself, which currently has the only military/veteran specific peer recovery positions outside the VA system (a Substance Abuse and Mental Health Services Administration – SAMHSA – highlighted best practice). Service members and veterans may be reluctant to reach out for behavioral health assistance due to stigma but many are open to bringing their needs to a peer veteran that models hope and recovery. Peer recovery specialists provide non-clinical, person-centered, wellness-focused, trauma-informed support while helping to ensure the consumer's coordinated resources plan reflects the needs and preferences of the person being served to achieve their measurable and individualized goals. Outreach and services to family members and caregivers is a unique role for VVFS (family services within the VA can be limited) and often opens the door to help seeking for the service member or veteran if reluctant before.

5.d – Monitoring veteran progress

The final set of program activities will focus on helping ensure the veteran is receiving the care they are supposed to, and that the services they are receiving are leading to improvement. Some veterans require comparatively moderate services that can address their needs in a few months. Others, though, require complex services that may take years. Especially for veterans with more complex needs, their progress can be impeded for many reasons, such as them not continuing with the prescribed services or medications, or providers themselves being in some way a barrier by scaling back services or other administrative issues.

6. Options to achieve the VVFS program goal and implement program activities

The working group has identified four structural options for how to achieve the goal of the VVFS program. As with many other state goals, the state can choose to contract with or provide grants to other entities to administer the program, administer the program directly, or use a combination of the two approaches.

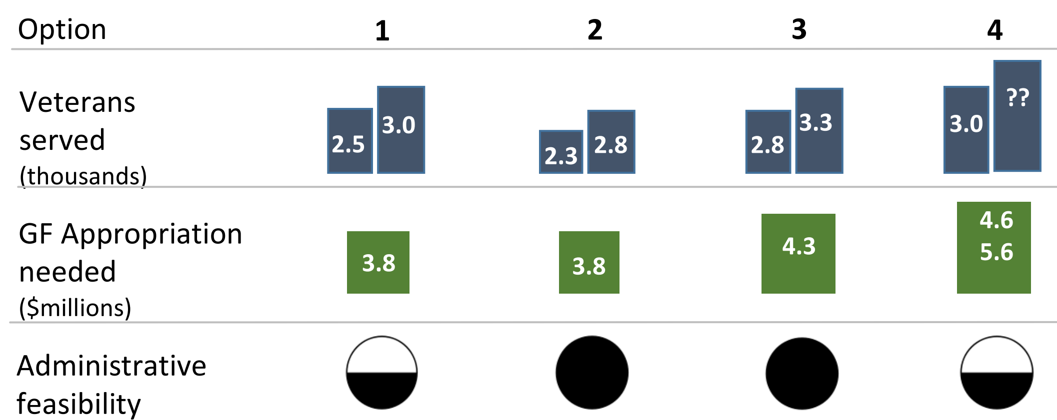
These options were developed based on lessons learned from operating the current VVFS program, issues identified during the 2015 JLARC review, a working group review of how other states attempt

to achieve similar goals, and working group deliberations. Appendix B includes a summary of the working group's review of other states.

The options were also developed in the context of the program's goal to be cost-effective and the state's current fiscal realities. The workgroup has assessed each of these four options against the program's cost-effectiveness goal by estimating how many veterans could be served under each option for the funding provided. The workgroup used FY 2018 appropriations as the baseline for cost comparison across the four options. The workgroup has also assessed each option's administrative feasibility, including how much direct control the state would have over program implementation and the ability of the program to effectively recruit and retain qualified staff over the long term (Figure 2).

None of the four options would change the continuity of referrals to the CSBs for clinical treatment, and, as at present, VVFS would continue to contract for clinical services based on availability of non-general fund dollars.

Figure 2
Veterans served, appropriations needed, and administrative feasibility of proposed VVFS options



Appendix C includes more details about how the appropriations needed for each option were estimated.

