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Exhibit K
Collaborative Discharge Requirements for Community Services Boards and State Hospitals

Contract No. P1636.CSBCode.3

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Department of Behavioral Health and Developmental Services

This document is designed to provide consistent direction and coordination of activities required of state hospitals and community services boards (CSBs) in the development and implementation of discharge planning. The activities delineated in these protocols are based on or referenced in the Code of Virginia or the community services performance contract. In these protocols, the term CSB includes operating CBSs, administrative policy CBSs, local government departments with a policy-advisory CSBs, established pursuant to § 37.2-100 of the Code of Virginia, and the behavioral health authority, established pursuant to § 37.2-601 et seq. of the Code of Virginia.

Shared Values:

Both CSBs and state hospitals recognize the importance of timely discharge planning and implementation of discharge plans to ensure the ongoing availability of state hospital beds for individuals presenting with acute psychiatric needs in the community or in local or regional jails. The recognition that discharge planning begins at admission is an important aspect of efficient discharge planning.

The Code of Virginia assigns the primary responsibility for discharge planning to CSBs; however, discharge planning is a collaborative process that must include state hospitals. CSBs and state hospitals are responsible for training new hires in the Collaborative Discharge Protocols.

Joint participation in treatment planning and frequent communication between CSBs and state hospitals are the most advantageous method of developing comprehensive treatment goals and implementing successful discharge plans. The treatment team, in consultation with the CSB, shall ascertain, document, and address the preferences of the individual and their surrogate decision maker (if one has been designated) in the assessment and discharge planning process that will promote elements of recovery, resiliency, self-determination, empowerment, and community integration.

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DBHDS state psychiatric facilities operate as acute care psychiatric settings. The intent is for the individual to receive timely care for stabilization and discharge back into the community (including jail). DBHDS facilities should not be considered long-term care settings. There should be careful attention paid to timely and appropriate discharge planning while assuring the individuals rights to treatment and services in least restrictive settings is maintained.

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Protocols for Children and Commonwealth Center for Children and Adolescents

I. Collaborative Responsibilities Following Admission to State Hospital

	State Hospital Responsibilities	Time Frame	CSB Responsibilities	Time Frame
1.1	State hospitals staff shall assess each minor upon admission and periodically thereafter to determine whether the state hospital is an appropriate treatment site. Inappropriate admissions including minors with a primary diagnosis of substance abuse disorder will be reported to the CSB.	*Within one (1) business day of admission*	As active participants in the discharge process and consultants to the treatment process, CSB staff shall participate in discussions to determine whether the state hospital is an appropriate treatment facility.	

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	State Hospital Responsibilities	Time Frame	CSB Responsibilities	Time Frame
1.2	State hospital staff shall contact the case management CSB to notify the CSB of the new admission. State hospital staff shall also provide a copy of the admissions information/face sheet, including the name and phone number of the social worker assigned and the name of the admitting unit, to the CSB. If the information has references to substance use disorder, a release of information must be signed by the minor and/or legal guardian or the information related to substance use and treatment must be redacted. For minors who are discharged prior to the development of the individualized treatment plan; the treatment team is responsible for completing the	*Within one (1) business day of admission* *Within one (1) business day of admission*	Upon notification of admission, CSB staff shall begin the discharge planning process for both civil and forensic admissions. If the CSB disputes case management responsibility for the minor, the CSB shall notify the state hospital social worker upon notification of admission. 1. For minors who are discharged prior to the development of the individualized treatment plan, CSB responsibilities post discharge will be reflected in the discharge instructions.	*Immediately upon notice of admission*

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	State Hospital Responsibilities	Time Frame	CSB Responsibilities	Time Frame
	Discharge Instructions in consultation with the CSB.		2. For every admission to a state hospital from the CSB's service area that is not currently an open case at that CSB, the CSB shall develop an open case and assign case management responsibilities to the appropriate staff 3. CSB staff shall establish a personal contact (face-to-face, telephone, etc.) with the assigned social worker at least once for an acute hospitalization, at least weekly for minors receiving extended treatment, and within 2 days prior to the minor's discharge.	

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	State Hospital Responsibilities	Time Frame	CSB Responsibilities	Time Frame
1.3	Upon identification that the minor admitted to the state hospital has a co-occurring diagnosis of DD/ the hospital social worker will notify the		If the minor has an DD/ and co-occurring SMI, the CSB MH and ID Directors (or their designees) will identify and	

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	State Hospital Responsibilities	Time Frame	CSB Responsibilities	Time Frame
	designated CSB lead for discharge coordination and will: • Assist the case managers to compile the necessary documentation to implement the process for waiver and/or out of home placement. • Serve as a consultant to the DD case manager as needed; • Assist with coordinating on-site assessments by representatives from potential placement options.		inform the state hospital social worker whether the ID or MH case manager will take the lead in discharge planning and work collaboratively with the CSB mental health discharge liaison on eligibility-planning activities and state hospital discharge procedures. CSB DD responsibilities include the following: 1. Assessment of the minor for Medicaid Waiver eligibility; 2. If applicable, initiate the process for Medicaid Waiver funding for the minor receiving services;	

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	State Hospital Responsibilities	Time Frame	CSB Responsibilities	Time Frame
			3. Initiating the referral to Child REACH; 4. Participation in the development and updating of the discharge plan; 5. Participation in treatment team meetings, discharge planning meetings and other related meetings; 6. Assist in coordinating assessments; 7. Assistance in locating and securing needed specialists who will support minor in the community once they have been discharged, i.e., doctors, behavioral support; 8. Providing support during the transition to community services;	

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	State Hospital Responsibilities	Time Frame	CSB Responsibilities	Time Frame
			9. Facilitation of the transfer of case management responsibilities to the receiving CSB or private provider according to the *Support Coordination/Case Management Transfer Procedures for Persons with Developmental Disability.*	
1.4	State hospital staff shall make every effort to contact the CSB Case Manager and legal guardian to discuss goals for treatment that will result in a timely discharge.	*Within one (1) business day of admission*	It is the joint responsibility of the hospital social worker and CSB staff to contact each other upon admission to discuss case specifics.	*Within one (1) business day*

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II. Needs Assessments & Discharge Planning

Joint Responsibility of the State Hospital & CSB				
2.1	The treatment team and CSB shall ascertain, document and address the preferences of the minor and his/her legal guardian in the individualized assessment and discharge planning process that will promote elements of recovery, self-determination, empowerment, and community integration.			
	State Hospital Responsibilities	**Time Frame**	**CSB Responsibilities**	**Time Frame**
2.2	The state hospital social worker shall complete the social work comprehensive assessment or readmission assessment update for each minor. This assessment shall provide information to help determine the minor's needs upon discharge.	*Within seven (7) calendar days of admission*	Discharge planning begins on the Initial Pre-Screening form and continues on the CSB/BHA discharge plan document. In completing the discharge plan, the CSB shall consult with members of the treatment team, the minor, his parent/legal guardian, and, with appropriate consent, other parties in determining the	

			needs/preferences of the minor upon discharge. The Discharge Plan shall be developed in accordance with the *Code of Virginia* and the community services performance contract and shall: • include the anticipated date of discharge from the state facility; • identify the services needed for successful discharge, to include outpatient, educational, residential or community placement and the frequency of those services; and • specify the public or private providers that have agreed to provide these services.	

2.3			The CSB shall initiate development of the discharge plan. The discharge plan shall address the discharge needs identified in the comprehensive assessment in addition to other pertinent information within the clinical record. For minors whose primary legal residence is out of state, the pre-screening CSB shall retain discharge planning responsibility. ***Note:*** According to § 16.1-346.1 of the Code of Virginia the CSB retains ultimate responsibility for a timely and appropriate discharge plan for all minors discharging from a state hospital, therefore oversight and responsibility for said plan of minors in the custody of the	*Immediately upon notice of admission*

			Department for Social Services remains with the CSB.	
2.4	As a minor's needs change, the state hospital social worker shall document changes in the state hospital social worker's progress notes and update the CSB Case Manager.		If the minor's needs change or as more specific information about the discharge plan becomes available, the CSB staff shall update the discharge plan accordingly.	
Joint Responsibility of the State Hospital & CSB				
2.5	The treatment team in collaboration with the CSB shall ascertain, document, and address the preferences of the minor and parent or legal guardian as to the placement upon discharge. These preferences shall, to the greatest degree practicable, be considered in determining the optimal and appropriate discharge placement. ***NOTE:*** This may not be applicable for certain forensic admissions due to their legal status**.**			

III. Readiness for Discharge

	State Hospital Responsibilities	Time Frame	CSB Responsibilities	Time Frame

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3.1	The CSB shall be notified when the treatment team determines that the minor is clinically ready for discharge and/or state hospital level of care is no longer required or, for voluntary admissions, when consent has been withdrawn or *any of the following:* • The minor is unlikely to benefit from further acute inpatient psychiatric treatment; or • The minor has stabilized to the extent that inpatient psychiatric treatment in a state hospital is no longer the least restrictive treatment intervention.	*Within one (1) business day*	Once the CSB has received notification of readiness for discharge, steps shall be taken to implement the discharge plan. The minor should be discharged from the state hospital when deemed clinically ready for discharge.	*Immediately upon notice of admission*
3.2	The hospital will conduct regularly scheduled reviews of all minors who are rated clinically ready for discharge or nearly ready (Rating of 1 or 2). These meetings will involve the participation of the hospital social worker(s).	*At least twice a month*	The CSB liaison (or their designee) assigned to any minor who is rated 1 or 2 on the Discharge Readiness scale will participate in all discharge review meetings and provide information related to discharge	

			planning and any anticipated or experienced barriers to discharge.	

IV. Discharge Readiness Scale – Child and Adolescent

Rating Code	Description
1	• Has met treatment goals and no longer requires inpatient psychiatric hospitalization • Is exhibiting baseline behavior that is not anticipated to improve with continued inpatient treatment • No longer requires inpatient hospitalization even if there are barriers preventing discharge such as lack of placement
2	• Has made significant progress towards meetings treatment goals, but requires additional inpatient care to fully address clinical issues and/or there is a concern about adjustment difficulties • Receiving medication changes that must be monitored in an inpatient setting • Exhibiting significant clinical improvement, but court ordered "ten-day" evaluation is not completed
3	• Displays symptoms typical of child psychiatric hospitalizations such as suicidality, aggression, depression or anxiety but has not made significant progress towards treatment goals and requires treatment and further stabilization in an acute psychiatric inpatient setting • Displays symptoms atypical of child psychiatric hospitalizations (such as psychosis, etc.), is making progress towards treatment goals, but still requires further stabilization in an acute psychiatric inpatient setting
4	• Recent admission still requiring assessment • Displays symptoms atypical of child psychiatric hospitalizations such as psychosis, delusional and disorganized thoughts or paranoia • No progress toward psychiatric stability since admission

	• Requires constant 24 hour a day supervision in an acute inpatient psychiatric setting • Presents significant risk and/or behavioral management due to psychiatric diagnosis that requires psychiatric hospitalization to treat • Unable to actively engage in treatment and discharge planning, due to psychiatric or behavioral instability

NOTE:
Discharge planning begins on admission and is continuously active throughout hospitalization independent of the clinical readiness for discharge rating.

V. Finalizing Discharge

Joint Responsibility of the State Hospital, CSB, and DBHDS Central Office When a disagreement between the state hospital and the CSB occurs regarding the discharge plan for an individual, both parties shall attempt to resolve the disagreement and will include parent/legal guardian as appropriate. If these parties are unable to reach a resolution, the state hospital will notify their Community Transition Specialist within three business days to request assistance in resolving the dispute. Please see appendix 4 for the Dispute Process.			
State Hospital Responsibilities	Timeframe	CSB responsibilities	Timeframe
The state psychiatric hospital will make every attempt to include all relevant parties in notification up to and including DSS, JDC and family		In the event that the CSB experiences extraordinary barriers to discharge and is unable to complete the discharge the determination that the youth is clinically ready for discharge, the CSB shall	*Within three (3) business days or five (5) calendar days of determination that individual is clinically ready for discharge*

		document in the CSB medical record the reason(s) why the discharge cannot occur The documentation shall describe the barriers to discharge - reason for placement on the Extraordinary Barriers List (EBL) and the specific steps being taken by the CSB to address these barriers.	

There is expectation of collaboration of all relevant parties. CSBs maintain discharge responsibility and therefore should include DSS or JDC as required in any cases.

Note: Discharge planning begins at admission and is continuously active throughout hospitalization, independent of an individual's clinical readiness for discharge rating.

Joint Responsibility of the State Hospital & CSB	
5.1	To the greatest extent possible, CSB staff, the minor and/or his legal guardian shall be a part of the discussion regarding the minor's clinical readiness for discharge. The state hospital social worker is responsible for communicating decisions regarding discharge readiness to the CSB staff. The state hospital social worker shall provide written notification of readiness for discharge when extraordinary barriers are known or anticipated and document the contact in the minor's medical record.

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	NOTE: For minors under the jurisdiction of DJJ security regulations, discharge notification will occur within one (1) calendar day of discharge to jail, DJJ state hospital or juvenile detention center. According Virginia Code § 16.1-346.1 "A minor in detention or shelter care prior to admission to inpatient treatment shall be returned to the detention home, shelter care, or other facility approved by the Department of Juvenile Justice within 24 hours by the sheriff serving the jurisdiction where the minor was detained upon release from the treating facility, unless the juvenile and domestic relations district court having jurisdiction over the case has provided written authorization for release of the minor, prior to the scheduled date of release."			
	State Hospital Responsibilities		**CSB Responsibilities**	**Time Frame**
5.3			All discharge plans are expected to be implemented. The CSB shall initiate an Extraordinary Barriers Report on the minor and update the DBHDS and the state hospital regularly in the event that barriers delay the discharge more than 4 days past clinical readiness. The report shall describe the barriers to discharge and the specific steps being taken to address them.	*Within no more than four (4) calendar days of notification of clinical readiness.*

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Joint Responsibility of the State Hospital & CSB	
5.4	The Office of Patient Clinical Services, Chief Medical Officer and Deputy Commissioner of Facility Services and CSB Executive Director shall monitor the progress of those minors with extraordinary barriers to discharge.

VI. Completing the Discharge Process

	State Hospital Responsibilities		CSB Responsibilities	
6.1	The treatment team shall prepare the discharge information and instructions (DIIF.) Prior to discharge, state hospital staff shall review the DIIF with the minor and/or parent/legal guardian and request his/her signature. Distribution of the DIIF shall be provided by the state hospital to the CSB **NOTE:**	*No later than 24 hours post discharge or the next business day.*	To reduce re-admissions to state mental health facilities, CSBs, in conjunction with the treatment team, shall develop and complete, as clinically determined, a safety and support plan that is part of the minor's final discharge plan. It is the CSB liaisons responsibility to distribute any requested copies of the DIIF (DBHDS form 226) and supporting documentation to other next level providers and to other CSB care providers. **NOTE:**	

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	State Hospital Responsibilities		CSB Responsibilities	
	Minor's review of the DIIF may not be applicable for certain forensic admissions due to their legal status.		Safety and support plans are generally not required for court ordered evaluations, restoration to competency cases, and transfers from DJJ and detention. However, at the clinical discretion of the treatment team or the CSB, the development of a specialized safety and support plan may be advantageous when the minor presents significant risk factors, and for those minors who may be returning to the community following a brief incarceration period.	
6.2	The facility medical director shall be responsible for ensuring that the discharge summary is provided to the case management CSB (and DJJ when appropriate)	*Within ten (10) calendar days of the actual discharge date.*	CSB staff shall ensure that all arrangements for psychiatric services and medical follow-up appointments are in place prior to discharge, either by consultation with private providers or by arrangement with the CSB.	
6.3			CSB staff shall ensure the coordination of any other intra-agency services, e.g. outpatient services, residential, etc.	

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	State Hospital Responsibilities		CSB Responsibilities	
6.4			If the CSB is providing services, minors discharged from a state hospital with continuing psychotropic medication needs shall be scheduled to be seen by the CSB psychiatrist. In no case shall this initial appointment be scheduled longer than fourteen (14) calendar days following discharge. If the minor is treated by a psychiatrist in the community, the CSB is expected to ensure the aforementioned schedule is met either with the community-based psychiatrist or through the CSB. ***Note:*** In no case should agency policy or procedure place an undue burden on the family or delay in meeting this expectation.	*Within seven (7) calendar days post discharge, or sooner if the minor's condition warrants.*

VII. Transfer of Case Management CSB Responsibilities

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	State Hospital Responsibilities	Time Frame	CSB Responsibilities	Time frame
7.1	The state hospital social worker shall indicate in the progress notes any intention that is clearly expressed by the parent/legal guardian to change or transfer case management CSB responsibilities and the reason(s) for doing so. This shall be documented in the minor's medical record and communicated to the case management CSB. **EXCEPTION**: This process may be accelerated for discharges that require rapid response to secure admission to the community or residential placement.	*Immediately upon notification*	Transfers shall occur when the parent/legal guardian decides to relocate to another CSB service area. Should a placement outside of the minor's catchment area be pursued, the case management CSB shall notify the CSB affected by the potential placement. The case management CSB must complete and forward a copy of the out of catchment referral form to the receiving CSB. ***NOTE:*** Coordination of the possible transfer shall, when possible, allow for discussion of resource availability and resource allocation between the two CSBs prior to advancement of the transfer**.**	

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	State Hospital Responsibilities	Time Frame	CSB Responsibilities	Time frame
7.2			At a minimum, the CSB shall meet (either in person, telephone, or video conferencing) with the minor and the treatment team. The case management CSB is responsible for completing the discharge plan, and safety and support plan. The case management CSB shall stay involved with the minor.	*Prior to the actual discharge date*

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Protocols for Adult and Geriatric Patients

I. General Requirements

Regional responsibility	Responsible entity	Timeframe
The CSB emergency services clinicians shall complete a tracking form documenting all private hospital contacts prior to seeking a bed of last resort at a state hospital, and transmit the form to the receiving state hospital, along with the preadmission screening form.	CSB emergency services	*Upon admission request to state hospital*
Each CSB shall provide the DBHDS Director of Clinical Services (or designee) with the names of CSB personnel who are serving as the CSB's state hospital discharge liaisons, Forensic Discharge Planners, Forensic Admissions Coordinator, MH directors or supervisors, DD directors and Executive Directors	CSBs	*At least quarterly, or whenever changes occur*
The DBHDS Office of Patient Clinical Services will update and distribute listings of all CSB discharge planning and state hospital social work contacts to the Office of Forensic Services, the CSB regional managers and state	DBHDS Office of Patient Clinical Services	*At least quarterly*

hospital social work directors, with the expectation that these will be distributed to individual CSBs and state hospital social workers.		
DBHDS shall develop a process for developing, updating, and distributing a list of available housing resources funded by DBHDS for individuals being discharged from state hospitals. DBHDS shall review and update the list and ensure that it is available to CSB state hospital liaisons, CSB Forensic Discharge Planners, state hospital Forensic Coordinators, and state hospital social work staff, Forensic Coordinators and Director of Psychology and Forensic Services to ensure that all resource options are explored for individuals in state hospitals. At each census management meeting, there shall be a review (bed availability/updates) of the DBHDS funded programs in census management meetings by the community transition specialist.	Office of Patient clinical Services	*Updated at least quarterly*

