

**BOARD OF DIRECTORS MEETING MINUTES
March 2, 2021**

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

RBHA Board members present were: Dr. Joy Bressler; Scott Cannady; Irvin Dallas, **Vice Chair**; Denise Dickerson, **Secretary/Treasurer**; Dr. Cheryl Ivey Green, **Chair**; Sabrina Gross; Karah Gunther; Colleen Howarth; Dr. Cynthia Newbille; Dr. Andrew Ramsey; Malesia "Nikki" Taylor and Eduardo Vidal.

RBHA Board members absent: Melodie Patterson.

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

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

Guests: None.

Proceedings:

- The meeting was called to order at 3:03 p.m. by Dr. Cheryl Ivey Green.
- The Board meeting minutes for February 2, 2021 were approved with a motion by Dr. Cynthia Newbille and seconded by Denise Dickerson. The minutes were unanimously approved.
- **Public Comment:** None.

Employee Recognitions

- Joey Siverd, Clinician in the Adult Mental Health PACT team, was recognized as employee of the month.
- Early Intervention/Part C in Developmental Services was recognized as team of the month.

Board Chair Report- Dr. Cheryl Ivey Green

- Dr. Green thanked the leadership team and all staff for the work they continue to do during this season of COVID.
- Dr. Green thanked the board members who participated in making calls to the legislators on the VACSB Advocacy Phone Blitz Day.

Chief Executive Officer's Report- Dr. John Lindstrom

- The CEO Report was discussed and is included in today's board meeting packet and with today's meeting minutes.
- Dr. Lindstrom thanked the Executive Leadership Team for the phenomenal work being done during the pandemic; and, especially the Human Resources staff for the incredible work they are doing in promoting the vaccine program at RBHA and managing the notifications for our COVID positive situations.
- By December 1st there should be implementation of the five targeted sites for the Marcus Alert, Richmond being one of those hubs.

RBH Foundation Report – Carolyn Seaman

- The Foundation Development Report was discussed and is included in today's board meeting packet and with today's meeting minutes.
- Several DIY projects, volunteer projects and community engagement projects are in the works.

Committee Reports:**Access & Service Delivery Committee – Malesia "Nikki" Taylor**

- The Access & Service Delivery Committee has not met since the last board meeting.

Advocacy & Community Education Committee – Scott Cannady

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

Executive Committee – Dr. Cheryl Ivey Green

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

Finance Committee – Denise Dickerson

- Total cash in the bank at January 31st was \$22.1 million, and RBHA's share of that cash is \$5.7 million.
- RBHA's current operating reserve ratio is up slightly from last month to 0.92 or just under two months of expenses.
- Net income has increased approximately \$3.4 million over the same period last year. This is mainly due to increases in State and Federal grants, notably STEP-VA and CCBHC, additionally, RBHA received its share of unrestricted regional funds disbursement. Net income is expected to increase once January revenue and receivables are posted to the system.
- The note payable balance at January 31st is \$3 million and has been recorded in the liabilities section of the Balance Sheet.
- Resolution for consideration by the RBHA Board of Directors to proceed with the letter of intent to assume the programs and assets of Human Resources, Inc., located at 15 West Cary Street, Richmond, Virginia.
 - ***The Finance Committee recommends the RBHA Board of Directors resolve to proceed with the letter of intent to assume the programs and assets of Human Resources, Inc., located at 15 West Cary Street, Richmond, Virginia; seconded by Sabrina Gross and unanimously approved.***
- Resolution for consideration by the RBHA Board of Directors for management to proceed with planned renovation of the first floor clinic and office spaces located at 107 South 5th Street, Richmond, Virginia, and to award a contract to an appropriate and qualified bidder.
 - ***The Finance Committee recommends the RBHA Board of Directors resolve to move forward with plans to renovate the first floor at 107 South 5th Street, Richmond, Virginia, and to award a contract to an appropriate and qualified bidder; seconded by Irvin Dallas and unanimously approved.***

Human Resources Committee – Irvin Dallas

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

Nominating & By-Laws Committee – Dr. Joy Bressler

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

Presentation: An Overview of Medicaid Behavioral Health Enhancement was presented by John Lindstrom, Ph.D., LCP, CEO and Shenée McCray, LCSW, COO, Mental Health Services. The presentation is included with today's meeting minutes.

Other Matters: Dr. Cynthia Newbille acknowledged Dr. Lindstrom and his Leadership Team for ensuring there is no loss in services and ensuring we are able to enhance and expand services available to Richmonders.

The meeting adjourned at 4:37 p.m. with a motion by Dr. Cynthia Newbille and seconded by Eduardo Vidal.

The next Board of Director's meeting will take place on **Tuesday, April 13, 2021 at 3:00 p.m. by teleconference/videoconference via Zoom.**

Respectfully Submitted:



Dr. Cheryl Ivey Green
RBHA Board Chair



Dr. John P. Lindstrom
Chief Executive Officer

Richmond Behavioral Health Authority
Board of Directors
Chief Executive Officer's Report
March 2, 2021

RBHA services continue to operate under the adopted COVID 19 guidelines. While there is provision for face-to-face service delivery, outpatient services and case management are relying heavily on telehealth and telephonic outreach. RBHA currently uses multiple telehealth platforms; however, we will be moving to a HIPPA compliant version of Zoom exclusively in the near future. We have not moved to increase office presence for our teleworking staff, though strategies are being explored which will allow more regular office access.

As of yesterday, March 1, 61 COVID 19 positive staff have been reported since the beginning of the pandemic. Positive tests have been reported on 169 of the individuals we serve. The rate of positive reports has slowed over the past few weeks. Progress has been made in getting willing staff vaccinated. To date we have received 437 responses to a voluntary rolling staff survey. As of yesterday, 345 report having received their first injection, 14 have not but have an appointment, 35 are seeking an appointment, and 49 reported that they do not wish to be vaccinated. Second doses have been received by 110 staff. Another 150 staff have appointments for second dose, 132 are seeking an appointment, and 51 expressed no interest.

FY'20 Annual Report

The FY'20 Annual Report has been published electronically and has been distributed accordingly. A print version will be available shortly.

STEP-VA and Marcus Alert Planning

Attached is a document entitled *STEP-VA Comprehensive Update – February 2021*. This update was recently provided by DBHDS and includes a description and status of next steps. Please note the timelines and funding information. RBHA is working with regional partners to develop plans for rolling out the Adult Mobile Crisis component. The Marcus Alert stakeholders workgroup has now completed four meetings. A series of listening sessions are underway to hear from citizens as to their ideas and expectations. There will also be three public information forums later in the spring. The work of the stakeholders group will wrap up in late May or early June as a report is due to the General Assemble on July 1.

FY 22 Budget Development

Budget worksheets and detailed personnel cost summaries have been distributed to all members of the Executive Leadership Team. This kicks off our FY'22 budget building process in earnest. The goal at this time is to have a final draft presented to the finance committee at its April meeting, then on to the full board for review at the May meeting. Any delay in the planning process would push back board action to the June meeting.

Continuing Infrastructure Needs

With the expansion of **Outpatient and Medical Services** (primary care screening, primary care, and office based opioid treatment or OBOT), we began the process of planning for the eventual repurposing of space in our 107 S. Fifth Street location. We undertook the development of design and construction drawings prior to the pandemic. The project was subsequently posted for bids. Proposals were received and evaluated, but due to financial uncertainties and the pandemic, the process was put on hold. An executive summary reflecting the history and need was provided at last month's board meeting. The proposal will now be advanced to the full board through the finance committee.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "John P. Lindstrom", with a long horizontal flourish extending to the right.

