COMMONWEALTH of VIRGINIA

NELSON SMITH
COMMISSIONER

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

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

January 16, 2026

To: The Honorable Winsome E. Sears, Lieutenant Governor of Virginia
The Honorable Don Scott, Speaker, Virginia House of Delegates
The Honorable R. Creigh Deeds, Chair, Behavioral Health Commission
R. Blake Andis, Chair, State Board of Behavioral Health and Developmental Services

From: Nelson Smith, Commissioner, Department of Behavioral Health and Developmental Services

RE: Chapter 683, 2017 Acts of Assembly & Item 295 OO.1

Chapter 683 of the 2017 Acts of Assembly and Item 295 OO.1 of the 2025 Regular Session Appropriation Act requires the Department of Behavioral Health and Developmental Services (DBHDS) to report on the implementation of System Transformation Excellence and Performance (STEP-VA) and on the performance of Community Services Boards (CSB) in improving the functioning levels of consumers. The language states:

§37.2-601- 1. In order to provide comprehensive mental health, developmental, and substance abuse services within a continuum of care, the behavioral health authority shall function as the single point of entry into publicly funded mental health, developmental, and substance abuse services.

2. That the provisions of the first enactment of this act shall become effective on July 1, 2019.

3. That, effective July 1, 2021, the core of services provided by community services boards and behavioral health authorities within cities and counties that they serve shall include, in addition to those set forth in subdivisions B 1, 2, and 3 of § 37.2 500 of the Code of Virginia, as amended by this act, and subdivisions C 1, 2, and 3 of § 37.2-601 of the Code of Virginia, as amended by this act, respectively, (i) crisis services for individuals with mental health or substance use disorders, (ii) outpatient mental health and substance abuse services, (iii) psychiatric rehabilitation services, (iv) peer support and family support services, (v) mental health services for members of the armed forces located 50 miles or more from a military treatment facility and veterans located 40 miles or more from a Veterans Health Administration medical facility, (vi) care coordination services, and (vii) case management services.

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.

Item 295 - OO.1. The Department of Behavioral Health and Developmental Services (DBHDS) shall report annually on (i) Community Services Boards (CSB) performance in improving the functioning levels of its consumers based on composite and individual item scores from the DLA-20 assessment, or results from another comparable assessment, by CSB, (ii) changes in CSB performance in improving consumer functioning

levels over time, by CSB, (iii) any substantial underperformance or non-compliance and associated enforcement actions, and (iv) the use of functional assessment data by the DBHDS to improve CSB performance to the State Board of Behavioral Health and Developmental Services, the Behavioral Health Commission, and each CSB governing board.

Please find enclosed the report in accordance with Chapter 683 & Item OO.1. DBHDS Staff are available should you wish to discuss this request.

CC: Janet V. Kelly, Secretary, Health and Human Resources

DBHDS

Virginia Department of Behavioral Health and Developmental Services

Report on STEP-VA Implementation and CSB Performance Relating to the DLA-20 Assessment

(Chapter 683, 2017; Item 295.OO.1 of the 2025 Regular Session Appropriation Act)

January 1, 2026

DBHDS Vision: A Life of Possibilities for All Virginians

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

Preface

Chapter 683 of the 2017 Acts of Assembly and Item 295 OO.1 of the 2025 Regular Session Appropriation Act requires the Department of Behavioral Health and Developmental Services (DBHDS) to report on the implementation of System Transformation Excellence and Performance (STEP-VA) and on the performance of Community Services Boards (CSB) in improving the functioning levels of consumers. The language states:

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Superscripts noted throughout the report indicate the following references:

[1] *Fiscal Year 2025 data reflect activity through April 2025; May and June data were not available for inclusion due to the transition to the new enterprise data warehouse (EDW). Starting FY 2026, all measures will be collected using standardized CPT/HCPCS Procedure Codes and ICD-1- Diagnostic Codes.*

[2] *EBP survey data reflect preliminary submissions. At the time of reporting, verification from all CSBs had not yet been received.*

[3] *Peer full-time equivalent (FTE) data were only collected through the FY 2025 Step-VA six-month check-in survey. At the time of reporting, not all CSBs had completed the survey.*

[4] *Reinert, m., Nguyen, T., & Fritze, D. (October 2025). The state of mental health in America 2025. Mental Health America. State-of-Mental-Health-2025.pdf*

Report on STEP-VA Implementation and CSB Performance Relating to the DLA-20 Assessment

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Executive Summary

The System Transformation Excellence and Performance (STEP-VA) initiative is Virginia's 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 require consistent quality measures and oversight. The nine services mirror the national best practice model of Certified Community Behavioral Health Clinics (CCBHCs) and include:

- Same Day Access
- Primary Care Screening
- Outpatient Services
- Crisis Services
- Peer and Family Support Services
- Psychiatric Rehabilitation Services
- Services for Service Members, Veterans, and their Families
- Case Management
- Care Coordination

The focus of STEP-VA is to increase the availability and accessibility of behavioral health services across the state, ensuring that Virginians have access to the services they need within their communities to increase and maintain behavioral health stability, and decrease the need for crisis interventions. DBHDS anticipates that STEP-VA will assist the Commonwealth in reaching key outcomes including decreased emergency room visits for psychiatric crisis and reduced criminal justice system involvement for individuals with behavioral health disorders.

Below are high-level updates for FY 2025:

The final three STEP-VA services: Care Coordination, Psychiatric Rehabilitation, and Targeted Case Management, are considered fully implemented as per the FY 2026 Performance Contract. This determination reflects the application of outcome measurements for each of these steps, ensuring not only that services are available statewide, but that they are measured consistently for quality and effectiveness.

DBHDS continued STEP-VA site visits across all 40 CSBs, including follow-up visits for higher-risk boards. Consistent with the work conducted in prior fiscal years, DBHDS maintained focus on updating service requirements to better align with nationally recognized best practices and the Substance Abuse and Mental Health Administration (SAMHSA) guidance. These updates included the addition of new outcome measurements designed to streamline services based on clinical need, strengthen program evaluation, and improve monitoring of wait time for services. DBHDS also launched multiple collaborative workgroups, meetings, and listening sessions to ensure that CSB experiences, feedback, and successful strategies were integrated throughout the ongoing review and realignment of the STEP-VA initiative.

DBHDS piloted the World Health Organization Disability Assessment Schedule (WHODAS 2.0) as a replacement for the Daily Living Activities-20 (DLA-20). The pilot demonstrated that WHODAS 2.0 is an evidence-based, efficient, and scalable tool that reduces administrative burden while producing meaningful outcome data. DBHDS will implement WHODAS 2.0 statewide beginning July 1, 2026, improving Virginia's ability to measure consumer functioning and system-level outcomes.

Additional updates are as follows:

- **Overall delivery** – All 40 CSBs across Virginia are currently delivering all nine of the core services required by STEP-VA to varying degrees. While some CSBs continue to report ongoing barriers preventing full implementation of some components, the vast majority of CSBs are fully implementing all nine required steps.
- **Same Day Access (SDA)** – 31,212 SDA assessments were completed across the system in FY 2025[1]. (Superscripts noted throughout the report are defined on page 4.)
- **Primary Care Screenings** – A total of 62,942 primary care screenings was conducted for 27,146 individuals. A total of 29,386 metabolic screens were conducted across 11,483 individuals in FY 2025.[1]
- **Outpatient Services** – The Columbia suicide screening continues to be utilized, and in year three of its utilization, 78.2 percent of children ages 6 to 17 received a screening and 77.0 percent of adults received a screening.[1] Also, of the 3,239 eligible staff, 2,098 met the minimum eight-hour trauma training requirement.[2] In addition, outpatient services demonstrated positive clinical outcomes as measured by the DLA-20, a functional impairment measure used at each CSB.
- **Initial Funding Received** – all nine steps have been funded by SGF since FY 2023, with increases seen to all steps over the FY 2025-2026 biennium. Total funding for STEP-VA in FY 2025 is set at $145.7 million to be distributed across the 40 CSBs to cover each of the nine steps.

Introduction

Over the past several years, Virginia has made concentrated and meaningful efforts to reform its strained public mental health system. STEP-VA focuses on improving access, quality, consistency, and accountability in the public mental health services available across Virginia, with the goal of creating a system in which a consistent set of high-quality services will be available to every Virginian no matter where they reside in the Commonwealth. STEP-VA requires all CSBs to provide the same nine core services (referred to as steps), which include Same Day Access, Primary Care Screening, Outpatient Services, Crisis Services, Peer and Family Support Services, Services for Service Members, Veterans, and their Families, Psychiatric Rehabilitation Services, Case Management, and Care Coordination. Over time, STEP-VA essentially shifted Virginia's public mental health system from two mandated services (case management and crisis services) to nine.

Over the past year, DBHDS has focused on examining each component of STEP-VA to ensure that the requirements are updated to align as close as possible with national best practices, SAMHSA requirements, and the changing needs that have been identified across the state over the past several years. In collaboration with the 40 CSBs, DBHDS has worked to identify ways to better define each step, refine the requirements outlined in the performance contracts, and improve methods for measuring success and service efficacy.

Figure 1 Total FY 2025 STEP-VA Funding by Category

		FY 2025 Budget
Grants to Localities Agency 790	Same Day Access	$13,134,321
	Primary Care Screening	$9,051,734
	Detoxification (Crisis Services)	$2,000,000
	Crisis Dispatch	$2,697,020
	Crisis Dispatch NGF	$7,453,798
	Mobile Crisis	$28,730,139
	Outpatient Services	$27,855,453
	Veterans Services	$4,242,364
	Peer Support & Recovery Services	$5,814,558
	Cross-Step Infrastructure/Ancillary	$10,962,375
	Psychiatric Rehabilitation	$3,970,250
	Case Management	$4,259,924
	Care Coordination	$6,844,427
	Marcus Alert	$9,600,000
	Regional Management	$937,300
	Transitioning Data Systems and Clinical Procedure	$5,190,000
	790 Total	**$142,743,663**
Central Office Agency 720	Same Day Access	
	Primary Care Screening	
	Detoxification (Crisis Services)	
	Crisis Dispatch	$500,000
	Crisis Dispatch NGF	$1,671,214
	Mobile Crisis	
	Outpatient Services	
	Veterans Services	
	Peer Support & Recovery Services	
	Cross-Step Infrastructure	
	CO Step VA Position	$786,851
	720 Total	**$2,958,065**
	720 + 790 Total	**$145,701,728**

Infrastructure for STEP-VA

STEP-VA has required significant changes, updates, and upgrades across the behavioral health system, both at CSBs and at DBHDS. Of primary significance have been improvements to information technology systems, data collection and reporting systems, electronic health records systems at CSBs, and administrative requirements. Funding for IT infrastructure improvements began in FY 2023 at $2.6 million and increased to $5.2 million for FY 2025 under the current biennium budget. These funds have primarily supported Electronic Health Record system upgrades and IT modernization efforts to meet the new state requirements. Cross-system administration funding began in FY 2022 at $4.9 million, rising to $10.9 million in FY 2024 and FY 2025, and $11 million under the current biennium budget. These funds have primarily supported the ancillary costs of expanding STEP-VA services at CSBs.

Same Day Access

Over the past year, DBHDS has worked closely with the 40 CSBs to examine the current Same Day Access requirements, identifying barriers to successful implementation and opportunities to replicate successes. Past requirements, which were based on recommendations by Measure-Transform-Maximize Consulting Services (MTM) (a private consultant hired in 2018), have not proven to appropriately meet the needs of some localities across the diverse geographic, demographic, and socio-economic topography of Virginia. In addition, changes in both the expectations of individuals needing services as well as to the behavioral health workforce have created new challenges as well as new opportunities. Through careful consideration of the needs of the varying communities across Virginia and of the requirements of SAMHSA's CCBHC specifications, DBHDS has updated the requirements of this step to better reflect the identified needs and available resources across the Commonwealth.