II. Collaborative Responsibilities Following Admission to State Hospitals: Civil/Non-Forensic Admissions

CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
The CSB emergency services clinician shall notify the CSB discharge planner of every admission to a state hospital	*Within 24 hours of the issuance of the TDO*		
CSB staff shall begin the discharge planning process for both civil and forensic admissions.	*Upon notice of admission*	State hospital staff shall contact the CSB to notify them of the new admission- See Appendix D.	*Within one (1) business day*

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
If the CSB disputes case management CSB/discharge planning responsibility for the individual, the CSB shall notify the state hospital social work director immediately upon notification of the admission (for reference, please see the definition of "case management CSB/CSB responsible for discharge planning" contained in the glossary of this document). See dispute section Appendix D	*Upon notice of admission*	State hospital staff shall also provide a copy of the admissions information/face sheet to the CSB, as well as the name and phone number of the social worker assigned and the name of the admitting unit For individuals admitted with a primary developmental disability (DD) diagnosis, or a co-occurring mental health and DD diagnosis, the hospital social work director (or designee) shall communicate with the CSB discharge liaison and the DD Director to determine who the CSB has identified to take the lead in discharge planning (CSB liaison or DD staff). At a minimum, the CSB staff is who assigned lead discharge planning responsibilities shall participate in all treatment team meetings and discharge planning meetings; however, it is most advantageous if both staff can participate in treatment teams as much as possible. Even if the hospital liaison takes the lead, the hospital will notify the support coordinator of	*Within one (1) business day*
1. For every admission to a state hospital from the CSB's catchment area that is not currently open to services at that CSB, the CSB shall open the individual to consumer monitoring and assign case management/discharge planning responsibilities to the appropriate staff.	*Upon admission*		
2. CSB shall document in the EHR case management and discharge planning activities.	*Ongoing*		
3. The individual assigned to take the lead in discharge planning will ensure that other relevant parties (CSB program	*Ongoing*		

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
staff, jail providers, private providers, etc.) are engaged with state hospital social work staff and attend treatment plan meetings as necessary.		all treatment team meetings, census management meetings, etc.	
4. CSB staff shall establish a personal contact (preferably in person) with the hospitalized individual in order to initiate collaborative discharge planning.	*Within seven (7) calendar days of admission*		
5. CSB staff shall maintain contact with the patient (in person, phone calls, or virtually) at least monthly to ensure consideration of patient preference and choice in discharge planning.	*At least twice monthly*		

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
CSB staff will make arrangements to attend CTP and TPR meetings in person. If CSB staff are unable to physically attend the CTP or TPR meeting, the CSB may request arrangements for telephone or video conference.	*Ongoing*	State hospital staff shall inform the CSB by email of the date and time of CTP meetings.	*At least two (2) business days prior to the scheduled CTP meeting.*
In the event that the arrangements above are not possible, the CSB shall make efforts to discuss the individual's progress towards discharge with the state hospital social worker within two business days of the CTP or TPR meeting.	*Within two (2) business days of the missed meeting*	If CTP and TPR meetings must be changed from the originally scheduled time, the state hospital shall make every effort to ensure that the CSB is made aware of this change.	*At least two (2) business days prior to the rescheduled meeting*
Note: While it may not be possible for the CSB to attend every treatment planning meeting, participation in person or via phone or video conference is expected. This is the most effective method of developing comprehensive treatment goals and implementing efficient and successful discharge plans.		The initial CTP meeting shall be held within seven calendar days of admission. **Note**: It is expected that the state hospital will make every effort to include CSBs in CTP and TPRs, including providing alternative accommodations (such as phone or video) and scheduling meetings so that liaisons can participate in as many treatment team meetings as possible.	*Within seven (7) calendar days of admission*

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III. Collaborative Responsibilities Following Admission to State Hospitals for Justice-Involved Persons admitted for Forensic Evaluation, Competency Restoration, or Emergency Treatment from Jail

Justice-involved persons admitted from Jail or community for Forensic Evaluation, Competency Restoration, or Emergency Treatment from Jail			
CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
CSB staff shall begin the discharge planning process for persons admitted from jail, or the community if on bond, as soon as possible following admission to a state hospital.	*Upon notice of admission*	Once admitted to a state hospital, state hospital staff shall contact the CSB designated liaison to notify them of the new admission. Hospital staff shall provide a copy of the admissions information/face sheet to the CSB, as well as the name and phone number of the social worker and Forensic Coordinator assigned, and the name of the admitting unit.	*Within one (1) business day*
If the CSB disputes case management CSB/discharge planning responsibility for the individual, the CSB shall notify the state hospital social work director (for reference, please see the definition of "case management CSB/CSB responsible for discharge planning" contained in the glossary of this document). See Appendix E	*Upon notice of admission*	Hospital staff will track court dates from the Virginia Judiciary Online Case Information System 2.0 found at: Virginia Judiciary Online Case Information System.	*Within seven (7) calendar days of admission; and ongoing during treatment planning*
For every person admitted to a state facility who is from the CSB's catchment area but is not currently open to services at that CSB, the	*Upon notice of admission*		*Ongoing, as*

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Justice-involved persons admitted from Jail or community for Forensic Evaluation, Competency Restoration, or Emergency Treatment from Jail			
CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
CSB shall open the individual to consumer monitoring and assign case management and discharge planning responsibilities to the appropriate staff. For CSBs with DBHDS-funded Forensic Discharge Planning (FDP) staff positions, CSBs should leverage those positions to support the successful transition and discharge planning of individuals returning to jail following hospital discharge. CSB shall document in the EHR case management and discharge planning activities. CSB staff shall establish personal contact (preferably in person) with the individual in order to initiate collaborative discharge	*Ongoing* *Within seven (7) calendar days of admission*	Hospital staff will provide the CSB timely updates on the forensic evaluators' findings, and updates on court dates during the course of hospitalization. **Note**: SSI reinstatement of benefits could occur without need for a new application within 12 months of being incarcerated. If the incarceration was over 12 months a new SSI application would be needed. If Medicaid coverage is required, the jail will initiate contact with Cover Virginia Incarcerated Unit (CVIU) using the DOC Pre-Release window of 45 days. Expedited coverage can be requested if discharge would occur before the 45 days.	*Needed*

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Justice-involved persons admitted from Jail or community for Forensic Evaluation, Competency Restoration, or Emergency Treatment from Jail			
CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
planning and to establish process for "warm hand-off" when returned to jail.			
The CSB's designated state hospital liaison will attend inpatient CTP and TPR meetings in person whenever possible. At a minimum, the CSB staff who is assigned lead discharge planning responsibilities shall participate in treatment team meetings and discharge planning meetings; however, it is most advantageous if the FDP staff can participate in treatment teams as much as possible. The individual assigned to take the lead in discharge planning will ensure that other relevant parties (CSB program staff, FDP staff, private providers, etc.) are engaged with state hospital social work staff and included in CTP and TPR meetings as needed to facilitate successful discharge.	*Ongoing* *Ongoing*	State hospital staff shall inform the CSB designated hospital liaison by email of the date and time of CTP and TPR meetings. The initial CTP meeting shall be held within seven calendar days of admission. If CTP and TPR meetings must be changed from the originally scheduled time, the state hospital shall ensure that the CSB is made aware of this change via email.	*At least two (2) business days prior to the scheduled meeting* *Within seven (7) calendar days of admission* *At least two (2) business days prior to the rescheduled meeting* *Ongoing*

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Collaborative Discharge Requirements for Community Services Boards and State Hospitals

Contract No. P1636.CSBCode.3

Justice-involved persons admitted from Jail or community for Forensic Evaluation, Competency Restoration, or Emergency Treatment from Jail			
CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
If CSB staff are unable to physically attend the CTP or TPR meeting, the CSB may request arrangements for video conference. In the event that the arrangements above are not possible, the CSB shall make efforts to discuss the individual's progress towards discharge with the state hospital social worker within two business days of the CTP or TPR meeting. CSB staff are responsible for identifying treatment and support needs not only in the community but also in local or regional jails, in cases where the individuals will return to jail upon hospital discharge.	*Ongoing* *Within two (2) business days of the missed meeting* *Ongoing*	It is expected that the state hospital will provide alternative accommodations (such as video or phone) if CSB staff are unable to attend in person, and that meetings will be scheduled so that liaisons can participate in as many treatment team meetings as possible. The state hospital social worker and Forensic Coordinator will invite appropriate jail staff to participate in treatment team planning and/or discharge meetings as needed.	*Ongoing*

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Justice-involved persons admitted from Jail or community for Forensic Evaluation, Competency Restoration, or Emergency Treatment from Jail			
CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
Note: It is expected that individuals returning to jail upon state hospital discharge will receive a full-continuum of discharge planning services, including but not limited to: ongoing face-to-face follow-up from the CSB at least monthly in cases where the person who will remain in jail for 21-days or more following hospital discharge, coordination with jail security and medical staff to monitor the individual's adjustment upon return to jail, and continued coordination of services upon the individual's release from jail. The length of time one remains in jail following discharge from the state hospital will vary, and may depend on the seriousness of the charges, prior criminal history, or other factors beyond the state hospital's or CSB's control. It is advised that treatment team social workers and CSB liaisons collaborate routinely with the state hospital Forensic Coordinator to discuss potential criminal case dispositions and monitor court dates, in order to provide effective discharge planning upon return to jail. For persons participating on a Behavioral Health Docket, information about potential disposition of their court case may be coordinated with the CSB's Docket liaison.			

IV. Collaborative Responsibilities Following a Not Guilty by Reason of Insanity (NGRI) Finding:

Initial NGRI Temporary Custody Evaluation Period			
CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
CSB staff shall begin the discharge planning process for NGRI acquittees as soon as possible following admission to a state hospital for Temporary Custody evaluation or notification that an NGRI acquittee has been	*Upon notice of inpatient admission or start of the OPTC period*	If an acquittee is admitted to a state hospital, state hospital staff shall contact the CSB NGRI Coordinator and CSB discharge planner to notify them of the new admission. Hospital staff shall provide a copy of the admissions	*Within one (1) business day of admission*

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Initial NGRI Temporary Custody Evaluation Period			
CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
placed on Outpatient Temporary Custody (OPTC) status. If the CSB disputes case management CSB/discharge planning responsibility for the individual, the CSB shall notify the state hospital social work director (for reference, please see the definition of "case management CSB/CSB responsible for discharge planning" contained in the glossary of this document). For every NGRI admitted to a state facility or placed onto Outpatient TC status who is from the CSB's catchment area but is not currently open to services at that CSB, the CSB shall open the individual to consumer monitoring and assign case management and discharge planning responsibilities to the appropriate staff. CSB staff shall establish a personal contact (preferably in person) with the NGRI acquittee	*Upon notice of admission or start of OPTC period* *Upon notice of admission or start of OPTC period* *Within seven (7) calendar days of*	information/face sheet to the CSB, as well as the name and phone number of the social worker assigned and the name of the admitting unit. The Office of Forensic Services will provide the CSB NGRI Coordinator copies of the court order and contact information for the acquittee, court, attorneys, and DBHDS Forensic Coordinator that will be responsible for oversight of the evaluation process. Hospital staff will provide the CSB timely updates on the Temporary Custody evaluators' findings, copies of all reports including the IARR, and updates on court dates during the Temporary Custody period. In cases where one or both evaluators recommend conditional or unconditional release from Temporary Custody, the state	*Within (7) calendar days of admission or start of OPTC period* *Within two (2) business days* *Within one (2) business days of*

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Initial NGRI Temporary Custody Evaluation Period			
CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
in order to initiate collaborative discharge planning.	*admission or start of OPTC period*	hospital will notify the CSB via email of the need to prepare a written Conditional or Unconditional Release Plan and the due date for the plan to be returned. The state hospital will establish a due date no less than ten (10) business days from notification.	*receipt of the evaluation(s)*
For Outpatient TC cases, CSB staff are responsible for identifying treatment and support needs in the community, initiating referrals for services, and communicating any updates on the individual's progress to the DBHDS facility's Forensic Coordinator and Office of Forensic Services.	*Upon start of OPTC period and Ongoing*	The hospital will work jointly with the CSB in the development of the Conditional or Unconditional Release Plan.	*Ongoing*
The CSB NGRI Coordinator shall develop and transmit to the state hospital a fully developed conditional release plan (CRP) or unconditional release plan (UCRP) with all required signatures.	*By the deadline indicated by the state hospital*	Hospital staff will provide notice to the CSB of the outcome of the Temporary Custody court hearing and copies of any orders issued from that hearing.	*Within two (2) business days of the court hearing or receipt of order*
If an NGRI acquittee is approved by the court for Conditional or Unconditional Release following the Temporary Custody period, the	*Upon receipt of court order approving release*		

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Initial NGRI Temporary Custody Evaluation Period			
CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
CSB is responsible for implementing the release plan.			
NGRI Inpatient Commitment for Treatment			
The CSB NGRI Coordinator and/or the CSB discharge planner will attend inpatient CTP and TPR meetings in person whenever possible. At a minimum, the CSB staff who is assigned lead discharge planning responsibilities shall participate in treatment team meetings and discharge planning meetings; however, it is most advantageous if both staff can participate in treatment teams as much as possible. If the CSB NGRI Coordinator is unable to attend CTP and TPR meetings, the CSB discharge planner will ensure that they receive a summary update following each meeting. However, the CSB NGRI Coordinator shall attend any CTP and TPR meetings for NGRI patients with approval for unescorted	*Ongoing* *Ongoing*	State hospital staff shall inform the CSB NGRI Coordinator and CSB discharge planner by email of the date and time of CTP and TPR meetings. The initial CTP meeting shall be held within seven calendar days of admission. If CTP and TPR meetings must be changed from the originally scheduled time, the state hospital shall ensure that the CSB is made aware of this change via email. It is expected that the state hospital will provide alternative accommodations (such as	*At least two (2) business days prior to the scheduled meeting* *Within seven (7) calendar days of admission* *At least two (2) business days prior to the rescheduled meeting* *Ongoing*

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Initial NGRI Temporary Custody Evaluation Period			
CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
community not overnight privileges and higher. If CSB staff are unable to physically attend the CTP or TPR meeting, the CSB may request arrangements for telephone or video conference. The individual assigned to take the lead in discharge planning will ensure that other relevant parties (CSB program staff, private providers, etc.) are engaged with state hospital social work staff. In the event that the arrangements above are not possible, the CSB shall make efforts to discuss the individual's progress towards discharge with the state hospital social worker within two business days of the CTP or TPR meeting.	*Ongoing* *Ongoing* *Within two (2) business days of the missed meeting*	phone or video) if CSB staff are unable to attend in person, and that meetings will be scheduled so that liaisons can participate in as many treatment team meetings as possible. State hospital staff shall provide notice to the CSB NGRI Coordinator of any meetings scheduled to review an acquittee's appropriateness for a privilege increase or release. The state hospital shall provide notice to the CSB NGRI Coordinator of the need for a risk management plan (RMP), a Conditional Release Plan (CRP), or an Unconditional Release Plan (UCRP) once the determination has been made that a privilege request packet must be developed. This notification will be emailed and will include a deadline by which the CSB should submit the required documentation; at a minimum the CSB should	*At least two (2) business days prior to the scheduled meeting* *Within two (2) business days of identifying the need for a RMP, CRP, or UCRP*

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Initial NGRI Temporary Custody Evaluation Period			
CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
The CSB NGRI Coordinator shall review, edit, sign, and return the risk management plan (RMP) for individuals adjudicated as NGRI. The CSB NGRI Coordinator shall develop and transmit to the state hospital a fully developed conditional release plan (CRP) or unconditional release plan (UCRP) with all required signatures by the due date indicated.	*Within seven (7) business days of receiving the draft RMP from the state hospital* *By the deadline indicated by the state hospital*	be provided 10 business days to supply the necessary product.	
Note: Virginia Code §§ 19.2-182.2, 19.2-182.5 (C), and 19.2-182.6(C) explicitly require CSBs or BHAs to plan for conditional release in conjunction with hospital staff and to implement the conditional release plan approved by the court. The conditional release plan shall be prepared jointly by the hospital and the CSB or BHA where the acquittee shall reside upon conditional release. **Note:** For some NGRI patients, the RMP or CRP may involve more than one CSB. It is essential that the CSB responsible for the development of these plans communicates effectively with other involved CSBs and ensures that these plans are signed as soon as possible according to the time frames above.			

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Initial NGRI Temporary Custody Evaluation Period			
CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
Note: While it may not be possible for the CSB to attend every treatment planning meeting, participation in person or via phone or video conference is expected. This is the most effective method of developing comprehensive treatment goals and implementing efficient and successful discharge plans.			

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V. Needs Assessment

CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
Discharge planning begins at the point of admission and continues throughout hospitalization. This should include those released at hearing. In completing the discharge plan, the CSB shall consult with the individual, members of the treatment team, the surrogate decision maker, and (with consent) family members or other parties, to determine the preferences of the individual upon discharge. The CSB shall obtain required releases of information. The discharge plan shall include: • The anticipated date of discharge from the state hospital • The identified services needed for successful community placement and the frequency of those services	*At admission and ongoing thereafter* *At admission and ongoing thereafter* *As soon as possible upon admission and ongoing*	The state hospital social worker shall complete the comprehensive social work assessment. This assessment shall provide information to help determine the individual's needs upon discharge. The treatment team shall document the individual's preferences in assessing their unique needs upon discharge.	*Prior to the CTP (or within 72 hours as noted by TJC)* *Ongoing*

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
• The specific public and/or private providers that have agreed to provide these services • If returning to jail, outline a plan for CSB follow-up in the jail until the individual's return to the community.			
CSB shall assist with any required forms of identification, or obtaining required documents that an individual may already have.	*As needed*	The state hospital shall assess if any form of identification will be required for discharge planning purposes, what forms of identification the individual may already have available, and begin the process of obtaining identification if needed	*Within one (1) week of admission*
If the individual's needs change or as more specific information about the discharge plan becomes available, the CSB staff shall update the discharge plan accordingly	*Ongoing*	As an individual's needs change, the hospital social worker shall document changes in their progress notes and through communications/meetings with the CSB.	*Ongoing*
Note: The CSB and the state hospital treatment team shall ascertain, document, and address the preferences of the individual and the surrogate decision maker as to the placement upon discharge. These preferences shall be addressed to the greatest degree possible in determining the optimal and appropriate discharge placement (please see attached memo regarding patient choice in state hospital discharges)			

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VI. Pre-Discharge Planning

Note: please see glossary for information regarding state and federal regulations concerning release of information for discharge planning purposes

CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
For the following services, the CSB shall confirm the availability of services, as well as the individual's appropriateness for services; or refer to a private provider for services: • Case management • Psychosocial rehabilitation • Mental health skill building • Permanent supportive housing • PACT/ICT • Other residential services operated by the CSB or region • Substance Use Services • PHP/IOP • Individual/group therapy • Other relevant services	*Within five (5) business days of receiving the referral*	The state hospital treatment team shall review discharge needs on an ongoing basis. If referrals for the following services are needed for the individual, the hospital social worker shall refer the individual to the CSB responsible for discharge planning for assessment for eligibility • Case management • Psychosocial rehabilitation • Mental health skill building • Permanent supportive housing • PACT/ICT • Other residential services operated by the CSB or region • Substance Use Services • PHP/IOP • Individual/ group therapy • Other relevant services	*Within two (2) business days of the treatment team identifying the need for the services*

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
The CSB shall share the outcome of the assessment and the date when the services will be available with the hospital treatment team.	*Immediately upon completion of the assessment*		
		Individuals Returning to Jail: The treatment team social worker in collaboration with the state hospital Forensic Coordinator will ensure the treatment team has a copy of the jail medication formulary. For medications that are not on the jail formulary but that the prescriber believes is necessary for patient care, the current prescriber will consult with the jail medical provider prior to the individual's return to jail and incorporate into the discharge plan the support needed for ongoing stability.	*Ongoing*
NGRI Acquittees: The CSB Executive Director shall appoint an individual with the	*Ongoing;*		

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
appropriate knowledge, skills, and abilities to serve as NGRI Coordinator for their agency (please see glossary for specific requirements)	*Changes in assigned NGRI Coordinator should be communicated to DBHDS Central Office Forensics staff within two (2) business days*		
Guardianship: Upon being notified of the need for a guardian, the CSB shall explore potential individuals/agencies to serve in that capacity. If the CSB cannot locate a suitable candidate who agrees to serve as guardian and lack of a guardian is a barrier to discharge, they shall notify the state hospital to begin the process of referral for a DBHDS guardianship slot. They will provide relevant documentation of attempts to find suitable guardian.	*Within two (2) business days of notification* *Within ten (10) business days of notification of need for a guardian*	**Guardianship:** Evaluation for the need for a guardian shall start upon admission and be addressed at each treatment team meeting for all patients; both civil and forensic. Activities related to securing a guardian (if needed) start and continue regardless of a patient's discharge readiness level. The hospital social worker shall notify the CSB discharge planner that the treatment team has determined that the individual is in need of a guardian in order to be safely discharged.	*Ongoing* *Within two (2) business days of determination*

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
If DBHDS awards a Mental Health Guardianship slot to the individual and the individual is accepted by a public or private guardianship program, the CSB shall retain an attorney on behalf of the individual to file a guardianship petition with the court.	*Immediately upon notification of acceptance by the guardianship program*	If notified by the CSB that a suitable candidate for guardianship cannot be located, the state hospital shall begin the process of referring the individual to DBHDS Central Office for a DBHDS Guardianship slot. This referral shall include a comprehensive assessment of the individual's lack of capacity, and potential for regaining capacity. This assessment shall be shared with the CSB upon completion by the evaluating clinician. Guardianship referrals required for forensic patients hospitalized for restoration should be submitted immediately upon being found unrestorably incompetent to stand trial (URIST) by the court.	*Immediately upon notification by the CSB of the need for a DBHDS guardianship slot*
Note: Discharge planning should include an evaluation of patient preferences in addition to their support and service needs based on least restrictive settings and available resources. DBHDS funded programs and services must be exhausted before DAP funding can be utilized. CSB shall keep a tracking sheet of all referrals made, date referred, follow-up dates, and outcomes.			