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

Attachment: STEP-VA Comprehensive Update

STEP-VA Comprehensive Update: February 2021

Because so many aspects of STEP-VA implementation were put on hold due to COVID-19 pandemic, instead of requesting a 6 month update survey from each CSB this February, we will provide you with this comprehensive update on the status of the STEP-VA project. The 6-month phase 2 check-ins will resume in August, 2021 to be included in the 2021 legislative report.

STEP-VA TIMELINE

This represents an updated working timeline (2020-2024) for STEP-VA implementation, incorporating the results of the Comprehensive Needs Assessment and JLARC studies (STEP-VA implementation and CSB Funding). Timeline based on State Fiscal Year.

- **SFY 2020**
Needs assessment results, planning, access
- **Q2-Q4, SFY 2021**
Written Scope of Services, Selection of Core Quality Measures, Paperwork and Funding Streamlining Initiatives, Technical assistance: DLA-20, ASAM
- **SESSION JANUARY 2021**
Seek funding to meet Governor and GA expectations for Outpatient, Crisis, Military/Veterans', Peer Services, Infrastructure
- **JULY 1, 2021**
Performance contract changes to reflect any achievements in streamlining, clarification regarding quality measures and statewide QI process. Initial expectations for 4 STEPs integrated into Performance Contract.
- **SESSION JANUARY 2022**
Seek funding to meet Governor and GA expectations for final three STEPs and infrastructure, any legislative changes
- **JULY 1, 2022**
Performance contract changes to reflect initial expectations for STEPs to date.
- **SFY 2022**
Care Coordination Planning, ES/Crisis and Care Coordination/Discharge Planning integration, Alternative Payment Methodologies, Implement Military/Veterans' Services and Peer and Recovery Supports, Regional Crisis Dispatch "go live"
TA: outpatient, crisis, billing/reimbursement
- **SESSION JANUARY 2023**
any legislative changes or funding requests to meet Governor and GA expectations
- **SFY 2023**
Initial implementation of final three STEPs, pilot or planning for any alternative payment methodologies, consider state certification or finalize site monitoring plan
- **JULY 1, 2024**
Performance contract changes to reflect expectations for STEP-VA
- **SFY 2024**
All STEPs implemented along with payment arrangements and quality monitoring in process, solicit updated Needs Assessment

Needs Assessment Results and Cross-STEP Updates

The results of the 18-month statewide needs assessment indicated primary findings that cut across STEPs to focus on broader system issues and improvements. The Needs Assessment had a total of 7 key findings and 11 recommendations. Further, our response to the 2019 JLARC CSB funding report was put on hold while the statewide Needs Assessment was completed.

Behavioral Health Index Equity (BHIE) Workgroup:

A workgroup comprised of CSB/BHA executive directors and DBHDS program, finance, data, contracting, and other administrative staff was formed and met six times over a 12 month period in 2020 and early 2021. The workgroup came to consensus recommendation regarding short term solutions to support the ongoing implementation of STEP-VA, including the use of a needs-based funding formula. The short term needs based formula is as follows:

45% population in poverty + ALICE + 25% BHI + 20% uninsured rate at CSB measured two ways [10% each] + 10% rurality indicator = share of funding

****note: the importance of using this formula in the context of an agreed upon "floor" for funding, to ensure that small CSBs receive enough funding to implement the base services required was agreed upon as well.***

The majority of recommendations set out a longer-term strategy to decrease the overall number of funding streams from DBHDS to CSB/BHAs (currently over 90) and a process to support first steps to modernize both our funding and performance frameworks as well as our data exchange. By

first focusing on achieving transactional data exchange and unique identifiers, we can then set more

ambitious goals such as cost-of-care models and shared reimbursement structures. The final report will be distributed soon.

Workforce initiatives: Needs Assessment results highlighted significant workforce issues, which have unfortunately been further exacerbated by COVID-19. In general, these related to position-based demands (paperwork, regulations, acuity/schedule) and salary/compensation not being competitive with private sector positions that required less paperwork and had fewer regulations. Successful workforce initiatives must consider both sides of this situation. Regarding paperwork, we have identified the following areas for further exploration of their feasibility. As you know, these are complicated issues with multiple offices and agencies involved and we will likely not be successful in achieving all of these. But, we are committed to clearly evaluating the feasibility and acceptability of each of these proposals which at face value are consistent with feedback from the Needs Assessment.

Paperwork reduction requests received by DBHDS and currently under review:

1	Decrease DLA-20 to every 6 months for all clients
2	No longer require DLA-20 for SUD only clients due to overlap with ASAM (still require for co-occurring)
3	No longer require quarterly review; move to 6 month review and ISP update
4	Fully integrate DBHDS and DMAS CNA requirements
5	Review paperwork requirements at each level of care with co-occurring lens and align requirements across MH and SUD

Regarding salary alignment, the idea of a statewide salary study was discussed in 2020. We have not pursued this at this time at DBHDS. A statewide workforce survey is in development in cooperation with MH/SUD council currently. We were thrilled to see the advocacy of VACSB for Behavioral Health Loan Repayment and believe this is an important avenue for workforce support.

Core Performance Outcomes: The importance of core performance outcomes that span across all program areas was highlighted by the Needs Assessment as well as both JLARC studies. It is not feasible for CSBs to achieve integration with the broader Medicaid system and work with 6 MCOs while also maintaining performance metrics for each historical DBHDS program. We have been working with Quality and Outcomes (Q&O) Committee to review historical performance outcomes in the performance contract as well as STEP-VA metrics. Currently, we are on track to have approximately 5 core metrics identified by July, 2021. The ultimate framework/estimate would be to achieve 10-12 core performance metrics. We hope to have Virginia/CSB system specific metrics (~5-6) as well as priority HEDIS measures (~5-6) once we achieve data and reporting upgrades described below. The idea is that some core metrics (e.g., DLA-20, engagement) could be evaluated for different programs and populations to serve multiple purposes. It is important to note that specific DBHDS programs (e.g., ACT, Permanent Supportive Housing, Jail Diversion, etc.) will retain their own individualized performance metrics. Initial measures being reviewed include Same Day Access measures, substance use engagement, continuity of care after state hospital discharge, and DLA-20 score improvements. Relatedly, consistent with a set of core performance metrics, a core description of the STEP-VA scope of services in a single document and associated updates to the performance contract is needed and DBHDS has begun drafting this documentation.

Data and Reporting upgrades: The vision for STEP-VA can only be achieved with a modernized data approach. Not only is this needed for quality and accountability, but also for us to better identify system

improvements regarding access and consistency. The primary investment needed is on the DBHDS side to transition to an EHR based data extract and software to replace the functions of CCS3 and little CARS. DBHDS has taken initial steps for internal approval and will soon engage with DMC to initiate planning. In order to ensure that modern structures invested in at DBHDS can interface with all EHRs at the CSBs, we will need to gather information to ensure that resources are provided to CSBs that would need a technical upgrade in order to interface with a modern, transaction-based data solution.