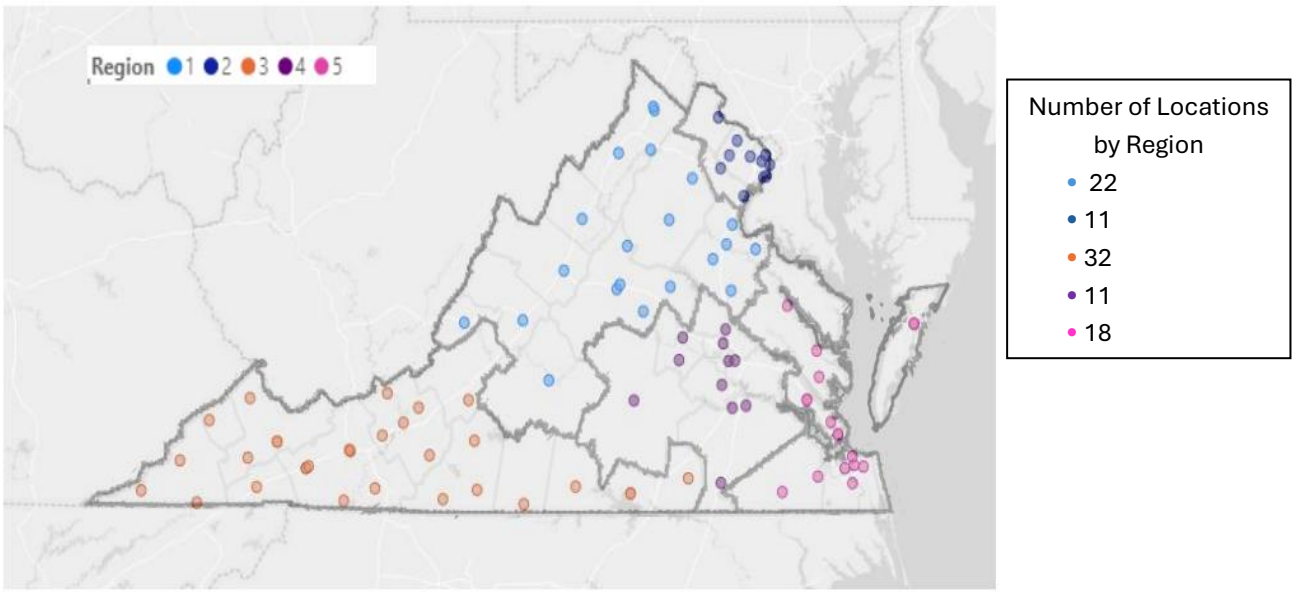
The original Same Day Access (SDA) model required that each CSB employ a walk-in process which would ensure that a comprehensive needs assessment was completed for any individual who presented in for services on the same day that they first walked into the CSB. This model proved successful in some communities but created unanticipated barriers in others. For example, walk-in clinics must operate on a first-come first-served basis, which does not evenly or efficiently utilize the time of licensed clinical staff, who have become more difficult to recruit and retain due to the current workforce shortages, and can create bottle-neck situations in which individuals may need to wait for many hours before they can receive an intake (or perhaps may need to be turned away if a clinic is overwhelmed with new walk-ins on that day). Additionally, replacing the first-come, first-served approach with the ability to schedule appointments has helped improve triage for individuals with higher service needs. Under the previous model, the requirement to appear in person to begin services often created barriers, especially for those with limited transportation or work and school schedules.

By modeling the requirements on the updated CCBHC guidance from SAMHSA and the Centers for Medicare & Medicaid Services (CMS), DBHDS hopes to create a Same Day Access service that will provide each CSB with the flexibility to meet the needs of their unique communities, efficiently utilize valuable staff resources, and ensure that services are provided rapidly to those who need them. The updated requirements will still allow for walk-in assessment services in communities where that has proven successful but will allow communities to utilize a same day triage screening service to identify those Virginians with critical needs who require same-day services, and those who are able to be scheduled within the upcoming 1-10 days based on low-moderate levels of risk.

Total SDA funding was $13,134,321 for FY 2025, an increase from FY 2024. Even distribution allocations were made across all 40 CSBs for ongoing implementation of SDA.

Currently, there are 94 service locations where SDA services are being offered statewide as noted in the August 2022 qualitative check-in survey (see map below).

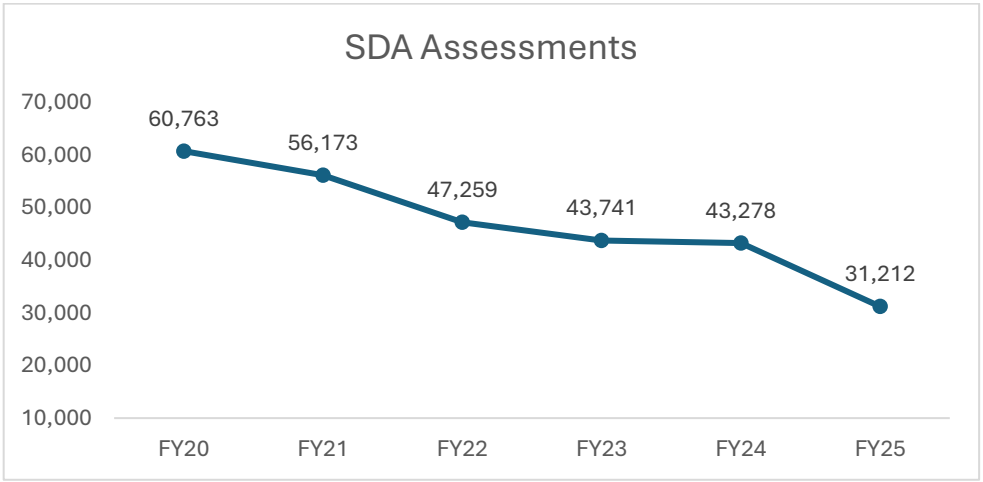
Figure 2. Same Day Access Locations



During fiscal year 2025, there were a total of 31,212 SDA assessments.[1]

There was a total of 31,212 SDA assessments conducted in FY 2025, with 26,689 follow-up appointments offered. Of these assessments, there were 24,075 follow up appointments offered within 10 days, and 17,802 of those follow up appointments were kept and attended within 10 business days.[1]

Figure 3. Trends in Same Day Access (SDA) Assessments



In FY 2025, CSBs reported 31,212 SDA assessments, a decline compared to prior years. This decrease does not reflect a reduction in consumer need but is primarily linked to ongoing challenges in data capture and reporting. Several contributing factors include:

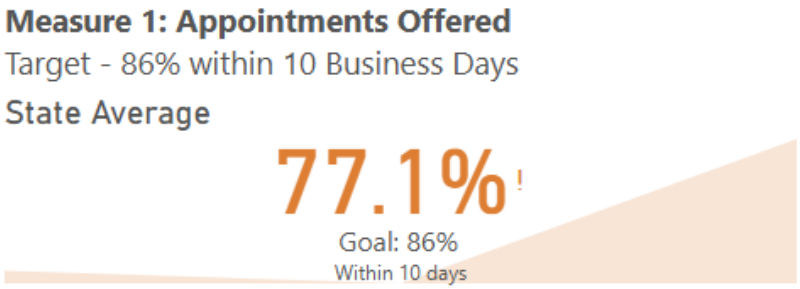
- Transition to the Enterprise Data Warehouse (EDW), which altered how SDA encounters were collected and validated.
- Inconsistent definitions and data entry practices across CSBs.
- Shifts in focus from measuring only the Comprehensive Needs Assessment (CNA) to tracking broader access and service connection measures.

To address these issues, the CSB's are implementing the I-SERV measure in FY 2026. This national CCBHC-aligned measure captures both timeliness of the CNA and connection to services, offering a more accurate picture of access to care. In addition, DBHDS is providing technical assistance and targeted site visits to CSBs showing the steepest declines to ensure both practice and data entry align with STEP-VA expectations. These steps will strengthen accountability and provide a more reliable picture of how Virginians are accessing services through SDA.

The current benchmarks for SDA performance metrics were established during the early statewide rollout of STEP-VA. The 70 percent target for appointments kept and the 86 percent target for appointments offered were based on the statewide performance averages observed during the initial years of implementation. These measures provided a consistent baseline to monitor CSB performance over time. However, as the I-SERV measure becomes fully operational, these targets will be revisited to align with updated definitions and data collection methods that better reflect timely access to care.

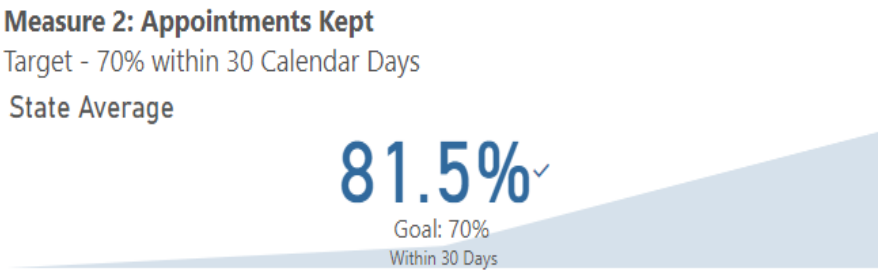
Appointments Offered[1]:

- 77.1 percent had appointments offered within 10 days
- 14.5 percent had no appointments offered
- 8.4 percent had an appointment offered more than 10 days



Appointments Kept[1]:

- 81.5 percent of appointments were kept within 30 days
  - 68.9 percent were kept within 10 days
  - 12.6 percent were kept 11-30 days
  - 2.7 percent were kept 31-60 days
- 15.8 percent of appointments were not kept



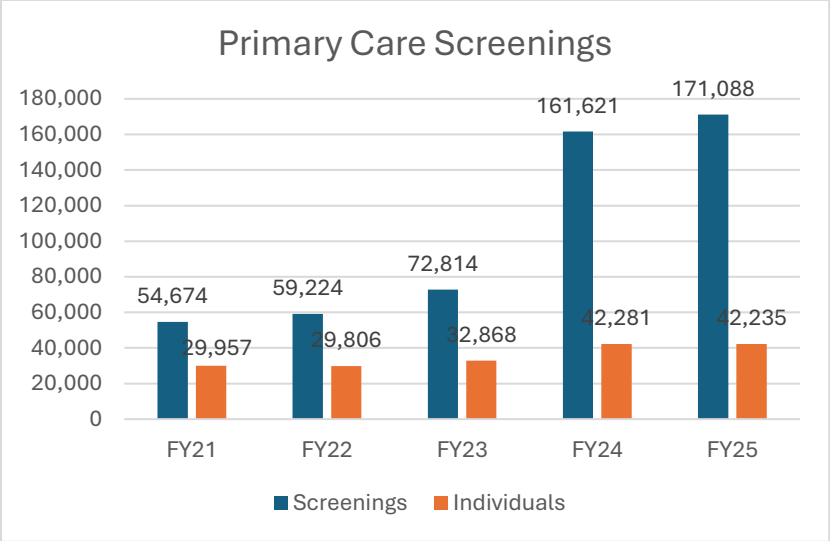
Primary Care Screening

Funding for Primary Care Screening increased from $7.4 million in FY 2024 to $9 million in FY 2025. Individuals with serious mental illness (SMI), a population primarily served by the CSB/BHAs, 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. DBHDS requires that CSBs must complete the following activities as components of this step:

1. Any child diagnosed with a serious emotional disturbance and receiving ongoing CSB/BHA behavioral health service, or any adult diagnosed with a serious mental illness and receiving ongoing CSB/BHA behavioral health service will be provided or referred for a primary care screening on a yearly basis.
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.

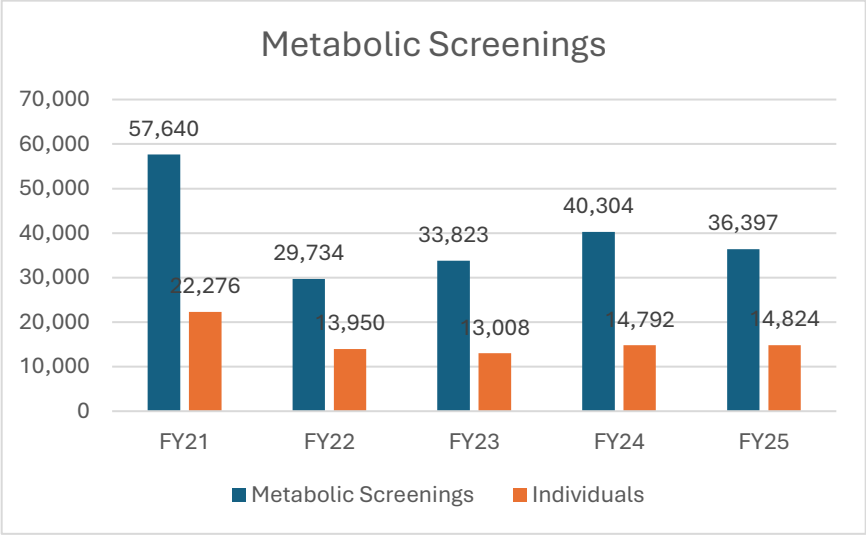
For FY 2025, a total of 171,088 primary care screenings were conducted on 42,235 individuals, an increase compared to prior fiscal years as shown below.

Figure 4. Trends in Primary Care Screenings



For individuals prescribed an antipsychotic medication, a total of 36,397 metabolic screens were conducted on 14,824 individuals, a decrease from the prior fiscal year.[1] This decrease is likely attributable to the reporting challenges during the transition to the EDW rather than actual reduction in service delivery.

Figure 5. Trends in Metabolic Screenings



Outpatient Services

Outpatient Services funding increased from $24.3 million in FY 2024 to $27.9 million in FY 2025.

Outpatient services are a critical component of an effective behavioral health continuum because these services can prevent people from going into crisis and needing higher intensity, more costly services and as such is a central step of STEP-VA. Outpatient services include both psychotherapy and psychiatry services for individuals across the lifespan. The Outpatient Services step seeks to ensure that every Virginian has access to high quality, evidence-based outpatient services regardless of where in the Commonwealth they live.