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
Permanent Supportive Housing (PSH)			
The CSB shall obtain verbal consent and releases, if necessary, from the individual or the surrogate decision maker to make referral to PSH program.	*As soon as PSH is being considered, and prior to the individual being determined to be RFD*	The state hospital shall assist in the facilitation of interviews/assessments required by PSH provider	*Upon request*
The CSB shall obtain required documentation and send the referral packet to the PSH program.	*As soon as PSH is being considered, and prior to the individual being determined to be RFD*	The state hospital will provide any copies of vital records and financial (benefits) information to the CSB for PSH application	*Within one (1) business day of request from CSB*
The CSB will determine options for a step-down, such as a hotel, while PSH unit is pending.	*As soon as accepted to PSH program*		
If a patient is denied, the CSB should attempt to obtain the reason for denial	*Upon notice of denial*		

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
Transitional			
The CSB shall obtain verbal consent and releases, if necessary, from the individual or the surrogate decision maker to make referral to transitional program.	*As soon as a transitional housing is being considered, and prior to the individual being determined to be RFD*	The state hospital shall assist in the facilitation of interviews/assessments required by transitional provider.	*Upon request*
The CSB shall obtain required documentation and send the referral packet to the transitional program.	*Within two (2) business days of becoming discharge ready level 2*	The state hospital will provide any copies of vital records and financial (benefits) information to the CSB for transitional application	*Within one (1) business day of request from CSB*
CSB will refer to PSH prior to discharge if the individual will transition to PSH upon completion of transitional program.	*Simultaneously with referrals for transitional*	The state hospital will document in the EHR and in the hospital discharge instructions that the individual is recommended for PSH, if appropriate, upon completion of transitional program.	*Prior to discharge*
If a patient is denied, the CSB should attempt to obtain the reason for denial	*Upon notice of denial*		

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
Mental Health Group Homes			
The CSB shall obtain verbal consent and releases, if necessary, from the individual or the surrogate decision maker to make referrals to mental health group homes.	*As soon as a mental health group home is being considered, and prior to the individual being determined to be RFD*	The state hospital shall assist in the facilitation of interviews/assessments required by transitional provider	*Upon request*
The CSB shall obtain required documentation and send the referral packet to mental health group homes.	*Within two (2) business days of becoming discharge ready level 2*	The state hospital will provide any copies of vital records and financial (benefits) information to the CSB for transitional application	*Within one (1) business day of request from CSB*
If a patient is denied, the CSB should attempt to obtain the reason for denial	*Upon notice of denial*		

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
Assisted Living (ALF) referrals:		**Assisted Living (ALF) referrals:**	
The CSB shall obtain verbal consent and releases from the individual or the surrogate decision maker to begin initial contacts to facilities regarding bed availability and willingness to consider the individual for placement.	*As soon as an ALF is being considered, and prior to the individual being determined to be RFD*	The state hospital will not recommend congregate settings without first completing the housing first evaluation to determine patient needs and preferences. The state hospital shall complete the UAI and DMAS-96	*Within five (5) business days of the individual being found discharge ready level 2*
The CSB shall obtain required documentation and send referral packets to multiple potential placements. The referrals are to be sent simultaneously.	*Within one (1) business day of receiving the UAI*	The state hospital shall transmit the UAI and DMAS- 96 to the CSB	*Immediately upon completion of the UAI*
		The state hospital shall assist the CSB in the facilitation of interviews/assessments required by potential ALF providers	*Upon request*
If the CSB does not receive a response from a potential placement, the CSB shall be follow up on the status of the referral. It is expected that the CSB will continue to communicate with the provider until a disposition decision is	*Within two (2) business days of sending the referral and at least weekly thereafter*		

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
reached or the patient discharges to a different placement. If a patient is denied, the CSB should attempt to obtain the reason for denial If it is determined that a secure Memory Care unit is recommended and that DAP will be required to fund this placement, the CSB shall completed the Memory Care Justification form, submit to the Community Transition Specialist for their hospital, and receive approval prior to referring to secure memory care units.	*Upon notice of denial* *Prior to referring to private pay Memory Care units*		
Nursing home (NH) referrals: The CSB shall obtain verbal consent and releases from the individual or the surrogate decision maker to begin initial contacts regarding bed availability and willingness to consider the individual for placement.	*As soon as an NH is being considered, and prior to the individual being determined to be RFD*	**Nursing home (NH) referrals:** The state hospital shall complete the UAI	*Within five (5) business days of the individual being found discharge ready level 2*

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
The CSB shall obtain required documentation and send referral packets to multiple potential placements. The referrals are to be sent simultaneously. If the CSB does not receive a response from a potential placement, the CSB shall be follow up on the status of the referral. It is expected that the CSB will continue to communicate with the provider until a disposition decision is reached or the patient discharges to a different placement. If a patient is denied, the CSB should attempt to obtain the reason for denial.	*Within one (1) business day after receiving the UAI* *Within two (2) business days of sending the referral and at least weekly thereafter* *Upon notice of denial*	For individuals who require PASRR screening, the state hospital shall send the referral packet to Maximus. The results of the level 2 PASRR screening shall be transmitted to the CSB. The state hospital shall assist the CSB in the facilitation of interviews/assessments required by potential nursing home providers.	*Within one (1) business day of RFD date* *Immediately upon receipt of the screening results* *Upon request*

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
Shelter placements: In the case of out of catchment shelter placements, CSB staff shall notify the CSB that serves the catchment area of the shelter and will follow the procedures as outlined in the CSB transfers section for out of catchment placements.	 *As soon as shelter discharge is identified as the discharge plan*	**Shelter placements:** If discharge to a shelter is clinically recommended and the individual or their surrogate decision maker agrees with this placement, the hospital social worker shall document this recommendation in the medical record. The hospital social worker shall notify the director of social work when CSB consultation has occurred. The director of social work shall review the plan for discharge to a shelter with the medical director (or their designee). Following this review, the medical director (or designee) shall document endorsement of the plan for discharge to a shelter in the individual's medical record. In the case of out of catchment shelter placements, hospital staff shall notify both the CSB responsible for discharge planning, as well as the CSB that serves the catchment area of the shelter.	*Prior to discharge*

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
Individuals with a developmental disability (DD) diagnosis:		**Individuals with a developmental disability (DD) diagnosis:**	
The CSB liaison and support coordinator shall participate in the development and updating of the discharge plan, including attending and participating in treatment team meetings, discharge planning meetings, census management and other related meetings.	*Within one (1) business day of admission*	Upon identification than an individual admitted to the state hospital has a DD diagnosis, the hospital social work director shall notify the CSB liaison/case manager and the CSB DD director (or designee).	*Immediately upon notification of diagnosis*
		The state hospital shall notify the designated CSB lead for discharge planning of all relevant meetings, as well as the REACH hospital liaison (if REACH is involved) so attendance can be arranged.	*Ongoing*
The CSB shall send referrals to multiple potential placements. The referrals are to be sent simultaneously. If the CSB does not receive a response from a potential placement, the CSB shall follow up on the status of the referral. It is expected that the CSB will continue to communicate with the provider until a disposition decision is reached or the patient discharges to a different placement.	*Within ten (10) business days of request for services*	The state hospital shall assist the CSB in compiling all necessary documentation to implement the process for obtaining a DD waiver and/or bridge funding. This may include conducting psychological testing and assessments as needed.	*Ongoing. Required psychological testing and assessment shall be completed within 21*

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
The CSB shall assist in scheduling tours/visits with potential providers for the individual and/or the individual's surrogate decision maker.	*Immediately upon notification of need*	The state hospital shall serve as a consultant to the DD case manager as needed.	*calendar days of referral* *Ongoing*
The CSB shall locate and secure needed specialists who will support the individual in the community at discharge.	*Within three (3) business days of admission*	The state hospital shall assist with coordinating assessments with potential providers.	*At the time that the individual is rated a discharge ready level 2*
If the individual is moving outside their home area, the CSB shall notify the CSB in which the individual will reside upon discharge	*Upon admission and ongoing*	The state hospital shall facilitate tours/visits with potential providers for the individual and/or the individual's surrogate decision maker.	*Ongoing*
If it is anticipated that an individual with a DD diagnosis is going to require transitional funding, the CSB shall complete an application for DD crisis funds.	*Immediately upon notification of need*	Note: When requested referrals or assessments are not completed in a timely manner, the state hospital director shall contact the CSB Executive Director to resolve delays in the referral and assessment process.	

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
The CSB will maintain contact with all service providers to ensure timely completion of tasks required for discharge. The Support Coordinator shall consult with the Community Integration Manager and or a Community Resource Consultant, as needed, to ensure required services are identified and in place prior to discharge. These supports may include, but are not limited to: • Therapeutic Consultation provider to develop, monitor, and revise a Behavior Support Plan • Customized Rate for increased staffing, specialized staffing, and or programmatic oversight • REACH Community Crisis Stabilization Support • Support training for residential provider staff	*Ongoing* *As needed*		

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
• Private duty or skilled nursing • Day Services			

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VII. Readiness for Discharge

CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
Once the CSB has received notification of an individuals' readiness for discharge, they shall take immediate steps to implement the discharge plan	*Immediately upon notification*	The treatment team shall assess and rate the clinical readiness for discharge for all individuals The state hospital social worker shall notify the CSB and DBHDS Community Transition Specialist through the use of email when the treatment team has made a change to an individual's discharge readiness rating. This includes when an individual is determined to be ready for discharge and no longer requires inpatient level of care. Or, for voluntary admissions, when consent has been withdrawn.	*A minimum of weekly* *Within one (1) business day*
CSB liaisons will provide a discharge planning update on all of their patients rated clinically ready for discharge (level 1) weekly either via email or participation in the census management meeting.	*Weekly by Close of business Friday*	The state hospital shall use encrypted email to provide notification to each CSB's liaison, DS director if applicable the liaison's supervisor, the CSB behavioral health director or equivalent, the CSB executive director, the state hospital social work director, the state hospital director, the appropriate Regional	*Weekly, no later than Wednesday*

		Manager, and the Central Office Community Transition Specialist, Community Integration Manager (and others as appropriate) of every individual who is ready for discharge, including the date that the individual was determined to be clinically ready for discharge. **Note**: These notifications and responses shall occur for all individuals, including individuals who were diverted from other state hospitals. Upon receipt of the CSB liaison's update, the state hospital will review	

VIII. Finalizing Discharge

Joint Responsibility of the State Hospital, CSB, and DBHDS Central Office
At a minimum, the state hospital and CSB staff shall review individuals rated a 1 on the clinical readiness for discharge scale on a weekly basis and document in the EHR on the identified form. Individuals rated a 2 on the clinical readiness for discharge scale shall be jointly reviewed at least once per month. To ensure that discharge planning is occurring at an efficient pace, the CSB shall provide updated discharge planning progress that shall be documented

in these reviews. The regional utilization structures shall review at least monthly the placement status of those individuals who are on the EBL.

The Office of Patient Clinical Services shall monitor the progress of those individuals who are identified as being ready for discharge, with a specific focus on individuals who are on the EBL.

When a disagreement between the state hospital and the CSB occurs regarding the discharge plan for an individual, both parties shall attempt to revolve the disagreement and will include the individual and their surrogate decision maker, if appropriate. If these parties are unable to reach a resolution, the state hospital will notify their Central Office Community Transition Specialist within three business days to request assistance in resolving the dispute.

Please see EBL definition in Glossary.

CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
In the event that the CSB experiences extraordinary barriers to discharge and is unable to complete the discharge within seven (7) calendar days of the determination that the individual is clinically ready for discharge, the CSB shall document in the CSB medical record the reason(s) why the discharge cannot occur within seven (7) days of determination.	*Within seven (7) calendar days of determination that individual is clinically ready for discharge*		

The documentation shall describe the barriers to discharge (i.e. reason for placement on the Extraordinary Barriers List (EBL) and the specific steps being taken by the CSB to address these barriers.			
The reduce readmissions to state hospitals, CSBs, in conjunction with the treatment team, shall develop and complete (when clinically indicated) a safety and support plan as part of the individual's discharge plan **Note**: Safety and support plans are generally not required for court-ordered evaluations, restoration to competency cases, and jail transfers; however, at the clinical discretion of the CSB and/or treatment team, the development of a safety and support plan may be advantageous when the individuals presents significant risk factors, and for those individuals who will be returning to the community following a brief incarceration period.	*Prior to discharge*	The state hospital shall collaborate and provide assistance in the development of safety and support plans **Note**: Safety and support plans are generally not required for court-ordered evaluations, restoration to competency cases, and jail transfers; however, at the clinical discretion of the CSB and/or treatment team, the development of a safety and support plan may be advantageous when the individuals presents significant risk factors, and for those individuals who will be returning to the community following a brief incarceration period.	*Prior to discharge*

Exception: Due to having a risk management plan as part of the conditional release plan, NGRI acquittees do not require a safety and support plan.		**Exception**: Due to having a risk management plan as part of the conditional release plan, NGRI acquittees do not require a safety and support plan	
If an individual would benefit from a trial pass due to clinical reasons, the CSB will make a request to the hospital to include the clinical reasons the pass is being requested. If a trial pass is approved, the CSB will take the lead on planning to include collaborating with the hospital on transportation, The CSB shall check in daily with the identified provider to include any problem	*Prior to discharge, as needed* *Once approved* *Daily*	Trial passes to an identified placement are approved on a case-by-case basis. The hospital will collaborate with the CSB and identified placement to address any issues that may arise during a trial pass. This will include set time and completion of an approved pass form with contacts, obligations, and agreement from facility to hold the individual.	*Upon request* *Upon request*

solving for issues that may arise. The CSB will keep the hospital informed. If the trial pass is a pass to discharge, the CSB will continue with discharge planning activities and confirm with the identified provider that discharge will move forward. until the individual is officially discharged.	*As needed*		

Exhibit K
Collaborative Discharge Requirements for Community Services Boards and State Hospitals

Contract No. P1636.CSBCode.3

CSB staff shall ensure that all arrangements for psychiatric services and medical follow up appointments are in place.	*Prior to discharge*	The state hospitals shall complete the H&P, PPD, other admissions paperwork, and signed orders for the placement.	*As soon as placement is identified*
CSB staff shall ensure the coordination of any other intra-agency services (e.g. employment, outpatient services, residential, etc.) and follow up on applications for entitlements and other resources submitted by the state hospital.	*Prior to and following discharge*	The state hospitals shall provide medication and/or prescriptions upon discharge.	*At discharge*
The CSB case manager, primary therapist, or other designated clinical staff shall schedule an appointment to see individuals who have been discharged from a state hospital.	*Within seven (7) calendar days, or sooner if the individual's condition warrants*		
The CSB case manager, discharge liaison, or other designated clinical staff shall ensure that an appointment with the CSB (or private) psychiatrist is scheduled when the individual is being discharged on psychiatric medications.	*Within seven (7) calendar days of discharge*		

AMENDMENT 3

AMENDED AND RESTATED

FY2026 AND FY2027 COMMUNITY SERVICES PERFORMANCE CONTRACT

MASTER AGREEMENT

Exhibit K
Collaborative Discharge Requirements for Community Services Boards and State Hospitals

Contract No. P1636.CSBCode.3

Exhibit K
Collaborative Discharge Requirements for Community Services Boards and State Hospitals

Contract No. P1636.CSBCode.3

Benefit applications: For any patient who is committed to a state facility (or CMA), and whose hospital stay is less than 30 days, the CSB shall initiate applications for Social Security benefits. The CSB shall complete the SSA-1696 Appointment of Representative Form and provide a copy to the hospital social worker or benefits coordinator. The CSB shall contact the entity responsible for processing entitlement applications (SSA, DSS, etc.) to ensure that the benefits application has been received and that these entities have all required documentation. If benefits are not active with 30 days of the patient's discharge, the CSB shall again contact the entity responsible for processing the entitlement application in order to expedite benefit approval.	*As soon as a discharge date is finalized* *Within three (3) business days of being requested* *Upon submission* *30 days post-discharge, and every 15 days thereafter until benefits are active*	**Benefit applications:** State hospital staff will verify insurance and benefits upon admission. State hospital staff shall initiate applications for Medicare, Medicaid, Social Security benefits, Auxiliary Grant, and other financial entitlements as necessary. Applications shall be initiated in a timely manner per federal and state regulations **Note**: For patients whose hospital stay is less than 30 days, the CSB will be responsible for Social Security applications **Note**: For patients that will be applying for an Auxiliary Grant some exceptions may apply for programs with other agreements. *State hospital will request that the CSB complete the SSA-1696.* To facilitate follow-up, if benefits are not active at the time of discharge, the state hospital shall notify the CSB of the type of entitlement application, as well as the date it	*Prior to discharge and per federal and state regulations* *When SSA benefits are being applied for*

		was submitted, and include a copy of entitlement applications with the discharge documentation that is provided to the CSB.	