Option 1 – Contract-out to Community Service Boards (CSBs)

Option 1 is essentially the current program model, but with the refined program goals and activities discussed above. The option would entail having several state employees located in Richmond and regional offices that set program policy and administer the contractual relationship between the state and CSBs. The bulk of total program funding, though, would be contractual payments to CSBs that choose to participate in the program. Using these program funds, each CSB would be responsible (with DVS contractual specifications and oversight) for recruiting and retaining the staff to conduct

the program's intake, planning and referral, and monitoring activities. Awareness would primarily be conducted by the state employees.

Option 1 could likely serve between 2,500 and 3,000 veterans per year at the FY 2018 appropriated level of $3,778,382 (GF) and $982,054 (NGF). This option represents the lowest cost per veteran served, but may not be the most effective option because of several administrative challenges, including:

- Difficulty standardizing level of service across CSBs,
- Reduced ability for VVFS state leadership to measure program delivery and quality, and
- Reduced ability to ensure a sufficient career path and effectively recruit and retain a workforce.

Some of these challenges can be at least partially addressed through the contracts with the CSB, but there will still be some variation in program delivery.

Option 2 – Develop and administer a state program, but with fewer staff than current program

Option 2 would entail having several state employees located in Richmond that set program policy and build awareness of the program, but unlike Option 1, would also administer the program with state employees. These employees would, whenever possible, be co-located with other DVS employees who administer the DVS benefits eligibility program. These benefits program employees are located across the state in 26 offices designed to balance geographic accessibility with where the majority of veterans are located (which is generally aligned with where the majority of the state's population is located in northern, central, and eastern Virginia).

Option 2 could likely serve between 2,300 and 2,800 veterans per year at the FY 2018 appropriated level of $3,778,382 (GF) and $982,054 (NGF). This option would likely be able to serve slightly fewer veterans than Option 1, primarily because having state employees administer the entire program would result in higher total compensation costs per employee. In nearly all cases, the cost to the state of providing health insurance and retirement benefits would be higher than what CSBs currently provide. Depending on the region of the state, salaries may also need to be higher than what CSBs currently pay. Co-location in DVS Benefits Services offices would entail some higher operating costs (primarily in the form of rent paid to private landlords) but the synergy created by co-location would create significant benefits. To offset this increase, general fund dollars earmarked as a pass-through to the Virginia Housing Development Authority could be redirected to VVFS operations.

This option would likely be more effective than Option 1 because it does not have same administrative challenges. It would be far easier to standardize the level of service across a single program administered by state employees, all of whom would report directly to VVFS program management. Assuming the state administered program develops and collects sufficient information through its monitoring activities, it would also be easier to gain insight into the quality and impact of the program.

Perhaps most importantly, this option substantially addresses administrative challenges related to having high-quality staff dedicated to building a career administering the program. Option 1 (and the current program) presents the uncertainty of sometimes annual re-negotiations of CSB contracts. This uncertainty from year-to-year makes it less likely staff will commit to the program over the long term. Furthermore, the valuable state employee health insurance, leave, and retirement benefits make it more likely that qualified applicants would be interested in applying for a position, and stay for a considerable period of time if they are hired.

Option 2 would likely rely on having full-time staff located on a daily basis at offices in northern, central, and eastern Virginia. Depending on how resource levels and future need evolve, though, this option could utilize a more regional approach in the southern and western parts of the state. This regional approach could consist of state employees covering larger geographic area by visiting different locations based on need on different days of the week.

Option 3 – Develop and administer a state program with the same number of staff used by the current program

Option 3 would entail the same state-administered approach as option 2, but maintain current staffing levels and by extension serve at least as many (but most likely more) veterans as the current program. Option 3 could likely serve between 2,800 and 3,300 veterans per year if appropriated an additional $700,000 compared to the FY 2018 levels. This amount can be reduced to $500,000 if general fund dollars earmarked as a pass-through to the Virginia Housing Development Authority are redirected to VVFS operations.

