Virginia Department of Behavioral Health & Developmental Services

Annual Report on the Implementation of Chapter 683 of the 2017 Acts of Assembly and Item 322.S of the 2020 Appropriation Act.

December 1, 2021

DBHDS Vision: A Life of Possibilities for All Virginians

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Preface

The Department of Behavioral Health and Developmental Services (DBHDS) is submitting this report in response to the requirements in Senate Bill 1005 and House Bill 1549 (2017) which amended and added to sections to the *Code of Virginia* related to services to be provided by the community services boards (CSBs) and behavioral health authority. The fourth enactment clause of this legislation reads as follows for both SB1005 and HB1549:

> *4. That the Department of Behavioral Health and Developmental Services shall report by December 1 of each year to the General Assembly regarding progress in the implementation of the provisions of this act.*

Also included in this report is information on Item 322.S of the 2020 Appropriations Act, requiring DBHDS to report on the use of funds allocated to provide child psychiatry and children's crisis response services:

> *S. Out of this appropriation, $8,400,000 the first year and $8,400,000 the second year from the general fund shall be used to provide child psychiatry and children's crisis response services for children with mental health and behavioral disorders. These funds, divided among the health planning regions based on the current availability of the services, shall be used to hire or contract with child psychiatrists who can provide direct clinical services, including crisis response services, as well as training and consultation with other children's health care providers in the health planning region such as general practitioners, pediatricians, nurse practitioners, and community service boards staff, to increase their expertise in the prevention, diagnosis, and treatment of children with mental health disorders. Funds may also be used to create new or enhance existing community-based crisis response services in a health planning region, including mobile crisis teams and crisis stabilization services, with the goal of diverting children from inpatient psychiatric hospitalization to less restrictive services in or near their communities. The Department of Behavioral Health and Developmental Services shall include details on the use of these funds in its annual report on the System Transformation, Excellence and Performance in Virginia (STEP-VA) process.*

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Executive Summary

The System Transformation Excellence and Performance (STEP-VA) initiative is Virginia's concentrated effort to reform the public mental health system by improving access, quality, consistency, and accountability in public mental health services across the Commonwealth. It requires that all 40 community services boards (CSBs) implement nine essential services, referred to as "STEPs," and requires consistent quality measures and oversight. After full implementation of STEP-VA, DBHDS anticipates a more robust community services system, which in turn will result in fewer admissions to state and private hospitals, decreased emergency room visits, and reduced involvement of individuals with behavioral health disorders in the criminal justice system.

Based on the results of the Comprehensive Needs Assessment, a more systemic approach was adopted for the implementation of STEP-VA in FY 2021, in addition to the design and implementation of each specific STEP. Systemic achievements during FY 2021 include the design of a core performance dashboard shared between DBHDS and the CSBs (three metrics adopted and benchmarked at the end of FY 2021); a performance contract supplement for metric review and accountability which became active July 1, 2021; the authorization of a large scale project to transform the data exchange between DBHDS and CSBs; and the completion of a workgroup regarding the use of the Behavioral Health Equity Index and CSB Funding more broadly.

Despite the continuation of the COVID-19 pandemic, STEP-VA implementation and planning have continued. Primary care screening, metabolic screenings, same day access (SDA), and outpatient services were delivered across 40 CSBs, with CSBs providing telehealth and telephonic services as needed per public health guidance. During FY 2021, 44,305 SDA assessments were completed across the system. Regarding primary care screenings, a total of 54,674 primary care screenings were conducted for 29,957 individuals. Across FY 2021, a total of 57,640 metabolic screens were conducted, which is a 67 percent increase from FY 2020. These screens were conducted across 22,276 individuals (which is a 30 percent increase from FY 2020). Thus, on average, individuals were receiving 2.6 screenings per year (up from 2.0 in FY 2020).

Outpatient services and crisis services have both reached initial implementation, with significant ongoing training in evidence based practices, as well as increases in utilization for children's residential crisis stabilization units. Also, 80 percent of the workforce achieved eight hours of trauma-focused training, 43 percent achieved 40 hours, and each region planned and implemented additional/specific training priorities. Additional data and analysis regarding the implementation of crisis services will be available following the launch of the initial (off the shelf) modules of Comprehensive Crisis System Data Platform in December 2021. Additional outpatient and crisis funding, as well as initial funding for two additional STEPs (SMVF and Peer and Family Supports) was appropriated for FY 2022 and has been disbursed to the CSBs and regions at the time of this report. There are three STEPs that have not yet been funded, which will be the focus of planning activities during FY 2022.

Introduction

Over the past several years, Virginia has made concentrated and meaningful efforts to reform its strained public mental health system. In an effort to improve the system, the Department of Behavioral Health and Developmental Services (DBHDS) worked with the McAuliffe and Northam Administrations, the General Assembly, and stakeholders and drew from national best practices to design System Transformation Excellence and Performance (STEP-VA). STEP-VA focuses on improving access, quality, consistency, and accountability in public mental health services across Virginia. STEP-VA requires all community services boards (CSBs) to provide the same services, commonly referred to as "STEPs," including same day access, primary care screening, outpatient services for mental health and substance use disorders, targeted case management, crisis services, and other critical services. The steps reflect a shift from a system of two mandated services to nine mandated services, which represent a broader array of behavioral health services. These essential services will be available consistently across all 40 CSBs.

In addition to requiring a uniform set of services across all 40 CSBs, STEP-VA also requires consistent quality measures and improved oversight in all Virginia communities through investment in CSB and DBHDS infrastructure. STEP-VA services are intended to foster wellness among children and adults with behavioral health disorders and prevent crises before they arise. STEP-VA is also intended to provide critical support for individuals at risk of incarceration, those in crisis, and those in need of stable housing. Statewide impact following full implementation is expected to result in a more robust community system that helps Virginians access quality services and manage symptoms before they reach a crisis level. The result of a stronger community system will include fewer admissions to state and private hospitals, decreased emergency room visits, and reduced involvement of individuals with behavioral health disorders in the criminal justice system.

Following is a brief timeline of funding activity for STEP-VA since inception:

- **FY 2018** – the General Assembly provided funding for all 40 CSBs to implement the first STEP-VA service, Same Day Access, which was funded for 18 CSBs the prior year.
- **FY 2019** – Primary Care Screening was funded
- **FY 2020** – Outpatient Services, Detox Services, and Mobile Crisis Services were funded. In addition, the budget passed by the General Assembly during 2020 Session included significant investments in STEP-VA for additional outpatient and crisis funding, peer recovery services, military and veterans' services STEPs, and critical infrastructure at the CSBs (e.g., billing staff) and Central Office (five positions to oversee these state general funded services in the community).
- **FY 2021** – Due to COVID-19 budget impacts, the additional funds for the significant investments in FY 2020 were unallotted for FY 2021. Ultimately, funding for outpatient services, crisis services, infrastructure, peer recovery services, and military and veterans' services STEPs were re-allotted for FY 2022.

Although new funding was frozen during FY 2021, implementation activities continued, including pivots based on COVID-19 pandemic impacts, changes in strategy based on the findings of the Needs Assessment and the JLARC Study, the integration of the Marcus Alert into the overall crisis system planning, further consideration of the intersection of STEP-VA and

Project BRAVO, and solidifying plans for when new funding was re-allotted (July 1, 2021).

Future STEP-VA budgets will need to address unallotted funds and continued level funding as the program expands and serves more Virginians. Table 1 below shows the funding and implementation status for each step as November 1, 2021.

Table 1: STEP-VA funding

STEP	Status Nov 1, 2021	FY 2021 Funding	FY 2022 Funding
Same Day Access	Implemented	$10,795,651	$10,795,651
Primary Care Screening	Implemented	$7,440,000	$7,440,000
Detoxification (Crisis Services)	Implemented	$2,000,000	$2,000,000
Outpatient	Implemented	$15,000,000	$21,924,980
Mobile Crisis	Initial Implementation	$7,800,000	$13,954,924
Crisis Dispatch	Initial Implementation		$4,697,020
Veterans Services	Initial Implementation		$3,840,490
Peer Support & Recovery Services	Initial Implementation		$5,334,000
Psychiatric Rehabilitation	Not implemented		
Care Coordination	Not implemented		
Case Management	Not implemented		
Cross-Step Infrastructure	Ongoing		$3,200,000

Infrastructure for Implementation of STEP-VA

Per the results of the Needs Assessment and the JLARC report, we first focus on the broad infrastructure for the implementation of STEP-VA and then report for each individual STEP.