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Collaborative Discharge Requirements for Community Services Boards and State Hospitals

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Vital Documents: For any patient who is committed to a state facility (or CMA), and whose hospital stay is less than 30 days, the CSB shall initiate acquiring vital documents if patient cannot provide those. The CSB shall complete the SSA-1696 Appointment of Representative Form and provide a copy to the hospital social worker or benefits coordinator. The CSB shall contact the entity responsible for acquiring these items (SSA, DMV, VDH, etc.) to ensure that the information has been received and what these entities may require for documentation. If vital documents have not been acquired within 30 days of the patient's discharge, the CSB shall again contact the entity responsible for processing.	*As soon as admission occurs* *Within three (3) business days of being requested* *Upon submission* *30 days post-discharge, and every 15 days thereafter until acquired*	**Vital Documents:** State hospital staff will verify vital documents upon admission. State hospital staff shall initiate applications for Photo ID's, Birth Certificates, Social Security cards, and other documents as necessary. Applications shall be initiated in a timely manner per federal and state regulations *State hospital will request that the CSB complete the SSA-1696.* To facilitate follow-up, if vital documents are not active at the time of discharge, the state hospital shall notify the CSB of the type of the vital documents still needed, as well as the date it was requested, and include a copy of any applications with the discharge documentation that is provided to the CSB	*Prior to discharge and per federal and state regulations* *When SSA benefits are being applied for*

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Contract No. P1636.CSBCode.3

Discharge Transportation: The CSB shall ensure that discharge transportation is arranged for individuals discharging from state hospitals. **Note**: When transportation is the only remaining barrier to discharge, the state hospital and CSB will implement a resolution process for resolving transportation issues when these are anticipated to result in discharges being delayed by 24 hours or more.	*Prior to scheduled discharge date*	**Note**: When transportation is the only remaining barrier to discharge, the state hospital and CSB will implement a resolution process for resolving transportation issues when these are anticipated to result in discharges being delayed by 24 hours or more.	
		Discharge Instructions: The treatment team shall complete the discharge information and instructions form (DIIF). State hospital staff shall review the DIIF with the individual and/or their surrogate decision maker and request their signature. Distribution of the DIIF shall be provided to all next level of care providers, including the CSB.	*Prior to discharge* *At discharge* *At discharge*

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Collaborative Discharge Requirements for Community Services Boards and State Hospitals

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		The state hospital medical director shall be responsible for ensuring that the physician's discharge summary is provided to the CSB responsible for discharge planning (and prison or jails, when appropriate)	

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Collaborative Discharge Requirements for Community Services Boards and State Hospitals

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Transfers between CSBs

CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
Transfers shall occur when an individual is being discharged to a different CSB catchment area than the CSB responsible for discharge planning. If a determination is made that an individual will be relocating post-discharge, the CSB responsible for discharge planning shall immediately notify the CSB affected.	*Prior to discharge as soon as accepting placement is confirmed*	The state hospital social worker shall indicate in the discharge instructions the Case Management CSB and the Discharge CSB to indicate a change in CSB.	*At discharge*
The CSB shall complete and forward a copy of the Out of Catchment Notification/Referral form to the receiving CSB. **see appendix for out of catchment referral	*Prior to discharge as soon as accepting placement is confirmed*		
Note: Coordination of the possible transfer shall, when possible, allow for discussion of resource availability and resource allocation between the two CSBs prior to the transfer.			
Exception to above may occur when the CSB, individual served, and/or their surrogate			

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Collaborative Discharge Requirements for Community Services Boards and State Hospitals

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
decision maker wish to keep services at the original CSB, while living in a different CSB catchment area. For individuals who are enrolled in CSB DD services, please follow the *Transferring Support Coordination/DD Waiver Slots* policy.			
At a minimum, the CSB responsible for discharge and the CSB that serves the discharge catchment area shall collaborate prior to the actual discharge date. The CSB responsible for discharge planning is responsible for completing the discharge plan, conditional release plan, and safety and support plan (if indicated), and for the scheduling of follow up appointments. While not responsible for the development of the discharge plan and the safety and support plan, the CSB that serves the catchment area where the patient will be discharged should be	*Prior to discharge as soon as accepting placement is confirmed*		

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Collaborative Discharge Requirements for Community Services Boards and State Hospitals

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
actively involved in the development of these plans. The arrangements for and logistics of this involvement are to be documented in the discharge plan and the individual's medical record. The CSB responsible for discharge planning shall provide the CSB that serves the catchment area where the patient will be discharging with copies of all relevant documentation related to the treatment of the individual.	*Within two (2) business days of notification of intent to transfer*		
If the two CSBs cannot agree on the transfer at discharge, they shall seek resolution from the Director of Clinical Services (or designee). The CSB responsible for discharge planning shall initiate this contact.			

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Collaborative Discharge Requirements for Community Services Boards and State Hospitals

Contract No. P1636.CSBCode.3

CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
NGRI Acquittees: The *Guidelines for the Management of Individuals Found Not Guilty by Reason of Insanity (Revised 2023)* indicate that individuals who have been found not guilty by reason of insanity may take up residence in any area of the state of their choosing. They are not required to return to the area from which they were originally acquitted by reason of insanity, nor to the jurisdiction where they lived prior to admission. All referrals for CSB case transfer of NGRI acquittee shall follow the standard transfer process as described above, including use of the Out of Catchment Notification/Referral Form (see appendix). CSBs shall not refuse to accept transfer of an NGRI case transfer unless they can clearly demonstrate that the necessary services or supports required to manage the acquittee's risk are unavailable through the CSB or private providers in the area and that the transfer would create increased risk to the community or the acquittee as a result. The CSB's current NGRI caseload size shall not be a reason for refusal to accept transfers. The court of jurisdiction MUST approve the placement for an insanity acquittee and their responsible CSB prior to placement in the community. This information will be identified in the proposed conditional release plan prepared by the referring CSB (with input from the receiving CSB).			

Exhibit K
Collaborative Discharge Requirements for Community Services Boards and State Hospitals

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Glossary

Acute admissions or acute care services: Services that provide intensive short-term psychiatric treatment in state mental health hospitals.

Case management CSB/CSB responsible for discharge planning: The public body established pursuant to § 37.2-501 of the *Code of Virginia* that provides mental health, developmental, and substance abuse services within each city and county that established it and in which, in the case of a minor, a minor's parent or legal guardian resides, or for adults, the adult resides or in which surrogate decision maker resides. The case management CSB is responsible for case management and liaising with the hospital when an individual is admitted to a state hospital, and for discharge planning. If the individual, surrogate decision maker, or parent/legal guardian (in the case of a minor) chooses for the individual to reside in a different locality after discharge from the state hospital, the CSB serving that locality becomes the receiving CSB and works with the CSB responsible for discharge planning/referring CSB, the individual, and the state hospital to affect a smooth transition and discharge. The CSB responsible for discharge planning is ultimately responsible for the completion of the discharge plan. Reference in these protocols to CSB means CSB responsible for discharge planning, unless the context clearly indicates otherwise.

Case management/ CSB responsible for discharge planning designations may vary from the definition above under the following circumstances:

- When the individual's living situation is unknown or cannot be determined, or the individual lives outside of Virginia, the CSB responsible for discharge planning is the CSB which completed the pre-screening admission form.
- For individuals who are transient or homeless, the CSB serving the catchment area in which the individual is living or sheltered at the time of pre-screening is the CSB responsible for discharge planning.
- When a CSB other than the pre-screening CSB is continuing to provide services and supports to the individual, then the CSB responsible for discharge planning is the CSB providing those services and supports.

- For individuals in correctional facilities, in local hospitals, or Veteran's Administration facilities, or in regional treatment/detox programs, the CSB responsible for discharge planning is the CSB serving the catchment area in which the individual resided prior to incarceration, or admission to local hospitals, Veterans Administration facilities, or regional detox programs
- In instances in which there is a dispute related to which CSB is responsible for discharge planning, the state hospital will work collaboratively with the CSBs involved to determine which CSB is responsible within two business days. If resolution cannot be reached, the state hospital will contact their Community Transition Specialist who will make a determination based on the available information.

Census Management Meetings: Collaborative meetings that are consistently facilitated between CSBs and state facilities in an effort to address barriers to discharge.

Comprehensive treatment planning meeting (CTP): A meeting which follows the initial treatment meeting and occurs within seven days (three days for children/adolescents) of admission to a state hospital. At this meeting, the individual's comprehensive treatment plan (CTP) is developed by the treatment team in consultation with the individual, the surrogate decision maker (or parent/legal guardian for minors), the CSB and, with the individual's (parent/legal guardian for minors) consent, family members and private providers. The purpose of the meeting is to guide, direct, and support all treatment aspects for the individual.

Co-occurring disorders: Individuals are diagnosed with more than one, and often several, of the following disorders: mental health disorders, developmental disability, or substance use disorders. Individuals may have more than one substance use disorder and more than one mental health disorder. At an individual level, co-occurring disorders exist when at least one disorder of each type (for example: a mental health and substance use disorder or developmental disability and mental health disorder) can be identified independently of the other and are not simply a cluster of symptoms resulting from a single disorder.

Discharge plan or pre-discharge plan: Hereafter referred to as the discharge plan, means an individualized plan for post-hospital services that is developed by the case management CSB in accordance with § 37.2-505 and § 16.1-346.1 of the Code of Virginia in consultation with

the individual, surrogate decision maker, parent/legal guardian (in the case of minors) and the state hospital treatment team. This plan must include the mental health, developmental, substance abuse, social, educational, medical, employment, housing, legal, advocacy, transportation, and other services and supports needed by the individual, consistent with subdivision A.3 of § 37.2-505, following an episode of hospitalization and must identify the public or private providers that have agreed to provide these services and supports. The discharge plan is required by § 37.2-505, § 16.1-346.1, and § 37.2-508 of the Code of Virginia.

Extraordinary Barriers List (EBL):

- Patients with a civil legal status who have been identified as 1- clinically ready for discharge and who have been RFD for 31+ days with a primary need of Willing Provider, Guardianship, Individual or Guardian unwilling to work toward discharge.
- Patients with a civil legal status who have been identified as 1- clinically ready for discharge RFD for 16+ days with a primary need of DD waiver process or Other.
- Patients with other barriers not resolved after escalation

EBL meeting: Refers to the twice monthly meetings for children and adolescents on the Extraordinary Barriers List at CCCA. Meetings are held every second and fourth week on Tuesdays, Wednesdays, and Thursdays, and include the CCCA treatment team, community providers, case managing CSB, parent/legal guardian, DBHDS Community Transition Specialist, and other DBHDS staff and community partners as needed. These meetings focus on discharge planning, addressing the significant barriers identified by participants.

Forensic Discharge Planners (CSB): (see *"DBHDS Forensic Discharge Planner Protocol for Community Service Boards & Local and Regional Jails," Revised 2023):* Refers to staff positions at the CSB that are funded by DBHDS to provide Forensic Discharge Planning to individuals with Serious Mental Illness (SMI) and co-occurring disorders who are in local or regional jails in Virginia. The forensic discharge planner is the single point of contact responsible for coordinating all necessary referrals and linkages within the jail and in the

community upon release. This individual should be a "boundary spanner," capable of navigating various criminal justice, clinical, and social services systems to ensure proper linkage. This role involves the development of a written discharge plan which prioritizes goals and objectives that reflect the assessed needs of the inmate. It also consists of care coordination with state hospital, community providers, and community supervision agencies, including the exchange of treatment records, communication of treatment needs, and linkage of clients with available services and support options upon release. In the context of state hospital admissions of individuals admitting from or returning to jail, the FDP staff are encouraged to participate in CTP/TRP meetings for individuals that they have determined qualify for services and who will be returning to jail from the state hospital. CSBs with FDP positions should leverage those positions to support the successful transition and discharge planning of individuals returning to jail following hospital discharge.

Forensic Evaluator: A licensed clinical psychologist or psychiatrist with specialized training, education, and experience in completing forensic evaluations.

High-Service Utilizer: A person admitted to a state hospital under a civil and/or pretrial forensic commitment 3 or more times within a 2-year period over the last 3 years. Due to the readmissions, this group may require special attention to discharge planning needs and placement in order to explore and address reasons for readmission and or repeated criminal justice involvement.

Involuntary admission: An admission of a minor that is ordered by a court through a civil procedure pursuant to § 16.1-346.1 §16.1-340-§ 16.1-345 of the *Code of Virginia.*

Level 2 PASRR Screening: Federal law requires that all individuals (regardless of payer source) who apply as a new admission to a Medicaid-certified nursing facility (NF) be evaluated for evidence of possible mental illness or developmental disability. This evaluation and determination are conducted to ensure that individuals are placed appropriately, in the least restrictive setting possible, and that individuals receive needed services, wherever they are living. The process involves two steps, known as Level 1(UAI) and Level 2 screening. The use of a Level 1 and Level 2 screening and evaluation is known as the Preadmission Screening and Resident Review

(PASRR) process. In Virginia, level 2 PASRR screenings are conducted by Ascend. Individuals with a sole or primary diagnosis of dementia are exempt from Level 2 screenings.

Minor: An individual who is under the age of 18 years. Any minor must have a legal guardian unless emancipated by a legal process. A minor who is 14 years of age or over must give consent for admission and treatment or a parent/legal guardian may consent to a voluntary objecting minor.

NGRI Coordinator (CSB):

Required knowledge:

- Understanding of the basic criminal justice process and the Virginia Code related to insanity acquittees
- Understanding of risk assessment and risk management in the community as well as the knowledge of what community resources are needed for risk management
- Ability to work with an interdisciplinary team
- Ability to communicate well, particularly knowledge of how to write to the court and how to verbally present information in a courtroom setting
- Knowledge of person-centered planning practices that emphasizes recovery principals.

Responsibilities:

1. Serving as the central point of accountability for CSB-assigned acquittees in DBHDS state hospitals
   a. Ensuring adequate and prompt communication with state hospital staff, Central Office staff, and their own agency staff related to NGRI patients
   b. Working with state hospital staff to resolve any barriers to treatment or release planning for NGRI patients

   c. Participating in all meetings where their presence is necessary in order to make decisions related to NGRI privilege increases or release
   d. Jointly preparing Risk Management Plans, Conditional Release Plans, or Unconditional Release Plans; Promptly responding to requests for modifications, reconciling differences, and returning signed documents to prevent delays to NGRI patient progress towards discharge
2. Serving as the central point for accountability and overseeing compliance of the CSB and the NGRI acquittee when court ordered for Conditional Release:
   a. Oversee compliance of the CSB with the acquittee's court-ordered Conditional Release Plan (CRP).
   b. Monitor the provision of CSB and non-CSB services in the CRP through agreed-upon means, including written reports, observation of services, satisfaction of the acquittee, etc.
   c. Assess risk on a continuous basis and make recommendations to the court
   d. Be the primary point of contact for judges, attorneys, and DBHDS staff.
   e. Coordinate the provision of reports to the courts & DBHDS in a timely fashion
   f. Assure that reports are written professionally and address the general and special conditions of the CRP with appropriate recommendations
   g. Prepare correspondence to the courts and DBHDS regarding acquittee non-compliance to include appropriate recommendations for the court to consider
   h. Provide adequate communication and coordinate the re-admission of NGRI acquittees to the state hospital when necessary
   i. Represent the CSB in court hearings regarding insanity acquittees
3. Maintain training and expertise needed for this role:
   a. Agree to participate in any and all DBHDS-developed training developed specifically for this role
   b. Agree to seek out consultation with DBHDS as needed
   c. Train other CSB staff and other provider staff (as appropriate) regarding the responsibilities of working with insanity acquittees, including the monthly and 6-month court report.

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Collaborative Discharge Requirements for Community Services Boards and State Hospitals

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Forensic Coordinator (State Hospital):

Required knowledge:

- Understanding of the basic criminal justice process and the Virginia Code related to pretrial defendants
- Serves as a liaison between the jails, courts, the state hospital, the Office of Forensic Services, and the Forensic Review Panel
- Ability to work with an interdisciplinary team
- Ability to communicate well, particularly knowledge of how to write to the court and how to verbally present information in a courtroom setting
- Knowledge of person-centered planning practices that emphasizes recovery principals.

Responsibilities:

1. Ensures compliance regarding admissions, transfers and discharges of patients transferred from jails or other correctional facilities in accordance with facility and Departmental policies and procedures; the laws of Virginia; court orders, NGRI Guidelines, and ethical and legal standards.
2. Ensures that patients transferred from correctional facilities are served in the most appropriate level of security.
3. Works collaboratively with admissions staff to ensure forensic patients are admitted according to DBHDS guidelines/Virginia statutes.
4. Reviews forensic waitlist daily, triages patients for admissions as needed
5. Works with CSB and medical/mental health staff in correctional facilities for care coordination.
6. Reviews each court order for pretrial hospitalization, evaluation, commitment, emergency treatment or temporary custody for legal sufficiency. If indicated, works with courts and attorneys to obtain revised court orders which meet legal standards and seeks assistance from the Office of Forensic Services, if needed.

7. Reviews, approves, and signs all correspondence to courts regarding forensic patients to ensure that policies and procedures are followed and comply with Virginia Code.
8. Communicates/consults with treatment teams and other staff regarding management decisions for patients transferred from jails.
9. Works closely with administrative assistant of forensic services and treatment team(s) and courts to monitor the schedules of due dates of reports and hearing dates. Maintains current listing of all scheduled court hearings, and due dates for reports to courts; ensure that appropriate persons and entities are notified of hearing dates and ensure that reports are submitted to court(s) on time
10. Supervises or collaborates with evaluation team or assigned evaluators for DBHDS.

Parent/legal guardian: (I) A biological or adoptive parent who has legal custody of the minor, including either parent if custody is shared under a joint decree or agreement, (ii) a biological or adoptive parent with whom the minor regularly resides, (iii) a person judicially appointed as a legal guardian of the minor or (iv) a person who exercises the rights and responsibilities of legal custody by delegation from a biological or adoptive parent, upon provisional adoption or otherwise by operation of law. The director of the local department of social services or his designee may stand as the minor's parent when the minor is in the legal custody of the local department of social services.

Primary substance use disorder: An individual who is clinically assessed as having one or more substance use disorder per the current Diagnostic and Statistical Manual of Mental Disorders (DSM) with the substance use disorder being the "principle diagnosis" (i.e. the condition established after evaluation to be chiefly responsible for the admission). The individual may not have a mental health disorder per the current DSM, or the mental health disorder is not the principle diagnosis.

Process Barriers: Any Barrier identified for an individual who is ready for discharge in which a CSB or State hospital process is causing a delay in movement to discharge. This includes identified CSB Tasks, Hospital tasks or Individuals with an identified discharge plan and a date is scheduled in the future.

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Releases of Information: The practice of authorizing a healthcare entity to release protected health information to other healthcare providers, non-healthcare organizations, or individuals. Obtained a signed release of information is best practice and should occur if at all possible; however, collaboration and information sharing for the purposes of discharge planning does not require a release of information, with the exception of SUD information protected by 42 CFR Part 2. While releases of information are best practice, they should not be a barrier to discharge. These activities are explained in the Code of Virginia § 37.2-839. Additionally please see HIPAA requirements on Treatment, Payment, & Health Care Operations. Lastly this provision is covered in the Human Right Regulations 12VAC35-115-80-B.8.g.

State hospital: A hospital or psychiatric institute, or other institution operated by DBHDS that provides acute psychiatric care and treatment for persons with mental illness.