This option is likely more effective than Options 1 or 2 because it does not have same administrative challenges as Option 1, and could serve more veterans than Option 2.

Option 3 proposes in addition to the existing DVS/VVFS state positions, all 34 currently-contracted positions would be converted to full time, DVS state employee positions. This conversion would allow for necessary standardization and permanence of VVFS operations and service-delivery and effect increased quality assurance measures. Each of these positions requires staff to work directly with the service members, veterans, and families (SMVF) population for the purpose of establishing a supportive connection, assessing presenting issues and needs, referring to appropriate services, and monitoring the SMVF's improved well being as a result of those service connections.

In Option 3 regional VVFS program operations would continue to include a DVS/VVFS state position (currently non-contracted) for each region.

Option 4 – Develop and administer a state program that also provides grants to help achieve program goals

Option 4 would entail the same state-administered approach as Option 3, but with an additional grant-making function that could be used to supplement direct state efforts to achieve the program's goal. The amount of the grant program could range from, for example $100,000 to $1 million, for a

total additional cost of $800,000 - $1.7M. The amount of the grant program would be driven by how the grant funds are deployed and the magnitude of additional effect the program would attempt to have. A smaller grant component, such as one for $100,000, could be used to augment state efforts to build awareness. A larger grant component could be used to provide additional planning and referral coverage in parts of the state not able to be fully served by the state-administered program. These grants could be provided to interested CSBs, private provider networks or hospitals, or other entities that may be interested in furthering the programs goals. Any grant recipient would need to demonstrate they have the capacity and ability to adequately fulfill the program's statutory intent.

These grants, particularly the larger they become and the more entities receive them, introduce a level of administrative complexity beyond Options 2 and 3. Consequently, it likely makes sense to revisit the ability of the program to effectively administer grants once the program itself if sufficiently defined and effectively implemented.

7. VVFS staff roles and responsibilities

In order to best meet the redesigned program's intent outlined in Section 5, the following VVFS Regional Operations positions are required to meet the full range of program requirements, and are applicable to all four options discussed above. The table below shows position titles and which of the four main program activities (awareness, intake, planning & referral, and monitoring) that the position supports.

Figure 3

VVFS Regional Operations – positions/roles and activities

	KEY PROGRAM ACTIVITIES			
Position/Role	***Awareness***	***Intake***	***Planning & referral***	***Monitoring***
Resource Specialist (RS)	✓	✓	✓	✓
Resource Coordinator (RCC)	✓	✓	✓	✓
Veteran Peer Recovery Specialist (VPRS)	✓	✓	✓	✓
Operation Family Caregiver coordinator (OFC-C)	✓		✓	✓
Regional Director (RD)	✓	✓	✓	✓

Appendix E presents a detailed description of proposed program roles and responsibilities for the five types of VVFS Regional Operations positions.

Appendix E also describes the duties of the six VVFS Program Office positions, which:

- Provide program leadership and oversight (Program Director, Clinical and Quality Assurance Director, and Operations Manager); and
- Subject-matter expertise and inter-agency coordination in key focus areas related to VVFS services, especially as it relates to the planning & referral function (Directors of Housing Development for Veterans and Criminal Justice Coordinator);

As VVFS moves into the FY18 program year, DVS should continue to work with the state's Department of Human Resource Management (DHRM) to ensure that the knowledge, skills, and abilities for each position are correctly aligned with performance requirements and salary.

The heart of direct VVFS service delivery is the five regions. The table below gives an example of how VVFS staff would be allocated geographically. The allocations are based on a geographic needs assessment with consideration given to regional SMVF population density and requests (historical) for program assistance and services.