Over the past year, DBHDS worked closely with the CSBs to better align the requirements of this step with best national practices. Through this process, DBHDS established a core set of Evidence-Based Practices (EBPs) that are now required as components of this core service across all 40 CSBs, along with a list of optional EBPs from which CSBs may select those most applicable to the needs of their communities. The performance contracts have been updated to reflect these enhanced requirements.

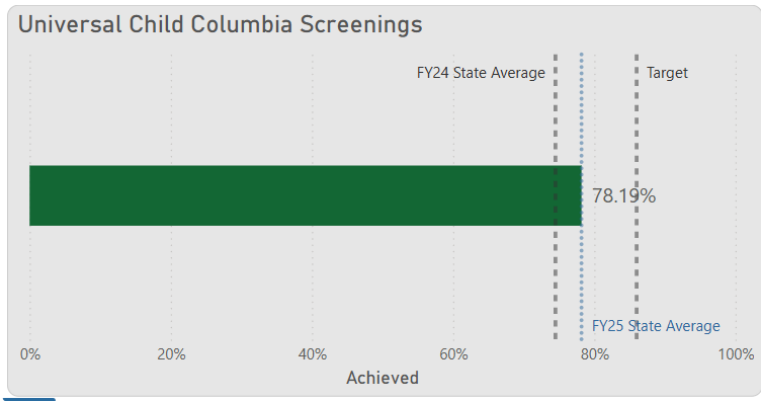
The FY 2025 changes reflect that STEP-VA now requires each CSB to offer, at a minimum, two EBPs for psychotherapy, including Cognitive Behavioral Therapy (CBT) and Motivational Interviewing (MI), **and** two for psychiatry, Medication Management and Long-Acting Injectable Psychotropic Medications.

And CSBs must offer at least one EBP selected from the list provided below which meets the needs identified by the Community Needs Assessment in the community served by the CSB:

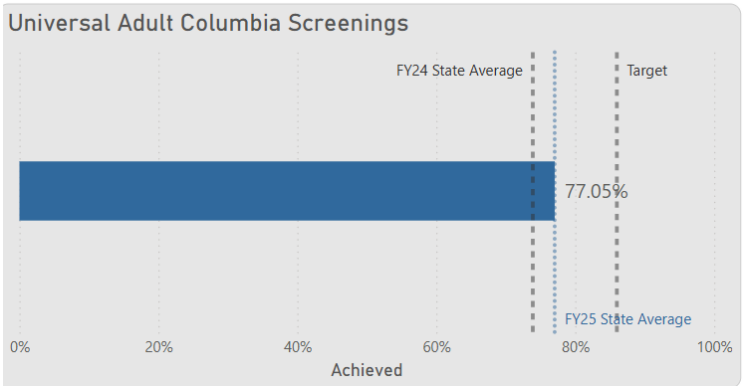
- Acceptance and Commitment Therapy
- Collaborative Assessment and Management of Suicidality (CAMS)
- Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
- Dialectical Behavior Therapy (DBT)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Functional Family Therapy (FFT)
- Hi-Fidelity Wraparound (HFW)
- Integrated Treatment for Co-Occurring Disorders
- Living in Balance
- Medication Assisted Treatment (MAT)
- Moral Reconation Therapy
- Motivational Enhancement Therapy
- Multi-Systemic Family Therapy (MST)
- Parent Child Interaction Therapy (PCIT)
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Seeking Safety
- Solution Focused Brief Therapy
- Trauma Focused CBT (TF-CBT)
- Effective but underutilized medications for SUD treatment

Primary metrics for monitoring and accountability for the Outpatient Services step include suicide screening (Columbia) data, trauma training, and change scores for the DLA-20. Current outcome measures for the three are as follows:

- Columbia Suicide Screening (target of 86 percent)
  - 78.2 percent of children aged 6 to 17 received a screening.[1]



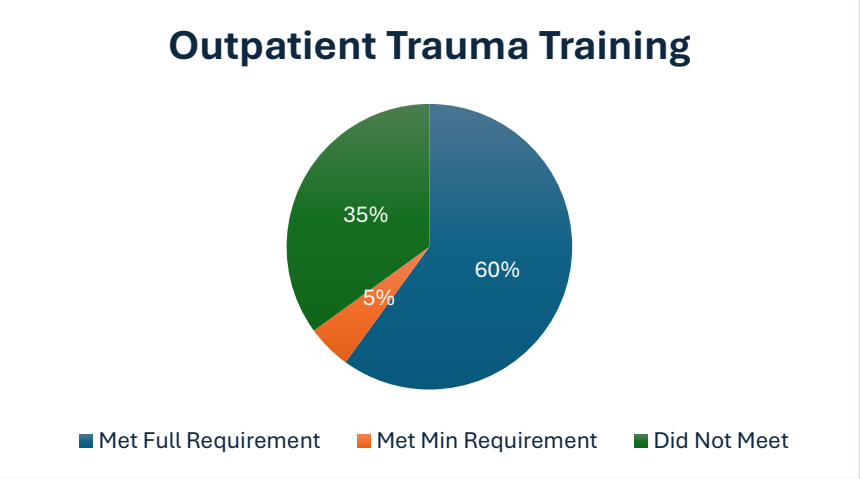
  - 77.0 percent of adults received a screening.[1]



Despite strong performance statewide, the 86 percent benchmark was not reached in both adults and children. This decline is largely attributed to data capture and documentation issues during system transitions rather than a reduction in screening activity.

- Outpatient Trauma Training
    - According to the EBP survey, of the 3,239 eligible staff, 2,098 met the minimum 8-hour training requirement, and of those, 1,937 went on to complete the full 40-hour requirement.[2]
    - During STEP-VA site visits, CSBs identified challenges such as high rates of staff turnover or identifying a need for improved training tracking systems as reasons why this requirement may not have been met.

Figure 6. Outpatient Trauma Training



Outcomes and Performance Utilizing the DLA-20

CSBs are evaluated using composite scores derived from the DLA-20 assessment, which measures the daily living activities and overall functioning of consumers. Individual item scores further assess specific areas of functioning, including self-care, social interactions, and managing mental health symptoms. This assessment is tracked by DBHDS in composite scores. Score descriptions are shown below:

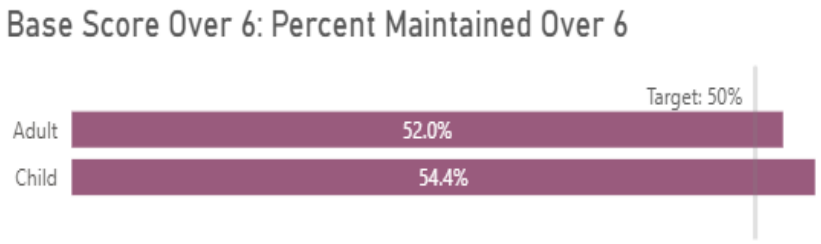
- DLA-20 > 6.00 = Adequate Independence, no significant or slight impairment in functioning
- DLA-20: 5.10- 6.0 = Mild impairments, minimal interruptions in recovery
- DLA-20: 4.10- 5.0 = Moderate impairment in functioning
- DLA-20: 3.10- 4.0 = Serious impairments in functioning
- DLA-20: 2.10- 3.0 = Severe impairments in functioning
- DLA-20: <= 2.0 Extremely severe impairments in functioning

For FY 2025, the performance target was for 35 percent of individuals with an initial DLA-20 score below 4.0 to demonstrate at least a 0.5-point improvement over two consecutive fiscal quarters. This benchmark reflects DBHDS's goal of showing measurable improvement in

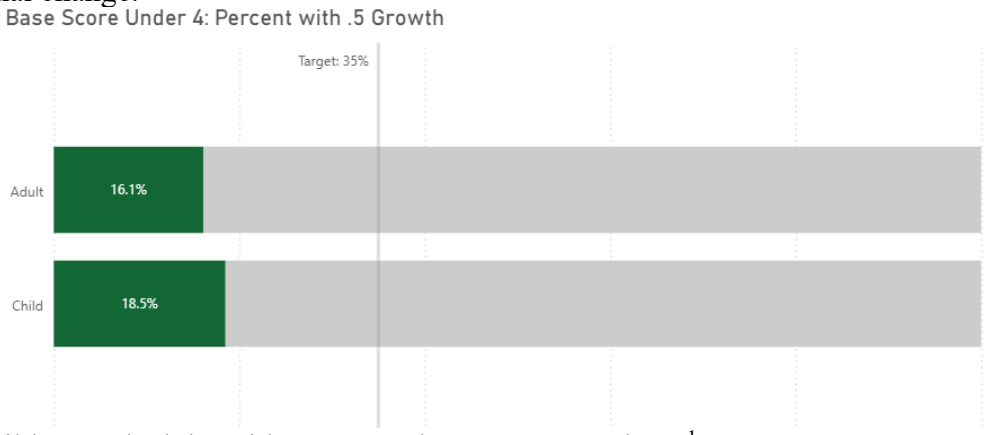
functioning among individuals with the most significant impairments, while recognizing that maintenance of higher scores (above 6.0) also indicates positive outcomes.

For the reporting period, performance data shows (Summary of Overall Performance):

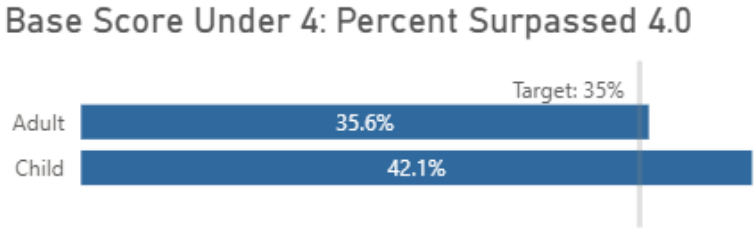
- The average composite score across CSBs was 4.82, with the highest performing CSB achieving a score of 5.93 and the lowest performing CSB recording 3.79.[1]
- Over half of both children and adults with scores over 6 are maintaining that score.[1]



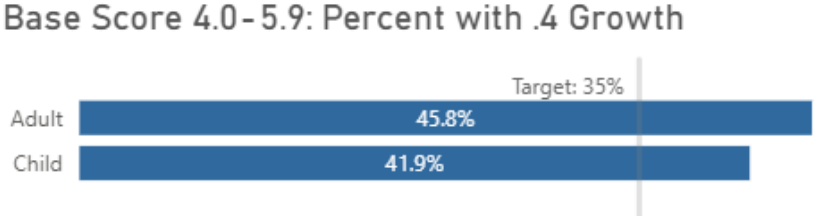
- Both children and adults with scores under 4.0 were off target of the 0.5 growth.[1] The pattern suggests that individuals with more significant impairments may require longer engagement in treatment and more coordinated support before showing measurable functional gains. It also underscores the importance of DBHDS's transition to the WHODAS 2.0, which will provide a more sensitive and standardized measure of functional change.



- Both children and adults with scores under 4.0 surpassed 4.0.[1]



- Both children and adults with scores 4.0-5.9 had over a .4 growth.[1]



Measuring CSB Performance Over Time
DBHDS monitors changes in CSB performance over time to assess improvements or regressions in consumer functioning levels. For FY 2025, 23,555 individuals had at least one DLA-20 screening, with follow-up screenings available for all individuals.[1] When comparing baseline and follow-up scores, the average change in functioning was modest: +0.17 between Q1 and Q3, +0.02 between Q2 and Q4, and +0.06 overall.[1] These results suggest only minimal improvement in functioning as measured by the DLA-20. This reinforces the rationale for DBHDS's transition to the WHODAS 2.0 beginning in FY 2026, which will provide a more evidence-based and sensitive tool to track changes in consumer functioning over time.

While FY 2025 represents progress in capturing both initial and follow-up screenings, declines in the total number of screenings compared to prior years highlight ongoing data system limitations rather than reductions in service delivery. DBHDS projects such as ongoing data modernization will help address these gaps and ensure more reliable evaluation of CSB performance.

Use of Functional Assessment Data to Improve CSB Performance
DBHDS utilizes the data from the DLA-20 and other comparable assessments to guide technical assistance and improve CSB performance. The department has implemented several strategies based on functional assessment data, including:

- **Targeted Training and Support**: CSBs demonstrating areas of weakness have received additional technical assistance from DBHDS staff to address these gaps.
- **Performance Dashboards**: A performance dashboard was created to allow CSBs to track their progress overtime and compare their performance to other boards.

These actions contribute to several key insights, including recognition of the administrative burden associated with the DLA-20 assessment and the limitations of the current data set.

Outcome and Performance Utilizing the WHODAS 2.0 Pilot

In FY 2025, DBHDS conducted a statewide pilot of the World Health Organization Disability Assessment Schedule (WHODAS 2.0) as a potential replacement for the DLA-20. The DLA-20, though widely used, is not evidence-based and imposes a significant administrative burden on staff. The WHODAS 2.0, by contrast, is an internationally validated, evidence-based tool that measures functioning across multiple domains, reduces administrative workload, and produces meaningful outcome data.