Surrogate decision maker: A person permitted by law or regulations to authorize the disclosure of information or give consent for treatment and services, including medical treatment, or participation in human research, on behalf of an individual who lacks the mental capacity to make these decisions. A surrogate decision maker may include an attorney-in-fact, health care agent, legal guardian, or, if these are not available, the individual's family member (spouse, adult child, parent, adult brother or sister, or any other relative of the individual) or a next friend of the individual (defined in 12VAC35-115-146).

Treatment team: The group of individuals responsible for the care and treatment of the individual during the period of hospitalization. Team members shall include, at a minimum, the individual receiving services and their parent/legal guardian (if a minor), psychiatrist, a psychologist or psychosocial representative, a social worker, and a nurse. CSB staff shall actively participate, collaborate, and consult with the treatment team during the individual's period of hospitalization. The treatment team is responsible for providing all necessary and appropriate supports to assist the CSB in completing and implementing the individual's discharge plan.

Treatment plan: A written plan that identifies the individual's treatment, educational/vocational and service needs, and states the goals, objectives, and interventions designed to address those needs. There are two sequential levels of treatment plans:

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1. The "initial treatment plan (or "initial plan of care")," which directs the course of care during the first hours and days after admission; and
2. The "comprehensive treatment plan (CTP)," developed by the treatment team with CSB consultation, which guides, directs, and supports all treatment of the individual.

Treatment plan review (TPR): Treatment planning meetings or conferences held subsequent to the CTP meeting.

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Collaborative Discharge Requirements for Community Services Boards and State Hospitals

CSB State Hospital Discharge Planning Performance Measures

1. Eligible patients will be seen by CSB staff (outpatient therapist, Forensic Discharge Planner, case manager, psychiatrist, etc.) within seven calendar days of discharge from a state hospital (assessments by emergency services are not considered follow-up appointments). 80% of eligible patients will be seen by a CSB clinical staff member within seven calendar days of the discharge date, either in the community or in a local or regional jail
2. CSBs will have a state hospital 30-day readmission rate of 7% or below
3. Civil Patients followed by CSBs will have an average length of stay on the extraordinary barriers list (EBL) of 60 days or less. CSBs that serve a population of 100,000 or more will have an average daily census of ten (10) beds or less per 100,000 adult and geriatric population. DBHDS shall calculate the CSBs' average daily census per 100,000 for the adult and geriatric population for patients with the following legal statuses: civil temporary detention order, civil commitment, court mandated voluntary, voluntary, and NGRI patients with 48 hours unescorted community visit privileges.

All data performance measure outcomes will be distributed to CSBs by DBHDS on a monthly basis or as available or be offered as a dashboard.

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Exhibit K
Appendix A - OUT OF CATCHMENT NOTIFICATION TEMPLATE

OUT OF CATCHMENT REFERRAL INSTRUCTIONS

The out of catchment referral is to be used when individuals are being discharged from the state hospital to a catchment area that is outside of the originating CSB's area. The form is utilized to provide information about the individual, as a referral for needed services, and notification for emergency services.

The form has two parts: notification and referral.

For individuals residing short term in another catchment area, or individuals not engaged in CSB services:

- **Please complete page 1- Notification-** This page provides necessary information for CSBs to be aware of individuals discharging from state facilities who are temporarily in another catchment area, or individuals discharging to a catchment area that will not be referred to CSB services.

For individuals being placed in another catchment who will require CSB services AND/OR have a DAP plan for services in another catchment area:

- **Please complete the entire referral form**
- **Please provide documentation including any EHR face sheet and most recent assessments. Additionally, at discharge, please provide the hospital discharge information to the accepting CSB.**

If the individual has a DAP plan, please be sure to submit the narrative and IDAPP to the accepting CSB and the regional manager.

OUT OF CATCHMENT NOTIFICATION/REFERRAL FORM

☐Notification Only *(Page 1)* ☐Full Referral (*Pages 1-3; for individuals who will be referred for services)*

Patient Name:

Last 4 of SS#: DOB: Click or tap to enter a date.

State Hospital: Choose an item.

Admission Date: Click or tap to enter a date.

Primary Diagnosis:

Anticipated Discharge Date: Click or tap to enter a date. Next Treatment Team Date:Click or tap to enter a date.

Social Worker: Phone Number:Click or tap here to enter text.

Current CSB: Choose an item.

Name of Contact:

Phone: Email:

CSB of Discharge Residence: Choose an item.

Name of Contact:

Phone: Email:

Discharge Address:

Type of Residence:

Phone Number:

Contact at Residence (if applicable):

Does this individual have a legal guardian or POA? Choose an item.

(If yes, please list below under "Emergency Contact")

Emergency contact:

Address:

Phone:

Does this individual have a conservator or payee? Choose an item.

Name:

Address:

Appendix A - OUT OF CATCHMENT NOTIFICATION TEMPLATE

Phone:

Will this individual be referred for any services at CSB of discharge residence? Choose an item.

(If yes, please complete the remaining pages of this form.)

I. **Previous Housing** – Please list the individual's housing prior to admission to the state hospital:

Type of Housing:

Name of Residence (if applicable):

Reason Not Returning:

II. **Entitlements and Funding Sources**

☐SSI/SSA Amount:

☐SSDI Amount:

☐Medicaid List # and Type:

☐Medicare List # and Type:

☐DD Waiver Choose an item.

☐Auxiliary Grant Local DSS office where application sent:

☐SNAP

☐VA Benefits Click or tap here to enter text.

☐Private Insurance List Type and #:

☐Other:

III. **DAP**

Type: Choose an item.

Reason Needed:

IV. **Community Support** – What type of community-based services will be required?

☐Case Management

☐PACT/ICT

☐Mental Health Skill Building

☐Psychosocial Rehabilitation

☐Employment Services:

☐Substance Use Services:

☐Outpatient Services:

☐Other:

☐DAP Monitoring

V. **Legal Status**

Does individual have a valid ID? Choose an item.

Does the patient have any existing/pending criminal charges or court dates? Choose an item.

List Charges:

Court:

Court Date(s):

Is the individual NGRI? Choose an item. If yes please follow NGRI protocols.

VI. **Safety and Support Plan/Crisis Plan Initiated?** - Choose an item.

(If Yes, please attach)

VII. **Electronic Signature**

Notifying/Referring CSB: _____ Date: _____

Referral Sent to: Click or tap here to enter text.

Date: Click or tap to enter a date.

Referral Communication Method: Choose an item.

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APPENDIX B - MEMO REGARDING PATIENT CHOICE AT DISCHARGE

COMMONWEALTH of VIRGINIA

ALISON G. LAND, FACHE
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

MEMORANDUM

Re: Guidance Regarding Individual Choice and Discharge Options

As referenced in a memo that was distributed by Daniel Herr, Deputy Commissioner for Facility
Services on September 25, 2019, below is guidance that was developed in consultation with the DBHDS Office of Human Rights. This guidance concerns an individuals' choice as it relates to community-based discharge options and continuing inpatient hospitalization.

This guidance is based upon the following primary considerations.

- Human Rights:
  - It is a violation of an individual's right to remain in the state's most restrictive setting, i.e., state hospital, when a more integrated and less restrictive level of care is available and addresses the individual's risks and treatment needs;
  - An individual does not have a right for the state to provide multiple alternatives when there is an existing clinically appropriate option currently

available ; and ○ The individual does not have a right to remain in the hospital once a community based option is made available.

- Patient Care and Safety: Given the state hospital census crisis, the impact of overcrowding and high case-loads for patient and staff safety, quality of care, and potential for delayed admissions for individuals in the community, state hospitals have an affirmative obligation to provide treatment focused on rapid discharge. An individual in a state hospital does not have the choice of waiting for a "more ideal" community alternative when another clinically appropriate option is available.

Guidance

Once an individual is determined ready for discharge, and services and a placement are available to meet their community needs, DBHDS expects that the individual will be discharged to that placement as expeditiously as possible.

If an individual requires funding support through DAP, the CSB and state hospital must first refer the individual to any appropriate DBHDS contracted placement, such as a group home or assisted living facility. DAP funds for alternative placements will not be available to the individual if existing funded resources are available and appropriate.

When appropriate services and housing have been identified, the individual should promptly be scheduled for discharge. If the individual wishes to make alternative arrangements, the individual must make those arrangements prior to discharge, or make their preferred arrangements from the community setting post discharge. The individual may not delay their discharge for the purpose of putting preferred arrangements into place.

Virginia Department of Behavioral Health & Developmental Services

DAP SECURE MEMORY CARE JUSTIFICATION

Instructions:

With the assistance of the state hospital social worker, complete to determine patient's need for secure memory care.

Patient Name: Click or tap here to enter text.

SECURE MEMORY CARE NEEDS	
Has this individual been diagnosed with Major Neurocognitive Disorder (dementia)? If yes, please list specific diagnosis: Click or tap here to enter text.	Choose an item.
What is this individual's level of mobility? Does this individual require equipment in order to ambulate? If yes, explain_Click or tap here to enter text.	Choose an item.
Has this individual engaged in exit-seeking behaviors on a consistent basis while hospitalized? If yes, explain_Click or tap here to enter text.	Choose an item.
Can the individual be supported safely to a less restrictive setting with a monitoring device such as project lifesaver or wander guard? Click or tap here to enter text.	Choose an item.
Is this individual currently formally identified by the state hospital as an elopement risk?Click or tap here to enter text.	Choose an item.
Please provide a justification as to why a secure (locked) facility is the least restrictive setting appropriate for this individual's discharge from the state hospital:_Click or tap here to enter text.	Choose an item.

CSB DAP Coordinator Signature_____

Date _____

Revised 3/2020

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Exhibit K – Appendix D- Admission Notifications

Appendix D- Admission Notifications

Individuals to include in admission notification: hospital liaison, liaison supervisor, MH/Clinical Director, ID Director if applicable

EMAIL TEMPLATE:

For the purpose of continuity of care, we are informing you that an individual was admitted to XXXX from your CSB/BHA catchment area on XXXX

Patient Name:

MRN #

Admitted under (legal status):

Social Worker:

Please respond to the questions below. In addition, if there are any of the following documents at your agency - medical/psychiatric records, most recent notes, last assessment, and medication list, please fax them to xxx-xxx-xxxx or send them via encrypted email.

Is the individual open to a core service at the CSB/BHA (if yes, specify which service)?

Person responsible for discharge planning:

Name:

Phone:

Email:

Supervisor/administrator phone and email:

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EXHIBIT K
APPENDIX E - DISCHARGE DISPUTE PROCESS
PC Contract No. P1636.XXX.3

Appendix E Discharge Dispute Process

Discharge Readiness Dispute Process for State Hospitals, CSBs, and DBHDS Central Office

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EXHIBIT K
APPENDIX E - DISCHARGE DISPUTE PROCESS
PC Contract No. P1636.XXX.3

1. The CSB shall notify the state hospital social work director (or designee), in writing, of their disagreement with the treatment team's designation of the individual's clinical readiness for discharge within three calendar days (72 hours) of receiving the discharge readiness notification.

2. The state hospital social work director (or designee) shall initiate a resolution effort to include a meeting with the state hospital and CSB staff at a higher level than the treatment team (including notification to the CSB executive director and state hospital director), as well as a representative from the Central Office Patient of Clinical Services. This meeting shall occur within one business day of receipt of the CSB's written disagreement.

3. If the disagreement remains unresolved, the Central Office of Patient Clinical Services will immediately give a recommendation regarding the patient's discharge readiness to the DBHDS Deputy Commissioner or Designee. The Deputy Commissioner or designee shall provide written notice of their decision regarding discharge to the CSB executive director and state hospital director.

4. During the dispute process outlined above, the CSB shall formulate a discharge plan that can be implemented within three business days if the decision is in support of clinical readiness for discharge.

5. Should the Commissioner determine that the individual is clinically ready for discharge and the CSB has not developed a discharge plan to implement immediately, then the discharge plan shall be developed by the Department and the Commissioner may take action in accordance with Virginia Code § 37.2-505(A)(3).

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APPENDIX E - DISCHARGE DISPUTE PROCESS
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Exhibit K
Appendix F: Clinical Readiness Scale for State Psychiatric Hospitals with Psycho-Legal Considerations

PC Contract No. P1636XXX.3

Appendix F: Clinical Readiness Scale for State Psychiatric Hospitals with Psycho-Legal Considerations

Level 1 - Clinically Ready for Discharge (Civil and NGRI)

- Has met treatment goals and no longer requires inpatient hospitalization
- Is exhibiting baseline behavior that is not anticipated to improve with continued inpatient treatment
- No longer requires inpatient hospitalization, but individual/family/surrogate decision maker is reluctant to participate in discharge planning
- NGRI patients with approval to begin 48-hour passes*
- NGRI patient for whom at least one forensic evaluator has recommended conditional or unconditional release and there is a pending court date*
- NGRI on revocation status and treatment team and CSB recommend conditional or unconditional release and there is a pending court date*
- Any civil patient for which the barrier to discharge is not clinical stability

Level 1 – Ready for Discharge (Forensic)

Restoration (47)
Opined Competent and Ready for Discharge

- Competence related abilities no longer impaired by psychiatric symptom presentation and/or underlying capacity issues (ID/DD, neurocognitive symptoms, treatment resistant SMI, etc.)
- Demonstrates a factual/rational understanding of legal situation and able to assist attorney
- Post-restoration evaluation completed, and the forensic evaluator has opined competent to stand trial
- Discharge back to jail appropriate

Remains Incompetent to Stand Trial at 45 days (for qualifying misdemeanor charges) with Recommendation for Release

- Competence related abilities continue to be impaired by psychiatric symptom presentation and/or underlying capacity issues (e.g. ID/DD, neurocognitive symptoms, treatment resistant SMI, etc.)
- Does not demonstrate factual, rational and/or ability to assist attorney
- Restoration attempts and medication options have been exhausted and there are no additional interventions reasonably available
- Response to medications and restoration efforts are adequately documented in the medical chart to demonstrate lack of progress/improvement

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- Symptom presentation and or/underlying capacity as well as competency related abilities are not anticipated to improve with continued treatment
- If medication trials not attempted, clinical reasoning for maintenance of current medication is documented
- Post-restoration evaluation completed, and the forensic evaluator has opined URIST with recommendation for release
- Civil commitment not recommended and discharge back to jail is appropriate (or community if on bond)

Opined Unrestorably Incompetent to Stand Trial (URIST)

- Competence related abilities continue to be impaired by psychiatric symptom presentation and/or underlying capacity issues (e.g. ID/DD, neurocognitive symptoms, treatment resistant SMI, etc.)
- Does not demonstrate factual, rational and/or ability to assist attorney
- Restoration attempts and medication options have been exhausted and there are not additional interventions reasonably available
- Response to medications and restoration efforts are adequately documented in the medical chart to demonstrate lack of progress/improvement
- Symptom presentation and or/underlying capacity as well as competency related abilities are not anticipated to improve with continued treatment
- If medication trials not attempted, clinical reasoning for maintenance of current medication is documented

Unrestorable (URIST)-Recommendation for Release

- Post-restoration evaluation completed, and the forensic evaluator has opined URIST with recommendation for release
- Civil commitment not recommended and discharge back to jail is appropriate (or community if on bond)

Unrestorable (URIST) - Charges Continued (48)

- Post-restoration evaluation completed, and the forensic evaluator opined URIST. At the time of the evaluation, civil commitment was recommended and the court subsequently ordered civil commitment.
- Ongoing hospitalization not required and individual no longer meets civil commitment criteria, however the charges have been continued and the individual remains under custody of the jail
- Forensic Coordinator notified regarding discharge readiness and provided discharge details
- Forensic Coordinator provides appropriate communication to the court

- Main barrier to discharge is Commonwealth's Attorney opposition to discharge and/or the court has retained jurisdiction

Unrestorable (URIST)-Aggravated Murder Charge

- Post-restoration evaluation completed, and the forensic evaluator has opined URIST
- Forensic Coordinator notified regarding discharge readiness and provided discharge details
- Forensic Coordinator provides appropriate communication to the court
- Main barrier to discharge or transfer to another facility is court approval per the code

Evaluations for CST, MSO or both (42, 43, 44, 45, 95, 96, 97)

- May or may not demonstrate a factual/rational understanding, ability to assist attorney
- Evaluation completed and the forensic evaluator rendered an opinion
  - Opined competent - Discharge back to jail appropriate
  - Opined IST, outpatient restoration - Discharge back to jail appropriate
  - Opined IST, inpatient restoration – facility determines if discharge back to jail is appropriate or should remain in the hospital until restoration order received
- If opined competent to stand trial and an MSO also ordered, the MSO evaluation is completed
- If MSO evaluation only, the evaluation is completed

Emergency Treatment from Jail (51, 52, 53, 55, 56)

- Documentation, observation and assessment indicate no observed symptoms of mental illness, and/or self-reported symptoms are inconsistent with mental illness
- Symptoms of mental illness have improved with treatment and may or may not continue to be present to some degree
- No longer a substantial likelihood that, as a result of mental illness, the individual will, in the near future, cause harm to self or others, or lack capacity to protect self
- Can be safely managed in the jail and discharge back to jail appropriate

Level 2 - Almost Clinically Ready for Discharge (Civil & NGRI)

- Has made significant progress towards meetings treatment goals, but needs additional inpatient care to fully address clinical issues and/or there is a concern about adjustment difficulties

Exhibit K
Appendix F: Clinical Readiness Scale for State Psychiatric Hospitals with Psycho-Legal Considerations

PC Contract No. P1636XXX.3

- Can take community trial visits to assess readiness for discharge; may have the civil privilege level to go on temporary overnight visits
- NGRI with unescorted community visits, not overnight privilege level

Level 2 – Almost Ready for Discharge (Forensic)

Restoration (47)

- Competence related abilities slightly impaired by psychiatric symptom presentation and/or underlying capacity issues (ID/DD, neurocognitive symptoms, treatment resistant SMI, etc.)
- Restoration is ongoing with consideration of specialized interventions that may be necessary depending on the nature of ongoing barriers to competency
- Response to medications and restoration efforts are adequately documented in the medical chart
- Demonstrates some factual/rational understanding of legal situation and/or ability to assist attorney
- Post-restoration evaluation not completed, and no opinion has been rendered by the forensic evaluator
- Referral for post-restoration evaluation anticipated within 30 days or less

Evaluations for CST and MSO (42, 43, 44, 45, 95, 96, 97)

- Two weeks post admission
- May or may not demonstrate a factual/rational understanding, ability to assist attorney
- Evaluation not completed
- Ongoing observation and documentation of psychiatric symptoms or other underlying capacity issues (ID/DD, neurocognitive symptoms, treatment resistant SMI, etc.) required
- Forensic Coordinator and/or assigned evaluator assesses appropriateness for evaluation or continued treatment
- If CST and MSO, assess appropriateness for completion of the MSO evaluation
- If MSO only, evaluator has been assigned and the evaluation is ongoing

Emergency Treatment from Jail (51, 52, 53, 55, 56)

- Significant improvement in symptoms of mental illness
- Continues to be substantial likelihood that, as a result of mental illness, the individual will, in the near future, cause harm to self or others, or lack capacity to protect self
- Cannot be safely managed at the jail

Level 3 - Not Clinically Ready for Discharge (Civil & NGRI)

- Has not made significant progress towards treatment goals and requires treatment and further stabilization in an acute psychiatric inpatient setting
- NGRI and does not have unescorted community visits privilege