First, a workgroup regarding the Behavioral Health Equity Index (BHEI) and CSB funding strategy was formed and met for six months during FY 2021. A final report was completed in January 2021 and was provided to VACSB and DBHDS leadership.
The workgroup reached consensus on six recommendations:

1) Adopt a short term needs based funding formula for STEP-VA purposes (45 percent population under 200 percent poverty line, 25 percent BHEI, 20 percent uninsured, and 10 percent rurality index).
2) Update the structure of the funding relationship between DBHDS and CSBs with a focus on differentiating between programs/initiatives.
3) Replace both Community Consumer Submission 3 (CCS3) and Community Automated Reporting System (CARS) to move to a transactional data exchange between CSBs and DBHDS.
4) Adopt a set of core performance metrics that will be used to monitor the success of STEP-VA and to identify system needs.
5) Initiate planning for integrated reimbursement structures.
6) Initiate planning for a stable system solution, such as a Certified Community Behavioral Health Clinics (CCBHC)-like payment structure or direct incentives between community funding and hospital bed days.

Some progress has been made regarding data exchange between DBHDS and CSBs and the implementation of a set of core performance metrics, but both are large-scale tasks with timelines that extend through FY 2022. Regarding the CCS/CARS replacement, a request for information (RFI) has been completed and all responses have been reviewed, a project manager has been hired, and a significant portion of one-time funding from SAMHSA has been earmarked for this project. The $3.2 million in infrastructure funding will be distributed to the CSBs to support the implementation of this project, as it will be a major change to electronic health records and how data are captured and reported to DBHDS.

At this time, three performance metrics have been benchmarked and integrated into the performance contract. Additionally, a supplemental document to the performance contract was agreed upon regarding accountability processes such as technical assistance, quality improvement plans, and corrective action plans. These benchmarks became active for monitoring July 1, 2021 and will be reportable in next year's report. Central Office received appropriations for five positions to support the implementation of STEP-VA as of July 1, 2021, and four of the five have been filled at the time of this report. These positions include analytic support, the first quality improvement staff member devoted to behavioral health, outpatient and Service Members Veterans and Families (SMVF) manager position with a focus on co-occurring disorders, and a child and family services manager. Of note, CSBs have not received funding for administrative support to implement any of the steps beyond the $3.2 million, which equates to $80,000 per CSB, making staffing and IT infrastructure improvements more challenging.

Same Day Access

Disbursement of Funds

SDA funding for FY 2021 was $10,795,651. This was stable from FY 2019 and FY 2020. Allocations to specific CSBs were also stable, and are provided in Appendix A.

Implementation

All 40 CSBs have successfully implemented SDA. Currently, there are 93 CSB locations where SDA is being offered across Virginia. This is 17 additional locations over this reporting year. SDA locations across Virginia. Impressively, these services have been adapted but still maintained during COVID-19 by shifting to telehealth services as well as in-person services when needed (and hybrid services; for example, telehealth between two rooms at the CSB to follow COVID-19 protocols).

Outcomes and Continuous Quality Improvement

At the time of this report, all five quality oversight and outcome measures and processes have been initially implemented for Same Day Access. Same Day Access is now in Phase 3 of implementation. The five outcome/CQI components below are the same for all STEPs, although all five have not yet been implemented for all STEPs.

1) Qualitative six-month implementation report-outs (collected during Phase 2 only; August 2021)
2) Internal CSB continuous quality improvement processes (documented in CSB policies and procedures)

3) Primary metrics (collected during Phase 2; considered reliable and valid by Phase 3)
4) Statewide data review via VACSB/DBHDS Data Management Committee (for data quality, reliability, and validity) and Quality and Outcomes Committee (for benchmarking and quality improvement)
5) Performance contract modifications and enforcement (use of peer to peer support, corrective action plans, and other means of escalating enforcement)

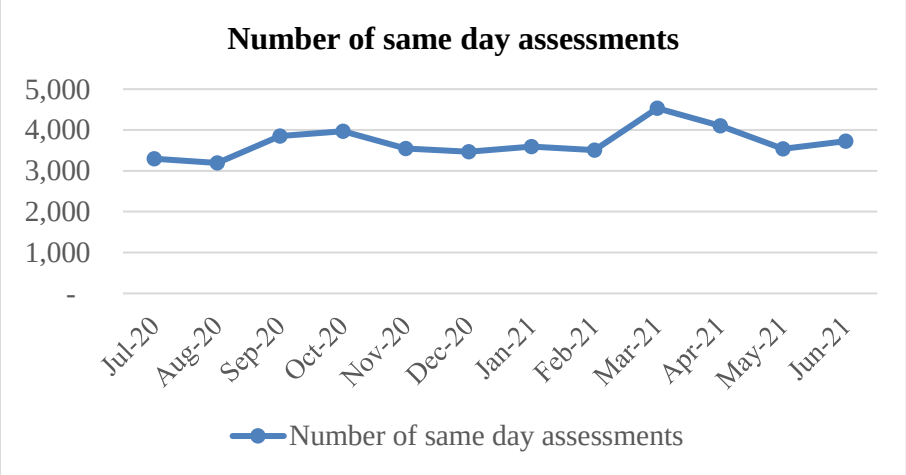
Data elements collected and reported by the CSBs as primary data elements include: (1) The date each SDA comprehensive assessment; (2) whether the assessment determined the individual needs services offered by the CSB; and (3) the date of the first service offered at the CSB for all individuals seeking mental health or substance use disorder services from the CSB. Then, existing data elements collect additional appointments at the CSB, allowing CSBs and DBHDS to track whether the individual attended their scheduled follow-up session.

The primary metrics include the number of individuals served by SDA; the average and range of wait times experienced by SDA consumers between initial assessment and first appointment offered; and percentage of individuals returning for a scheduled follow-up appointment. It is important to note that these elements are captured in Community Consumer Submission 3 (CCS3) exports, which is the system found to be significantly inadequate in the needs assessment findings and JLARC study. There remain some data quality, reliability, and validity issues due to the lack of transactional data. Preliminary data indicate a high number of SDA assessments conducted system-wide.

During fiscal year 2021, a total of 44,305 same day assessments were conducted.

During FY 2021, a total of 44,305 same day assessments were conducted. This is down 26 percent from FY 2020. Patterns across months can be seen in Figure 1. Overall, the pattern is similar to last year, but there was less variability month-to-month for the current year. These numbers were likely impacted by COVID-19.

Figure 1: SDA Volume, July 2020-June2021



Beginning July 1, 2021, specific benchmarks were set collaboratively by reviewing the existing data within the Quality and Outcomes Committee (joint VACSB-DBHDS committee). The agreed upon benchmarks were 86 percent for appointment offered and 70 percent for attendance at scheduled follow-up appointments.[1] Accountability to these benchmarks and a quality review process began formally July 1, 2021 (due to the 3 month lag in data, the process is only newly actionable at the time of this report).

Data quality issues remain because the "date of appointment offered" is not a data point naturally kept in an electronic health record and scheduling systems can be separate from the health record. Similarly, current systems are not sophisticated enough to indicate whether the individual was found to be in need of an appointment, but scheduled with a private provider. DBHDS can confirm that 89.1 percent of individuals who were offered a follow up appointment were offered that appointment within 10 days. Also, 10.9 percent of individuals were offered an appointment but it was outside of the 10-day window). There are approximately 14,320 same day access appointments for which it is unclear whether the individual was found not to be in need of an appointment, needed an appointment but chose not to schedule a follow- up appointment, or was referred to a separate provider. Thus, this data should be considered preliminary.