Figure 4

VVFS Regional Staff Allocation – Example

Region	RS	RCC	VPRS	OFC-C
Region 1 (Northwestern)	5	1	1	
Region 2 (Northern)	3	1	2	1
Region 3 (Southwestern)	5	1		
Region 4 (Central)	3	1	2	
Region 5 (Hampton Roads)	5.5	1		1.5
Total	**21.5**	**5**	**5**	**2.5**

8. Recommendation of the VVFS Working Group

Option 3 represents the best near-term way to achieve the VVFS program goal

The proposed program structure, in a totally converted state model, would allow VVFS to meet the needs of its target population by establishing and putting into effect uniform operational and hiring policies to guide program operations and prioritize the work of VVFS staff and services. Additionally, an all-state employee model will create permanence and standardization in VVFS

service-delivery which will permit the uniform development and implementation of new measures of the impact and success of VVFS program services.

In the current contractor model there exists an increased level of variability in the implementation of VVFS services. While DVS is able to have some influence on hiring criteria and job descriptions through the annual contracts, variability continues to exist in hiring criteria, job descriptions, position classifications, and employee performance evaluations due to the diversity in local CSB human resource systems and procedures. Over time, this variability often presents as administrative, fiscal, and partner collaboration challenges. Option 3 eliminates this variability.

In Option 3, VVFS staff would continue to be regionally located.

There are opportunities to co-locate DVS Benefits and VVFS staff in up to 15 of the planned 30 DVS Benefits offices. This offers significant opportunity to facilitate needs assessment and referral, if necessary, to behavioral health, rehabilitative and supportive services for veterans that seek benefits assistance.

In localities where co-location is not feasible or operationally optimal, VVFS staff would, ideally, continue to operate from current locations to facilitate collaborations with CSBs and other local partnering agencies to ensure the SMVF population would have easy access to VVFS staff and program services.

Partnerships with CSBs will continue to be a top priority for VVFS staff in a state run model. Program staff will continue to work with CSBs regularly to ensure access to community behavioral health services for service members, veterans, and families (SMVF) that lack timely and accessible services in the VA system. VVFS staff will also continue to partner with DBHDS and CSBs to increase military cultural competency among community behavioral health providers and conduct ongoing analysis of CSB demographic and services data to facilitate resource planning for SMVF.

FY17 Funding should be used for one-time costs

Chapter 780, 2016 Acts of Assembly, Item 466, set aside $393,494 from the general fund "for the purpose of implementing the recommendations of the working group for the Virginia Veteran and Family Support program."

The VVFS Working Group recommends that $300,000 be transferred to the Department of Veterans Services in FY17 for one-time expenditures associated with implementing Option 3, including costs to co-locate VVFS staff in up to 15 DVS Benefits Services offices and the purchase of new IT equipment and furniture. The balance should be applied to other veterans programs or returned to the Treasury.

Revisions should be made to §2.2-2001.1 of the Code of Virginia

The VVFS Working Group recommends revising the Code of Virginia to update the statute that established the VVFS program. The working group has concluded a revision is important to provide updated guidance to program staff about the program's purpose and primary activities. The working group has also concluded that new statutory language can be drafted reflecting the lessons

learned since 2008 when the program was established, and the evolving nature of veterans needs and services.

The language would codify the program's goal and specify the key program activities related to awareness, intake, planning and referral, and monitoring. Appendix B includes a draft bill that could be used as the starting point to revise the Code.

The VVFS Working Group should continue to meet periodically

The VVFS Working Group recommends it continues to meet periodically to ensure that the recommendations of this report, as approved by JLARC, are efficiently and effectively implemented. The VVFS Working Group further recommends that the Secretaries of Veterans and Defense Affairs and Health and Human Resources continue their close collaboration on VVFS and on other issues related to the CSBs and behavioral health care for veterans and families.

Appendix A – VVFS Workgroup Charter

Chapter 780, 2016 Acts of Assembly, Item 466

B.1. There is hereby established a working group comprised of the Secretary of Veterans and Defense Affairs, the Secretary of Health and Human Resources, and the Director, Joint Legislative Audit and Review Commission, or their designees. The working group shall be chaired by the Secretary of Veterans and Defense Affairs.