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Exhibit K
Appendix F: Clinical Readiness Scale for State Psychiatric Hospitals with Psycho-Legal Considerations

PC Contract No. P1636XXX.3

Level 3 – Not Ready for Discharge (Forensic)

Restoration (47)

- Competence related abilities significantly impaired by psychiatric symptom presentation and/or underlying capacity issues (ID/DD, neurocognitive symptoms, treatment resistant SMI, etc.)
- Lacks critical aspects of factual/rational understanding of legal situation, unable to assist attorney due to symptom presentation and/or underlying capacity issues
- Response to medications and restoration efforts are adequately documented in the medical chart
- Restoration is ongoing and targets main barrier to competency/symptoms or other issues impairing competence related abilities
- Post-restoration evaluation not completed, and no opinion has been rendered by the forensic evaluator
- Progress in restoration is considered in the context of average length of stay for restoration cases in the facility and cases beyond this number (or at 90 days) are escalated to the Forensic Coordinator and Clinical Leadership

Evaluations for CST and MSO (42, 43, 44, 45, 95, 96, 97)

- One week post admission
- May or may not demonstrate a factual/rational understanding, ability to assist attorney
- Evaluation not completed
- Ongoing observation, treatment and documentation of psychiatric symptoms or other underlying capacity issues (ID/DD, neurocognitive symptoms, treatment resistant SMI, etc.) required
- Forensic evaluator may be assigned to monitor the case
- Consult with the Forensic Coordinator for any MSO only orders given this discharge level

Emergency Treatment from Jail (51, 52, 53,55, 56)

- Some improvement in symptoms of mental illness
- Continues to be substantial likelihood that, as a result of mental illness, the individual will, in the near future, cause harm to self or others, or lack capacity to protect self
- Cannot be safely managed at the jail

Level 4 - Significant Clinical Instability Limiting Privileges and Engagement in Treatment (Civil & NGRI)

- Not nearing psychiatric stability
- Requires constant 24 hour a day supervision in an acute inpatient psychiatric setting

Exhibit K
Appendix F: Clinical Readiness Scale for State Psychiatric Hospitals with Psycho-Legal Considerations

PC Contract No. P1636XXX.3

- Presents significant risk and/or behavioral management issues that requires psychiatric hospitalization to treat
- Unable to actively engage in treatment and discharge planning, due to psychiatric or behavioral instability

Level 4 – Significant Instability Limiting Engagement in Treatment (Forensic)

Restoration (47)

- Competence related abilities severely impaired by psychiatric symptom presentation and/or underlying capacity issues (ID/DD, neurocognitive symptoms, treatment resistant SMI, etc.)
- Lacks factual/rational understanding of legal situation, unable to assist in defense due to symptom presentation and/or underlying capacity issues
- Main barrier to competency/psychiatric symptoms or other issues impairing competence related abilities identified and interventions initiated
- Post-restoration evaluation not completed, and no opinion has been rendered by the forensic evaluator

Evaluations for CST and MSO (42, 43, 44, 45, 95, 96, 97)

- Evaluation should occur within 30 days or less
- May or may not demonstrate a factual/rational understanding, ability to assist attorney
- Observation and documentation of psychiatric symptoms or other underlying capacity issues (ID/DD, neurocognitive symptoms, treatment resistant SMI, etc.) initiated
- Consult with the Forensic Coordinator for any MSO only orders given this discharge level

Emergency Treatment from Jail (51, 52, 53, 55, 56)

- Presents with severe symptoms of mental illness
- There is substantial likelihood that, as a result of mental illness, the individual will, in the near future, cause harm to self or others, or lack capacity to protect self
- Cannot be safely managed at the jail

**For any patient in which the legal system (e.g. court system, probation, etc.) is required to approve their discharge plan, their designation on the discharge ready list should be noted with a double asterisk (**)*

Note: Discharge planning begins at admission and is continuously active throughout hospitalization, independent of an individual's clinically readiness for discharge rating.

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COMMUNITY SERVICES PERFORMANCE CONTRACT MASTER AGREEMENT AND SUPPLEMENTAL DOCUMENTS
Appendix G: Discharge Medication Protocol
Contract No.P1636.CSBCode.3

Beginning March 1, 2025, ALL state mental health hospitals will begin sending discharge prescriptions and medications as follows:

1. **For patients with <u>active</u> insurance:**

Up to 14 days eRx sent to pharmacy of choice

2. **For patients with <u>no active</u> insurance discharging to the community**:

Up to 14 days physical medications

3. **For patients discharging to <u>any</u> ALF/Jail/NH/Facility responsible for medication management:**

Up to 3 days physical medications, up to 14 days eRx sent to pharmacy of choice or Rx

4. **In <u>extenuating</u> circumstances, the Facility Medical Director may approve physical medications and/or a larger quantity of medications to ensure a successful discharge.**

As noted in the protocols, a psychiatric medication appointment is expected at the time of discharge. Please continue to work with the state hospitals to ensure a psychiatric medication appointment is available to the patient for continuity of care.

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Contract No.P1636.CSBCode.3

Responsible Party Timeline			
Social Work	Confirm discharge date/time, and location. For patients with active insurance: Confirm preferred pharmacy for discharge medications. Provide information to relevant staff/teams within the facility	Confirm copay with pharmacy	Collaborate with nursing staff to ensure that any physical medications that are provided to the patient at discharge are ready and a staff person is designated to ensure that the medications are given to the patient prior to leaving the facility.
Pharmacy	For prescriptions called into pharmacies: Confirm that prescriptions are received by pharmacies and available. Verify copay and communicate with Social Work. Verify any prior auth and communicate to physician.	For medications that will be distributed at discharge: Prepare medications according to physician's order and ensure they are available at the time of discharge.	
Physician	Patients with insurance: Confirm discharge medication, routes, and dosages. Patients with insurance going to non-supervised settings: Send prescription for discharge medications to pharmacy of choice Patients with insurance going to supervised settings or jail: Confirm order for facility to provide a supply of 3 days of medications at discharge; Send prescription for discharge medications to identified pharmacy.	Complete prior authorizations communicated from pharmacy	

	Patients with no confirmed insurance: Confirm order for facility to provide a 14 day supply of medications at discharge		
Nursing		Collaborate with social work staff to ensure that any physical medications that are provided to the patient at discharge are ready and a staff person is designated to ensure that the medications are given to the patient prior to leaving the facility.	
CSB	Partner with hospital social worker to identify the most appropriate pharmacy for patients with active insurance. Ensure that patient has required appointments with psychiatric provider and medical provider (if needed) within seven days of discharge, but no more than 14 days post-discharge.	Secure DAP if needed for copay or other medication coverage needs.	Ensure that patient will be able to obtain/pick up medications from pharmacy (may involved coordinating with patient, family, caregiver, other providers, etc.)

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APPENDIX H: DISCHARGE PILOT PROTOCOLS FOR CENTRAL STATE HOSPITAL, SOUTHWESTERN VIRGINIA MENTAL HEALTH INSTITUTE, OR SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE

Contract No. P1636.CSBCode.3

DBHDS
Virginia Department of Behavioral Health and Developmental Services

30-day discharge pilot

What is it?

- HB 314/SB 719 (Hope/Favola)- State Hospitals; Discharge Planning; report – This legislation does not go into effect until January 1, 2025. States that if an individual is discharged within 30 days of admission **from Central State Hospital, Southwestern Virginia Mental Health Institute, or Southern Virginia Mental Health Institute**, the community services board will implement the discharge plan developed by the facilities; otherwise, it is the responsibility of the board or behavioral health authority to develop the plan. This bill has an annual reporting requirement for certain information, due to the General Assembly by August 1 of each year. Additionally, DBHDS is required to submit an evaluation of the impacts of this legislative change by November 1, 2025.

What are the expected outcomes?

- Allow CSB liaisons to focus on patients with more intense discharge needs
- Decrease in LOS for all patients
- Assessment of processes and readmissions as part of the report to the General Assesmbly.

Who is excluded?

- Confirmed diagnosis of ID/DD/Autism (due to intensive community resource need)
- Restorations (as the average thus far is around 88 days),
- Patients with complex health care needs/dementia (requires UAIs and/or PASSR- other assessments)
- NGRIs (due to length of stay)

Expectations of State Facilities

- Expedited treatment plan team/assessment where feasible- within 48 hours of admission (excluding weekends and holidays)
- Continue to follow any protocols regarding notification of the CSB
- Inviting CSB to participate in any treatment team meetings

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APPENDIX H: DISCHARGE PILOT PROTOCOLS FOR CENTRAL STATE HOSPITAL, SOUTHWESTERN VIRGINIA MENTAL HEALTH INSTITUTE, OR SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE

Contract No. P1636.CSBCode.3

- Create a safe discharge plan with the patient – The final plan that is communicated with the CSB.
    - This discharge plan will include setting up any transportation, housing needs, referrals and aftercare appointments

Expectations of CSB

- Maintain awareness of admitted patients who are assigned to the CSB
- Participate as able in treatment team meetings for patients
- Execute discharge plan as developed by state facility
- Provide contact and follow up appointments for eligible discharges
- Follow- up with patient after discharge to assure patient follows the discharge plan and medication regimen.

What if they stay over 30 days?

- The hospital discharge planner will notify the CSB liaison at day 25 (or next business day) if it appears the individual will need further treatment and discharge may not occur by day 30.
- At day 31 discharge planning responsibilities will revert to CSB.
- State facility will share any discharge plans already secured.

What if there are discharge costs?

- Hospitals have access to limited funding through central office to cover one-time expenses.
- Any ongoing needs requiring funding will require collaboration with the CSB.

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MASTER AGREEMENT Exhibit M: Department of Justice Settlement Agreement Requirements
Contract No. P1636. [CSB Code].3

The CSB and the Department agrees to comply with the following requirements in the Settlement Agreement for Civil Action No: 3:12cv00059-JAG between the U.S. Department of Justice (DOJ) and the Commonwealth of Virginia, entered in the U. S. District Court for the Eastern District of Virginia on August 23, 2012 [section IX.A, p. 36], and in compliance indicators agreed to by the parties and filed with the Court on January 14, 2020.

Sections identified in text or brackets refer to sections in the agreement requirements that apply to the target population defined in section III.B of the Agreement: individuals with developmental disabilities who currently reside in training centers, (ii) meet criteria for the DD Waiver waiting list, including those currently receiving DD Waiver services, or (iii) reside in a nursing home or an intermediate care facility (ICF).

To support Virginia's efforts to ensure all people with DD and their families have access to Medicaid information, the CSB will post a message for individuals with DD and their families related to the DMAS document titled "Help in Any Language" to the CSB website and provide the information through other means, as needed, or requested by individuals with DD and their families who are seeking services. This document can be accessed at https://dmas.virginia.gov/media/2852/language-taglines-for-dmas.pdf or by contacting DBHDS or DMAS.

1.) Case Managers or Support Coordinators shall provide anyone interested in accessing DD Waiver Services with a DBHDS provided resource guide (i.e. the Individual and Family Support Program (IFSP) First Steps Document) that contains information including but not limited to case management eligibility and services, family supports- including the IFSP Funding Program, family and peer supports, and information on the My Life, My Community Website, information on how to access REACH services, and information on where to access general information. [section III.C.2. a-f, p. 1].

2.) Case management services, defined in section III.C.5.b, shall be provided to all individuals receiving Medicaid Home and Community-Based Waiver services under the Agreement by case managers or support coordinators who are not directly providing or supervising the provision of Waiver services to those individuals [section III.C.5.c, p. 8].

3.) **For individuals receiving case management services** pursuant to the Agreement, the individual's case manager or support coordinator shall meet with the individual face-to-face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs [section V.F.1, page 26].

a. At these face-to-face meetings, the case manager or support coordinator shall: observe the individual and the individual's environment to assess for previously unidentified risks, injuries, needs, or other changes in status; assess the status of previously identified risks, injuries, needs, or other changes in status; assess whether the individual's individual support plan (ISP) is being implemented appropriately and remains appropriate for the individual; and ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs.
b. The case manager or support coordinator shall document in the ISP the performance of these observations and assessments and any findings, including any changes in status or significant events that have occurred since the last face-to-face meeting.
c. If any of these observations or assessments identifies an unidentified or inadequately addressed risk, injury, need, or change in status, a deficiency in the individual's support plan

or its implementation, or a discrepancy between the implementation of supports and services and the individual's strengths and preferences, then the case manager or support coordinator shall report and document the issue in accordance with Department policies and regulations, convene the individual's service planning team to address it, and document its resolution.

4.) DBHDS shall develop and make available training for CSB case managers and leadership staff on how to assess change in status and that ISPs are implemented appropriately. DBHDS shall provide a tool with elements for the case managers to utilize during face-to-face visits to assure that changes in status as well as ISP are implemented appropriately and documented.

a. CSB shall ensure that all case managers and case management leadership complete the training that helps to explain how to identify change in status and that elements of the ISP are implemented appropriately prior to using the On-Site Visit Tool. The CSB shall deliver the contents of the DBHDS training through support coordinator supervisors or designated trainers to ensure case managers understand the definitions of a change in status or needs and the elements of appropriately implemented services, as well as how to apply and document observations and needed actions.
b. CSB shall ensure that all case managers use the DBHDS On-Site Visit Tool during one face-to-face visit each quarter for individuals with Targeted Case Management and at one face-to-face visit per month for individuals with Enhanced Case Management to assess at whether or not each person receiving services under the waiver experienced a change in status and to assess whether or not the ISP was implemented appropriately. ~~The completed On-Site Visit Tool and corresponding note from the visit will be uploaded by the CSB to the location designated by DBHDS under Person's Information in WaMS within 30 days of completion.~~

5.) Using the process developed jointly by the Department and Virginia Association of Community Services Boards (VACSB) Data Management Committee (DMC), the CSB shall report the number, type, and frequency of case manager or support coordinator contacts with individuals receiving case management services [section V.F.4, p. 27].

6.) **Key indicators** - The CSB shall report key indicators, selected from relevant domains in section V.D.3 on page 24, from the case manager's or support coordinator's face-to-face visits and observations and assessments [section V.F.5, p 27]. Reporting in WaMS shall include the provision of data and actions related to DBHDS defined elements regarding a change in status or needs and the elements of appropriately implemented services in a format, frequency, and method determined by DBHDS [section III.C.5.b.i.].

7.) **Face-to-Face Visit** - The individual's case manager or support coordinator shall meet with the individual face-to-face at least every 30 days (including a 10day grace period but no more than 40 days between visits), and at least one such visit every two months must be in the individual's place of residence, for any individuals who [section V.F.3, pages 26 and 27]:

a. Receive services from providers having conditional or provisional licenses;
b. Have more intensive behavioral or medical needs as defined by the Supports Intensity Scale category representing the highest level of risk to individuals
c. Have an interruption of service greater than 30 days;
d. Encounter the crisis system for a serious crisis or for multiple less serious crises within a three-month period;
e. Have transitioned from a training center within the previous 12 months; or

f. Reside in congregate settings of five or more individuals. Refer to Enhanced Case Management Criteria Instructions and Guidance and the Case Management Operational Guidelines issued by the Department.

8.) Case managers or support coordinators shall give individuals a choice of service providers from which they may receive approved DD Waiver services, present all options of service providers based on the preferences of the individuals, including CSB and non-CSB providers, and document this using the Virginia Informed Choice Form in the waiver management system (WaMS) application. [section III.C.5.c, p. 8]. The CSB SC will complete the Virginia Informed Choice form to document provider and SC choice for Regional Support Team referrals, when changes in any provider, service, or service setting occurs, a new service is requested, the individual is dissatisfied with a service or provider, and no less than annually. The CSB will document the selected Support Coordinator's name on the Virginia Informed Choice form to indicate individuals, and as applicable Substitute Decision-Maker's, choice of the assigned SC.

9.) **Support Coordinator Quality Review** - The CSB shall complete the Support Coordinator Quality Review process for a statistically significant sample size as outlined in the Support Coordinator Quality Review Process.

a. DBHDS shall annually pull a statistically significant stratified sample of individuals receiving HCBS
waiver and send this to the CSB to be utilized to complete the review.
b. Each year, the CSB shall complete the number of Support Coordinator Quality Reviews and provide data to DBHDS as outlined by the process.
c. DBHDS shall analyze the data submitted to determine the following elements are met:
    i. The CSB offered each person the choice of case manager/provider
    ii. The case manager assesses risk, and risk mitigation plans are in place
    iii. The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed.
    iv. The case manager assists in developing the person's ISP that addresses all of the individual's risks, identified needs and preferences.
    v. The ISP includes specific and measurable outcomes, including evidence that employment goals have been discussed and developed, when applicable.
    vi. The ISP was developed with professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served.
    vii. The ISP includes the necessary services and supports to achieve the outcomes such as medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services necessary.
    viii. Individuals have been offered choice of providers for each service.
    ix. The case manager completes face-to-face assessments that the individual's ISP is being implemented appropriately and remains appropriate to the individual by meeting their health and safety needs and integration preferences.
    x. The CSB has in place and the case manager has utilized where necessary, established strategies for solving conflict or disagreement within the process of developing or revising ISPs, and addressing changes in the individual's needs, including, but not limited to, reconvening the planning team as necessary to meet the individuals' needs.

d. DBHDS shall review the data submitted and complete a semi-annual report that includes a review of data from the Support Coordinator Quality Reviews and provide this information to the CSB. To ensure consistency between reviewers, DBHDS shall complete an inter-rater reliability process.
e. As requested by DBHDS, the CSB will submit an performance improvement plan (PIP) or Corrective Action Plan (CAP) when two or more indicators (Item 9c above) are found to be below 60% during any year reviewed. CSB and the Department shall follow the PIP or CAP process as outlined in Section 15 Compliance and Remediation of the most recent version of the community services performance contract.
f. The CSB shall cooperate with DBHDS and facilitate its completion of on-site annual retrospective reviews at the CSB to validate the findings of the CSB Support Coordinator Quality Review to provide technical assistance for any areas needing improvement.

10.) **Education about Integrated Community Options** - Case managers or support coordinators shall offer education about integrated community options to any individuals living outside of their own or their families' homes and, if relevant, to their authorized representatives or guardians [section III.D.7, p. 14]. Case managers shall offer this education at least annually and at the following times:

a. At enrollment in a DD Waiver
b. When there is a request for a change in Waiver service provider(s)
c. When an individual is dissatisfied with a current Waiver service provider,
d. When a new service is requested
e. When an individual wants to move to a new location, or
f. When a regional support team referral is made as required by the Virginia Informed Choice Form

11.) **Co-occurring Mental Health conditions or engaging in challenging behaviors** For individuals receiving case management services identified to have co-occurring mental health conditions or engaging in challenging behaviors, the individual's case manager or support coordinator shall assure that effective community based behavioral health and/or behavioral supports and services are identified and accessed where appropriate and available.

a. If the case manager or support coordinator incurs capacity issues related to accessing needed behavioral support services in their designated Region, every attempt to secure supports should be made to include adding the individual to several provider waitlists (e.g., based upon individualized needs, this may be inclusive of psychotherapy, psychiatry, counseling, applied behavior analysis/positive behavior support providers, etc.) and following up with these providers quarterly to determine waitlist status. [SA. Provision: III.C.6.a.i-iii Filing reference: 7.14, 7.18]
b. DBHDS will provide the practice guidelines and a training program for case managers regarding the minimum elements that constitute an adequately designed behavioral program, as provided under Therapeutic Consultation waiver services, and what can be observed to determine whether the plan is appropriately implemented. The CSB shall ensure that all case managers and case management leadership complete the training such that case managers are aware of the practice guidelines for behavior support plans and of key elements that can be observed to determine whether the plan is appropriately implemented. [SA. Provision: III.C.6.a.i-iii Filing reference: 7.16, 7.20]

12.) The CSB shall identify children and adults who are at risk for crisis through the standardized

crisis screening tool or through the utilization of the elements contained in the tool at intake, and if the individual is identified as at risk for crisis or hospitalization, shall refer the individual to REACH. [SA. Provision: III.C.6.a.i-iii Filing reference: 7.2]

Enhanced Case Management - For individuals that receive enhanced case management, the case manager or support coordinator shall utilize the standardized crisis screening tool during monthly visits; for individuals that receive targeted case management, the case manager or support coordinator shall use the standardized crisis screening tool during quarterly visits. Any individual that is identified as at risk for crisis shall be referred to REACH. [S.A. Provision: III.C.6.a.i-iii Filing reference: 7.3]

13.) The CSB shall ensure that CSB Executive Directors, Developmental Disability Directors, case management or support coordination supervisors, case managers or support coordinators, and intake workers participate in training on how to identify children and adults who are at risk for going into crisis.