Data regarding attendance at scheduled follow-up appointments can be considered more reliable (i.e., the different elements of the metric are all generally captured in an electronic health record), although data qualities noted about CCS3 remain relevant. Statewide, 29,993 individuals attended a follow-up appointment within 30 calendar days, with 24,562 attending the second appointment within 10 business days. The statewide average for percent of individuals attending their follow up appointment within 30 calendar days was 70.1 percent. This is a strong indicator for engagement, even during a pandemic.

Primary Care Screening

In FY 2021, $7.4 million was appropriated towards primary care screening for CSBs, which was stable from FY 2020. Primary Care Screening was implemented among the CSBs by July 1, 2019. Allocations can be found in Appendix A.

This STEP was fully defined in a committee of DBHDS and CSB staff. Individuals with serious mental illness (SMI), a population primarily served by the CSBs, are known to be at higher risk for poor physical health outcomes largely due to unidentified chronic conditions. Therefore, it is important for behavioral health staff to provide primary care screening to identify and provide related care coordination to ensure access to needed physical health care. The objectives of the STEP that were implemented during FY 2019 are as follows:

> *Objective 1:* Any child diagnosed with a serious emotional disturbance and receiving ongoing CSB behavioral health service or any adult diagnosed with a serious mental illness and receiving ongoing CSB behavioral health service (defined as targeted case management services) will be provided or referred for a primary care screening on a yearly basis.

[1] 86 percent is a standard number used in the DOJ Settlement Agreement.

Objective 2: Screen and monitor any individual over age 3 being prescribed an antipsychotic medication by a CSB prescriber for metabolic syndrome following the American Diabetes Association guidelines.

These clients are required to be provided with a yearly primary care screening to include, at minimum, height, weight, blood pressure, and body mass index (BMI). This screening may be done by the CSB or the individual may be referred to a primary care provider to have this screening completed. If the screening is done by a primary care provider, the CSB is responsible for the screening results to be entered in the patient's CSB electronic health record. The CSB will actively support this connection and coordinate care with physical health care providers for all service recipients.

The funding formula was determined representing 50 percent of funding based on demand, using information about meeting needs of uninsured population, 25 percent based on community needs, using Health Opportunity Index information as a proxy, and 25 percent based on needs associated with provider shortages, using Health Provider Shortage Areas as a proxy. This formula yielded the amounts reported above and has been used since initial implementation.

This appropriation was used to fund nurse practitioner positions, nurse positions, and other necessary aspects of beginning or expanding primary care screening offerings for each CSB. All CSBs were offering primary care screening beginning July 1, 2019. The COVID-19 pandemic and transition to telehealth had a significant impact on this STEP. Due to the in-person nature of primary care screenings, DBHDS supported CSBs to guide decision-making with clinical expertise and person-centered planning. Concerns included consideration for clients who are uncomfortable coming in person and whether an in-person screen is indicated if there is not another reason for the client to come in-person and the screen is not clinically indicated (e.g., the individual has had a primary care comprehensive evaluation in the last 12 months). For this reason, DBHDS indicated that a window of 18 months will be evaluated regarding conducting primary care screens. Across the system, in-person screens are still being conducted in the following circumstances: if the client is presenting in-person for any reason; if the client does not have a primary care physician; or if the client is at high clinical or physical risk (primarily for the metabolic screenings). For example, psychiatric yearly evaluations are being conducted in person at many sites. Additionally, case managers and nurses are gathering height and weight to calculate BMI via telehealth appointments and are continuing discussions and motivational interviewing regarding the importance of primary care appointments and physical health. Beginning July 1, 2021, DBHDS returned to a 12 month window and will have a 12 month look back period (required to calculate the decided upon metric) by July 1, 2022.

Outcomes and Continuous Quality Improvement

As described, DBHDS provided guidance to CSBs to focus on clinical decision-making and a person-centered approach in the implementation of the Primary Care Screening STEP during FY 2021. Yet, the overall goal for five areas of outcomes and continuous quality improvement remains the same, although delayed. These five areas were listed on pages 5-6. Currently, three of the five have been implemented for this STEP. Primary Care Screening STEP remains in Phase 2.

During FY 21, a total of 54,674 primary care screens were conducted for 29,957 individuals.

Due to COVID-19, the time frame for 2019-2020 physical screens was extended to 18 months. At the time, it was unknown that the pandemic continue for so long; as a result, DBHDS provided guidance for CSBs to provide screenings based on clinical decision making and person-centered planning. Combining primary care screenings across FY 2020 and the first half of FY 2021, 51,142 total individuals were reported as receiving screens, but it is possible that some individuals are duplicative in the FY 2020 and FY 2021 data.

The second goal of this STEP is to ensure that individuals over the age of three on an antipsychotic medication will receive screening, monitoring and referral to the appropriate provider for treatment of metabolic syndrome according to guidelines of the American Diabetes Association.

Indicators of the screening include: Glucose Hemoglobin A1c Lipid profile, blood pressure, weight, waist circumference to determine abdominal obesity, and BMI. The associated metric will be whether the metabolic screen is conducted, and whether it is out of range. CSBs received DBHDS guidance to prioritize metabolic screenings over primary care screenings, and to conduct screenings based on clinical indications. Across FY 2021, a total of 57,640 metabolic screens were conducted, which is a 67 percent increase from FY 2020. These screens were conducted across 22,276 individuals (which is a 30 percent increase from FY 2020). Thus, on average, individuals were receiving 2.6 screenings per year (up from 2.0 in FY 2020).

Outpatient Services

Outpatient services received $15 million in state general funds for FY 2020. The funds were distributed as following: approximately 52 percent as base funding, approximately 37 percent as needs-based funding, and approximately 10 percent distributed regionally for outpatient training in evidence-based and trauma-informed practices.

A needs-based funding formula was developed specific to outpatient services. Needs were considered across the system by comparing CSBs to one another. In other words, needs identified do not indicate an absolute level of need, rather, it indicates a relative level of need as compared to other CSBs. Amounts disbursed to each CSB for each round of funding can be found in Appendix A.

Through STEP-VA outpatient funding, over 100 new positions for licensed clinicians or license-eligible clinicians have been supported in the CSB system. Funds were further used for salary alignment within CSBs and across CSBs; recruitment bonuses and performance bonuses; retention bonuses; and other investments in outpatient services. For CSBs with high needs, DBHDS allowed for critical infrastructure purchases as well that supported outpatient services (e.g., EHR add-ons to be able to analyze outcomes for outpatient services).

Outcome Measures and Continuous Quality Improvement

As with other STEPs, there are five components to the overall outcome and quality improvement plan (see pages 5-6. Currently, two of the five are complete for Outpatient Services and all five are in progress.

Because Outpatient Services is currently in Phase 2, a qualitative check-in survey was conducted in August 2021. This survey indicated that Outpatient services are being offered through 139 service locations statewide. The primary difficulty facing the public behavioral health system at this time is workforce challenges. Workforce challenges are an issue across the behavioral health sector and across the nation. Outpatient funding has been used to address some of these challenges, but the shortages remain and the need for flexible funding which can be used to meet specific workforce needs across the state also remains (e.g., tuition reimbursement, hiring bonuses, retention bonuses, overall higher salaries and lower caseloads). The second difficulty facing the public behavioral health system is administrative burden. Clinicians continue to report that paperwork is a deterrent to working at the CSB and inhibits outpatient caseloads. CSB caseloads are already higher than in the private sector. For outpatient services, private providers tend to practice under Department of Health Professions licenses, whereas CSBs and some private providers must meet DBHDS Outpatient license criteria as well. Additionally, there is not full alignment between DMAS and DBHDS paperwork. Finally, due to workforce shortages, limited funding (i.e., this STEP was only partially funded in FY 2021), and increasing demand and access via SDA, caseloads are rising and there is concern that wait times will move to an average outside of the 10-day window.

A primary investment across STEP-VA has been the implementation of the Daily Living Assessment 20 (DLA-20) which is a validated measure of functional impairment. DBHDS continues to invest federal resources, and CSBs have invested additional state resources into ongoing DLA-20 training. It is expected that primary outcomes for outpatient services will include DLA-20 change scores (i.e., did the client demonstrate improvement or stabilization, as compared to worsening status) as well as engagement measures. The measurement of engagement in treatment services can be calculated based on national standards provided through HEDIS. These metrics have been collected for substance use treatment, and we will expand them to capture engagement in mental health treatment services, as well (national benchmarks exist only for substance use engagement).