2. The working group shall conduct a review of mental health and rehabilitative services for veterans, and make recommendations for efficient and effective coordination and monitoring of services for veterans in Virginia, as set forth in § 2.2- 2001.1, Code of Virginia. This review fulfills the requirements of recommendations 13 and 14 of the 2015 JLARC report "Operation and Performance of the Department of Veterans Services".

3. The working group shall conduct a rigorous and objective review to (i) determine the nature of monitoring and coordination needed by veterans in order to receive adequate and timely mental health and rehabilitative services, (ii) measure the current and projected need for coordination and monitoring of mental health and rehabilitative services for veterans; (iii) measure the current and projected capacity of private, federal, state, regional, and local entities to provide monitoring and coordination of mental health and rehabilitative services to veterans, by geographic region of the state; (iv) assess the extent of any gap between need and capacity; and (v) review and report how other states coordinate and monitor mental health and rehabilitative services for veterans. The review of other states shall include an assessment of the advantages and disadvantages of models used by other states.

4. After thoroughly considering alternative approaches, the working group shall recommend how the state can best monitor and coordinate mental health and rehabilitative services to ensure that veterans receive adequate and timely mental health and rehabilitative services as required by statute. The recommendations should include (i) organizational structures, programs, partnerships, staff responsibilities, staff qualifications, and licensure; (ii) statutory or regulatory changes, as necessary; and (iii) estimates of the cost to the state and local governments of implementing these recommendations.

5. All agencies of the Commonwealth shall provide technical or other assistance to the working group, upon request.

6. The working group shall direct the appropriate agency staff to develop a detailed implementation plan for the Virginia Veteran and Family Support program, and present the plan to the Joint Legislative Audit and Review Commission no later than November 15, 2016.

7. Upon unanimous request from the members of the working group, the Director, Department of Planning and Budget, shall transfer $393,494 from the general fund amounts included within this item to the Department of Veterans Services for the purpose of implementing the recommendations of the working group for the Virginia Veteran and Family Support program.

Appendix B – Draft VVFS legislation

HOUSE BILL NO. TBD
Offered TBD
Filed TBD

A BILL to amend the Code of Virginia by revising §2.2-2001.1 *to update and clarify the purpose and activities of a state program for veterans with mental health, rehabilitative, or other needs related to their military service or combat experience.*

Patrons --- TBD

Referred to TBD

Be it enacted by the ~~General~~ Assembly of Virginia:

1. That §2.2-2001.1 of Code of Virginia is amended as follows:

The Department, in cooperation with the Department of Behavioral Health and Developmental Services and the Department for Aging and Rehabilitative Services, shall ~~establish~~ *operate the Virginia Veteran and Family Support* ~~a~~ program ~~to monitor and coordinate mental health and rehabilitative services support~~ for Virginia veterans and members of the Virginia National Guard and Virginia residents in the Armed Forces Reserves not in active federal service. The program shall also support family members affected by covered military members' service and deployments. The purpose of the program is to *cost-effectively refer veterans to mental health, physical rehabilitative, and other services as needed to help them to achieve individually-identified goals, and periodically monitor their progress towards achieving these goals.* ~~ensure that adequate and timely assessment, treatment, and support are available to veterans, service members, and affected family members.~~

The program shall ~~facilitate support for covered individuals to provide timely assessment and treatment for stress-related injuries and traumatic brain injuries resulting from military service, and~~ subject to the availability of public and private funds appropriated for them, ~~case management services, outpatient, family support, and other appropriate behavioral health and brain injury services necessary to provide individual services and support.~~ *(i) build awareness of veterans needs and the program through marketing and outreach; training first responders, service providers, and others; and as feasible collaborating with applicable agencies of the Commonwealth, local jurisdictions, and providers to develop and implement a consistent method of identifying how many Virginia veterans may currently or eventually will need mental health, rehabilitative services, or other services (ii) work with veterans to develop a coordinated resources plan that identifies appropriate service providers (iii) refer veterans to appropriate and available providers based on the coordinated resources plan and (iv) monitor veterans progress through the resources plan.*