CSBs shall ensure that training on identifying risk of crisis for intake workers and case managers (or support coordinators) shall occur within 6 months of hire. [S.A. Provision: III.C.6.a.i-iii Filing reference: 7.5]

14.) The CSB shall provide data on implementation of the crisis screening tool as requested by DBHDS when it is determined that an individual with a developmental disability has been hospitalized and has not been referred to the REACH program.

a. The CSB shall provide to DBHDS upon request copies of the crisis risk assessment tool, or documentation of utilization of the elements contained within the tool during a crisis screening, for quality review purposes to ensure the tool is being implemented as designed and is appropriately identifying people at risk of crisis. [S.A. Provision: III.C.6.a.i-iii Filing reference: 7.6]
b. DBHDS shall develop a training for the CSB to utilize when training staff on assessing an individuals risk of crisis/hospitalization.
c. DBHDS shall initiate a quality review process to include requesting documentation for anyone psychiatrically hospitalized who was not referred to the REACH program and either actively receiving case management during the time frame or for whom an intake was completed prior to hospitalization. The CSB shall promptly, but within no more than 5 business days, provide the information requested.
d. DBHDS shall request information to verify presence of DD diagnosis for persons that are psychiatrically hospitalized that are not known to the REACH program. The CSB shall promptly, but within no more than 5 business days, provide the information requested. [S.A. Provision: III.C.6.b.ii.A Filing references 8.6, 8.7]

15.) **CSB Case manager shall work with the REACH program** to identify a community residence within 30 days of admission to the program including making a referral to RST when the system has been challenged to find an appropriate provider within this timeframe.

If a waiver eligible individual is psychiatrically hospitalized, is a guest at a REACH CTH, or is residing at an Adult Transition Home and requires a waiver to obtain a community residence, the CSB shall submit an emergency waiver slot request. [S.A. Provision III.C.6.b.ii.A Filing reference 10.2]

16.) **CSB emergency services** shall be available 24 hours per day and seven days per week, staffed

with clinical professionals who shall be able to assess crises by phone, assist callers in identifying and connecting with local services, and, where necessary, dispatch at least one mobile crisis team member adequately trained to address the crisis for individuals with developmental disabilities [section III.C.6.b.i.A, p. 9].

a. The mobile crisis team shall be dispatched from the Regional Education Assessment Crisis Services Habilitation (REACH) program that is staffed 24 hours per day and seven days per week by qualified persons able to assess and assist individuals and their families during crisis situations and that has mobile crisis teams to address crisis situations and offer services and support on site to individuals and their families within one hour in urban areas and two hours in rural areas as measured by the average annual response time [section III.C.6.b.ii, pages 9 and 10].
b. All Emergency services staff and their supervisors shall complete the REACH training, created and made available by DBHDS, that is part of the emergency services training curriculum.
c. DBHDS shall create and update a REACH training for emergency staff and make it available through the agency training website.
d. CSB emergency services shall notify the REACH program of any individual suspected of having a developmental disability who is experiencing a crisis and seeking emergency services as soon as possible, preferably prior to the initiation of a preadmission screening evaluation in order to allow REACH and emergency services to appropriately divert the individual from admission to psychiatric inpatient services when possible.
e. If the CSB has an individual receiving services in the REACH Crisis Therapeutic Home (CTH) program with no plan for discharge to a community residence and a length of stay that shall soon exceed 30 concurrent days, the CSB Executive Director or his or her designee shall provide a weekly update describing efforts to achieve an appropriate discharge for the individual to the Director of Community Support Services in the Department's Division of Developmental Services or his/her designee.
f. DBHDS shall notify the CSB Executive Director or designee when it is aware of a person at the REACH CTH who is nearing a 30-day concurrent stay.

17.) **Comply with State Board Policy 1044 (SYS) 12-1 Employment First** [section III.C.7.b, p. 11]. This policy supports identifying community-based employment in integrated work settings as the first and priority service option offered by case managers or support coordinators to individuals receiving day support or employment services.

a. CSB case managers shall take the on-line case management training modules and review the case management manual within 30 days of hire.
b. CSB case managers shall initiate meaningful employment conversations with individuals starting at the age of 14 until the age of retirement (65).
c. CSB case managers shall discuss employment with all individuals, including those with intense medical or behavioral support needs, as part of their ISP planning processes.
d. CSB case managers shall document goals for or toward employment for all individuals 18-64 or the specific reasons that employment is not being pursued or considered.
e. DBHDS shall create training and tools for case managers regarding meaningful conversation about employment, including for people with complex medical and behavioral support needs. The CSB shall utilize this training, the SC Employment Module, with its staff and document its completion within 30 days of hire.

18.) CSB case managers or support coordinators shall liaise with the Department's regional community resource consultants regarding responsibilities as detailed in the Performance Contract [section III.E.1, p. 14].

19.) Case managers or support coordinators shall participate in discharge planning with individuals' personal support teams (PSTs) for individuals in training centers and children in ICF/IIDs for whom the CSB is the case management CSB, pursuant to § 37.2-505 and § 37.2-837 of the Code that requires the CSB to develop discharge plans in collaboration with training centers [section IV.B.6, p. 16].

20.) In developing discharge plans, CSB case managers or support coordinators, in collaboration with facility PSTs, shall provide to individuals and, where applicable, their authorized representatives, specific options for types of community residences, services, and supports based on the discharge plan and the opportunity to discuss and meaningfully consider these options [section IV.B.9, p. 17].

21.) CSB case managers or support coordinators and PSTs shall coordinate with specific types of community providers identified in discharge to provide individuals, their families, and, where applicable, their authorized representatives with opportunities to speak with those providers, visit community residences (including, where feasible, for overnight visits) and programs, and facilitate conversations and meetings with individuals currently living in the community and their families before being asked to make choices regarding options [section IV.B.9.b, p. 17].

22.) CSB case managers or support coordinators and PSTs shall assist individuals and, where applicable, their authorized representatives in choosing providers after providing the opportunities described in subsection 13 above and ensure that providers are timely identified and engaged in preparing for individuals' transitions [section IV.B.9.c, p.17]. Case managers or support coordinators shall provide information to the Department about barriers to discharge for aggregation and analysis by the Department for ongoing quality improvement, discharge planning, and development of community-based services [IV.B.14, p. 19].

23.) In coordination with the Department's Post Move Monitor, the CSB shall conduct post- move monitoring visits within 30, 60, and 90 days following an individual's movement from a training center to a community setting [section IV.C.3, p.19]. The CSB shall provide information obtained in these post move monitoring visits to the Department within seven business days after the visit.

24.) If a CSB provides day support or residential services to individuals in the target population, the CSB shall implement risk management and quality improvement processes, including establishment of uniform risk triggers and thresholds that enable it to adequately address harms and risks of harms, including any physical injury, whether caused by abuse, neglect, or accidental causes [section V.C.1, p. 22].

25.) Using the protocol and the real-time, web-based incident reporting system implemented by the Department, the CSB shall report any suspected or alleged incidents of abuse or neglect as defined in § 37.2-100 of the Code, serious injuries as defined in 12 VAC 35- 115-30 of the *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services* or deaths to the Department within 24 hours of becoming aware of them [section V.C.2, p. 22].

26.) CSBs shall participate with the Department to collect and analyze reliable data about individuals Receiving services under this Agreement from each of the following areas:

a. safety and freedom from harm
b. physical, mental, and behavioral
c. avoiding crises
d. choice and self-determination
e. community inclusion, health and well-being
f. access to services
g. provider capacity
h. stability [section V.D.3, pgs. 24 & 25]

27.) CSBs shall participate in the regional quality council established by the Department that is responsible for assessing relevant data, identifying trends, and recommending responsive actions in its region [section V.D.5.a, p. 25].

29.) CSB's shall review and provide annual feedback on the Quality Review Team (QRT) End of Year Report.

30.) CSBs shall participate in DBHDS initiatives that ensure the reliability and validity of data submitted to the Department. Participation may include reviews of sampled data, the comparison of data across DBHDS and CSB systems, and the involvement of operational staff to include information technology. Meeting frequency shall be semi-annually, but not more than monthly depending on the support needed.

31.) CSBs shall provide access to the Independent Reviewer to assess compliance with this Agreement. The Independent Reviewer shall exercise his access in a manner that is reasonable and not unduly burdensome to the operation of the CSB and that has minimal impact on programs or services to individuals receiving services under the Agreement [section VI.H, p. 30 and 31]

32.) CSBs shall participate with the Department and any third party vendors in the implementation of the National Core Indicators (NCI) Surveys and Quality Service Reviews (QSRs) for selected individuals receiving services under the Agreement. This includes informing individuals and authorized representatives about their selection for participation in the NCI individual surveys or QSRs; providing the access and information requested by the vendor, including health records, in a timely manner; assisting with any individual specific follow up activities; and completing NCI surveys [section V.I, p. 28].

During FY22 the QSR process will be accelerated and will require the CSB to fully participate in the completion of QSR implementation twice during a nine-month period. This will ensure that the Commonwealth can show a complete improvement cycle intended by the QSR process by June 30, 2022. The attached GANTT details the schedule for the QSR reviews of 100% of providers, including support coordinators, for two review cycles.

33.) The CSB shall notify the community resource consultant (CRC) and regional support team (RST) in the following circumstances using the RST referral form in the waiver management system (WaMS) application to enable the RST to monitor, track, and trend community integration and challenges that require further system development:

a. within five calendar days of an individual being presented with any of the following residential options: an ICF, a nursing facility, a training center, or a group home/congregate setting with a licensed capacity of five beds or more;

b. if the CSB is having difficulty finding services within 30 calendar days after the individual's enrollment in the waiver; or
c. immediately when an individual is displaced from his or her residential placement for a second time [sections III.D.6 and III.E, p. 14].

34.) DBHDS shall provide data to CSBs on their compliance with the RST referral and implementation process.

a. DBHDS shall provide information quarterly to the CSB on individuals who chose less integrated options due to the absence of something more integrated at the time of the RST review and semi-annually
b. DBHDS shall notify CSBs of new providers of more integrated services so that individuals who had to choose less integrated options can be made aware of these new services and supports.
c. CSBs shall offer more integrated options when identified by the CSB or provided by DBHDS.
d. CSBs shall accept technical assistance from DBHDS if the CSB is not meeting expectations.

35.) Case managers or support coordinators shall collaborate with the CRC to ensure that person-centered planning and placement in the most integrated setting appropriate to the individual's needs and consistent with his or her informed choice occur [section III.E.1- 3, p. 14].

a. CSBs shall collaborate with DBHDS CRCs to explore community integrated options including working with providers to create innovative solutions for people.
b. The Department encourages the CSB to provide the Independent Reviewer with access to its services and records and to individuals receiving services from the CSB; however, access shall be given at the sole discretion of the CSB [section VI.G, p. 31].

36.) **Developmental Case Management Services**

a. Case managers or support coordinators employed or contracted by the CSB shall meet the knowledge, skills, and abilities qualifications in the Case Management Licensing Regulations, 12 VAC 35-105-1250. During its inspections, the Department's Licensing Office may verify compliance as it reviews personnel records.
b. Reviews of the individual support plan (ISP), including necessary assessment updates, shall be conducted with the individual quarterly or every 90 days and include modifications in the ISP when the individual's status or needs and desires change.
c. During its inspections, the Department's Licensing Office may verify this as it reviews the ISPs including those from a sample identified by the CSB of individuals who discontinued case management services.
d. The CSB shall ensure that all information about each individual, including the ISP and VIDES, is imported from the CSB's electronic health record (EHR) to the Department on or prior to the effective date of the ISP through an electronic exchange mechanism mutually agreed upon by the CSB and the Department into the electronic waiver management system (WaMS). CSBs must continue to provide the information to provider agencies in a timely manner to prevent any interruption in an individual's services.
e. If the CSB is unable to submit via the data exchange process, it shall enter this data directly through WaMS, when the individual is entered the first time for services, or when his or her living situation changes, her or his ISP is reviewed annually, or whenever changes occur, including the individual's Race and the following information:

i. full name
ii. social security number
iii. Medicaid number
iv. CSB unique identifier
v. current physical residence address
vi. living situation (e.g., group home
vii. family home, or own home)
viii. level of care information
ix. change in status
x. terminations
xi. transfers
xii. waiting list information
xiii. bed capacity of the group home if that is chosen
xiv. Current support coordinator's name

f. Case managers or support coordinators and other CSB staff shall comply with the SIS® Administration Process and any changes in the process within 30 calendar days of notification of the changes.
g. Case managers or support coordinators shall notify the Department's service authorization staff that an individual has been terminated from all DD waiver services within 10 business days of termination.
h. Case managers or support coordinators shall assist with initiating services within 30 calendar days of waiver enrollment and shall submit Request to Retain Slot forms as required by the Department. All written denial notifications to the individual, and family/caregiver, as appropriate, shall be accompanied by the standard appeal rights (12VAC30-110).
i. Case managers or support coordinators shall complete the level of care tool for individuals requesting DD Waiver services within 60 calendar days of application for individuals expected to present for services within one year.
j. Case managers or support coordinators shall comply with the DD waitlist process, DD waitlist review process and slot assignment process and implement any recommendations or changes in the processes within 30 calendar days of written notice from the Department.

37.) **Targeted Technical Assistance**

a. The CSB shall participate in technical assistance as determined by the Case Management Steering Committee. Technical assistance may be comprised of virtual or on-site meetings, trainings, and record reviews related to underperformance in any of the following areas monitored by the committee: Regional Support Team referrals, Support Coordination Quality Review results, Individual Support Plan entry completion, and case management contact data.
b. DBHDS shall provide a written request that contains specific steps and timeframes necessary to complete the targeted technical assistance process.
c. The CSB shall accommodate technical assistance when recommended within 45 days of the written request.
d. CSB failure to participate in technical assistance as recommended or demonstrate improvement within 12 months may result in further actions under Exhibit I of this contract.

38.) CSB Quality Improvement Committees will review annually the DMAS-DBHDS Quality Review Team's End of Year report on the status of the performance measures included in the DD HCBS Waivers' Quality Improvement Strategy with accompanying recommendations to the DBHDS Quality Improvement Committee. CSB documentation of these reviews and resultant CSB-specific quality improvement activities will be reported to DBHDS within 30 days of receiving the report.

39.) **Support Coordination Training Requirements**

DD Support Coordination Training Requirements			
Training	**Location**	**Timeframe**	**Supplemental Information**

General Orientation	CSB per 12VAC35-105-450	w/in 15 days of hire	https://law.lis.virginia.gov/admincode/title12/agency35/chapter105/section440/
SC Modules 1-10	https://sccmtraining.partnership.vcu.edu/sccmtrainingmodules/	w/in 30 days of hire	https://dbhds.virginia.gov/case-management/dd-manual/
SC Employment Module	https://covlc.virginia.gov/ [keyword search: Employment]	w/in 30 days of hire	https://dbhds.virginia.gov/developmental-services/employment/
Independent Housing Curriculum for SCs	https://covlc.virginia.gov/ [keyword search: Housing]	w/in 30 days of hire	https://dbhds.virginia.gov/developmental-services/housing/
KSA related trainings for DD TCM only	CSB per 12VAC30-50-490	8 hours annually	https://law.lis.virginia.gov/admincode/title12/agency30/chapter50/section490/
Behavioral Training	https://covlc.virginia.gov/ [keyword search: Behavioral]	w/in 180 days of hire	https://dbhds.virginia.gov/developmental-services/behavioral-services/
On-site Visit Tool (OSVT) Training	https://dbhds.virginia.gov/wp-content/uploads/2022/03/osvt-training-slides-understanding-change-in-status-10.30.20-final-sm.pptx	Prior to use	https://dbhds.virginia.gov/case-management/dd-manual/
Crisis Risk Assessment Tool (CRAT) Training	https://covlc.virginia.gov/ [keyword search: Crisis]	Prior to use	https://dbhds.virginia.gov/case-management/dd-manual/
Understanding PC ISP v4.0 Parts I-IV	https://vimeo.com/1008790734/700ec3fddc	Prior to facilitating an ISP meeting	https://dbhds.virginia.gov/wp-content/uploads/2024/09/ISP_JA_WhatsNewV4-071924-final.pdf https://dbhds.virginia.gov/wp-content/uploads/2024/09/PC-ISP-v4.0-Sample-Parts-I-IV-Maria-September-2024.pdf

Individual Support Plan (ISP) Modules 1-3	https://covlc.virginia.gov/ [keyword search: ISP] [keyword search: ISP]	w/in 30 days of hire	https://dbhds.virginia.gov/developmental-services/provider-network-supports/https://dbhds.virginia.gov/developmental-services/provider-network-supports/
HCBS Rights Training	https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-training-series	Prior to site visits	

AMENDMENT 3
AMENDED AND RESTATED
FY2026 AND FY2027 COMMUNITY SERVICES PERFORMANCE CONTRACT
MASTER AGREEMENT

ADDENDUM I
ADMINISTRATIVE REQUIREMENTS AND PROCESSES AND PROCEDURES

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AMENDMENT 3
AMENDED AND RESTATED
FY2026 AND FY2027 COMMUNITY SERVICES PERFORMANCE CONTRACT
MASTER AGREEMENT

ADDENDUM I
ADMINISTRATIVE REQUIREMENTS AND PROCESSES AND PROCEDURES

I. Background

The Administrative Requirements and Processes and Procedures include statutory, regulatory, policy, process and procedures and other requirements that are not expected to change frequently. The CSB and the Department shall comply with these requirements and processes and procedures. This document is incorporated into and made a part of the Community Services Performance Contract (PC) by reference. The Department will work with the CSBs regarding any substantive changes to this document, with the exception of changes in statutory, regulatory, policy, or other requirements.

The provisions of this agreement apply to all CSBs, Chapter 5 Section 37.2-100 defines the four types of CSB organizational structure and Chapter 6 Section 37.2-601 further defines the organizational structure of a Behavioral Health Authority (BHA). As such, the precise application of these provisions will vary across the different organizational types. All CSBs are required to meet the provisions herein, but some CSBs may meet said provisions by their nature as subsections of a local government or similar. This agreement does not, in any way, seek to contradict or otherwise be in opposition to local government policy/procedure as it applies to any of the subject matter discussed.