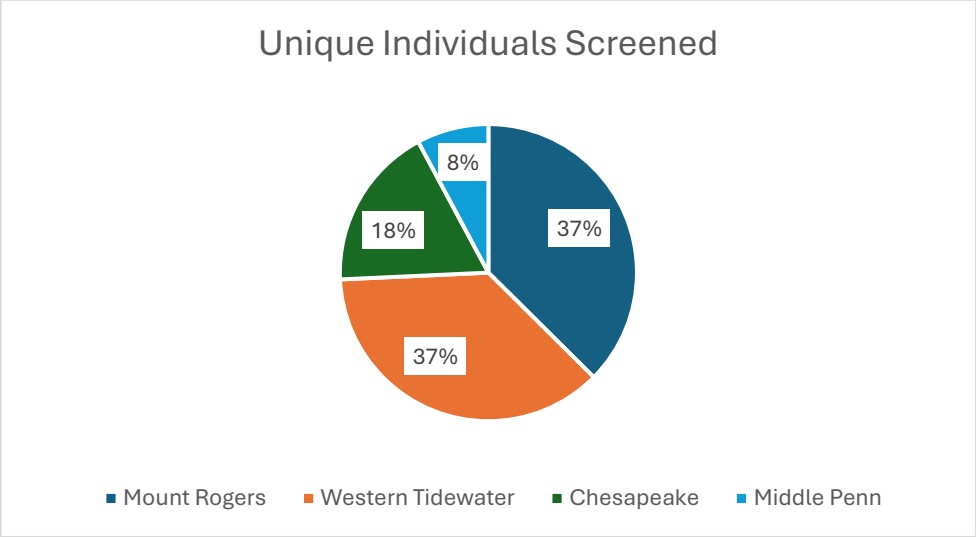
The pilot, conducted across four CSBs and involving more than 5,000 individuals, demonstrated that the WHODAS 2.0 is both feasible and effective for Virginia's behavioral health system. Staff reported that the short version of the tool was easier and faster to administer than the DLA-20, while still supporting both baseline and longitudinal measurement. Based on these findings, DBHDS has decided to formally replace the DLA-20 with the WHODAS 2.0 (short version), with statewide implementation beginning July 1, 2026.

This transition ensures that Virginia will be using an outcome measure that is evidence-based, scalable, and aligned with national best practices. The WHODAS 2.0 will provide more accurate insights into consumer functioning, enabling DBHDS to better measure CSB performance over time and use outcome data to drive continuous improvement across the Commonwealth.

Measuring CSB Performance Over Time

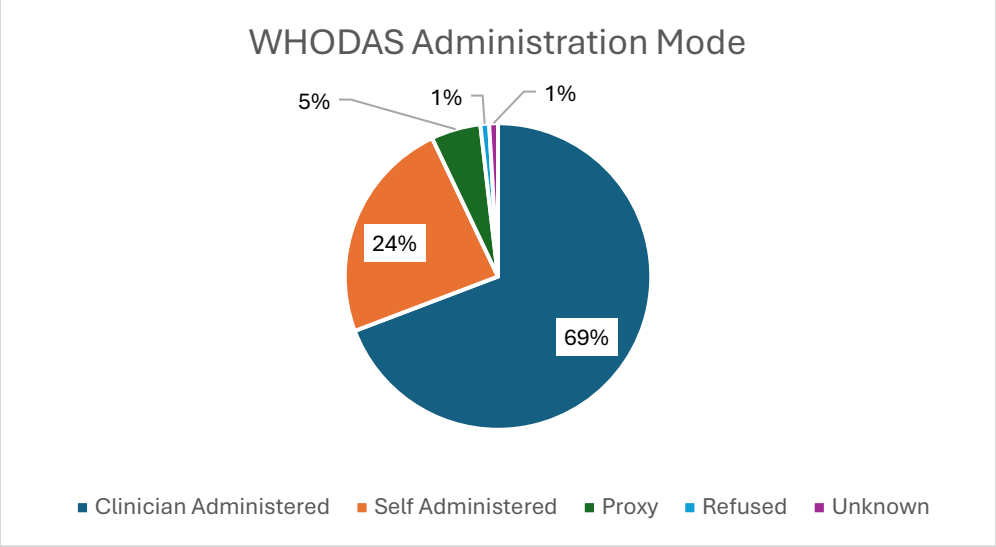
The adoption of the WHODAS 2.0 will allow DBHDS to measure CSB performance more reliably over time. Unlike the DLA-20, which was inconsistently applied and difficult to interpret, the WHODAS 2.0 offers standardized domain scores that can be compared across CSBs and across years. During the pilot, CSBs used the tool both at intake and in follow-up screenings, confirming its ability to track changes in consumer functioning longitudinally. As shown in the figure below, across the four pilot CSBs, 5,302 individuals were screened with 1,149 individuals receiving at least one follow-up screening, demonstrating the tool's capacity to capture performance trends overtime.

Figure 7. WHODAS Screenings Completed by CSB



In addition, the figure below illustrated that the WHODAS 20. can be flexibly administered: 3,670 screenings were clinician-administered, 1,257 were self-administered, and 277 were completed using a proxy, showing its adaptability across different service contexts.

Figure 8. WHODAS Administration by Mode

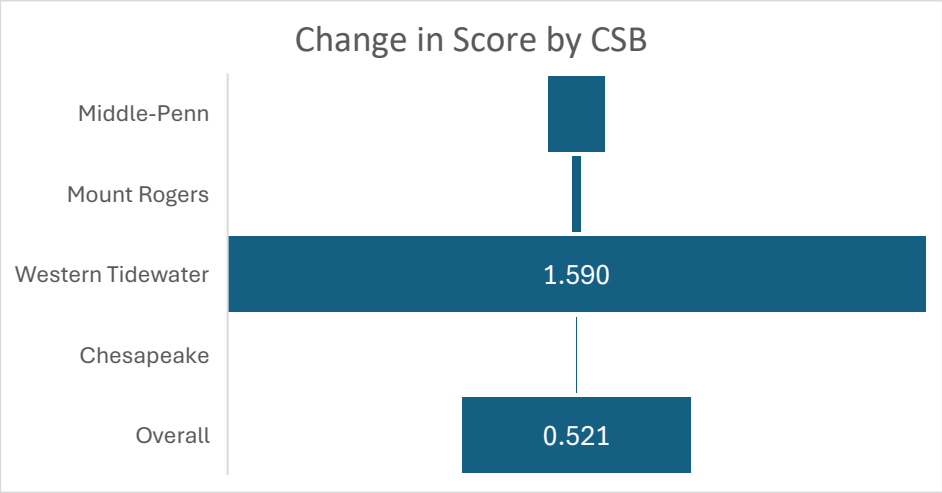


As implementation proceeds, DBHDS will use WHODAS 2.0 data to identify trends in improvement or regression at the individual, CSB, and statewide levels. This will support more accurate monitoring of performance and strengthen accountability for outcomes.

Use of Functional Assessment Data to Improve CSB Performance

Beyond tracking performance, WHODAS 2.0 data will also serve as a foundation for improving service delivery. By reporting results across six functional domains, the WHODAS 2.0 provides actionable insights into where consumers experience the greatest challenges. As shown below, CSBs approached the pilot differently, some focused on intake screenings while others applied the WHODAS 2.0 longitudinally.

Figure 9. WHODAS Score Changes Across CSBs



These different uses of cases confirmed the tool's flexibility to meet local needs. DBHDS will use these results to inform technical assistance, guide resource allocation, and highlight areas where targeted interventions are needed. To ensure that CSBs can effectively use the data, DBHDS will provide standardized reporting protocols, training, and ongoing quality checks. Over time, this evidence-based approach will create a feedback loop where functional assessment data drives system improvements, resulting in better outcomes for consumers and stronger performance by CSBs.

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

STEP-VA funding for crisis services includes previous investments in specialized children's crisis services. The report to the General Assembly regarding the impact of this funding is included as part of this STEP-VA report. We first describe the impact of this investment, followed by planning and initial implementation of the new STEP-VA funds for crisis services. It is important to note that DBHDS provides an annual report on the comprehensive crisis continuum as required by the Marcus-David Peters Act, which is the most comprehensive annual report regarding the crisis system.

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 Community Consumer Submission (CCS) application. The data provided in this report is from the service categories in CCS that are most frequently provided to children in crisis. Those services include Psychiatry Services, Mobile crisis services, and Residential crisis stabilization services.

Strategy 1: Child and Adolescent Psychiatry Services

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:

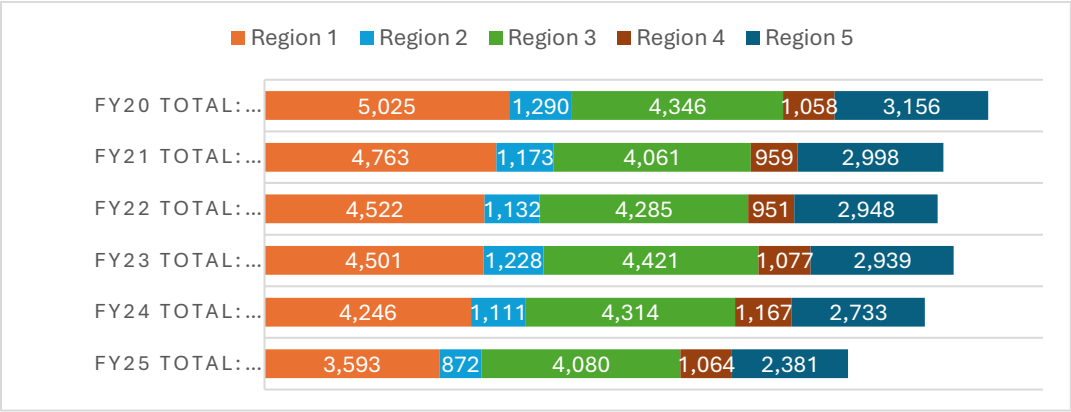
- Face-to-face office visits with children;
- Tele-psychiatry services to children in remote sites; and
- Child psychiatry consultations with other providers, such as pediatricians, primary care providers and others.

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.

Beginning in FY 2026, data will be collected at a more granular, service level. Future reporting will leverage discrete, nationally standardized procedure code sets (Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS), standard diagnostic code sets (ICD-10), and age filters to provide more detailed insights into the delivery and effectiveness of child and adolescent psychiatry services. The figure below depicts the number of children served by psychiatric services in FY 2020-2025.[1]

Figure 10. FY 2020 – FY 2025 Psychiatry Services Offered by CSB Region



Region 1: In Region 1, the Regional Office provides funding to nine Community Services Boards (CSBs) for Child Crisis and Psychiatry services. These services include Crisis Intervention, Crisis Stabilization, and Psychiatric support. Reporting from CSBs has varied, with approximately half submitting regular updates. Among those that have consistently reported, CSBs are delivering either Crisis Intervention or Community Stabilization services. At present, no CSB in Region 1 is delivering both service types simultaneously.

Region 2: In Region 2, funding for child psychiatry provides access to a psychiatric prescriber for children receiving a mobile crisis response by the Community Regional Crisis Response (CR2) program. In FY 2025, the CR2 program provided Mobile Crisis Response (MCR) services to a total of 127 youth. Of those served, 81 youth received MCR services only, while 46 youth received both MCR and Psychiatric Services. This reflects the program's commitment to delivering responsive and integrated behavioral health support to youth experiencing crises.

Region 3: In Region 3, the Regional Office 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 on the same day.

Region 4: In Region 4, St. Joseph's Villa's Crisis Stabilization Unit (CSU) serves children with access to expanded psychiatric support through a contracted provider that delivers tele-psychiatry and psychiatric consultation via On-Demand Tele-psychiatry. In addition, the region continues to offer 20 hours per week of child psychiatry and consultation services through the RBHA-operated community-based mobile crisis program, the Crisis Response and Stabilization Team (CReST).

Region 5: In Region 5, psychiatry services are provided by the Children's Behavioral Health Urgent Care Center (CBHUCC). The Center provides rapid access to crisis intervention and psychiatric care to the entire region and can maintain services for children until they are linked with long term providers. Additionally, eight out of nine CSBs in Region 5 provide outpatient child psychiatry.