The program shall *develop coordinated resources plans and refer veterans in a timely manner. The program shall prioritize veterans served based on the immediacy and severity of the veterans' need, and the likelihood of the needs being attributable to their military service or combat experience.*

The program shall cooperate with localities that may establish special treatment procedures for veterans and active military service members such as authorized by §§ 9.1-173 and 9.1-174. To facilitate local involvement and flexibility in responding to the problem of crime in local communities and to effectively treat, counsel, rehabilitate, and supervise veterans and active military service members who are offenders or defendants in the criminal justice system and who need access to proper treatment for mental illness including major depression, alcohol or drug abuse, post traumatic stress disorder, traumatic brain injury or a combination of these, any city, county, or combination thereof, may develop, establish, and maintain policies, procedures, and treatment services for all such offenders who are convicted and sentenced for misdemeanors or felonies that are not felony acts of violence, as defined in § 19.2-297.1. Such policies, procedures, and treatment services shall be designed to provide:

1. Coordination of treatment and counseling services available to the criminal justice system case processing;

2. Enhanced public safety through offender supervision, counseling, and treatment;

3. Prompt identification and placement of eligible participants;

4. Access to a continuum of treatment, rehabilitation, and counseling services in collaboration with such care providers as are willing and able to provide the services needed;

5. Where appropriate, verified participant abstinence through frequent alcohol and other drug testing;

6. Prompt response to participants' noncompliance with program requirements;

7. Ongoing monitoring and evaluation of program effectiveness and efficiency;

8. Ongoing education and training in support of program effectiveness and efficiency;

9. Ongoing collaboration among public agencies, community-based organizations and the U.S. Department of Veterans Affairs health care networks, the Veterans Benefits Administration, volunteer veteran mentors, and veterans and military family support organizations; and

10. The creation of a veterans and military service members' advisory council to provide input on the operations of such programs. The council shall include individuals responsible for the criminal justice procedures program along with veterans and, if available, active military service members.

The program shall report annually to the Governor and General Assembly the number of veterans and others referred for service, the quality and status of services provided to veterans have been referred, and the number of veterans not referred.

Appendix C – Summary of selected other states with programs similar to VVFS

State	# of veterans	Administering agency	Program summary	State $
CA	1,755,680	CA Department of Healthcare Services	Mental Health Services Act (MHSA) and Fund. Passed in 2004. Broad continuum of prevention, early intervention, programs and services to support state mental health system	$2B in 2016/17 (funded through 1% income tax on incomes over $1 million)
		CA National Guard	Joint Service Behavioral Health Office	$1.6 million and 8 positions
		CA Department of Veterans Affairs	Grants to counties to encourage early intervention of mental health needs	Over $500,000 in MHSA funding
TX	1,670,186	TX Department of State Health Services	Peer-to-peer counseling; access to licensed mental health professionals for volunteer coordinators and peers; a list of approved training for peers; technical assistance for volunteer coordinators and peers; recruiting, retaining, and screening community-based therapists; suicide prevention training for volunteer coordinators and peers; and coordinating services with jail diversion programs, such as veterans courts	$5,000,000
		TX Veterans Commission	Fund for Veteran Assistance: grants to 73 organizations providing general assistance, including mental health and housing	$14,000,000
PA	895,681	PA Department of Military and Veterans Affairs	Veteran Trust Fund grants to statewide charitable organizations, including VSOs and county offices, to assist veterans in areas of homelessness, PTSD, employment, and workforce	$400,000 in grant funding available in 2016 to charitable $150,000 for county veterans offices
		PA Department of Human Services	Allocations to 45 counties as part of *Mental Health Matters* grant	$500,000
NY	834,526	NY Office of Mental Health	State funds to counties to provide crisis intervention and peer support Emphasis on assisting with PTSD	$2,100,000 in 2014/15 $2,780,000 in 2016/17 for peer-to-peer $450,000 for mental health training grants
OH	830,089	OH Adjutant General and Department of Mental Health and Addiction Services	OHIOCARES: a key purpose is to enhance the "safety net" of community behavioral health services available for military personnel and their families and to complement the services available through the VA and Vet Centers by linkages with county alcohol, drug and mental health boards and behavioral health care providers	$0 (primarily federal VA funds)
		OH Department of Veterans Services	Star Behavioral Health Program – training, information dissemination, and referral program	