Primary metrics for monitoring and accountability for the Outpatient Services STEP include training data, measures of engagement, and change scores for the DLA-20. July 2021 baseline data regarding training was collected. In addition to the collection of baseline training data, significant progress was made regarding benchmarking measures. In response to the Needs Assessment, we are hoping to ultimately develop a set of core metrics (as opposed to each STEP having multiple metrics). An existing metric that is used for federal reporting and board reporting regards substance use disorder (SUD) engagement in treatment. This measure is also an example of a high quality measure because it is based on a national HEDIS quality indicator. It is important to note that due to the structure of CCS3 data, this is not a perfect parallel for national standards for HEDIS calculation. Yet, parameters of the HEDIS measure (e.g., number of appointments required to attend) were used to create the Virginia metric in the context of our existing data. Significant progress was also made on the validation of the DLA-20 change score measure. The Quality and Outcomes committee has worked toward preliminary benchmarks and are on target to begin accountability processes regarding all Outpatient Services measures July 1,

2022. One core performance metric with relevance for Outpatient Services (engagement in SUD services) was benchmarked this year at 50 percent with accountability processes beginning July 1, 2021. DLA-20 change scores, which will likely be considered a core performance metric for relevance across STEPs, is being benchmarked for outpatient services (i.e., the DLA-20 change scores of individuals specifically in outpatient services) through the Quality and Outcomes Committee. Additionally, DBHDS is currently working with the Quality and Outcomes committee to consider and calculate a metric for engagement with mental health services, which will be considered for benchmarking next year. This would be similar to the SUD metric described below.

Engagement in SUD Services

Engaging clients in SUD services continues to be a strength of the CSBs. Although the national average based on HEDIS is 13.56 percent, the Virginia CSB benchmark is set at fifty percent. This is based on our review of Virginia historical data, the described inexact nature of our calculations as it relates to the HEDIS measure, and the specific population served by CSBs, which often includes court-mandated individuals and others who may have greater treatment needs than those seen in the broader healthcare system.

The SUD engagement measure is defined as follows: *Percentage of adults and children ages 13 years of age and older who have a new episode of SUD services as a result of a new SUD diagnosis who initiated any SUD services within 14 days of the new SUD diagnosis and received two or more additional SUD services within 30 days of the new SUD service.* Statewide, there were 16,928 individuals with a new SUD diagnosis in FY 2021. Of these, 9,772 met the definition of SUD engagement in services, which represents 57.7 percent.

Statewide, 57.7 percent of individuals with a new SUD diagnosis were considered engaged in SUD services.

Outpatient Training Data (Baseline)

As mentioned, the baseline training data were collected July 2021. All 40 CSBs completed the survey, but eight CSBs had incomplete training data/did not report on all employees that will ultimately need to be trained in the upcoming fiscal year.

Across the state, training data were received for 1,560 direct services Outpatient staff. Of these, 73.4 percent met the minimum trauma training requirement (8 hours per year), and 43.1 percent met the full trauma training requirement (40 hours total).

STEP-VA Crisis Services and Children's Psychiatry and Crisis Response Funding

STEP-VA crisis STEP funding has been focused on the build out of a regional mobile crisis response. These investments are being coordinated with broader investments in the Crisis System Transformation, including DOJ settlement requirements, purchase of a call center data platform, implementation of the Marcus-David Peters Act, and planning for the implementation of 9-8-8. The plan that was required as of July 1, 2021 for the implementation of the Marcus-David Peters Act included a comprehensive overview of the current crisis system and the intersections between STEP-VA, Project BRAVO, and the Marcus Alert, and that document can be found here: https://dbhds.virginia.gov/assets/doc/hr/Health-Equity/mdpa/final-state-plan_july-1-2021_ma.pdf, and the plan with a full catalog included in the document can be found here: https://dbhds.virginia.gov/assets/doc/hr/Health-Equity/mdpa/mdp_act_state-plan_with-catalog_july-1-2021_technical.pdf

STEP-VA crisis appropriations were $7.8 million for FY 2021, and Children's Psychiatry and Response Funding is an ongoing appropriation of $8.4 million. For STEP-VA specifically, $7.8 million was appropriated towards mobile crisis in FY 2020 and this funding was stable for FY 2021. This funding was disbursed regionally as follows. Amounts per region can be found in Appendix A.

- **$5.8 million** to establish or expand mobile crisis assessment and stabilization teams for children and youth with behavioral health challenges; and
- **$2.0 million** to establish or expand mobile crisis assessment and stabilization services for adults with mental illness who have cognitive impairments due to the severity of their illness and present with functional support needs.

Additional funding for mobile crisis was frozen due to COVID-19 during FY 20, although there was a large-scale investment in the Crisis Call Center Data Platform, for which a contract was awarded to Netsmart as well as their subcontractor Behavioral Health Link (BHL) who designed the state of Georgia's data platform. Additional appropriations for mobile crisis were made for FY 2022 and began to be sent to regions July 1, 2021. In total, $4,697,020 in funding for call center staff (approximately 6 months coverage) was appropriated as was $6,154,924 for additional adult mobile crisis teams. These teams, as well as any coordinated community care teams developed through the Marcus Alert initial implementation areas, will be developed over the next fiscal year. Each of the community care teams received $600,000 for their local implementation.

Children's Crisis Services, STEP-VA, and a Comprehensive Crisis Continuum

The following describes the impact of funding from the General Assembly allocation for Child Psychiatry and Children's Crisis Response in three strategy areas. CSBs report data on community services in the DBHDS CCS application. The data provided in this report are from

the service categories in the CCS that are most frequently provided to children in crisis. Those services include:

1. Psychiatry Services,
2. Ambulatory crisis stabilization services, and
3. Residential crisis stabilization services.

Strategy 1: Child and Adolescent Psychiatry Services

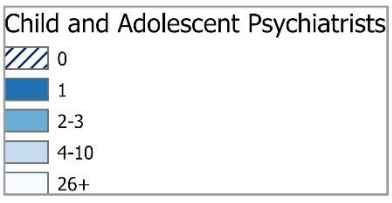
In order to extend the reach of very limited child psychiatry resources, regions were asked to provide child psychiatry in one or more of the following three venues:

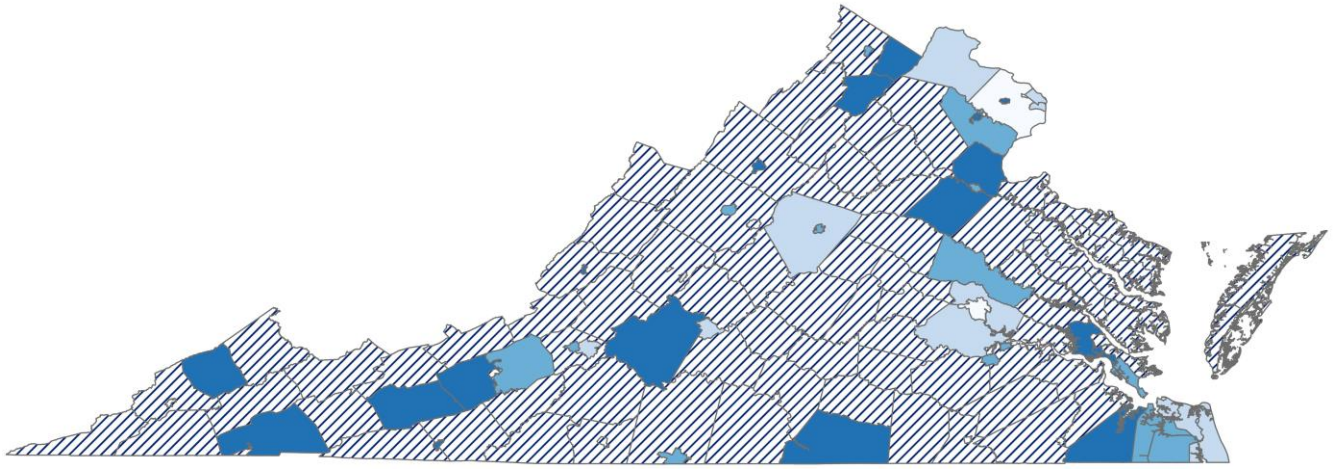
- Face-to-face office visits with children;
- Tele-psychiatry services to children in remote sites; and
- Child psychiatry consultations to other providers, such as pediatricians, primary care providers and others.