Billing and reimbursement improvements: The transition to carved-in behavioral health services and six MCOs drastically impacted business procedures for the CSBs. Unfortunately, due to the data limitations described above and lack of data integration with DMAS, DBHDS has had limited success in providing the support needed to identify areas of improvement for reimbursement practices. There were initial discussions in 2020 regarding the initiation of a statewide contractor to work with CSBs in this domain; however, given competing demands and COVID-19 impacts, CSBs indicated the preference was not to pursue at this time although still remains an idea for consideration. If the CSBs are interested in working with a contractor for this purpose, there is funding available to pursue this through DBHDS, please communicate back to us via VACSB.

Training and Clinical Quality: The Needs Assessment also recommended a statewide contract focused on evidence based practice and clinical quality improvement, however, as with billing and reimbursement improvements, these recommendations were made prior to COVID-19. We have been impressed with the significant investments in training in evidence based practices that the regions have achieved with self-directed planning over the last two years. We would like to continue allocating \$1.5 million in outpatient funding (FY 20) towards training, and continue the regional approach launched with those funds. Additional 'set asides' within other steps (Service Members, Veterans, and Family Members, for example) can augment these funds. A subgroup of the Quality and Outcomes (Q&O) committee has recently formed which will be a critical partner in planning. This subgroup, led by Stacy Gill (ED, Goochland-Powhatan CSB), is advising on issues related to learning management systems, and what would be the best way to manage trainings that are to be statewide.

The most pressing training needs from our perspective regard continuation of DLA-20 training, ongoing ASAM training, and new trainers needed for the statewide children's mobile crisis training curriculum. We envision set asides from STEP VA funding would support the development of regional training infrastructure (e.g. outpatient services, SMVF, etc) (more on that below), as well as the new required block grant crisis set-aside.

In order to meet the upcoming, significant and on-going needs regarding training under STEP-VA, we request further structuring the initiative as follows:

- 1) Each region with at least .5 or 1 FTE regional training coordinator
- 2) Each region with at least 1.0 FTE regional trainer

With the upcoming required mobile crisis trainings for both adults and children, there will be an on-going need to have dedicated regional trainers. In summary, in the short term, these new requirements can be supplemented by additional block grant dollars being received by Virginia, but planning should begin now to ensure that over the next two years the infrastructure described is invested in using these outpatient training dollars. Initial focus of state-sponsored trainers, regardless of funding stream, will be DLA-20 and children's mobile crisis.

Infrastructure Funding: \$3.2 million is provided in the 2022 budget for CSBs to build infrastructure needed for the implementation of STEP-VA. This will not cover all of the above stated infrastructure needs across the system. DBHDS will assess the costs associated with any CSB EHR upgrades needed to interface with a modern data system in the coming months. The remaining dollars can be disbursed either using a needs based formula, which would mean a small amount of funding for each CSB, or in a two step approach, where high needs CSBs are first identified and then funding is distributed among those CSBs who need the infrastructure funding the most. DBHDS seeks VACSB input into this determination so that decisions for planning can be made by May, 2021.

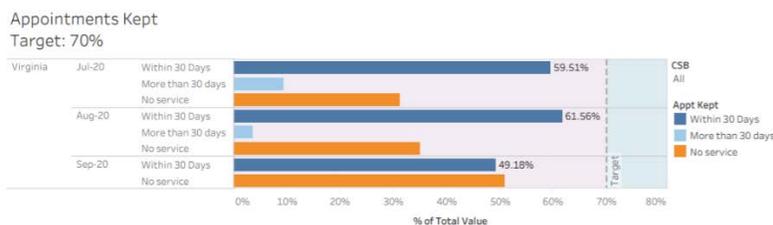
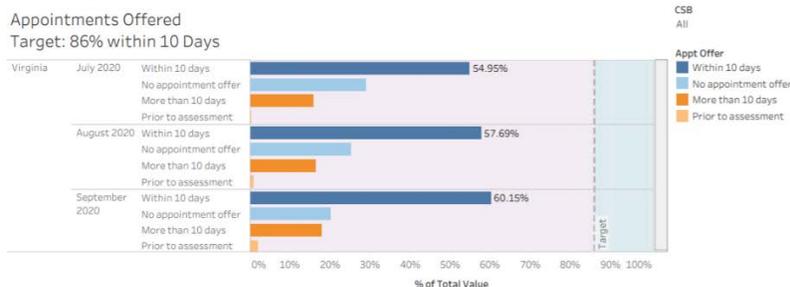
Individual Step Updates

Same Day Access

All CSBs continued providing SDA throughout the COVID-19 pandemic, with a focus on transitioning to telehealth platforms, and calibrating processes to ensure that services were also continuously available for individuals without access to telehealth while maintaining staff safety. Innovations included drive up services, two-room approaches, and more.

Data Management Committee (DMC) as well as a subgroup focused on data quality has been working to improve data quality around Same Day Access metrics. The goal is to implement any behavioral changes, CSB guidance, DBHDS quality checks, and shared understanding of any remaining limitations of the data in its current status by July, 2021. The status of the data currently is reflected below. We plan to make this information available to CSBs on a refreshed data dashboard beginning in FY22. As you can see, the capture of “appointment offered” remains an issue (and we understand that this is not a data element captured for any other purpose or captured as part of typical business procedures). The appointment kept measure has fewer identified data issues, and as can be seen, at a state-wide level, we are close to meeting the target of 70%, which is extremely promising.

Same Day Access Outcomes FY2021



Primary Care Screening

Early in the pandemic, we released guidance on the implementation of this STEP that supported CSBs to focus on clinical need when determining primary care screening services. Further, we expanded the window for 2020 screenings from 12 months to an 18 month window. In determining clinical need for a primary care screen, factors to consider include whether the individual has a primary care physician (PCP) and whether they have had a recent visit with their PCP. The completion of metabolic screens for individuals prescribed antipsychotic medication is a more pressing clinical issue, and it is our understanding that most CSBs have continued to see these clients in person, even if less frequently, as clinically indicated.

Little did we know the pandemic would still be having major impacts on in-person services a year later. Clinically, our guidance remains the same: primary care screens should be prioritized for individuals without connections to primary care, all clients should be connected to primary care and followed to ensure successful connections, and metabolic screens remain highly important for individual prescribed antipsychotic medications, with best practice considered to be screening at each maintenance appointment (approximately every 3 months). With more advanced data capture, we would pursue measuring this more closely, but unfortunately, the limits of CCS3 and continuing impediments associated with the pandemic make it very difficult to clearly identify these processes when they are being determined based on clinical need. Thus, we are relying on CSBs to continue to evaluate their internal data for quality improvement. At the state level, we continue to monitor the number of screens completed each month. This is a key area we hope to improve with improvements to the DBHDS-CSB data relationship.

Outpatient Services

Outpatient service offerings have grown significantly with the \$15 million investment, including over 100 new positions across outpatient provider types, broadening specializations within CSBs across adult SMI, adult SUD, and child and family services, innovative retention and recruitment efforts, and a range of training and development initiatives. Outpatient services is also a STEP where additional funding is expected for fiscal year 2022.