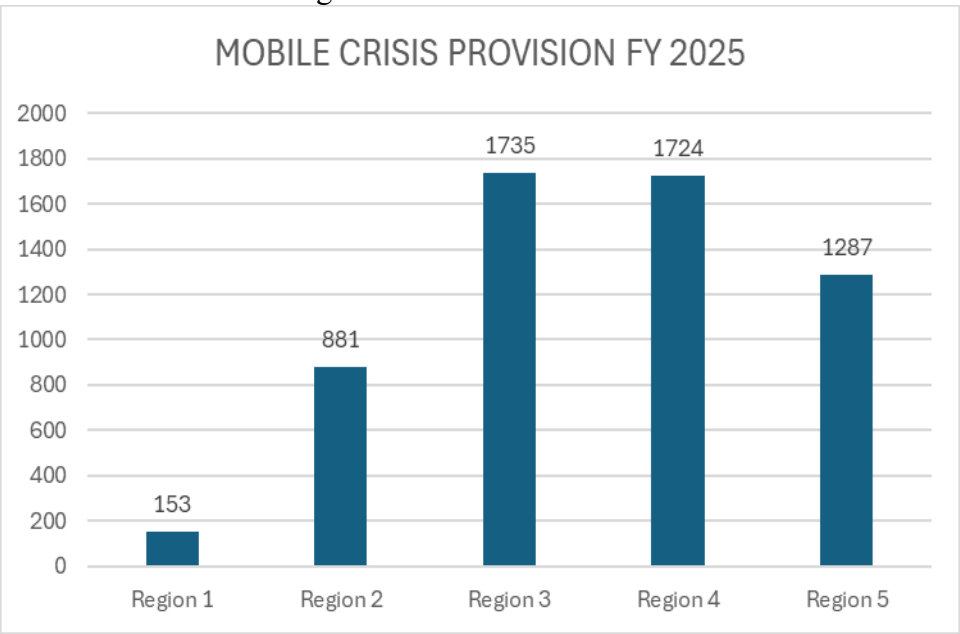
A new Licensed Manager for the CBHUCC began in February 2025, following a short period of vacancy for this position. The Licensed Manager position is essential in meeting community needs, with referrals for crisis response and psychiatry received from a range of referral sources. The CBHUCC and Children's Mobile Crisis programs are critical to serving the community and respond to serious traumatic community incidents that affect citizens.

Strategy 2. Mobile Crisis Services

Mobile Crisis Response provides direct care and intervention to individuals experiencing a behavioral health crisis. Services are available to people of all ages, across the lifespan, and are designed to prevent unnecessary hospitalization, re-hospitalization, or disruption of the individual's living situation. The goals are to ensure safety, provide stabilization, and connect

individuals to appropriate community-based support. Mobile Crisis Response may be delivered to an individual's home or in another community setting. The following table offers data on the number of individuals served through mobile crisis services in FY 2025.

Figure 11. Individuals Served through Mobile Crisis in FY 2025



Region 1: In Region 1, the Regional Office provides funding to nine CSBs for Mobile Crisis Response. These services include Crisis Intervention and Community-Based Stabilization.

Reporting from CSBs has varied, with approximately half submitting regular updates. Among those that have consistently reported, CSBs are delivering either Crisis Intervention or Community-Based Stabilization services.

Region 2: In Region 2, the Community Regional Crisis Response (CR2) program is available to provide mobile crisis responses across the lifespan to individuals in the community, 24 hours a day, 7 days a week. Staff provide short-term crisis services, linkages to new or current community providers, and access to a psychiatric prescriber, as needed. Service duration is based on the individuals' needs to resolve the existing crisis. In FY 2025, this program changed vendors; National Counseling Group, who had been the provider of CR2 since its inception, transitioned out in the Spring, and Easterseals, who has been the provider for Region 2's REACH services for over a decade were awarded the CR2 contract. Due to a dip in staffing when the vendors changed, in FY 2025, the program operated at an average of 72 percent of staffing. Despite this lowered average staffing, the program did not have to deny anyone services due to program capacity throughout FY 2025.

Region 3: In Region 3, center-based crisis stabilization is provided at Cumberland Mountain Community Services Board, along with mobile crisis response and community stabilization. Highlands CSB utilizes funding for a youth mobile crisis clinician position and PD1 is offering Children's Emergency Services as well. Danville-Pittsylvania CSB provides mobile crisis and community stabilization. Blue Ridge Behavioral Health has transitioned funding to cover an

additional intake person who can support access overflow and/or meet with families outside of access hours. Funding was transitioned into this role due to long term vacancy when it was posted as mobile crisis. Piedmont utilizes funding to provide short term crisis intervention. Geographical barriers for CSBs that cover several rural counties have been an obstacle in expanding mobile crisis services. The region uses funding to expand limited crisis services to community-based responders, or staff embedded in high crisis referral locations.

Region 4: In Region 4, Mobile Crisis Response and Community Stabilization services for children are delivered through the Crisis Response and Stabilization Team (CReST). Since January 2021, Region 4 REACH and CReST have operated a shared 24/7 call line. Beginning in December 2021, both programs also began coordinating with the Regional Crisis Call Center contractor to dispatch mobile crisis response when the call center, in consultation with the caller and service provider, determined that level of response was appropriate.

In December 2023, both programs added the ability to dispatch Mobile Crisis Response using the state's Behavioral Health Platform. The CReST team continues to collaborate with CSB Emergency Services, local schools, emergency departments, acute inpatient hospitals, and directly with parents, caregivers, and community referrals. They also support psychiatric hospitals by serving children ready for discharge who are at risk of re-hospitalization without active services.

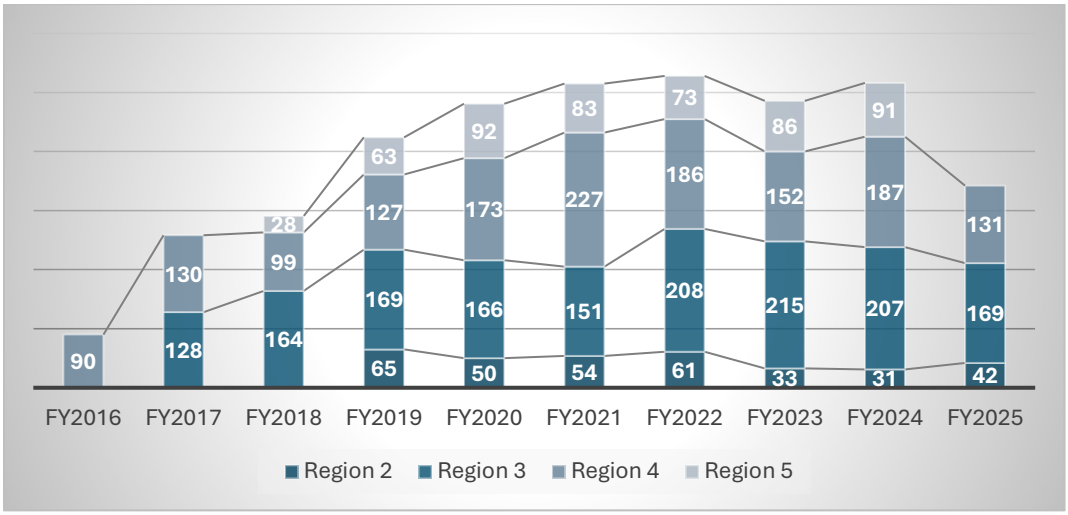
Despite ongoing recruitment challenges like those faced by many community-based behavioral health programs, the CReST team has maintained sufficient staffing to provide uninterrupted, direct services 24/7/365 since January 2024.

Region 5: In Region 5, with the additional funding through STEP-VA for mobile crisis response, the region has chosen to enhance the current positions that provide this service with the purpose of ensuring coordination between the regional crisis teams and each local community services board, to most effectively serve individuals requiring an in-person crisis response. The current mobile crisis positions complement Virginia's comprehensive crisis system, enhancing access to treatment and interventions for children, adolescents, and families. In addition to rapid response and assessment, individuals can be linked to community-based services to promote stabilization and to promote success for them in the home, school, and community.

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 focused on maintaining family contact and returning children to their homes and schools. Regions 3, 4, and 5 have residential crisis stabilization units. The table below provides data on the number of children served through residential crisis stabilization services from FY 2016 through FY 2025.[1]

Figure 12. Number of Children Served through Residential Crisis Stabilization (Unduplicated)



Region 3: Region 3 has a twelve-bed crisis stabilization unit (PATH Crisis Stabilization Unit (CSU)) located at Mount Rogers CSB. When needed, the region provides transportation assistance to overcome geographic barriers. A behavior analyst is available at CSU to provide the expertise needed to address the needs of children with developmental disabilities. 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 FY 2021. No bed adjustments occurred over the past fiscal year. PATH CSU now offers withdrawal management (detox) for adolescents as well.

Region 4: Through a public-private partnership, Region 4 operates its eight-bed CSU at St. Joseph's Villa (SJV). The Villa collaborates closely with both the Crisis Response and Stabilization Team (CReST) and REACH to ensure youth receive the most appropriate level of crisis care at the right time.

SJV maintains a defined referral process with the Commonwealth Center for Children and Adolescents for CSB/BHA referrals, as well as direct referrals from local hospitals and families. To improve access, SJV developed a virtual tour of the CSU, posted admissions forms and information on their website, and expanded marketing and education about the unit in the post-pandemic era.

The needs of youth and families presenting for CSU services have grown in both acuity and complexity. Increasingly, families refuse to allow admitted youth to return home or indicate a desire to give up custody. The largest number of referrals continue to come from hospitals, seeking CSU admission as a step-down from inpatient care before youth return home.

Workforce challenges remain significant. Hiring employees with the right credentials and competencies for crisis settings is difficult, leaving a limited candidate pool. Staffing vacancies increase the workload on remaining employees, contributing to turnover. This cycle is further strained by the lengthy process for new hires to become license-eligible, which prevents them from fully functioning in their roles. Vacancies, rising salary expectations, and the need for a broad array of professionals (clinical, medical, psychiatric) add to the strain on staffing. These

challenges collectively impact operational viability and CSU's ability to provide timely, responsive services.

Region 5: In Region 5, there is an eight-bed CSU located in Suffolk, Virginia. This unit returned to full operational capacity of 8 this fiscal year. The Region collaborates with regional emergency services departments, local inpatient and residential facilities, weekly outreach to CCCA, and other CSB departments to divert children from inpatient hospitalization. Overall, the unit continues to work hard to establish a full workforce to support the needs of the unit, through contacts for nursing agencies and PRN contracts within the WTCSB agency. This has allowed Region 5 to service the community at the maximum level without staffing issues being a barrier.

Services for Service Members, Veterans, and their Families

The fifth step of STEP-VA requires that CSBs provide specialized and culturally informed services for service members, veterans, and their family members (SMVF). CSBs that serve communities located farther from VA medical centers have additional requirements to ensure access to appropriate support and services. Initial funding for this step started at $3.8 million in FY 2022 and increased to $4.2 million for FY 2025. Alexandria and Arlington pooled their funding to best maximize the utilization of the funding, as well as provide the best quality service to the most individuals in the community. There are four major areas for use of funds for each region – support a Regional Navigator position; support the goals of Lock and Talk; promote training and capacity building; and enhance clinical services. The CSBs that serve as the fiscal agents for the CSBs in their respective regions receive equal allocations for the first three aforementioned areas (with a rate differential for Region 2 related to the Regional Navigator).

The five Regional Navigators collaborate with DBHDS and the Department of Veterans Services (DVS) for continued support and resources, as needed. Additionally, DBHDS continues to collaborate with DVS to review and update a Memorandum of Understanding to continue promoting partnerships and initiatives that advance behavioral health, supportive services, and suicide prevention for SMVF. Also, DBHDS and DVS work together to support implementation and STEP-VA initiatives for SMVF.

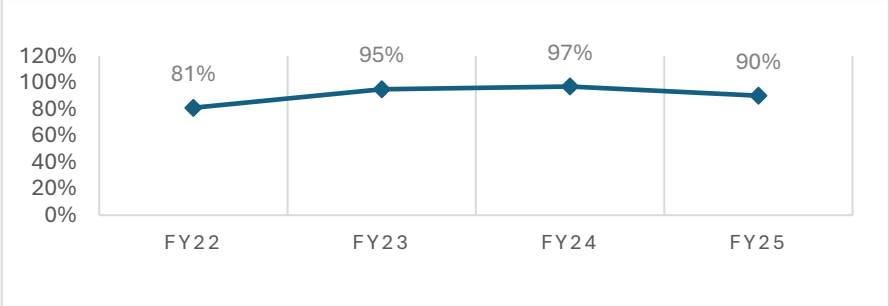
Performance measures for SMVF step have thus far focused on process data to determine to what extent the step is being implemented at each CSB. Below, a review of this data demonstrates the extent to which this step has been implemented across the state. In FY 2026, DBHDS will shift to measuring success of this step through measuring the outcomes of those individuals identified as SMVF who are receiving services at a CSB utilizing an outcome measurement instrument such as the WHODAS 2.0.

Currently, the goal is to measure the following performance indicators:

- **Collection of the Military status of all individuals seen at the CSBs** in FY 2025 was 95 percent, consistent with FY 2024 (95 percent).[1] This performance remains well above the benchmark of 90 percent.
- **Columbia Suicide Screening for all veterans**, 78 percent conducted on all veterans, a one percent increase from FY 2024 and slightly below benchmark of 86 percent.[1]

- **Military Cultural Competence Training (goal: 100 percent of staff)**, reached 90 percent in FY 2025, slightly below the benchmark and a decrease from FY 2024.[2] This change likely reflects reporting and verification differences in the EBP survey data rather than a true decline in training completion.