Child psychiatry services are reported in the Medical Services category in CCS. Medical Services are defined as the provision of psychiatric evaluations and psychiatric, medical, psychiatric nursing, and medical nursing services by licensed psychiatrists, physicians, psychiatric nurse practitioners, other nurse practitioners, and nurses and the cost of medications purchased by the CSB and provided to individuals. Medication services include prescribing and dispensing medications, medication management, and pharmacy services. Medication only visits are provided to individuals who receive only medication monitoring on a periodic (monthly or quarterly) basis from a psychiatrist, other physician, psychiatric nurse, or physician's assistant. A total of 13,954 youth (unduplicated) were served through Psychiatry Services in FY 2021, as compared to 14,875 in FY 2020.

Some regions continue to experience delays with hiring and contracting because of the shortage of child psychiatrists in the Commonwealth. Regions persistently advertise and utilize different approaches, such as locum tenens (a temporary psychiatrist), to fill the need. Tele-psychiatry is used to increase access to child psychiatrists. The FY 2021 decrease in children served through child psychiatry from may be due to the COVID-19 pandemic. Regions reported that some parents/guardians were uncomfortable with face-to-face services. Additionally, for some young children tele-health visits can be difficult. Figure 2 below illustrates the shortage of child psychiatrists throughout the Commonwealth.

Figure 2: Child and Adolescent Psychiatrists (CAP) in Virginia





Note: Source: American Academy of Child and Adolescent Psychiatry workforce map. 2021

Regions

The Department is utilizing the following Region designations as described in the 2018 Overview of Community Services in Virginia (source: https://dbhds.virginia.gov/assets/doc/BH/oss/csb-overview-may-16-2018.pdf).

Region	Localities/CSBs Covered
Region 1: Northwestern Virginia (9 CSBs)	Alleghany Highlands CSB Harrisonburg-Rockingham CSB Horizon Behavioral Health Northwestern CSB Rappahannock Area CSB Rappahannock-Rapidan CSB Region Ten CSB Rockbridge Area Community Services Valley CSB
Region 2: Northern Virginia (5 CSBs)	Alexandria CSB Arlington County CSB Fairfax-Falls CSB Prince William County CSB Loudoun County Department of Mental Health, Substance Abuse and Developmental Services
Region 3: Southwestern Virginia (10 CSBs)	Blue Ridge Behavioral Healthcare Cumberland Mountain CSB Danville-Pittsylvania CSB Dickenson County Behavioral Health Services Highlands CSB Mount Rogers CSB New River Valley Community Services

	Piedmont CSB Planning District One Behavioral Health Services Southside CSB
Region 4: Central Virginia (7 CSBs)	Chesterfield CSB Crossroads CSB District 19 CSB Goochland-Powhatan Community Services Hanover County CSB Henrico Area Mental Health and Developmental Services Board Richmond Behavioral Health Authority
Region 5: Eastern Virginia (9 CSBs)	Chesapeake Integrated Behavioral Healthcare Colonial Behavioral Health Eastern Shore CSB Hampton-Newport News CSB Middle Peninsula-Northern Neck CSB Norfolk CSB Portsmouth Department of Behavioral Healthcare Services Virginia Beach CSB Western Tidewater CSB

Region 1:
Funding for child psychiatry in Region 1 provides psychiatric services both through face-to-face visits and tele-psychiatry for children and youth at four CSBs with the highest need for child psychiatry. Those CSBs are Horizon, Rappahannock Area, Rappahannock Rapidan, and Region Ten. The Region 1 face-to-face psychiatric services for children in crisis are provided at both Horizon and Region Ten CSBs. The Region 1 psychiatrist and nurse practitioner additionally provide tele-psychiatry for children in crisis at all four CSBs. The psychiatrist and nurse practitioner are consistently collaborating with primary care physicians, crisis staff, as well as other care providers involved in a child's treatment in order to offer the highest level of care.

Region 2:
In Region 2, funding for child psychiatry provides access to a psychiatrist for children receiving mobile crisis stabilization services by the Children's Regional Crisis Response (CR2) program. All CSBs in Region 2 provide child psychiatry.

Region 3:
Region 3 has a contract with the University of Virginia's Department of Psychiatry and Neurobehavioral Sciences (UVA) to provide tele-psychiatry. In times of need, up to 42 hours per week of psychiatry care can be requested. The wait to obtain a psychiatric intake tends to be 6-12 weeks or more. Since the region has a tele-psychiatry contract with UVA, children referred for an emergency intake are scheduled within the week of request. Children that are admitted to any crisis stabilization service offered in Region 3 are seen within 72 hours, some even the same day. Region 3 has been able to increase continuity of care by having the same psychiatrist who

provides medication management services in the Crisis Stabilization Unit (CSU) to follow the child back into the community post discharge.

Region 4:
While children are receiving services at St. Joseph's Villa's Crisis Stabilization Unit (CSU), Region 4 partners with InSight Physicians to provide tele-psychiatry and psychiatric consultation. Additionally, the region continues to provide 20 hours per week of child psychiatry and consultation services through to their community-based mobile crisis program, Children's Response and Stabilization Team (CReST).

Region 5:
Psychiatry services are provided by the Children's Behavioral Health Urgent Care Center. The Center provides rapid access to crisis intervention and psychiatric care to the entire region and is able to maintain cases until children are linked with long term providers. In response to the COVID-19 public health emergency, services have been made available through in-person and telehealth modalities to further promote stability for children and their families in community settings. Additionally, eight out of nine CSBs in Region 5 provide outpatient child psychiatry.

Strategy 2. Ambulatory Crisis Stabilization Services

Ambulatory crisis services provide direct care and treatment to non-hospitalized children. The goals are to avoid unnecessary hospitalization, re-hospitalization, or a disruption of living situation, and to assure safety, security, and the stabilization of children in crisis. Services may involve mobile crisis teams. Ambulatory crisis stabilization services may be provided in an individual's home or in a community-based program. The following table offers data on the number of children served through ambulatory crisis stabilization.

Table 2: Unduplicated Number of Children Served through Ambulatory Crisis Stabilization Services

Region	FY2018	FY2019	FY2020	FY2021	Percent Change (Since 2018)
1	371	229	195	331	-11%
2	487	420	591	514	+6%
3	375	358	392	555	+48%
4	82	88	104	194	+137%
5	198	248	195	282	+42%
Totals	1,513	1,443	1,477	1,876	+24%

In FY 2021, there was a DBHDS CCS application coding change which affects the way that the CSBs report Emergency Services which include Ambulatory Crisis Stabilization Services. The coding change was refined to be more comprehensive and may represent a slight over reporting compared to previous years. The additional categories that are included in the FY 2021 Ambulatory Crisis Stabilization Services are: Crisis Intervention Services/Mobile, Crisis Intervention Services/Day Program, Crisis Stabilization Services/Mobile, Crisis Stabilization Services/ Crisis Day Program and Crisis Stabilization Services/Crisis 23 hour.

Region 1:

Horizon Behavioral Health has center-based ambulatory crisis stabilization services located in Lynchburg and Campbell County. These services provide evidence based strategies and interventions in their ambulatory crisis stabilization units. For FY21, all Region 1 CSBs provided crisis intervention services in the home, school, and community settings. The crisis clinicians housed at each CSB also work with the System Transformation Excellence and Performance Virginia (STEP-VA) Mobile Crisis program as a referral source for children and youth who receive a crisis response in the home, school, or community setting. While the overall percent change was down11% from FY 2018, the percent change from FY 2020 to FY 2021 was up69.74%.