Based on the BHI formula above, allocations of the remaining \$6.9 million in outpatient funding would be as follows. It is important to note that a base allocation is a key part of the formula; since a base had been applied with the original funding, this could be interpreted two ways. The numbers below do not provide a *new* base for the \$6.9 million, but instead distribute the \$6.9 million according to the formula considering the original base allocation as the base. Chart 1 has estimated allocations for the \$6.9 million in one column and then the total ongoing outpatient allocation would be (inclusive of the fully allocated \$15,000,000). Final decisions regarding funding for outpatient services will be made in late April, so ensure that any input is provided back to DBHDS by March for consideration in this funding process. Please send input via VACSB. Please also note that baseline measures for trauma training/EBP use will be integrated into the end of year block grant report and collected for baseline measurement this June/July.

CSB/BHA	Additional Allocation (of \$6.9 million)	Total Outpatient Allocation
Alexandria CSB	\$176,799	\$455,784
Alleghany Highlands CSB	\$61,872	\$390,187
Arlington County CSB	\$204,045	\$483,030
Blue Ridge Behavioral Healthcare	\$198,435	\$585,815
Chesapeake Integrated Behavioral Healthcare	\$166,101	\$513,996
Chesterfield County CSB	\$139,237	\$423,272
Colonial Behavioral Health	\$80,707	\$364,742
Crossroads CSB	\$122,761	\$470,656
Cumberland Mountain CSB	\$155,647	\$483,962
Danville-Pittsylvania Community Services	\$106,351	\$454,246
Dickenson County Behavioral Health Services	\$60,101	\$388,416
District 19 CSB	\$214,709	\$602,089
Eastern Shore CSB	\$82,741	\$430,636
Fairfax-Falls Church CSB	\$482,976	\$796,261
Goochland-Powhatan CSB	\$60,886	\$448,266
Hampton-Newport News CSB	\$214,824	\$498,859
Hanover County CSB	\$61,853	\$390,168
Harrisonburg Rockingham CSB	\$160,588	\$508,483
Henrico Area MH and DS	\$269,261	\$597,576
Highlands CSB	\$129,770	\$413,805
Horizon Behavioral Health	\$231,874	\$579,769
Loudoun County CSB	\$193,691	\$506,976
Middle Peninsula-Northern Neck CSB	\$144,958	\$532,338
Mount Rogers CSB	\$146,128	\$494,023
New River Valley Community Services	\$207,071	\$554,966
Norfolk CSB	\$257,783	\$605,678
Northwestern CSB	\$233,026	\$620,406
Piedmont CSB	\$159,433	\$507,328
Planning District One Behavioral Health Services	\$134,836	\$463,151
Portsmouth Department of Behavioral Healthcare Services	\$106,768	\$454,663
Prince William County CSB	\$323,220	\$680,785
Rappahannock Area CSB	\$269,874	\$657,254
Rappahannock-Rapidan CSB	\$147,130	\$495,025
Region Ten CSB	\$223,044	\$570,939
RBHA	\$244,471	\$572,786
Rockbridge Area CSB	\$77,508	\$425,403

Southside CSB	\$104,501	\$432,816
Valley CSB	\$154,150	\$438,185
Virginia Beach CSB	\$261,080	\$608,975
Western Tidewater CSB	\$154,795	\$483,110

Total outpatient allocations would range from about \$364,000-\$796,000. Additional guidance will be forthcoming regarding planning for these additional funds.

Crisis Services

Crisis Services is the most complex STEP of STEP-VA. We continue to be grateful for your honest feedback as well as grace in working through the complexities of an integrated cross-disability, highly accessible, state-wide crisis system. We remain committed to this vision, and believe Virginia is poised to be the first state to successfully build this in the public sector while integrating existing safety net structures and private providers of crisis services into a statewide Crisis Now model. The private sector providers will also play a role in partnering to provide crisis services in coordination with the regional hubs. We acknowledge that there have been miscommunications and difficulties along the way, and are grateful that we have arrived at a mutually agreeable shared vision and are now taking steps to bring this to life. The key components and their status are:

[Statewide shared infrastructure for data capture, tracking, and dispatch of mobile crisis:](#) Request for Proposals has been posted for this technological infrastructure.

[9-8-8 Implementation:](#) Federal law now requires that 9-8-8 is available July 16, 2022, and Virginia plans to integrate 9-8-8 implementation with broader crisis system transformation. Virginia was recently awarded a 9-8-8 implementation planning grant, which will begin with forming a 9-8-8 coalition in the coming months.

[Regional call center operators:](#) a description of the call center operations has been reviewed in STAC and the parameters document and draft funding structure have been shared with the regions. Funds for call center staff will be available beginning July 1, 2021. If your region has not solidified a plan or vision for operating as a call center, it is time to do so now. We also urge you to consider creative solutions including partnering or subcontracting with existing NSPL call centers in Virginia and considering cross-regional collaborations to ensure efficiency where it makes sense.

[Specialized child mobile crisis services:](#) regions continue to build their child hubs and teams. Please ensure that your teams will be ready to bill Medicaid December, 2021. As you know, a statewide 36-hour training curriculum is in development that will be required of all providers of STEP-VA. This training will assist with developing the workforce to have the skills and core base competencies needed to provide child and adolescent mobile crisis services and allow for greater uniformity of services across the state to expand consistent service delivery and dispatch. Each module will be six hours and will cover the following topics: safety, screening/assessment, family dynamics, trauma, intellectual and developmental disabilities and de-escalation. Currently, there is an expectation through the draft medical necessity criteria that all crisis providers (private and public) will be required to participate in the statewide training to ensure continuity and consistency. There will be a request forthcoming for trainer nominations to ensure that we have trainers in the curriculum in each region. As part of the new MHBG crisis set-aside, there is potential funding for trainer positions, and we believe that having current

staff, such as supervisors, to be trained as trainers, in addition to devoted training positions would be the best path forward.

Adult mobile crisis services: Partial funding for adult mobile crisis services will be available July 1, 2022. All teams funded through STEP-VA will be managed by the regional hubs. Parameter document and draft budget were distributed through STAC for completion and submission by March 19, 2021

Crisis integration: A comprehensive plan for integration will be developed following the implementation of the call center and dispatch leveraging community providers to ensure comprehensive coverage throughout the regions. A comprehensive plan for integration of crisis services refers to the long-term alignment of the community systems' current system to align with national best practices, create low and no barrier entries to crisis services (i.e. no wrong door, easy access), and eventual leveraging and blending of funds across current traditional disability-specific funding lines to create a comprehensive system that supports people in their own communities, focuses on trauma informed care, and meets individual needs regardless of disability or diagnosis. Plan elements would include, for example, timeline, funding considerations, workforce capacity needs and gaps, and policy, Code and regulatory considerations, and timeline.