Figure 13. Staff Trained in Military Competency



Peer and Family Support Services

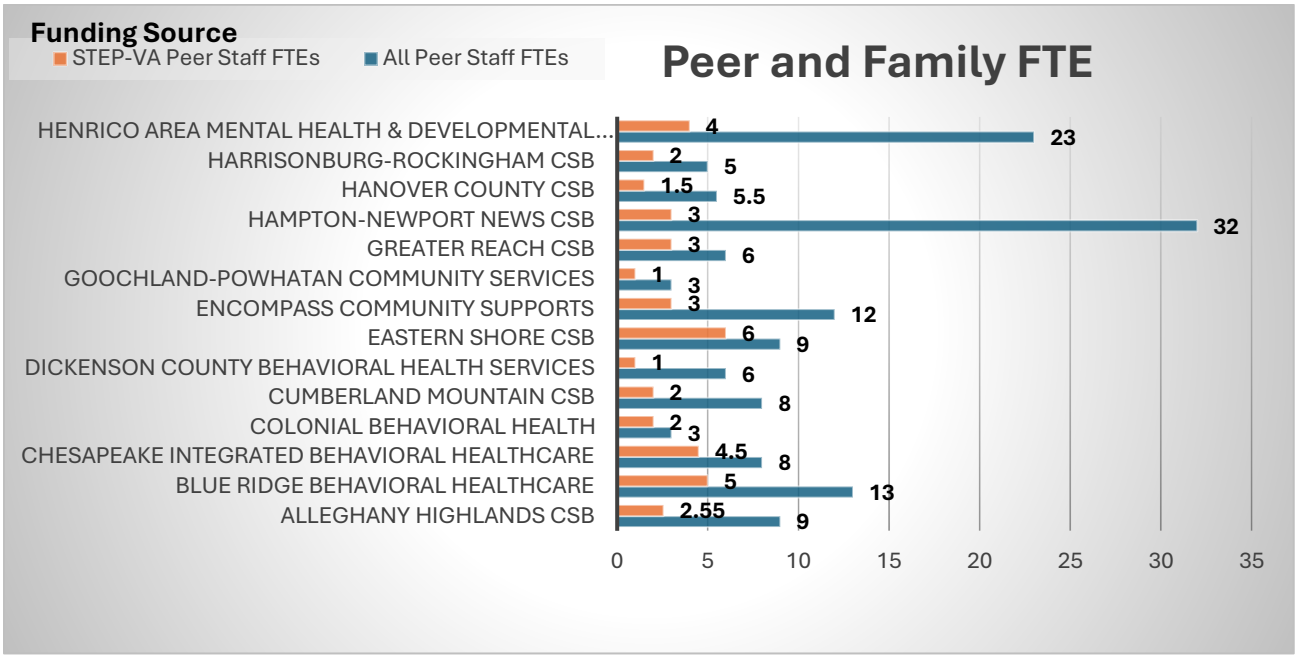
Peer and Family Support Services, the sixth STEP-VA step, provide person-centered, strength-based, and recovery-oriented supports delivered by individuals and family members with lived experience of mental health and substance use recovery. These evidence-based services improve outcomes, expand recovery pathways, and strengthen resiliency and wellness.

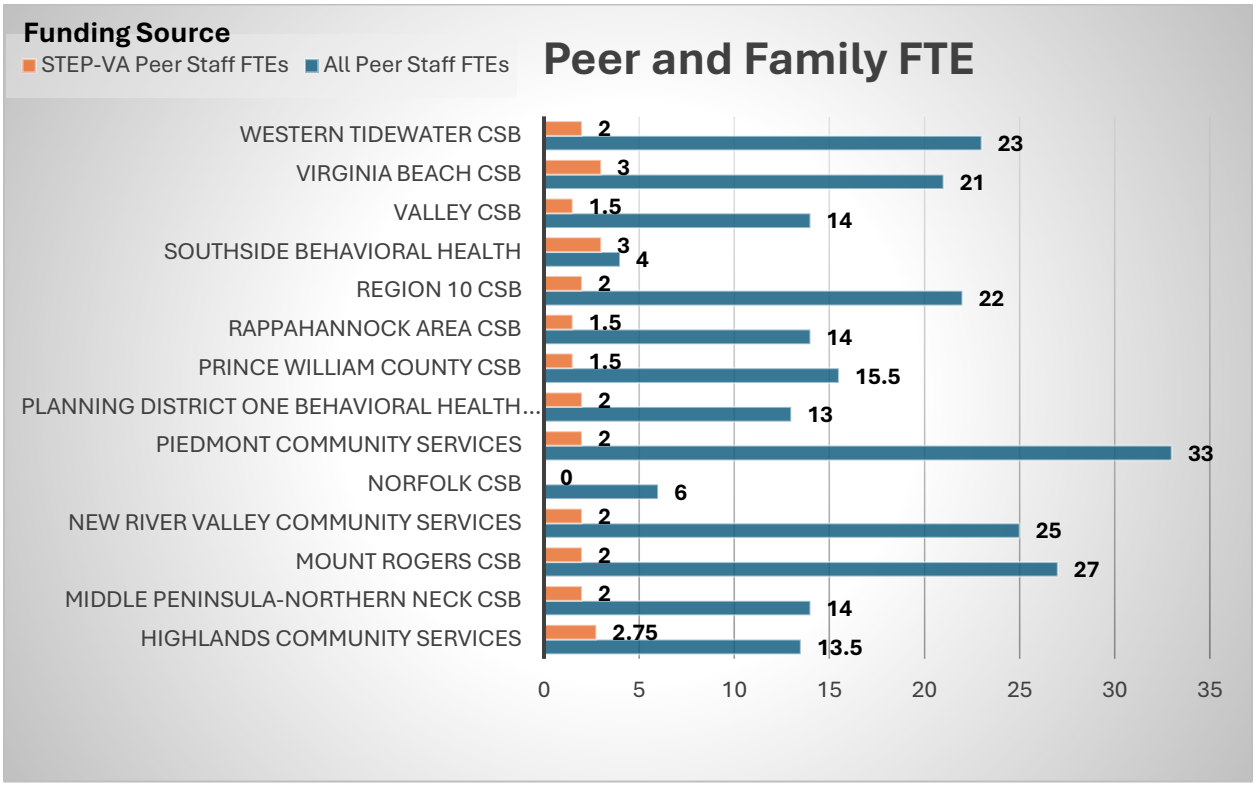
In FY 2025, DBHDS developed online training videos for CSB peer supervisors and direct care staff to reinforce role fidelity and strengthen interdisciplinary collaboration. The General Assembly allocated $5.8 million to support this step, providing funding for each CSB to hire a full-time Peer Supporter or Family Support Partner, along with additional resources to build workforce capacity and expand the Family Support Partner role. A new engagement measure was also implemented this year.

By FY 2025, all CSBs had implemented this step and utilized their Full-Time Equivalent (FTE) funding. Eighty-six CSB staff completed PRS Supervisor training, an essential component of workforce development. DBHDS also requested regional proposals to guide use of 20 percent of STEP-VA funds toward the recruitment and retention of Family Support Partners. While workforce growth has been slower than anticipated, new approaches are yielding results. To sustain progress, DBHDS convenes quarterly regional meetings for monitoring, collaboration, and technical assistance. Utilization of the peer and family workforce varies across CSBs, with some demonstrating strong integration and others with less extensive use.

As part of data improvement, beginning in FY 2025, DBHDS no longer receives data from the legacy reporting system. As a result, all Peer FTE counts for FY 2025 were obtained exclusively from the STEP-VA Six-Month Survey. While this change improves consistency in data collection, not all CSBs completed the survey by the reporting deadline.[3] The figures shown below reflect only those CSBs that submitted data and are not intended to represent cumulative statewide totals. [3] STEP-VA funded peers and family workforce are depicted in orange.

Figure 14. Peer and Family Full Time Equivalent (FTE)





Psychiatric Rehabilitation Services

First funded in FY 2023 at $2.2 million per year, this step has seen an increase in funding, with $3.9 million allocated for FY 2025.

Psychiatric Rehabilitation Services (PRS) promote recovery, full community integration, and improved quality of life for individuals who have been diagnosed with any behavioral health condition that seriously impairs their ability to lead meaningful lives. Psychiatric Rehabilitation Services are collaborative, person directed, and individualized. These services are an essential element of the health care and human services spectrum and should be evidence-based. (*Anthony, W. A., & Farkas, M. D. (2009). Primer on the psychiatric rehabilitation process. Boston: Boston University Center for Psychiatric Rehabilitation.)*

PRS emphasizes functional outcomes focused on building competency and enhancing a person's quality of life and supporting long term recovery. To explain the process most simply and to facilitate the involvement and understanding of the people served and their families, the Boston University Center for Psychiatric Rehabilitation also has explained the psychiatric rehabilitation process from the service recipient's perspective as a Choose-Get-Keep (CGK) process. In other words, from the perspective of the people being served, the psychiatric rehabilitation process helps people choose their goals, get, or achieve their goals, and/or keep their goals, depending on their needs and wants. (*Anthony, W. A., & Farkas, M. D. (2009). Primer on the psychiatric rehabilitation process. Boston: Boston University Center for Psychiatric Rehabilitation.)*

Over the past year, DBHDS has worked closely with the CSBs to determine how to improve the requirements of this step to better align with national best practices and current evidence and data informed decision making. Through this process, DBHDS defined a set of services that meet the definition and requirements of the step, and these updates are now reflected in the FY 2025 performance contract.

As part of the updated definition and requirements, CSBs will be required to select one or more of the following services to provide based on the needs identified within the communities they serve:

- MH intensive outpatient (IOP)
- SUD intensive outpatient (IOP)
- Assertive Community Treatment (ACT)
- MH and SU Supported Employment
- MH and SU supervised residential
- MH and SU supervised intensive residential
- Intensive In-Home Services
- Therapeutic Day Treatment (TDT)
- Coordinated Specialty Care (CSC) for First Episode Psychosis
- Mental Health Skill Building (MHSS)
- Psychosocial Rehabilitation Services (PRS)
- Clubhouse model/Fountain House model
- Permanent Supportive Housing (PSH)
- High Fidelity Wraparound
- Parent Child Interaction Therapy (PCIT)
- MH and SU individual peer support
- MH and SU group peer support
- Illness Management and Recovery (IMR)
- Social Skills Training
- Cognitive Behavioral Therapy for Psychosis

Of note, this step will likely undergo significant changes with the launch of Medicaid Redesign, as Medicaid Redesign is primarily focused on Psychiatric Rehabilitation and skill acquisition.

Targeted Case Management

Targeted Case Management is one of the required services for STEP-VA and must be available at each CSB for both adults and children. The purpose of Targeted Case Management is to ensure behavioral health and physical health needs are routinely assessed to link appropriate services in a coordinated, effective, and efficient manner to support the needs of the individual and family and promote wellness and integration into all aspects of life. Each CSB is responsible for providing high quality targeted case management services that will assist individuals diagnosed with serious mental illness, substance use disorder, or serious emotional disturbance in sustaining recovery and gaining access to needed medical, social, legal, educational, and other services and supports.

Services include identifying and reaching out to individuals in need of services, assessing needs and planning services, linking the individual to services and supports, assisting the individual directly to locate, develop, or obtain needed services and resources, coordinating services with other providers, enhancing community integration, making collateral contacts, monitoring service delivery, and advocating for individuals in response to their changing needs and preferences, increasing health literacy and empowering self-advocacy.

High quality targeted case management should include support for people deemed at high risk of suicide, particularly during times of transitions such as from an emergency room or psychiatric hospitalization.

Targeted Case Management services, often seen as the core or backbone service of the behavioral health continuum of care, are generally not covered by private insurance or Medicare, but are funded through Virginia Medicaid for specific populations and needs. The STEP-VA funding for Case Management services allows CSBs to ensure that Targeted Case Management is available to all Virginians who qualify for and need this service, regardless of their insurance provider or ability to pay. Funding for Case Management began in FY 2023 at $3.2 million and increased to $4.3 million in FY 2025.

DBHDS is currently working to develop methods for effectively measuring the success of Targeted Case Management services at CSBs and will look for improvements in outcome measurement scores using instruments such as the DLA-20 or WHODAS 2.0. After successfully transitioning to the new data exchange, DBHDS anticipates incorporating external data sources, such as rates of psychiatric hospitalization and incarceration, into measurements for reporting on the success of this step. One limitation of relying on outcome measurement instruments for measuring the success of targeted Case Management services is the intent and goal of the service; Targeted Case Management is designed to assist individuals with maintaining stability in the community over a long period of time, rather than focusing on targeted improvements in a short span. Thus, it will be essential for DBHDS to have access to updated data reporting capabilities to allow the tracking of the individuals served across multiple systems.

Care Coordination

Individuals served by Virginia's CSB system tend to have complex needs that extend beyond their behavioral health diagnosis, often including chronic and acute medical issues, as well as needs connected with other services and systems (such as DSS, Corrections, Judicial system, law enforcement, etc.). Care coordination is an activity, practice, and philosophy that promotes team-based care among all the participants concerned with an individual's care and is not a distinct service. Care coordination activities are an essential component to all healthcare services, including but not limited to case management services, hospital liaison services, and discharge planning services.