Region 2:
The Children's Regional Crisis Response (CR2) program provides 24 hours a day, seven days a week mobile crisis stabilization services. Staff provide short-term crisis services, linkages to new or current community providers, and tele-psychiatry as needed. Service duration is based on time needed to resolve the existing crisis. In FY 2021, CR2 was able to divert 94% of children from hospitalization, and 92% of those served were able to retain their living arrangement.

Region 3:
Center based ambulatory crisis stabilization is provided at Cumberland Mountain. Highlands CSB closed their ambulatory crisis stabilization program due to low referrals during the COVID-19 pandemic. The CSB redirected funding to a crisis clinician position. Mt. Rogers and Danville-Pittsylvania provide mobile crisis stabilization. Geographical barriers for CSBs that cover several rural counties has been an obstacle in expanding ambulatory crisis services. The region uses funding to expand limited crisis services to a youth specific pre-screener, community-based responders, or staff embedded in high crisis referral locations such as pediatric offices.

Region 4:
Mobile Crisis Response and Community Stabilization services for children are provided through the Crisis Response and Stabilization Team (CReST). In January 2021, CReST launched a call line, in collaboration with Region 4 REACH. This shared call line supports the expanded provision of immediate in-person response to children in the community. The CReST team now offers both immediate mobile crisis response, as well as follow-up and referral-based community stabilization services. The CReST team works with CSB Emergency Services, local schools, pediatric Emergency Departments, acute inpatient hospitals, and directly with parent/caregiver and/or community referrals. The team also assists psychiatric hospitals with children who are ready to discharge but who are at risk of re-hospitalization without active services. St. Joseph's Villa in Region 4 continues to operate two (2) day placements that offer center-based crisis stabilization services, enhancing the system of crisis care for youth in the region. COVID-19 has affected the operations and utilization of Region 4 child crisis services since March 2020. The child CSU implemented COVID screening and visitation protocols and paused Day Service admissions during the pandemic. Day service admissions were reinstated as of September 2021. CReST continues to engage in COVID screening prior to in-person sessions and provides the option of telehealth where clinically appropriate or necessary to ensure youth and families in crisis can be served. Although a temporary drop in service utilization occurred when the pandemic began, since March 2021, the monthly referral rate for community stabilization services has remained approximately two and one-half times higher than in any previous year.

Region 5:
With the additional funding through STEP-VA for children's mobile crisis stabilization, the region has chosen to transition the current positions that provide mobile crisis support with this General Assembly allocation to crisis navigators. After the initial crisis intervention from the newly formed STEP-VA mobile crisis teams, the crisis navigators will provide on-going community-based crisis stabilization for those that need additional support including linkage to on-going community based services.

Strategy 3. Residential Crisis Stabilization Services/Crisis Stabilization Units

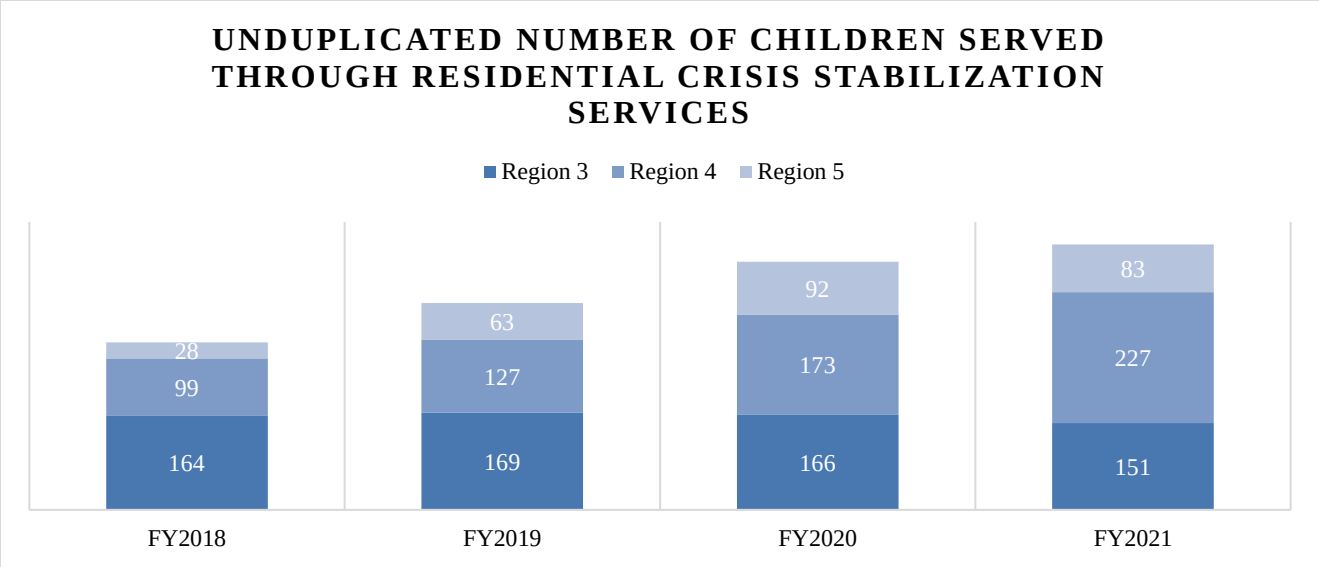
Based on service gaps identified in their proposals, each region has different needs and resources for residential crisis stabilization services. All residential crisis stabilization services are short-term and focus on maintaining family contact and returning children to their homes and schools. Regions 3, 4, and 5 have residential crisis stabilization units. The table and figure below provide data on the number of children served through residential crisis stabilization services.

Table 2: Unduplicated Number of Children Served through Residential Crisis Stabilization Services/Crisis Stabilization Units

Region	FY2018	FY2019	FY2020	FY 2021	Percent Change (Since 2018)
1	NA	NA	NA	NA	-
2	NA	NA	NA	NA	-
3	164	169	166	151	-8%
4	99	127	173	227	+129%
5	28	63	92	83	+196%
Totals	291	424	481	515	+77%

Numbers of children are unduplicated.

Figure 4: Trend over Time of the Number of Children Served through Residential Crisis Stabilization/Crisis Stabilization Units



Region 3:
Region 3 has an eight bed crisis stabilization unit (CSU) located at the Mt. Rogers Community Services Board. When needed, the region provides transportation assistance to overcome geographic barriers. A behavior analyst is available at the CSU to provide the expertise needed to address the needs of children with developmental disabilities. Psychological testing when requested is an additional service provided by the CSU. At times, during the COVID-19 pandemic, Region 3 reduced the number of available beds. This may account for the decrease in number of children served during FY2021.

Region 4:
Through a public-private partnership, Region 4 has an eight-bed crisis stabilization unit at St. Joseph's Villa (SJV) and the capacity for both overnight and day-only services. In order to facilitate admissions, the CSU accepts direct referrals from the community. St. Joseph's Villa works closely with both CReST and Regional Education Assessment Crisis Services Habilitation (REACH) to ensure youth are accessing the most appropriate level of crisis care at the right time. St. Joseph's Villa has a defined referral process with Commonwealth Center for Children and Adolescents with frequent contact to expedite referrals. There is also a defined referral process for CSB referrals as well as direct referrals. St. Joseph's Villa has posted both procedures to the new St Joseph's Villa CSU website. In addition, SJV developed a virtual tour to the CSU and posted it on the website to allow families to be able to view the unit remotely. To facilitate service access, SJV has posted all the needed forms for admission on the website.

Region 5:
Region 5 has a six-bed Crisis Stabilization Unit (CSU) located in Suffolk, Virginia. The Region collaborates with regional emergency services departments, local inpatient and residential facilities, and other CSB departments to divert children from inpatient hospitalization. At times, during the COVID-19 pandemic, Region 5 reduced the number of beds that were available. This may account for the decrease in number of children served during FY2021.

Service Members, Veterans, and Family Members

As one of the nine required services for STEP-VA, the purpose of the Service Members Veterans and Families (SMVF) step is to ensure SMVF receive needed mental health and supportive services in the most efficient and effective manner available. Services are to be high quality, evidence-based, trauma-informed, culturally-competent, and accessible.