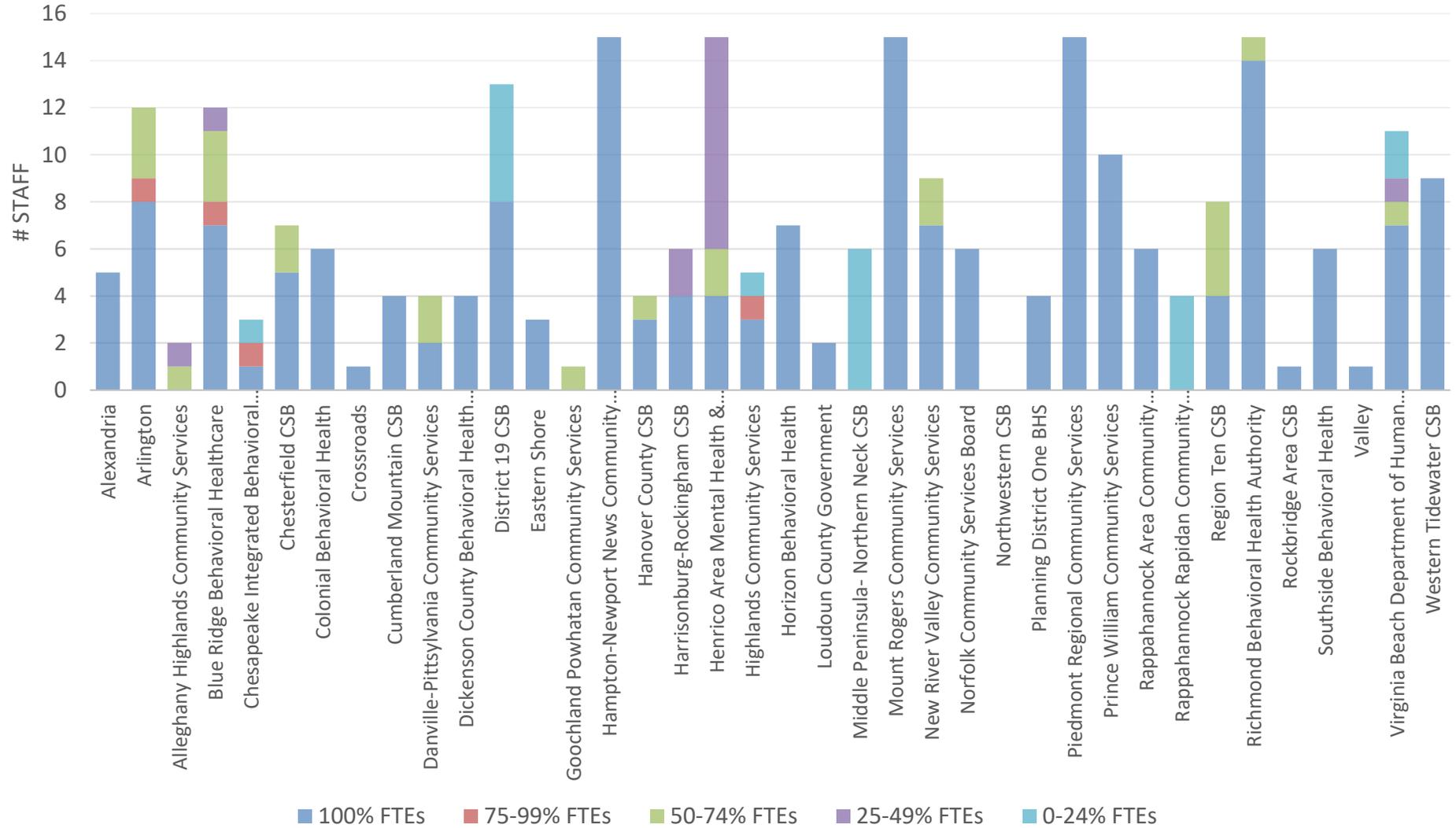
Marcus Alert: Although the addition of the Marcus Alert requirements added complexities to the STEP-VA crisis implementation, we believe this is a unique opportunity to critically analyze and enhance the design of our crisis system to focus on equitable access, racial disparities, and coordination with law enforcement from a racial equity perspective while the system is still in development. We remain focused on building upstream mobile crisis services without law enforcement as the key feature of our crisis system, and believe that the Marcus Alert requirements are complementary to this goal. Statewide coverage by STEP-VA mobile crisis will partially meet the Marcus Alert community coverage requirements, although we understand that localities/catchment areas will also be investing in co-responder models and other programs. It is important to note that even if your area invests in a co-responder model, crises that can be managed by STEP-VA crisis services need to be diverted to the behavioral health system to ensure equal access to least restrictive services. A comprehensive array of crisis services is a robust continuum with structures and protections at the state, regional, and local level, with flexibilities extended to ensure coordination between systems, and the Marcus Alert is an opportunity for each locality to engage with a systems perspective on planning and integration.

Peer and Family Support

Funding initially allocated to this STEP was frozen due to COVID-19 pandemic, and we are glad that this funding is re-allocated for fiscal year 2022. Due to the funding freeze, instead of providing a funding plan, you each completed a needs assessment survey to provide us with insight into your current peer services and needs for expansion. Some of these survey results are summarized below. Funding for this STEP will begin July, 2021. Information about disbursements and requirements will be formalized by April, 2021.

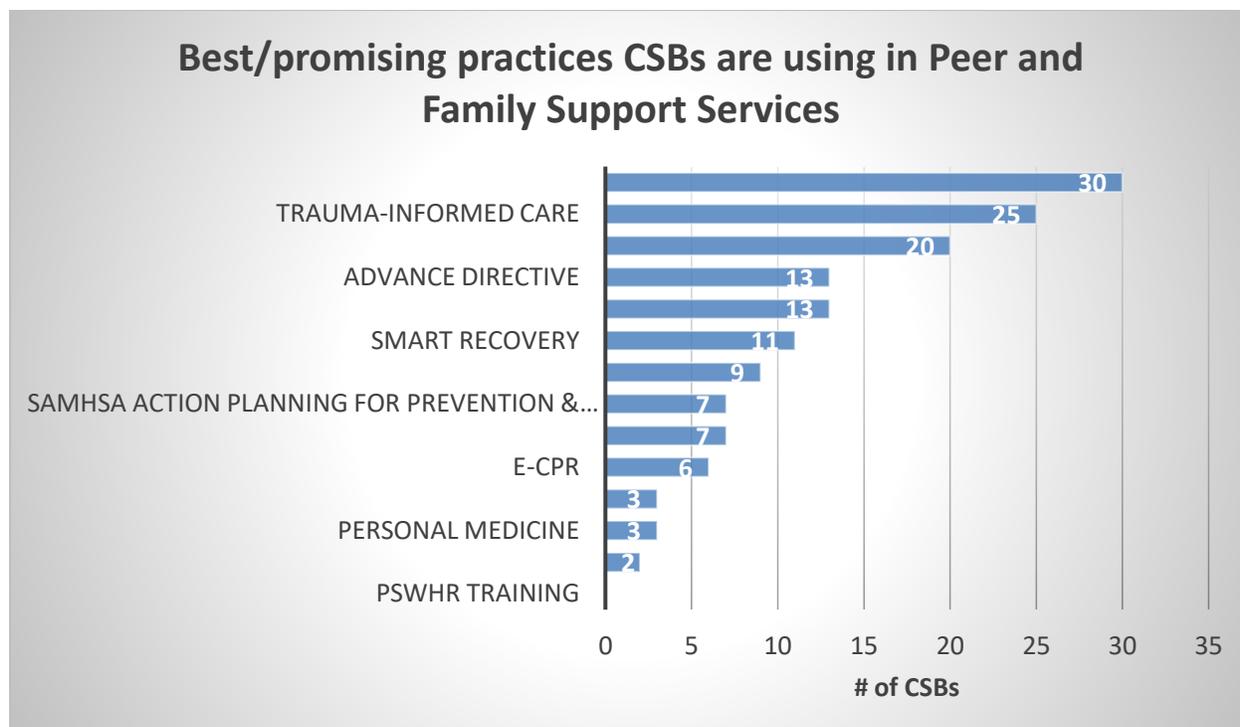
Until this current fiscal year, direct capturing and reporting of services specifically offered by Peer Recovery Specialists or Family Support Partner staff was largely missed by our community service data systems. The chart below allows us to gauge the landscape of how these staff are distributed across CSBs.