Based on a person and family-centered plan of care and consistent with best practices, CSBs coordinate care across the spectrum of health services, including access to physical health services (acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person. Care coordination strives for seamless transitions of care in and out of CSB services, considering individuals' choice. Care coordination facilitates integrated care by intentionally organizing individual care activities, information, and needs and preferences across all appropriate care settings.

STEP-VA requires that everyone served by a CSB must have care coordination included as a part of their care. Funding for care coordination began in FY 2023 at $6.5 million and increased to $6.8 million in FY 2025.

Data Quality

In FY 2025, DBHDS' Behavioral Health Quality Management System was fully functional. This Continuous Quality Improvement (CQI) structure served as a standardized method for the development and review of STEP-VA performance metrics. This system provided an organized framework for the review and analysis of data to drive informed decision-making and quality improvement initiatives across the state through established Behavioral Health Quality Committees.

As part of the BH Quality Management System, a monitoring and technical assistance process had been developed and implemented with CSBs regarding STEP-VA metrics in FY 2025. This process outlined a standardized approach for:

- Monitoring STEP-VA data via the Behavioral Health Dashboard
- Identifying opportunities for improvement
- Providing technical assistance and support to CSBs
- Elevating identified system-level needs to the appropriate Behavioral Health Quality Committee

Since the successful implementation of the monitoring and technical assistance process, 23 CSBs have requested and received assistance from DBHDS in FY 2025. All CSB requests for technical assistance were responded to within seven business days and resolved in 90 days or less.

Implementation Barriers during FY 2025 and Expected Upcoming Activities for FY 2026

CSB staffing has been an ongoing concern related to all services but has had a significant impact on the continuation of STEP-VA activities. Throughout the review period, our community service board partners have reported extensive workforce shortages across all populations. According to Mental Health America's 2025 State of Mental Health in America report, Virginia ranks 37th nationally in behavioral health workforce availability, with 410 individuals per mental health provider, compared to the national average of 320:1.[4] The recruitment of all positions is a challenge in community services. It is difficult to hire qualified staff for STEP-VA positions thus slowing down program development at the provider level. Importantly, CSBs have made efforts to maintain and expand services despite these issues; however, the strain of long-standing workforce concerns are felt across the aspects of planning.

Additionally, in early FY 2025, several CSBs have shared feedback with DBHDS on the implementation of STEP-VA's Same Day Access step, noting that the current measure does not adequately meet the needs of the system. The issues identified by the CSBs and DBHDS are bulleted below, with a response from DBHDS with what progress was made during FY 2025.

- Inconsistent definitions and tracking limited DBHDS's ability to monitor performance fairly across all 40 CSBs. In FY 2025, the Quality Management System, as well as the EDW were deployed. These two mechanisms should improve DBHDS' ability to receive and track, as well as interpret and fairly monitor performance.
- Same Day Access is a Virginia-specific measure, not fully aligned with CCBHC requirements or national benchmarks. This has been addressed in the FY 2026 Performance Contract with the addition of the I-SERV measurement, a CCBHC measurement, as a required performance indicator.
- Differences in data entry practices, documentation, and interpretation across CSBs created inconsistencies. This should be addressed with the release of the new Enterprise Data Warehouse (EDW) in early FY 2026.
- Variability in how Same Day Access is implemented and tracked, making it difficult to compare performance statewide. Additional requirements have been added to the Performance Contract in FY 2026 which further define SDA (such as the I-SERV measurement, which also helps further define expectations.
- Alignment with best practice standards remains an ongoing priority, supported by using standardized measures that promote consistent reporting and compliance. This effort is part of the Quality Management System deployed for behavioral health at DBHDS.
- Same Day Access tracked initial evaluation timeliness but did not always connect to outcomes such as engagement in services or continuity of care. The connection to services was addressed in FY 2025 with additional measurements added to the FY 2026 Performance Contract; as a note, there are also engagement measurements embedded in the Block Grant indicators.
- Same Day Access focused only on time to Comprehensive Needs Assessment (CNA) after first contact, without capturing the full client experience of timely access to services. This was addressed in the FY 2026 Performance Contract with the addition of I-SERV and connection to services measurements.

Given the consistent and extensive criticism of how the Same Day Access step was being measured, consideration was given to adopt a different outcome measure to evaluate timely access across the public mental health system as indicated above.

With the launch of the new EDW in FY 2026, DBHDS will begin collecting granular, service-level data from the CSBs. This shift will incorporate standardized procedure (CPT/HCPCS), and diagnostic code (ICD10) sets along with age filters, strengthening and supporting deeper insights into the delivery and effectiveness of all STEP-VA services and steps.

Additional activities will include the evaluation of current performance measures, and development of performance measures that measure areas like access, outcomes, and CSB Performance, rather than processes.

DBHDS will continue the site visit process implemented nearly two calendar years ago to provide Technical Assistance (TA), review performance measures and gain more information about what resources are needed for success. DBHDS has found that this process increases accountability and collaboration. DBHDS will continue to improve upon previously established CSB site visits by incorporating a more standardized site visit and TA process in the upcoming calendar year. Updates to this process will include, but are not limited to: subject matter experts in various services of STEP-VA participation in TA and/or site visits as appropriate, implementation of a pre-visit questionnaire to streamline the site visit process with CSBs, further exploration regarding use of STEP-VA funds, review of more up-to-date data as available through the EDW, and review of relevant STEP-VA policies, procedures, and workflows.

DBHDS will continue to visit boards more frequently who demonstrated significant deviation from expectations. All Performance Contracts will be updated accordingly to reflect areas which need more detail, as well as any changes. DBHDS also provides several forums for CSB feedback as it pertains to the ongoing implementation of STEP-VA, to include weekly office hours and a collaborative STEP-VA Program Workgroup with DBHDS and CSB representatives.

Additionally, the following considerations have been made for FY 2026: the development and implementation of a formalized community needs assessment in order to determine what needs exist in communities and which resources are available to them either at the local CSB or through private entities (potential contract relationships); consideration of funding formulas for disbursement of funds in order to better account for various funding sources which vary greatly between CSB's; reduction of redundancy between steps so as to better clarify funding and outcome data; review of finalized changes made during DMAS' Medicaid Redesign and their impact on service provision through STEP-VA; ongoing research as to the alignment of measurements with best practices as allowable in current funding and data structure.

Conclusion

STEP-VA implementation and sustainability efforts have continued to advance, reflecting Virginia's commitment to improving the quality of behavioral health care in communities across the Commonwealth. In FY 2025, DBHDS and the CSBs made significant progress in advancing the STEP-VA initiative. All nine core services are now operational across Virginia's 40 CSBs, and important updates were made to align service requirements with national best practices and

SAMHSA guidance. Financial investments supported the expansion of Same Day Access, primary care screenings, and outpatient services, while performance dashboards and technical assistance processes improved accountability. FY 2025 also marked the piloting of the WHODAS 2.0 assessment tool, positioning Virginia to adopt more evidence-based functional outcome measures.

Looking ahead to FY 2026, DBHDS will build on these improvements through deployment of the new Enterprise Data Warehouse and continued data modernization efforts. These changes will enable more granular, standardized reporting using CPT/HCPCS and ICD-10 codes, while enhancing the ability to evaluate outcomes such as access, engagement, and equity. DBHDS will also continue to address workforce challenges, refine performance measures to align with best practices, and strengthen the monitoring process through site visits and technical assistance. Together, these actions will ensure STEP-VA continues to expand access, improve in quality, and provide consistent, accountable behavioral health services across the Commonwealth.

Appendix

Appendix A

Acronyms and Definitions

Acronym	Definition
CSB	Community Services Board
DBHDS	Department of Behavioral Health and Developmental Services
STEP-VA	System Transformation, Excellence, and Performance in Virginia
SDA	Same Day Access
I-SERV	Initial Service Engagement and Referral Validation
WHODAS	World Health Organization Disability Assessment Schedule
EBP	Evidence-Based Practice
SMVF	Service Members, Veterans, and their Families
FY	Fiscal Year
EDW	Enterprise Data Warehouse
HL7	Health Level Seven (interoperability standard for health data exchange)
CPT/HCPCS	Current Procedural Terminology / Healthcare Common Procedure Coding System
CNA	Comprehensive Needs Assessment
DLA-20	Daily Living Activities-20
READS	Research, Evaluation, and Data SMEs
CMS	Centers for Medicare & Medicaid Services

SAMHSA	Substance Abuse and Mental Health Services Administration

Allocations by CSB-SDA

CSB	Same Day Access Allocation FY25
Alexandria	$299,125.00
Alleghany	$299,125.00
Arlington	$299,124.00
Horizon/Central Va	$299,124.00
Chesapeake	$299,124.00
Chesterfield	$299,125.00
Colonial	$299,125.00
Crossroads	$299,124.00
Cumberland	$299,124.00
Danville Pittsylvania	$299,124.00
Dickenson	$299,125.00
Eastern Shore	$299,125.00
Fairfax Falls Church	$299,124.00
Goochland	$299,125.00
Hampton NN	$299,124.00
Hanover	$299,125.00
Harrisonburg-Rock	$299,124.00
Henrico	$299,124.00
Highlands	$299,125.00
Loudoun	$299,125.00
Mid Peninsula NN	$299,124.00
Mt. Rogers	$299,124.00
New River Valley	$299,124.00
Norfolk	$299,124.00
Northwestern	$299,124.00
Piedmont	$299,124.00
PD1	$299,124.00
District 19	$299,124.00
Portsmouth	$299,125.00
Prince William	$299,124.00
Rapp Area	$299,124.00
Rapp-Rapidan	$299,125.00

Region Ten	$299,124.00
Richmond	$299,124.00
Blue Ridge	$299,124.00
Rockbridge	$299,125.00
Southside	$299,125.00
Valley	$299,125.00
Virginia Beach	$299,124.00
Western Tidewater	$299,124.00
Total	**$11,964,986**

Primary Care Allocations

CSB	Primary Care Screening Allocations FY25
Alexandria	$144,299.00
Alleghany	$67,307.00
Arlington	$181,869.00
Horizon/Central Va	$503,142.00
Chesapeake	$132,364.00
Chesterfield	$125,600.00
Colonial	$89,105.00
Crossroads	$263,807.00
Cumberland	$175,300.00
Danville Pittsylvania	$164,879.00
Dickenson	$76,596.00
Eastern Shore	$110,021.00
Fairfax Falls Church	$450,177.00
Goochland	$57,993.00
Hampton NN	$365,391.00
Hanover	$45,794.00
Harrisonburg-Rock	$110,397.00
Henrico	$228,204.00
Highlands	$153,618.00
Loudoun	$54,275.00
Mid Peninsula NN	$245,844.00
Mt. Rogers	$405,380.00
New River Valley	$294,073.00
Norfolk	$313,438.00
Northwestern	$246,990.00
Piedmont	$297,546.00

PD1	$213,311.00
District 19	$179,299.00
Portsmouth	$125,541.00
Prince William	$144,421.00
Rapp Area	$280,458.00
Rapp-Rapidan	$91,529.00
Region Ten	$315,727.00
Richmond	$398,785.00
Blue Ridge	$385,993.00
Rockbridge	$110,766.00
Southside	$173,604.00
Valley	$101,475.00
Virginia Beach	$218,602.00
Western Tidewater	$202,945.00
Total	**$8,245,865**

Outpatient Services Allocation

CSB	**Outpatient Allocation FY25**
Alexandria	$505,152.00
Alleghany	$432,450.00
Arlington	$535,350.00
Horizon/Central Va	$642,567.00
Chesapeake	$569,670.00
Chesterfield	$469,119.00
Colonial	$404,249.00
Crossroads	$521,635.00
Cumberland	$536,383.00
Danville Pittsylvania	$503,448.00
Dickenson	$430,487.00
Eastern Shore	$477,281.00
Fairfax Falls Church	$1,223,870.00
Goochland	$496,820.00
Hampton NN	$552,893.00
Hanover	$432,429.00
Harrisonburg-Rock	$563,560.00
Henrico	$662,303.00
Highlands	$458,626.00
Loudoun	$561,889.00
Mid Peninsula NN	$589,998.00

Mt. Rogers	$547,533.00
New River Valley	$956,439.00
Norfolk	$671,282.00
Northwestern	$687,606.00
Piedmont	$562,279.00
PD1	$513,317.00
District 19	$667,305.00
Portsmouth	$503,910.00
Prince William	$754,525.00
Rapp Area	$728,445.00
Rapp-Rapidan	$548,644.00
Region Ten	$974,142.00
Richmond	$976,189.00
Blue Ridge	$649,268.00
Rockbridge	$471,481.00
Southside	$479,697.00
Valley	$485,647.00
Virginia Beach	$674,936.00
Western Tidewater	$876,799.00
Total	**$24,299,623**