In FY 2022, $3,840,490 was allocated to DBHDS (Grants to Localities) in support of SMVF STEP-VA. This critical funding was re-allotted during the 2020 Special Session. There are four major areas for use of funds for each region: 1. support for Regional Navigator positions; 2. support for Lock and Talk; 3. promotion of training and capacity building; and 4. enhancement clinical services. The regional office or as part of regional services with a CSB that will serve as the fiscal agent for the CSBs in that region will receive equal allocations for the first 3 aforementioned areas (with a rate differential for Region 2 related to the Regional Navigator). Fiscal agents for SMVF Regional Services are: Region 1: Region Ten CSB: Region 2: Region 2 Regional Office; Region 3: Blue Ridge Behavioral Health CSB; Region 4: Region 4 Regional Office; and Region 5: Western Tidewater CSB. Funds are compatible with the 2020-2021 DBHDS SMVF Needs Assessment submitted by each CSB/Behavioral Health Authority and approved DBHDS. Funding for Clinical Services Enhancement is based on a needs-based formula, which is indicated below; and will be awarded to individual CSBs.

Final Clinical Services Enhancement Funding Formula:
[Vet Pop (.5) + Vet Suicides (.25) + SMVF Served (.15) + Current Capacity (.1)] * Access Multiplier (x1, x1.5 or x2)

The primary metrics for the SMVF STEP are planned as follows:

1. Conduct military cultural competency training for 100 percent of Direct Services CSB staff
    a. Baseline measurement reported beginning July 1, 2021 (with end of year block grant Evidence-Based Practice survey). Baseline data indicated 73.3 percent of direct service staff received the training during FY 2021 (one year ahead of the requirement).
    b. First assessment of compliance July 1, 2022
2. Track SMVF status for 90 percent of individuals presenting for services
    a. Required to be reporting this element in CCS3 beginning July 1, 2021
    b. First 12 months of data collection will be under Phase 2 conditions where data quality is assessed
3. Track referral destination to military/veteran resources
    a. Of those served by the CSB who are SMVF, at least 70 percent will be referred to Dept. of Veterans Services (DVS), Veterans Health Administration facilities and services (VHA), and/or Military Treatment Facilities and services (MTF) beginning July 1, 2021.
4. Conduct suicide risk screening using the Columbia Suicide Severity Rating Scale brief screen for 60 percent of Military Service Members and Veterans
    a. Beginning July 1, 2021 obtain baseline for Year 1 (For July 1, 2021 through June 30, 2022)
    b. Year 2 target is 85 percent (FY 2023)

Service Implementation

Proposals were submitted by each of the CSBs and Regional Leads/Fiscal Agents on the proposed implementation of SMVF in July 2021. DBHDS reviewed the plans submitted and followed up with each of the CSBs and Regional Leads to ensure the plans met the required goals for STEP VA SMVF.

Additionally, DBHDS has collaborated with the Department of Veterans Services in order to develop a Memorandum of Understanding to promote partnerships and initiatives that advance behavioral health, supportive services, and suicide prevention for SMVF. DBHDS and DVS work also together to support implementation and STEP-VA initiatives for SMVF.

Peer and Family Services

As one of the nine required services for STEP-VA, the purpose of the Peer Support and Family Services is to support and empower people and families to make the best decisions for themselves as they strive towards their recovery and resiliency goals.

Peer Support Services assist individuals in achieving positive coping mechanisms for the stressors and barriers encountered during their path to wellness and recovery. Family Support Partner services are strength-based, individualized, person-centered, and growth-oriented supports provided to the parent/caregiver of a youth or young adult under the age of 21 with a behavioral health or developmental or substance use challenge or co-occurring mental health, substance use or developmental challenge that is the focus of support. The services provided to the parent/caregiver must be directed exclusively toward the benefit of the individual in need of services. Services are expected to improve outcomes for the individual and increase the individual's and family's confidence and capacity to manage their own services and supports while promoting wellness and healthy relationships. Peers and family support partners are an essential component of recovery-focused systems and are key across settings and stages of recovery and resiliency. Peer and Family Support improve outcomes throughout the continuum of care.

The Peer and Family Services STEP completed planning and funds will be initially disbursed for FY 2022. Following the development and completion of a needs survey to assess baseline status regarding peer recovery and family support partner status and needs, parameters were developed to guide requirements and implementation: funds were designed to be used to increased capacity in each locality for either a Peer Recovery Specialist or a Family Support Partner and to be certified through the certified peer recovery specialist (CPRS) process with the Virginia Certification Board within 12 months of hiring and registered with the Board of Counseling within 15 months of hiring. Second, funds were allocated to expand workforce through paid internships and supervision and support for infrastructure to increase billing capabilities. Last, funds were allocated to support regional training and capacity-building to enhance, align with,

and augment system-wide initiatives including efforts related to older adults, opioid use disorder, crisis system, and other areas.

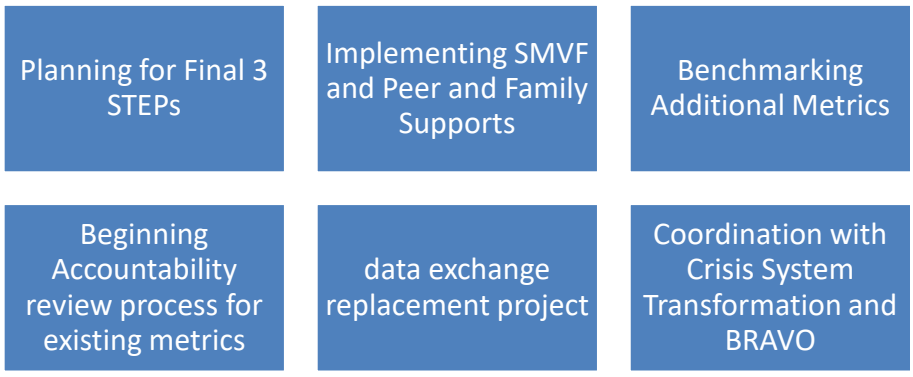
Status of Additional Steps

The final three STEPs (Case Management, Care Coordination, Psychiatric Rehabilitation) were not funded for the current (2021-2022) biennium. Thus, planning on these STEPs continues but at a slower rate due to prioritization of the ongoing implementation of funded STEPs as well as COVID-19 impacts on CSB capacity for planning. The workgroups that will be active during the upcoming year are a joint Case Management/Care Coordination workgroup, Psychiatric Rehabilitation workgroup, and the BHEI/CSB Funding workgroup. There are also a number of other working groups such as those formed for the Crisis System transformation that also continue to meet.

Implementation Barriers during FY 2021 and Expected Upcoming Activities for FY 2022

The COVID-19 pandemic and associated economic downturn has already begun to increase mental health demand in communities, and this trend is expected to continue. Without ongoing support for the behavioral health system in Virginia, demand may quickly outpace capacity. Key implementation barriers are workforce issues in behavioral health, ongoing adjustment, calibration, and management of the relationship between CSBs and MCOs, and reducing the administrative burden in public community behavioral health. Level funding and underfunding the STEPs also creates barriers to full implementation.

Looking ahead to FY 2022, STEP-VA activities will be focused in the following areas:



Conclusion

In total, $43,035,651 was distributed to the CSBs, with approximately a quarter of funds going to regional initiatives, such as mobile crisis hubs. CSBs have used this funding to implement the SDA process; hire staff, including nurses and nurse practitioners; purchase equipment needed to create and sustain the SDA and primary care screening processes within their CSBs; hire outpatient clinicians; improve employee retention and recruitment with salary improvements;

provide training in evidence-based practices; and begin to form regional hubs for mobile crisis implementation. CSBs have also completed planning for the STEPs funded for FY 2022 (SMVF and Peer and Family Supports). Planning continues for the final three STEPs. Since the time that STEP-VA was planned, the implementation context has changed drastically (budget cuts, behavioral health carve-in with managed care, COVID-19 pandemic). This has required significant pivots in the implementation of STEP-VA. At the time of this report, four STEPs have been implemented, and two more will be implemented by July 2022. There are three STEPs that have not yet received funding. Funding and implementation of these services is a crucial step to transform Virginia's behavioral health care system. DBHDS will ensure implementation of STEP-VA is responsive and integrated with other efforts to transform Virginia's behavioral health care system and is grateful for ongoing attention and investments to these priorities.