Appendix D – Financial detail for VVFS options

Option 1

# of state employees	# CSB employees	Total $ for state employee salaries & benefits	Operations (non-personnel) $	Contractual $	Grants $	Total $GF
11	34	$1,077,631	$290,905	$2,209,846	$200,000*	$3,778,382

*Pass through to VHDA Granting Freedom Program

Option 2

# of state employees	# CSB employee	Total $ for state employee salaries & benefits	Operations (non-personnel) $	Contractual $	Grants $	Total $GF
39	0	$3,050,699	$756,900	0	0	$3,778,382

Option 3

# of state employees	# CSB employee	Total $ for state employee salaries & benefits	Operations (non-personnel) $	Contractual $	Grants $	Total $GF
45	0	$3,419,571	$900,915	0	0	$4,278,382

Option 4

# of state employees	# CSB employee	Total $ for state employee salaries & benefits	Operations (non-personnel) $	Contractual $	Grants $	Total $GF
45	0	$3,419,571	$900,915	0	$300,000 to $1.2M**	$4,578,382 to $5,578,382

** Includes both grants to community groups and pass-through to VHDA

Appendix E – VVFS positions – roles and functions

VVFS Regional Operations

Each of the five VVFS Regions is lead by a Regional Director and a Regional Care Coordinator, and has a mix of Resource Specialists and Veteran Peer Recovery Specialists (levels vary by region). Some VVFS regions also have a Caregiver Coach.

- **Regional Director** (RD) – responsible for regional program oversight as well as identifying regional program needs. The Regional Director manages area program operations to ensure effective program operations, program administration, fiscal management, partner collaboration, resource expansion and staff development.

- **Regional Care Coordinator** (RCC) – functions as a senior Resource Specialist with the addition of team lead responsibilities. These additional duties include providing assistance and guidance of service referral coordination; regional data collection; and helping to establish and maintain linkages among service providers and regional team members.

- **Resource Specialist** (RS) – assists SMVF with the intake, planning, and referral activities. Identifies and addresses concerns related to behavioral health, rehabilitative and supportive service needs. In collaboration with the SMVF, the RS follows a care coordination process of completing a preliminary needs assessment and establishing a coordinated resources plan to identify and link the individual to needed resources, and then routinely connects with the SMVF to monitor services received and the successful resolution of their needs. Resource connections include behavioral healthcare, rehabilitative services, military benefits, housing, employment, and other public and private assistance programs.

- **Veteran Peer Recovery Specialist** (VPRS) – provides enhanced *peer support* via non-clinical, person-centered, strength based coaching to SMVF engaged in a behavioral health/brain injury recovery process. These skills are essential during the intake and planning activities. The enhanced peer support is based on a relationship of shared experience. The VPRS supports SMVF with developing a wellness-recovery plan (a component of the coordinated resources plan) that is reflective of the individual's needs, preferences, and personal goals for recovery resiliency and self-advocacy. The VPRS offers personal recovery experience and knowledge, role modeling, supportive coaching, connection, navigation and hope.