Mobile Crisis Allocations

Region	**Mobile Crisis Allocation FY25**
Region I	$5,557,433
Region II	$6,253,878
Region III	$5,285,407
Region IV	$4,358,394
Region V	$5,499,812
Total	**$26,954,924**

Marcus Alert

CSB	**Marcus Alert Allocation FY25**
Chesterfield	$600,000
Fairfax Falls Church	$600,000

Hampton NN	$600,000
Highlands	$600,000
Prince William	$600,000
Rapp Area	$600,000
Rapp-Rapidan	$600,000
Richmond	$600,000
Blue Ridge	$600,000
Virginia Beach	$600,000
Total	**$6,000,000**

SMVF Allocations

CSB	SMVF Allocation FY25
Alexandria	$0
Alleghany	$56,025
Arlington	$129,920
Horizon/Central Va	$81,546
Chesapeake	$84,961
Chesterfield	$72,127
Colonial	$77,765
Crossroads	$78,780
Cumberland	$64,286
Danville Pittsylvania	$78,489
Dickenson	$50,073
Eastern Shore	$85,854
Fairfax Falls Church	$273,363
Goochland	$58,947
Hampton NN	$92,892
Hanover	$60,305
Harrisonburg-Rock	$71,501
Henrico	$68,295
Highlands	$62,346
Loudoun	$75,443
Mid Peninsula NN	$88,774
Mt. Rogers	$61,719
New River Valley	$69,090
Norfolk	$84,924
Northwestern	$99,269
Piedmont	$82,079
PD1	$72,015

District 19	$77,856
Portsmouth	$81,178
Prince William	$82,206
Rapp Area	$82,991
Rapp-Rapidan	$70,737
Region Ten	$238,684
Richmond	$222,388
Blue Ridge	$235,265
Rockbridge	$68,940
Southside	$78,488
Valley	$69,575
Virginia Beach	$102,108
Western Tidewater	$249,286
Total	**$3,840,490**

Peer and Family Allocations

CSB	Peer Support Allocation FY25
Non-CSB	$200,121
Alexandria	$121,073
Alleghany	$92,000
Arlington	$130,516
Horizon/Central Va	$132,361
Chesapeake	$109,565
Chesterfield	$100,255
Colonial	$92,000
Crossroads	$94,545
Cumberland	$105,942
Danville Pittsylvania	$92,000
Dickenson	$92,000
Eastern Shore	$92,000
Fairfax Falls Church	$321,185
Goochland	$92,000
Hampton NN	$126,451
Hanover	$92,000
Harrisonburg-Rock	$107,655
Henrico	$145,318
Highlands	$96,974
Loudoun	$126,927

Mid Peninsula NN	$102,238
Mt. Rogers	$102,643
New River Valley	$223,764
Norfolk	$141,340
Northwestern	$132,760
Piedmont	$107,255
PD1	$98,730
District 19	$126,411
Portsmouth	$92,000
Prince William	$171,100
Rapp Area	$145,530
Rapp-Rapidan	$102,990
Region Ten	$229,300
Richmond	$236,726
Blue Ridge	$120,772
Rockbridge	$92,000
Southside	$92,000
Valley	$105,424
Virginia Beach	$142,482
Western Tidewater	$205,647
Total	**$5,334,000**

Psychiatric Rehabilitation Allocations

CSB	**Psychiatric Rehabilitation Services Allocation FY25**
Alexandria	$95,500
Alleghany	$95,500
Arlington	$95,500
Horizon/Central Va	$95,500
Chesapeake	$95,500
Chesterfield	$95,500
Colonial	$95,500
Crossroads	$95,500
Cumberland	$95,500
Danville Pittsylvania	$95,500
Dickenson	$95,500
Eastern Shore	$95,500
Fairfax Falls Church	$95,500
Goochland	$95,500

Hampton NN	$95,500
Hanover	$95,500
Harrisonburg-Rock	$95,500
Henrico	$95,500
Highlands	$95,500
Loudoun	$95,500
Mid Peninsula NN	$95,500
Mt. Rogers	$95,500
New River Valley	$95,500
Norfolk	$95,500
Northwestern	$95,500
Piedmont	$95,500
PD1	$95,500
District 19	$95,500
Portsmouth	$95,500
Prince William	$95,500
Rapp Area	$95,500
Rapp-Rapidan	$95,500
Region Ten	$95,500
Richmond	$95,500
Blue Ridge	$95,500
Rockbridge	$95,500
Southside	$95,500
Valley	$95,500
Virginia Beach	$95,500
Western Tidewater	$95,500
Total	**$3,820,000**

Case Management Allocations

CSB	**Case Management Allocation FY25**
Alexandria	$101,962
Alleghany	$101,962

Arlington	$101,962
Horizon/Central Va	$101,962
Chesapeake	$101,962
Chesterfield	$101,962
Colonial	$101,962
Crossroads	$101,962
Cumberland	$101,962
Danville Pittsylvania	$101,962
Dickenson	$101,962
Eastern Shore	$101,962
Fairfax Falls Church	$101,962
Goochland	$101,962
Hampton NN	$101,962
Hanover	$101,962
Harrisonburg-Rock	$101,962
Henrico	$101,962
Highlands	$101,962
Loudoun	$101,962
Mid Peninsula NN	$101,962
Mt. Rogers	$101,962
New River Valley	$101,962
Norfolk	$101,962
Northwestern	$101,962
Piedmont	$101,962
PD1	$101,962
District 19	$101,962
Portsmouth	$101,962
Prince William	$101,962
Rapp Area	$101,962
Rapp-Rapidan	$101,962
Region Ten	$101,962
Richmond	$101,962
Blue Ridge	$101,962
Rockbridge	$101,962
Southside	$101,962
Valley	$101,962
Virginia Beach	$101,962
Western Tidewater	$101,962
Total	**$4,078,480**

Care Coordination Allocations

CSB	Care Coordination Allocation FY25
Alexandria	$145,299
Alleghany	$92,784
Arlington	$179,103
Horizon/Central Va	$206,483
Chesapeake	$121,231
Chesterfield	$90,000
Colonial	$116,969
Crossroads	$162,521
Cumberland	$149,170
Danville Pittsylvania	$109,982
Dickenson	$90,000
Eastern Shore	$107,950
Fairfax Falls Church	$284,201
Goochland	$90,000
Hampton NN	$184,127
Hanover	$90,000
Harrisonburg-Rock	$170,139
Henrico	$208,650
Highlands	$138,843
Loudoun	$141,285
Mid Peninsula NN	$170,937
Mt. Rogers	$165,963
New River Valley	$226,653
Norfolk	$198,269
Northwestern	$220,228
Piedmont	$183,125
PD1	$162,219
District 19	$203,606
Portsmouth	$93,096
Prince William	$249,050
Rapp Area	$225,787
Rapp-Rapidan	$175,787
Region Ten	$210,036
Richmond	$198,570
Blue Ridge	$187,524

Rockbridge	$131,500
Southside	$120,387
Valley	$179,159
Virginia Beach	$155,304
Western Tidewater	$178,201
Total	**$6,514,138**

Appendix B

Data Dictionary and Business Rules

Purpose and Context

To ensure transparency and consistency in statewide reporting, the following Data Dictionary and Business Rules summarize the core data elements and logic used to calculate STEP-VA performance measures across Community Services Boards (CSBs). These definitions reflect measures currently validated through the legacy Enterprise Data Warehouse (EDW), with transition to the new EDW environment as part of DBHDS's Data Modernization Initiative.

This addendum provides a concise reference for how data are defined, validated, and interpreted across multiple STEP-VA components, supporting uniform analysis and reporting for the General Assembly and DBHDS leadership.

Table A1. Data Dictionary

Field / Measure	Description / Purpose	Source System or Table	Calculation / Logic Summary	Notes
SDA (First Contact Date)	Date consumer first requested or received behavioral health services through Same Day Access.	ADS.ASSESSMENT / ADS.SERVICES	Earliest ASSESSMENT_ACTION_CD = '01A' or SERVICE_CD IN ('96127','V0009').	Used as starting point for I-SERV timeliness measure.
SDA Follow-Up Appointment	Tracks if consumer received a follow-up within 10 business days of initial assessment.	ADS.ASSESSMENT	DATEDIFF(DAY, FIRST_CONTACT_DT, ASSESSMENT_DT) ≤ 10 for SDA_ASSESSMENT_IND = 'Y'.	Reported as % of SDA assessments meeting 10-day target.
I-SERV (Initial Service Engagement)	Measures time from first contact to Comprehensive Needs Assessment (CNA).	ADS.ASSESSMENT / ADS.SERVICES	% of new clients receiving CNA within 10 business days of first contact.	Replaces SDA timeliness measure beginning FY26.
Columbia Suicide Screening (C-SSRS)	Standardized suicide-risk screen administered at first contact	ADS.ASSESSMENT	Presence of Columbia screen record per episode.	Used within **SMVF** and **Outpatient** steps for

	and periodically in care.			clinical risk tracking.
Crisis Services Encounters	Identifies CSB crisis service contacts and stabilization episodes.	ADS.SERVICES / Crisis Extract Tables	SERVICE_CD mapped to Crisis Response categories.	Includes Mobile Crisis and Crisis Receiving Center data.
SMVF Participation	Consumers identified as service members, veterans, or family members.	ADS.PERSON / ADS.DEMOGRAPHICS	SMVF_FLAG = 'Y' based on veteran status fields or self-report.	Supports SMVF step reporting and federal alignment.
EBP Training Hours	Tracks staff completion of 8-hour minimum and 40-hour training benchmarks.	EBP Survey / Training Extract	% of eligible staff meeting each threshold.	FY25 data unverified pending CSB confirmation.
Peer FTE Count	Number of full-time peer positions funded through STEP-VA.	STEP-VA 6-Month Survey	Self-reported CSB count validated annually.	Used for Peer Services step monitoring.
DLA-20 Composite Score	Functional assessment measuring daily living activities and recovery progress.	ADS.ASSESSMENT	Average score per client and growth ≥ 0.5 between baseline and follow-up.	Transitioning to WHODAS 2.0 in FY26.
WHODAS 2.0	New functioning measure to replace DLA-20 for adults and youth.	Future EDW Integration	Standardized score based on six domains of functioning.	Implementation in FY26.

Table A2. Business Rules Summary

Measure	Business Rule Description	EDW Logic / Calculation	Reporting Notes
SDA 10-Day Completion	% of SDA assessments where follow-up appointment occurred within 10 business days of assessment.	DATEDIFF(DAY, ASSESSMENT_DT, FOLLOWUP_DT) ≤ 10 and SDA_ASSESSMENT_IND = 'Y'.	Legacy measure until replaced by I-SERV.
I-SERV Timely CNA	% of new clients receiving Comprehensive Needs Assessment within 10 days of first contact.	DATEDIFF(DAY, SDA_ASSESSMENT_DT, FIRST_CONTACT_DT, CNA_DT) ≤= 10.	Becomes primary access measure FY26.
I-SERV 30-Day Engagement	% of new clients receiving any billable service within 30 days of first contact.	DATEDIFF(DAY, FIRST_CONTACT_DT, SERVICE_DT) ≤ 30 for valid SERVICE_CD.	Pilot underway FY26.
Columbia Suicide Screening (C-SSRS)	All clients should receive screen at initial contact and as clinically indicated.	Presence of screen record per episode; may occur at SDA or Outpatient entry.	Used for SMVF and Outpatient steps; captured in EDW.
Crisis Response Performance	Monitors CSB crisis encounter timeliness and coverage by region.	SERVICE_CD grouping for mobile, receiving, stabilization services.	Regional aggregation in quarterly Crisis report.
SMVF Access Rate	% of SMVF-identified consumers served through STEP-VA services.	COUNT(SMVF_FLAG='Y') / TOTAL_CONSUMERS.	Benchmarked at 90% service identification rate.
EBP Training Completion	% of eligible staff completing minimum and full training hours.	(Staff 8-hour / Total Eligible) and (Staff 40-hour / Total Eligible).	Data from EBP survey; unverified FY25.
Peer Service Capacity	Peer FTEs reported through STEP-VA survey.	Sum of FTE reported per CSB.	Validated annually through STEP Check-In Survey.
DLA-20 Functional Improvement	% of individuals with baseline < 4.0 who show ≥ 0.5 increase in score over two quarters.	AVG(Δ Score ≥ 0.5) / Eligible Population.	Performance benchmark = 35%.
WHODAS Transition	Adoption of WHODAS 2.0 for functioning tracking and reporting.	Standard score recorded for adults and youth.	Full implementation targeted for FY 2026.

The Data Dictionary and Business Rules outlined above establish a standardized framework for defining, collecting, and validating STEP-VA performance measures across Virginia's CSBs. These rules ensure consistency in how outcomes are measured and compared statewide, providing the foundation for data-driven decision-making. As DBHDS continues its data modernization initiative, the migration of these measures into the new EDW will allow for automated reporting, improved data quality, and expanded analytic capabilities beginning in FY 2026. Future STEP-VA reports will include updated business rules and data definitions aligned with the enhanced system.