Appendix A

Allocations of FY 2021 SDA State General Funds

CSB	Same Day Access Allocation FY 21
Alexandria	$269,891
Alleghany	$269,891
Arlington	$269,891
Blue Ridge	$269,891
Chesapeake	$269,891
Chesterfield	$269,891
Colonial	$269,891
Crossroads	$269,891
Cumberland	$269,891
Danville Pittsylvania	$269,891
Dickenson	$269,891
District 19	$269,891
Eastern Shore	$269,891
Fairfax Falls Church	$269,891
Goochland	$269,891
Hampton NN	$269,891
Hanover	$269,891
Harrisonburg-Rock	$269,891
Henrico	$269,891
Highlands	$269,891
Horizon	$269,891
Loudoun	$269,891
Mid Peninsula NN	$269,891
Mt. Rogers	$269,891
New River Valley	$269,891

Norfolk	$269,891
Northwestern	$269,891
PD1	$269,891
Piedmont	$269,891
Portsmouth	$269,891
Prince William	$269,891
Rapp Area	$269,891
Rapp-Rapidan	$269,891
Region Ten	$269,891
Richmond	$269,891
Rockbridge	$269,891
Southside	$269,891
Valley	$269,891
Virginia Beach	$269,891
Western Tidewater	$269,891

Primary Care Screening, Disbursement of Funds, FY 2020

CSB	Primary Care Screening Funds
Alexandria	$130,197
Alleghany	$60,729
Arlington	$164,095
Blue Ridge	$348,270
Chesapeake	$119,428
Chesterfield	$113,325
Colonial	$80,397
Crossroads	$238,025
Cumberland	$158,168
Danville Pittsylvania	$148,765
Dickenson	$69,110
District 19	$161,776
Eastern Shore	$99,269
Fairfax Falls Church	$406,181
Goochland	$52,325
Hampton NN	$329,681
Hanover	$41,318
Harrisonburg-Rock	$99,608
Henrico	$205,902
Highlands	$138,605
Horizon	$453,970
Loudoun	$48,971
Mid Peninsula NN	$221,818

Mt. Rogers	$365,762
New River Valley	$265,333
Norfolk	$282,806
Northwestern	$222,852
PD1	$192,464
Piedmont	$268,467
Portsmouth	$113,272
Prince William	$130,307
Rapp Area	$253,049
Rapp-Rapidan	$82,584
Region Ten	$284,871
Richmond	$359,812
Rockbridge	$99,941
Southside	$156,638
Valley	$91,558
Virginia Beach	$197,238
Western Tidewater	$183,111
TOTAL	**$7,440,000**

Disbursement of Funds for Outpatient Services

CSB	Outpatient Base Funding	Outpatient Needs Based Funding	Total Outpatient Funding FY 20
Alexandria	$198,656	$54,735	$253,391
Alleghany	$198,656	$133,315	$331,971
Arlington	$198,656	$54,735	$253,391
Blue Ridge	$198,656	$192,380	$391,036
Chesapeake	$198,656	$152,895	$351,551
Chesterfield	$198,656	$89,035	$287,691
Colonial	$198,656	$89,035	$287,691
Crossroads	$198,656	$152,895	$351,551
Cumberland	$198,656	$133,315	$331,971
Danville Pittsylvania	$198,656	$152,895	$351,551
Dickenson	$198,656	$133,315	$331,971
District 19	$198,656	$192,380	$391,036
Eastern Shore	$198,656	$152,895	$351,551
Fairfax Falls Church	$198,656	$89,035	$287,691
Goochland	$198,656	$192,380	$391,036
Hampton NN	$198,656	$89,035	$287,691
Hanover	$198,656	$133,315	$331,971

Harrisonburg-Rock	$198,656	$152,895	$351,551
Henrico	$198,656	$133,315	$331,971
Highlands	$198,656	$89,035	$287,691
Horizon	$198,656	$152,895	$351,551
Loudoun	$198,656	$89,035	$287,691
Mid Peninsula NN	$198,656	$192,380	$391,036
Mt. Rogers	$198,656	$152,895	$351,551
New River Valley	$198,656	$152,895	$351,551
Norfolk	$198,656	$152,895	$351,551
Northwestern	$198,656	$192,380	$391,036
PD1	$198,656	$152,895	$351,551
Piedmont	$198,656	$133,315	$331,971
Portsmouth	$198,656	$152,895	$351,551
Prince William	$198,656	$133,315	$331,971
Rapp Area	$198,656	$192,380	$391,036
Rapp-Rapidan	$198,656	$152,895	$351,551
Region Ten	$198,656	$152,895	$351,551
Richmond	$198,656	$133,315	$331,971
Rockbridge	$198,656	$152,895	$351,551
Southside	$198,656	$133,315	$331,971
Valley	$198,656	$89,035	$287,691
Virginia Beach	$198,656	$152,895	$351,551
Western Tidewater	$198,656	$133,315	$331,971
TOTAL	**$7,946,240**	**$ 5,513,570**	**$13,459,810**

Remaining $1.5 million was distributed to the five regions to fund regional training plans in evidence-based practices and trauma informed care.

Children's Mobile Crisis Allocations ($5.8 million, STEP-VA)

Region	Total Allocation
Region I	$1,296,500
Region II	$1,342,000
Region III	$1,296,500
Region IV	$750,500
Region V	$1,164,500
Total	$5,800,000

Adult Mobile Crisis Allocations ($2 million, STEP-VA)

Region	Total Allocation
Region I	$341,126
Region II	$394,529
Region III	$387,508
Region IV	$400,425
Region V	$476,590
Total	$2,000,000

SMVF FY 2022 Allocations (NOTE: these began in July 2021)

CSB	Total SMVF Funding FY 22
Alexandria	$ 65,600.05
Alleghany	$ 56,025.38
Arlington	$ 64,319.79
Blue Ridge	$ 76,264.86
Chesapeake	$ 84,961.08
Chesterfield	$ 72,127.23
Colonial	$ 77,764.87
Crossroads	$ 78,780.39
Cumberland	$ 64,286.29
Danville Pittsylvania	$ 78,488.69
Dickenson	$ 50,073.35
District 19	$ 77,855.74
Eastern Shore	$ 85,854.22
Fairfax Falls Church	$ 98,763.33
Goochland	$ 58,947.15
Hampton NN	$ 92,891.54
Hanover	$ 60,305.32
Harrisonburg-Rock	$ 71,501.16
Henrico	$ 68,295.14
Highlands	$ 62,346.22
Horizon	$ 81,546.15
Loudoun	$ 75,442.68

Mid Peninsula NN	$ 88,774.15
Mt. Rogers	$ 61,718.95
New River Valley	$ 69,089.74
Norfolk	$ 84,923.93
Northwestern	$ 99,269.26
PD1	$ 82,078.85
Piedmont	$ 72,015.49
Portsmouth	$ 81,177.58
Prince William	$ 82,206.27
Rapp Area	$ 82,991.08
Rapp-Rapidan	$ 70,736.80
Region Ten	$ 79,683.55
Richmond	$ 63,387.53
Rockbridge	$ 68,939.70
Southside	$ 78,488.12
Valley	$ 69,574.83
Virginia Beach	$ 102,107.79
Western Tidewater	$ 90,285.73
TOTAL	**$ 3,029,890**

SMVF FY 2022 Regional Allocations

Region	SMVF – Reg Navigator	SMVF – Lock & Talk	SMVF – Training	Total
Region I	$109,000	$25,000	$25,000	$159,000
Region II	$124,600	$25,000	$25,000	$174,600
Region III	$109,000	$25,000	$25,000	$159,000
Region IV	$109,000	$25,000	$25,000	$159,000
Region V	$109,000	$25,000	$25,000	$159,000
Total	**$560,600**	**$125,000**	**$125,000**	**$810,600**