STAFFING INFORMATION FOR ALL PEER RECOVERY SPECIALIST (PRS)/FAMILY SUPPORT PARTNER (FSP) STAFF



In total, there are 257 PRS and FSP staff reported by the 38 CSBs responding to the survey. The dark blue bars represent how many of those are full-time 100% FTEs. Full-time FTEs strongly outweigh part-time staff and comprise about 77% of all PRS/FSP staff. CSBs range in having anywhere from 0 to 1 staff to 15 staff in these roles.

The following chart identifies what types of best practices are used by the CSBs to support this service area. WRAP (wellness recovery action plan), Trauma-Informed Care, and Permanent Supportive Housing were the most popular items selected amongst the list provided.



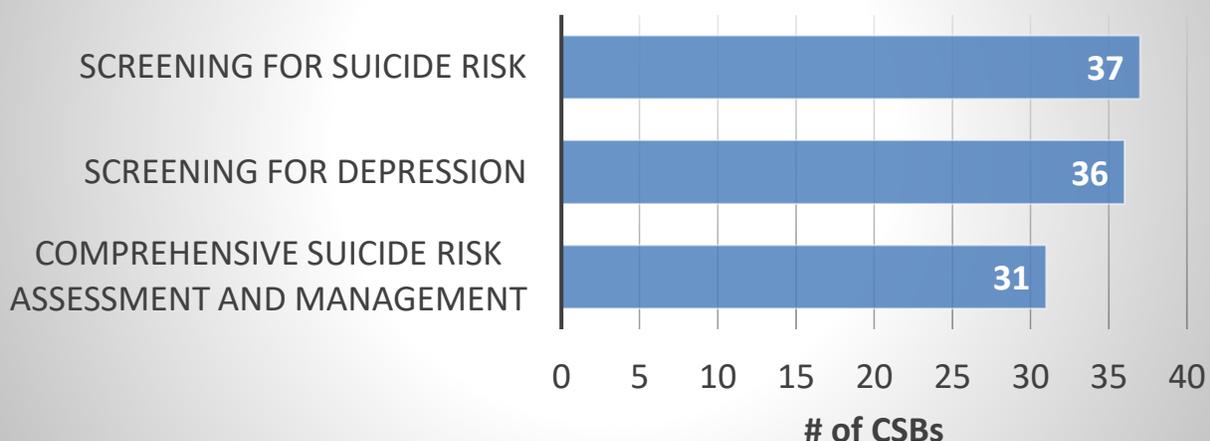
Service Members, Veterans, and Family Members (SMVF)

Similar to Peer and Family Support, this funding was initially frozen but has been reallocated for fiscal year 2022. Results of the needs assessment will be utilized to inform additional planning and centers on four key components as established by the work group throughout 2019-2020: 1) Clinical service enhancements; 2) Regional navigators/coordinators; 3) Lock and Talk Program Support and Development; and 4) Training and Capacity Building. DBHDS experienced a loss with the departure of Brandi Jancaitis, but we are happy the Commonwealth has retained her in an important role at Department of Veterans Services. Funding for this STEP will begin July, 2021 and will apply both regionally (Regional Navigators; Lock and Talk; Training and Capacity Building) and CSBs (Clinical Service Enhancements). Information about disbursements and requirements will be formalized by April, 2021.

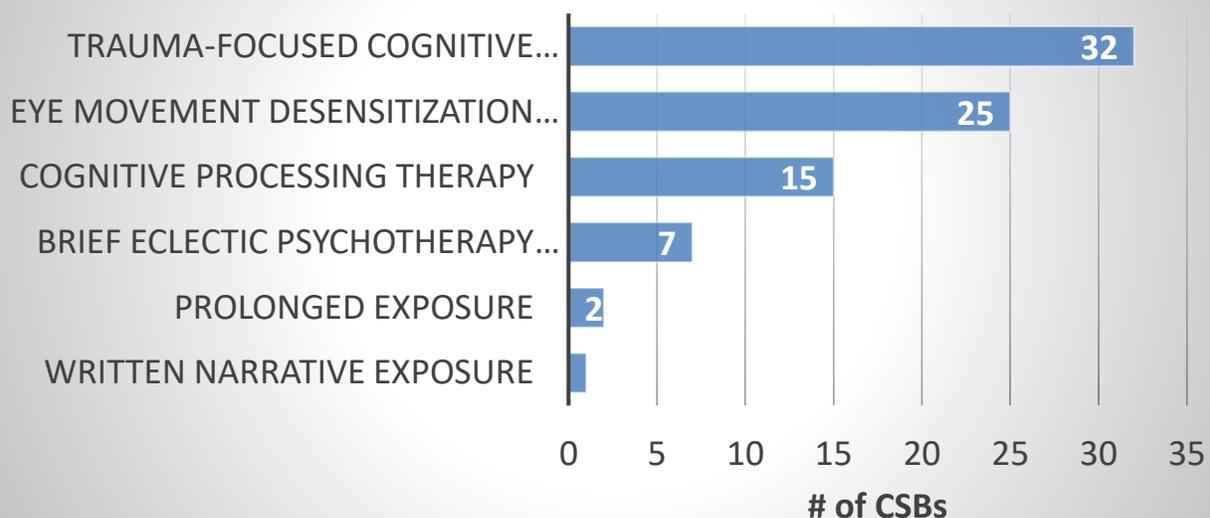
CSBs recently responded to a survey to identify current infrastructure to support this STEP and what is required to progress to implementation of this STEP. Some of the findings below illustrate CSB's current