- **Operation Family Caregiver Coach** (OFC-C) – provides assistance to SMVF caregivers in the development of problem solving skills and strategies needed to mitigate the long and short term effects of challenges experienced in the caretaking of military service members and veterans. The OFC-C develops a customized care coordination plan targeted to address the caretaking challenges experienced by the caregiver. The plan outlines the development of skills designed to help the caregiver be better prepared to take care of their families, report

fewer health complaints, and improve life satisfaction. The OFC-C utilizes an evidenced based curriculum designed by the Rosalynn Carter Institute for Caregiving and is administered in accordance with prescribed implementation strategies and grant standards. The OFC-C is co-located in the regions of the Commonwealth of Virginia where service delivery has been identified by the requirements of the Operation Family Caregiver grant.

In addition to the specific position responsibilities above, the VVFS regional staffs are accountable for:

- Outreach among community partners and organizations to increase awareness of program availability and improve access to services for SMVF;
- Collaboration with federal, state, and local partners to develop and maintain regional resource network and service connections;
- Training on military cultural competency, service member transition, and crisis intervention to partner organizations and stakeholders; and
- Facilitating family services initiatives including but not limited to Mission: Healthy Relationships and Families Retreats, and Operation Family Caregiver.

VVFS Program Office

At the VVFS program office there are six positions which support the VVFS program:

- **VVFS Program Director** – provides statewide management and leadership of the VVFS program. The Director manages and promotes an active partnership among federal, state, and local agencies and community partners; manages the VVFS Program Office, five regional areas and the Regional Directors, Housing Development, Criminal Justice, Virginia Veterans Corps, and Clinical and Quality Assurance Directors. Directs the statewide program to monitor and coordinate mental health and rehabilitative services support for Virginia veterans and members of the Virginia National Guard and Virginia residents in the Armed Forces Reserves not in active federal service.

- **Director of Housing Development for Veterans** - provides senior leadership and oversight on a statewide basis to the development and implementation of the Department's long range plans and initiatives related to obtaining housing for veterans and their families with a special focus on preventing and eliminating homelessness; manages the Department's capacity building for veterans' housing initiative statewide ensuring the full coordination of activities within the program's five regional areas.

- **Criminal Justice Coordinator** – provides leadership and oversight on a statewide basis to the development and implementation of the Department's long range plans and initiatives related to coordination of prevention and reintegration resources and services for veterans with exposure to the criminal justice system and their families. This position has a special focus on strengthening prevention systems that can divert veterans from entering into the

criminal justice system, as well as reintegration systems that can ensure seamless transitions for re-entering citizen veterans. Additionally, this position manages the Department's capacity building for veterans' specific criminal justice initiatives statewide.

- **Virginia Veteran Corps (VCC) AmeriCorps Program Director** – manages the personnel and grant related activities for the Virginia Veterans Corps (VCC) AmeriCorps service program. This position serves as the liaison between the VVFS, Office of Volunteerism and Community Service (external grant officer), VVC member sites, and community partners. The VVC affords volunteers opportunity to provide service to veterans and military families by providing quality of life support related to housing, employment, education, and financial wellness. Primary responsibilities of the VCC Director include planning, implementing, supporting and maintaining all aspects of the grant to successfully accomplish the annual program goals.
- **Clinical and Quality Assurance Director (CQAD)** – designs and implements standardization of program operational policies and procedures to ensure quality service delivery. The CQAD develops and implement staff orientation, training, and support protocols for VVFS. The CQAD designs performance management and feedback protocols to measure and improve the quality of program services. The CQAD works regularly with the VVFS Director and Regional Directors and teams to support training and staff performance needs.
- **VVFS Program Operations Manager** – manages the VVFS Central program office and the development and oversight of administrative policies and procedures for the statewide program. Provides administrative and programmatic coordination for the five Regional Directors, Housing Development Director, Criminal Justice Coordinator, Clinical and Quality Assurance Director and AmeriCorps Program Director.