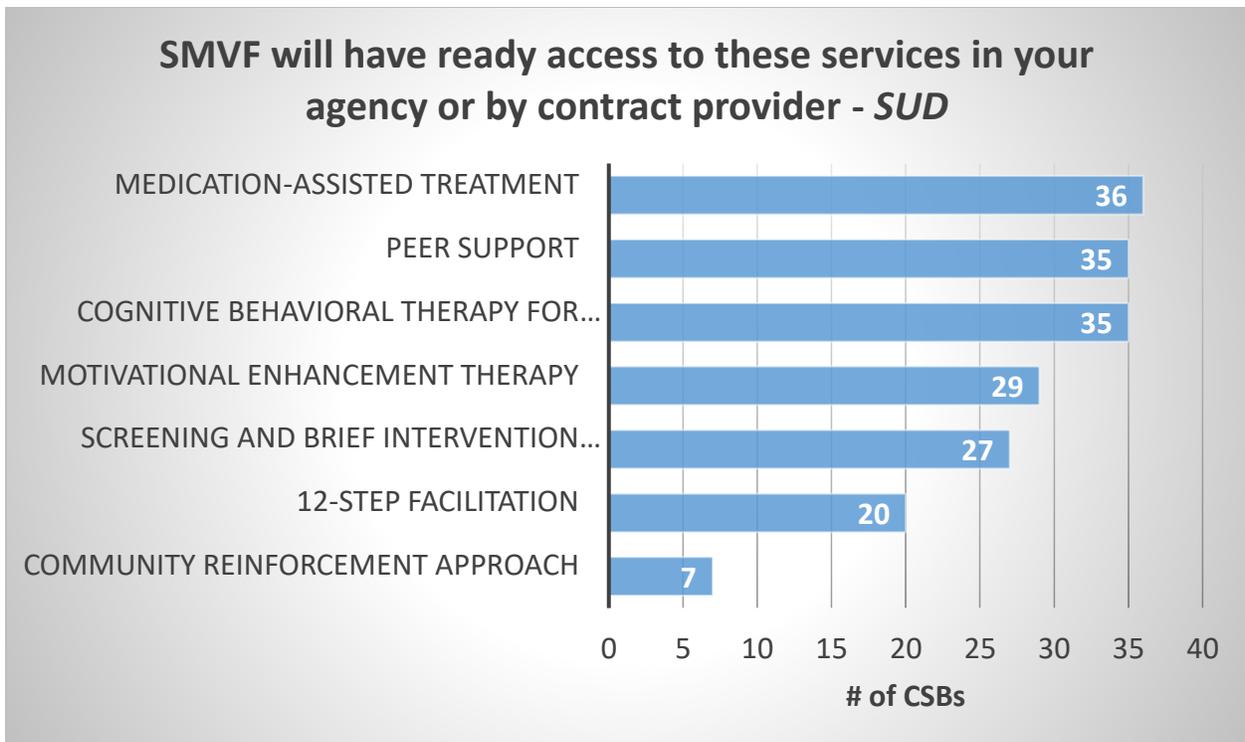
ability to offer services to SMVF individuals recommended by the Department of Defense and Veterans Health Administration.

SMVF* will have ready access to these services in your agency or by contract provider - *Suicide Risk Assessment/Management*



SMVF will have ready access to these services in your agency or by contract provider - *Trauma*





Case Management, Care Coordination, and Psychiatric Rehabilitation

The implementation of the final three STEPs of STEP-VA is expected during the 2023-2024 biennium. Results of the needs assessment emphasized the importance of pivoting plans to focus on Medicaid integration for sustainability and long-term success, given important systems changes such as Medicaid expansion and carve-in of behavioral health services that have transpired since STEP-VA was originally designed. DBHDS recommends the integration of STEP-VA implementation for these STEPs with the Behavioral Health Enhancements process through Virginia Medicaid. Due to the timelines and approvals needed regarding any further progress on the BH Enhancements project, we do not have a specific update at this time, outside of our general plan to seek integrated implementation during the 2023-2024 biennium.

RBHA Board Meeting
Development Report – March 2, 2021

Richmond Behavioral Health Foundation

YTD Income (minus grants) to RBHF: \$14,526.97 (as of February 28, 2021)

YTD grants awarded: \$51,320 (as of February 28, 2021)

YTD gifts-in-kind: \$57,816.40 (as of February 28, 2021)

YTD Total Revenue: \$123,663.37

	Current Year (FY21)	Previous Year (FY20)	Two Years Ago (FY19)
	Total Grants/Requests Submitted in FY21 (July 1, 2020 – June 30, 2021)	Total Grants/Requests Submitted in FY20 (July 1, 2019 – June 30, 2020)	Total Grants/Requests Submitted in FY19 (July 1, 2018 – June 30, 2019)
Number of Submitted Grants/Requests	6 Total: \$108,820	2 carryover from FY19 (\$40,000) 10 (TOTAL: \$151,000)	9 \$418,500 and up to \$500,000 (TOTAL: \$918,500)
Number of Funded Grants/Requests	3	7	5
Dollar Value of Awarded Grants/Requests	\$51,320	\$142,000	\$59,795
Number of Pending Grants/Requests	1	0	2
Dollar Value of Pending Grants/Requests	\$2500	0	\$40,000
Number of Denied Grants/Requests/Postponed	2	2 - denied 3 - cancelled (COVID)	3
Dollar Value of Denied or Partially Funded Grants/Requests	\$55,000	\$59,000	\$821,500.00
Gifts in Kind Monetary Value	\$57, 816.40	\$57,671.25	\$9,342.00
Volunteer Hours	1362	863	200

RBHA Board Meeting Development Report – March 2, 2021

Update on Grants and Gifts: See attached chart

Communications:

- Internal and external transitioning to new brand graphics has begun.
- Moving close to roll out of all brand components with employees and beginning transition to incorporating Brand Identity – internally and externally
- Next Steps:
 - Brand Standards Manual to be completed
 - Print Collateral Strategic Plan to be finalized
 - Begin transition of internal documents and external facing communications
- Developing a Communications Plan
- Developing a Social Media Plan
- Beginning work on Employee Recruitment Plan

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

Key Metrics:

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

Volunteer Appeals/Events:

- RBHF Board is actively pursuing additional Board Members
- Initial Planning for a North Campus – CSC and Walking Trail – Ribbon Cutting Event
- Exploring additional DIY Volunteer Project Kits to initiate:
 - Indoor Activity Kits – for children & adults
 - Outdoor Activity Kits – for children (for spring)
- DIY Volunteer Project Outcomes:
 - Volunteer Service Hours:
 - Painted Rocks for NC Walking Trail: 58
 - Nourishment Kits: 449
 - Hygiene Kits: 252
 - Cold Weather Item Kits: 1266
- DIY Volunteer Project Impact:
 - Items have been distributed to 17 RBHA programs for distribution to individuals and families in need
- Planning several Volunteer Appeals in partnership with Hands On Greater Richmond - primary goal is to connect with individuals in the community and establish new relationships
 - Painted Rocks – North Campus Walking Trail
 - Hygiene Kits – Marshall Center, MRTC, PACT, Homeless Services

RBHA Board Meeting
Development Report – March 2, 2021

- Nourishment Kits – Homeless Services
- Cold Weather Kits – to grow our Giving Tuesday Cold Weather Item Collection
- Walking Trail – North Campus – November 2020 – Work to begin this week – tentatively scheduling 2 small volunteer opportunities around the installation of the walking trail

Appeals:

- Year End Appeal Results with new branding:
 - 33% increase in monetary donations
 - 947% increase in tangible donations
 - 44 new page followers on Facebook
 - Doubled our followers on Instagram
- Annual Appeal Campaign begins this week
 - Mailing
 - Email
 - Social Media Campaign
- Annual Appeal to begin in late October – first wide distribution of the new RBH brochure
- **Planning a campaign for the Children’s Services Center at North Campus** – Outdoor Needs – primary goal is to involve/reach community members and increase community awareness of RBHA – Spring 2021
- GIVING TUESDAY – December 1, 2020 – plans underway for securing cold weather clothing items
- United Way Employee Campaign – November 16, 2020

An Overview of Medicaid Behavioral Health (BH) Enhancement

Presented by:

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

Shenee McCray, LCSW, Chief Operating Officer for Mental Health

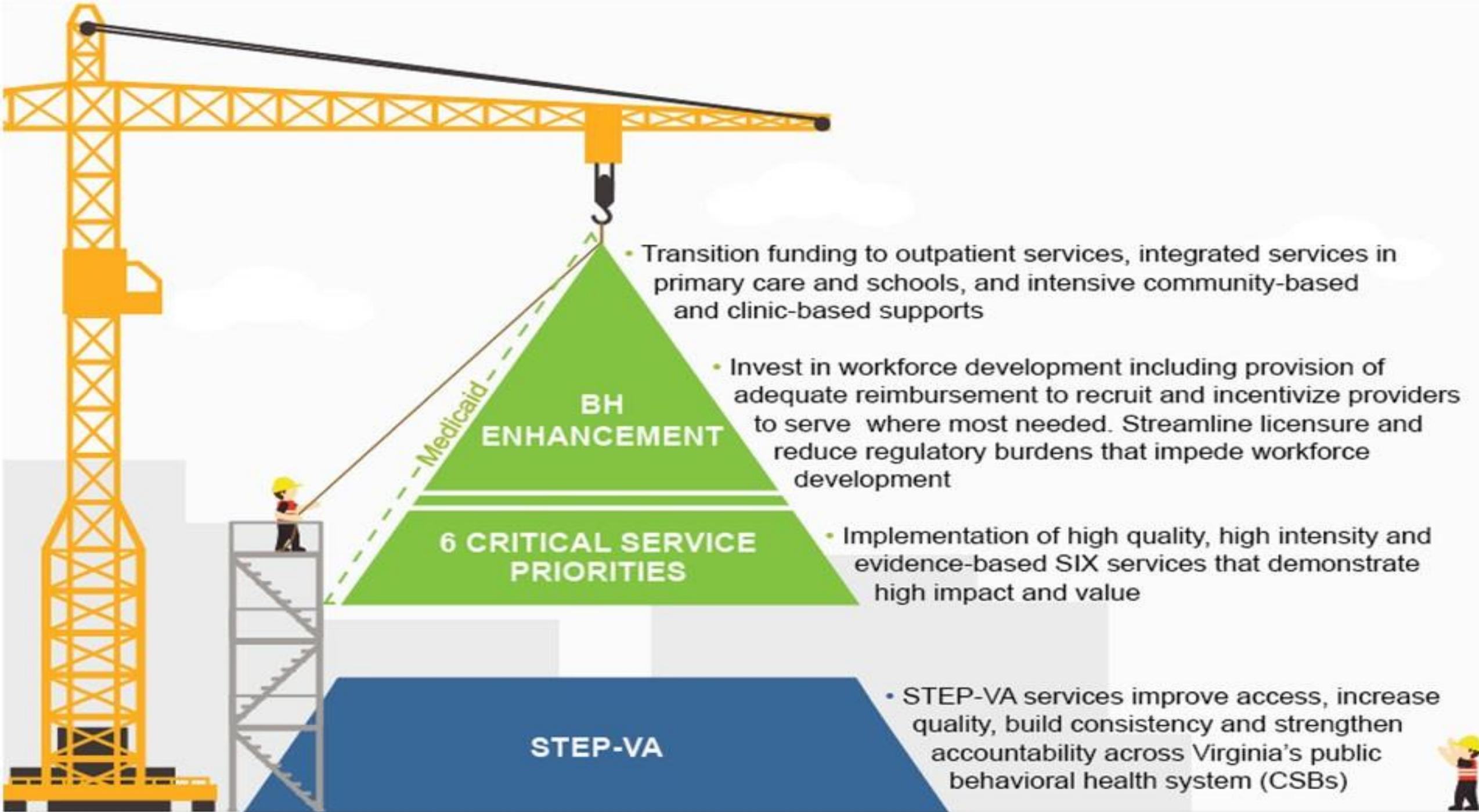
What is BH Enhancement?

Fully Integrated BH services

Builds a continuum of care

Improves quality of care

Evidenced-based and trauma-informed



- Transition funding to outpatient services, integrated services in primary care and schools, and intensive community-based and clinic-based supports

- Invest in workforce development including provision of adequate reimbursement to recruit and incentivize providers to serve where most needed. Streamline licensure and reduce regulatory burdens that impede workforce development

- Implementation of high quality, high intensity and evidence-based SIX services that demonstrate high impact and value

- STEP-VA services improve access, increase quality, build consistency and strengthen accountability across Virginia's public behavioral health system (CSBs)

Current Medicaid-funded Behavioral Health Services

Prevention

Recovery

Outpatient

Community Mental Health
Rehabilitation Services

Inpatient / Residential

Early intervention Part C • Screening • EPSDT services

Peer and family support partners

Outpatient psychotherapy • Psychiatric medical services

Therapeutic day treatment
Mental health skill building services
Intensive in-home services
Crisis intervention & stabilization
Behavioral therapy
Psychosocial rehabilitation
Partial hospitalization / Day treatment
Mental health case management
Treatment foster care case management
Intensive community treatment

Inpatient hospitalization
Psychiatric residential treatment
Therapeutic group home

Continuum of Behavioral Health Services Across the Life Span

Promotion & Prevention

Recovery Services

Outpatient & Integrated Care

Intensive Community Based Support

Intensive Clinic-Facility Based Support

Comprehensive Crisis Services

Group Home & Residential Services

Inpatient Hospitalization

Behavioral Therapy Supports

>>>> <<<<

Case Management*

>>>> <<<<

Recovery & Rehabilitation Support Services*

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

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

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

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

Intensive outpatient programs • Partial hospitalization programs

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

Therapeutic group homes
Psychiatric residential treatment

Psychiatric inpatient hospitalization

INTEGRATED PRINCIPLES/MODALITIES

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

*Key STEP-VA service alignment

What's on the Horizon?



Timeline for Implementation

July 2021 –
ACT* (Formerly PACT)
MH IOP*
Partial Hospitalization



DEC 2021
MST*, FFT and Crisis Continuum
(23-hour Observation*, CSU*,
Community-based Stabilization,
Mobile Crisis Intervention*)

***services that are either being
enhanced or considered for new
service lines at RBHA**

Assertive Community Treatment (ACT) Enhancements

- Service must maintain fidelity to Tool for Measurement of ACT (TMACT)
- Billing will be based on a per diem (per day) instead of billable units
- Flexibility on the use of nurse practitioner as a prescriber
- The establishment of an ACT license with DBHDS

Multisystemic Therapy (MST) Enhancements

- This is a new service for Medicaid reimbursement
- New billing structure for MST services
- Standards for service provision will be aligned with national model
- Standards for staffing including credentials
- Inclusion of service in DBHDS Office of Licensing

Mobile Crisis Intervention

- This is an enhanced service for Medicaid reimbursement
- Initial crisis response (up to 72 hours)
- Region 4 program to service youth and adults across all disabilities (MH, SUD, ID/DD) and ages
- 24/7/365 service provided in the community (homes, parks, etc. and not in EDs, jails, hospitals)
- The goal is to avert hospitalizations or readmissions
- Involves counseling, safety planning, de-escalation, peer supports, and linkage to ongoing services

Community-Based Crisis Stabilization

- This is a new service for Medicaid reimbursement
- Short-term (less than 30 days) designed to support continued de-escalation and crisis stabilization
- Region 4 program accessible 24/7/365 to youth and adults across all disabilities (MH, SUD, ID/DD) and ages
- Psychiatric services, medication linkages, safety planning, de-escalation, peer supports, and skill acquisition and building
- The goal is to avert hospitalization and/or readmission

Action Steps for RBHA

Active participation on DMAS' service-specific workgroups

Prepare for enhancement of existing services (PACT to ACT; MST)

Amend billing structures to maximize reimbursement

Explore the feasibility of implementing MH IOP

Develop Internal workgroups to implement services across the crisis continuum