An illustrative example: All CSBs are required to have an annual audit. Operational CSBs must conduct this audit by contracting with an appropriate third party. Administrative Policy CSBs may satisfy this requirement by ensuring the CSB is included appropriately in the required annual audit conducted by the local governing body.

II. CSB Requirements

A. Financial Management Requirements, Policies, and Procedures
CSB's financial management and accounting system shall operate and produce financial statements and reports in accordance with Generally Accepted Accounting Principles, compliance with requirements of Governmental Accounting Standards Board (GASB), and Code of Federal Regulations, 2 CFR Part 200.

1. **Accounting:** CSBs shall account for all service and administrative expenses accurately and submit timely reports to the Department to document these expenses.

2. **Annual Independent Audit:** CSBs shall obtain an independent annual audit conducted by certified public accountants.

    a. Audited financial statements shall be prepared in accordance with generally accepted accounting principles (GAAP) and compliance with Code of Federal Regulations, 2 CFR Part 200.

    b. Copies of the audit and the accompanying management letter shall be provided to the Office of Budget and Financial Reporting in the Department and to each local government that established the CSB.

    c. Deficiencies and exceptions noted in an audit or management letter shall be resolved or corrected in a timely manner defined more precisely through discussions between the CSB and the Department.

    d. For a CSB that is included in the annual audit of its local government.
        i. Copies of the applicable portions of the accompanying management letter shall be provided to the Office of Budget and Financial Reporting in the Department.
        ii. Deficiencies and exceptions noted in a management letter shall be resolved or corrected in a timely manner defined more precisely through discussions between the CSB, the local government entity and the Department.

3. **Federal Audit Requirements:** When the Department issues subawards of federal grants to a CSB, the CSB shall satisfy all federal government audit requirements.

4. **Subcontractor Audits:** The CSB shall obtain, review, and take any necessary actions on audits of any subcontractors that provide services that are procured under the Virginia Public Procurement Act and included in a CSB's performance contract. The CSB shall provide copies of these audits to the Office of Budget and Financial Reporting in the Department.
5. **Bonding:** CSB employees with financial responsibilities shall be bonded in accordance with local financial management policies.
6. **Fiscal Policies and Procedures:** A CSB's written fiscal policies and procedures shall conform to applicable local government policy or, in absence of local governing requirements, State Board policies and Departmental Policies and procedures.
7. **Additional Financial Management Requirements:** The CSB shall comply with the following requirements, as applicable.
    a. CSBs may not use the same Certified Public Accountant (CPA) for both production of their annual financial statements and execution of their independent audit.
    b. Operating CSBs and the BHA shall rebid their CPA audit contracts at least every five (5) years once the current CPA contracts expire. CSB's will ensure their contract with the audit firm gives them the right to rebid annual audit services if the firm is more than 60 days late for two consecutive years.
    c. All CSB bank accounts shall be reconciled monthly, with the appropriate segregation of duties, and a designated staff person not involved in preparing the reconciliation shall approve it.
    d. A contract administrator shall be identified for each contract for the purchase of services entered into by the CSB, and every contract shall be signed, with the appropriate segregation of duties by a designated staff person, and each other party to the contract, where applicable.
    e. A designated staff person shall approve and document each write-off of account receivables for services to individuals. The CSB shall maintain an accounts receivable aging schedule, and debt that is deemed to be uncollectable shall be written off periodically. The CSB shall maintain a system of internal controls including separation of duties to safeguard accounts receivable assets. A designated staff person who does not enter or process the CSB's payroll shall certify each payroll.
    f. Documentation for all expenditures must adhere to the respective fund requirements for both state and federal funding sources.
    g. The CSB shall maintain an accurate list of fixed assets as defined by the state and federal policies.
    h. Access to the CSB's information system shall be controlled and properly documented. Access shall be terminated in a timely manner when a staff member is no longer employed by the CSB to ensure security of confidential information about individuals receiving services and compliance with the Health Insurance Portability and Accountability Act of 1996 and associated federal or state regulations.
    i. The CSB shall assess operating reserves at least monthly to ensure it maintains an operating reserve of funds sufficient to cover at least two months of personnel and operating expenses and ensure that the CSB's financial position is sound.
    j. At any point during the term of this contract, if it determines that its operating reserve is less than two months, the CSB shall notify the the Department within 10 business days of the determination and work with the Department to develop a corrective action plan to increase the reserve to at least two months in a reasonable agreed upon timeframe.

B. Procurement Requirements, Policies, and Procedures

CSBs shall have written procurement policies and procedures that comply with the Virginia Public Procurement Act.

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C. Reimbursement Requirements, Policies, and Procedures

1. **Reimbursement System:** Each CSB's reimbursement system shall comply with § 37.2-504 and § 37.2-511 or § 37.2-605 and § 37.2-612 and with § 20-61 of the Code of Virginia and State Board Policy 6002 (FIN) 86-14. Its operation shall be described in organizational charts identifying all staff positions, flow charts, and specific job descriptions (as they relate to reimbursement policy/process) for all personnel involved in the reimbursement system.

2. **Policies and Procedures:** Written fee collection policies and procedures shall be adequate to maximize fees from individuals and responsible third-party payers.

3. **Schedule of Charges:** A schedule of charges shall exist for all services that are included in the CSB's performance contract, shall be related reasonably to the cost of the services, and shall be applicable to all recipients of the services.

4. **Ability to Pay:** A method, approved by a CSB's board of directors that complies with applicable state and federal regulations shall be used to evaluate the ability of each individual to pay fees for the services he or she receives.

5. **Medicaid and Medicare Regulations:** CSBs shall comply with applicable federal and state Medicaid and Medicare regulations, policies, procedures, and provider agreements. Medicaid non-compliance issues identified by Department staff will be communicated to the Department of Medical Assistance Services.

D. Human Resource Management Requirements, Policies, and Procedures

1. **Statutory Requirements:** The CSB shall operate a human resource management program that complies with state and federal statutes, regulations, and policies.

2. **Policies and Procedures:** If the CSB is not otherwise required to adhere to local government human resource management requirements, policies, and procedures, written human resource management policies and procedures shall include a classification plan and uniform employee pay plan and, at a minimum, shall address:
   a) nature of employment;
   b) equal employment opportunity;
   c) recruitment and selection;
   d) criminal background and reference check requirements;
   e) classification and compensation, including a uniform employee pay plan;
   f) employment medical examinations (e.g., TB);
   g) nepotism (employment of relatives);
   h) probationary period;
   i) initial employee orientation;
   j) transfer and promotion;
   k) termination, layoff, and resignation;
   l) benefits, including types and amounts of leave, holidays, and health, disability, and other insurances;
   m) hours of work;
   n) outside employment;
   o) professional conduct;
   p) employee ethics;
   q) compliance with state Human Rights Regulations and the CSB's local human rights policies and procedures;
   r) HIPAA compliance and privacy protection;
   s) compliance with the Americans with Disabilities Act;

t) compliance with Immigration Reform and Control Act of 1986;
u) conflicts of interests and compliance with the Conflict of Interests Act;
v) compliance with Fair Labor Standards Act, including exempt status, overtime, and compensatory leave;
w) drug-free workplace and drug testing;
x) maintenance of a positive and respectful workplace environment;
y) prevention of sexual harassment;
z) prevention of workplace violence;
aa) whistleblower protections;
bb) smoking;
cc) computer, internet, email, and other electronic equipment usage;
dd) progressive discipline (standards of conduct);
ee) employee performance evaluation;
ff) employee grievances;
gg) travel reimbursement and on-the-job expenses;
hh) employee to executive director and board of directors contact protocol; and
ii) communication with stakeholders, media, and government officials.

3. **Job Descriptions**
A CSB shall have written, up-to-date job descriptions for all positions.
Job descriptions shall include identified essential functions, explicit responsibilities, and qualification statements, expressed in terms of knowledge, skills, and abilities as well as business necessity and bona fide occupational qualifications or requirements.

4. **Grievance Procedure**
A CSB's grievance procedure shall satisfy §15.2-1507 of the Code of Virginia.

5. **Uniform Pay Plan**
A CSB shall adopt a uniform pay plan in accordance with §15.2-1506 of the Code of Virginia and the Equal Pay Act of 1963.

E. Comprehensive State Planning

1. **General Planning:** The CSB shall participate in collaborative local and regional service and management information systems planning with state facilities, other-CSBs, other public and private human services agencies, and the Department, as appropriate. In accordance with § 37.2-504 or § 37.2-605 of the Code of Virginia, the CSB shall provide input into long-range planning activities that are conducted by the Department.

2. **Participation in State Facility Planning Activities**
The CSB shall participate in collaborative planning activities with the Department to the greatest extent possible regarding the future role and structure of the state facilities.

F. Interagency Relationships

Pursuant to the case management requirements of § 37.2-500 or § 37.2-601 of the Code of Virginia, the CSB shall, to the extent practicable, develop and maintain linkages with other community and state agencies and facilities that are needed to assure that individuals it serves are able to access treatment, training, rehabilitative, and habilitative mental health, developmental, or substance abuse services and supports identified in their individualized services plans. The CSB shall comply with § 37.2-504 or § 37.2-605 of the Code of Virginia regarding interagency agreements.

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The CSB also shall develop and maintain, in conjunction with the courts having jurisdiction in the cities or counties served by the CSB, cooperative linkages that are needed to carry out the provisions of § 37.2-805 through § 37.2-821 and related sections of the Code of Virginia pertaining to the involuntary admission process.

The CSB shall develop and maintain the necessary linkages, protocols, and interagency agreements to effect the provisions of the Comprehensive Services Act for At-Risk Youth and Families (§ 2.2-5200 through § 2.2-5214 of the Code of Virginia) that relate to services that it provides. Nothing in this provision shall be construed as requiring the CSB to provide services related to this act in the absence of sufficient funds and interagency agreements.

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III. The Department Requirements

A. Comprehensive State Planning

The Department shall conduct long-range planning activities related to state facility and community services, including the preparation and dissemination of the Comprehensive State Plan required by § 37.2-315 of the Code of Virginia.

B. Administrative Fee

The Department shall partner with the CSBs to establish administrative fee policies and procedures.

C. Department Review

While it does not conduct routine reviews of the entirety of a CSB's administrative activities, the Department may conduct a review in response to significant deficiencies, irregularities, or problems identified in the CSB's independent annual audit or management letter or in response to complaints or information that it receives.

If Departmental review identifies compliance deficiencies, CSBs will submit formal plans of correction to the appropriate Office of Administrative Services in the Department within 45 days of receipt of official reports of reviews. Minor compliance issues shall be corrected within 45 days of submitting a plan. Action to correct major compliance issues shall be initiated within 45 days and completed within 180 days of submitting a plan, unless, following discussion with the CSB, the Department grants an extension.

Additional information about departmental review of various administrative functions is available in the Technical Manual.

D. Complaint Follow-up

In response to complaints from constituents or other entities related to CSB financial, procurement, reimbursement, or human resource policy, the Department will forward those complaints to the Board, the local government or local governing body for resolution. If resolution is not attained within a reasonable period, DBHDS may conduct a review of these policies, departments, and activities, within the extent allowable by state law, to seek resolution.

E. Information Technology

The Department shall operate and provide technical assistance and support, to the extent practicable, to the CSB about any/all systems through which operational or service-level data are exchanged and will comply with State Board Policies 1030.

1. Pursuant to § 37.2-504 and § 37.2-605 of the Code of Virginia, the Department shall implement procedures to protect the confidentiality of data accessed or received in accordance with the performance contract.

2. The Department shall ensure that any software application that it issues to the CSB for reporting purposes associated with the performance contract has been field tested in accordance with Appendix D by a reasonable number of CSBs to assure compatibility and functionality with the major IT systems used by CSBs, is operational, and is provided to the CSB sufficiently in advance of reporting deadlines to allow it to install and run the software application.

3. The Department shall collaborate with the VACSB DMC in the implementation of any new data management or data warehousing systems to ensure appropriate interoperability and workflow management.

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Appendix A: CSB and Board of Directors Organization and Operations

These requirements apply to the CSB board of directors or staff pursuant to § 37.2-501 - § 37.2-502 of the Code

A. CSB Organization
The CSB shall maintains an organizational chart that includes the local governing body or bodies that established the CSB and the board's committee structure.

B. Board Bylaws
Board of directors (BOD) bylaws shall be consistent with local government resolutions or ordinances establishing the CSB, board policies, and the CSB's organization chart and shall have been reviewed and/or revised in the last two years.

C. CSB Name/Appointment Changes
If the name of a CSB changes, the CSB shall provide the Department resolutions or ordinances approving the CSB's new name that were adopted by the boards of supervisors or city councils (local governing bodies) that established the CSB. If the number of appointments made to the CSB by its local governing bodies changes, the CSB shall attach to this contract copies of the resolutions or ordinances adopted by the local governing bodies that changed the number of appointments.

D. BOD Member Job Description
The BOD and executive director shall develop a board member position description, including qualifications, duties and responsibilities, and time requirements that the CSB shall provide to its local governing bodies to assist them in board appointments.

E. BOD Member Training
The executive director shall provide new board members with training on their legal, fiduciary, regulatory, policy, and programmatic powers and responsibilities and an overview of the performance contract within one month of their appointment. New board members shall receive a board manual before their first board meeting with the information needed to be an effective board member.

F. BOD Policies
The BOD shall adopt policies governing its operations, including board- staff relationships and communications, local and state government relationships and communications, committee operations, attendance at board meetings, oversight and monitoring of CSB operations, quality improvement, conflict of interests, freedom of information, board member training, privacy, security, and employment and evaluation of and relationship with the executive director.

G. FOIA Compliance
The BOD shall comply with the Virginia Freedom of Information Act (FOIA). BOD Meeting Schedule
The BOD shall adopt an annual meeting schedule to assist board member attendance.

H. Meeting Frequency
The BOD shall meet frequently enough (at least six times per year) and receive sufficient information from the staff to discharge its duties and fulfill its responsibilities. This information shall include quarterly reports on service provision, funds and expenditures, and staffing in sufficient detail and performance on the behavioral health and developmental performance measures and other performance measures in Exhibit B. Board members shall receive this information at least one week before a scheduled board meeting.

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I. Reporting Fraud

1. Upon discovery of circumstances suggesting a reasonable possibility that a fraudulent transaction has occurred, the CSB's executive director shall report this information immediately to any applicable local law enforcement authorities and the Department's Internal Audit Director.

2. All CSB financial transactions that are the result of fraud or mismanagement shall become the sole liability of the CSB, and the CSB shall refund any state or federal funds disbursed by the Department to it that were involved in those financial transactions.

3. The CSB shall ensure that new CSB board members receive training on their fiduciary responsibilities under applicable provisions of the Code and this contract and that all board members receive annual refresher training on their fiduciary responsibilities.

J. Employment of a CSB Executive Director or Behavioral Health Authority (BHA) Chief Executive Officer (CEO) Position

1. CSBs are compliant with § 37.2-504 item 6 or § 37.2-605 item 7 of the Code of Virginia as it relates to the hiring and employment of their leaders. Coordination with the Department is required at varying levels based on the type of CSB.

2. The CSB is required to coordinate with the Department to ensure the appointed individual meets the minimum qualifications established by the department (for all CSB/BHA types) and is in compliance with appropriate salary ranges (for operating CSBs and BHAs).

3. Additional guidance is provided in the TM

Appendix B: Disaster Response and Emergency Service Preparedness Requirements

A. The CSB agrees to comply with section 416 of Public Law 93-288 (the Stafford Act) and § 44-146.13 through § 44-146.28 of the Code regarding disaster response and emergency service preparedness. These Code sections authorize the Virginia Department of Emergency Management, with assistance from the Department, to execute the *Commonwealth of Virginia Emergency Operations Plan*, as promulgated through Executive Order 50 (2012).

B. Disaster behavioral health (DBH) assists with mitigation of the emotional, psychological, and physical effects of a natural or man-made disaster affecting survivors and responders. Disaster behavioral health support is most often required by Emergency Support Function No. 6: Mass Care, Emergency Assistance, Temporary Housing, and Human Services; Emergency Support Function No. 8: Health and Medical Services; and Emergency Support Function No. 15: External Affairs. The CSB shall:

1. Provide the Department with and keep current 24/7/365 contact information for disaster response points of contact at least three persons deep
2. Report to the Department all disaster behavioral health recovery and response activities related to a disaster
3. Within the scope of widely accepted FEMA doctrine, the National Response Framework and the National Incident Management System, comply with all Department directives coordinating disaster planning, preparedness, response, and recovery to disasters.

C. Local partnerships are critical to successful disaster response and recovery operations. The CSB shall work with local partners and response agencies to ensure local emergency operations plans incorporate appropriate disaster behavioral health provisions. The Disaster Behavioral Health provisions should include:

1. An accurate listing of DBH response and recovery assets both internal to the CSB and otherwise available to the locality in the aftermath of a disaster.
2. Protocols and procedures for providing behavioral health services and supports to the local community during emergency operations;
3. Participation in local, regional, and statewide planning, preparedness, response, and recovery training and exercises;
4. Disaster response agreements with local governments and state facilities; and
5. Coordination with state facilities and local health departments or other responsible local agencies, departments, or units in preparing all hazards disaster plans.

Appendix C: Unspent Balances Principles and Procedures

A. Unspent Balances Principles and Procedures

1. **CSB Unspent Federal Funds:** Federal funds remaining unspent beyond the period of performance for which the funds were granted shall be returned to the Department at the end of the funding period in which they were allocated pursuant to the timeline and closeout process outlined in section III of Exhibit F exception in circumstances in which the expenditure of federal funds for allowable unliquidated obligations within appropriate unliquidated obligation spend-down periods as outlined in Exhibit F.

2. **CSB Allocations of State Funds**: Given provisions in State Board Policy 6005 and § 37.2-509 or § 37.2-611 of the Code of Virginia, the Department shall allocate funds in Grants to Localities in the Appropriation Act without applying estimated year-end balances of unspent state funds to the next year's awards to CSBs.

3. **Calculation of Balances:** In order to identify the correct amounts of unspent state fund balances, the Department shall continue to calculate unspent balances for all types of funds sources, except for federal grants.
4. The Department shall calculate balances for restricted and unrestricted state funds, local matching funds, and fees~~,~~ based on the end of the fiscal year Community Automated Reporting System (CARS) reports submitted by all CSBs no later than the deadline in Exhibit E of the performance contract. The Department shall continue to communicate information about individual balances to each CSB.

5. **Unspent Balances for Regional Programs**: While all unspent balances exist in CSB financial management systems, unspent balances for a regional program may be handled by the fiscal agent and CSBs participating in the regional program as they decide for purposes allowable for the regional program. All participating CSBs must review and approve how these balances are handled and the agreed upon uses must fall within the allowable uses for any restricted regional programs. Balances for regional programs may be prorated to each participating CSB for its own locally determined uses or allocated to a CSB or CSBs for regionally approved uses, or the CSB that functions as the regional program's fiscal agent may retain and expend the funds for purposes determined by all of the participating CSBs. Procedures for handling regional program balances of unspent funds should be included in the regional program memorandum of agreement for the program among the participating CSBs, and those procedures must be consistent with the principles and procedures in this Appendix and the applicable provisions of the current performance contract.

6. **Allowable Uses of Unspent State Fund Balances**: Consistent with the intent of the Grants to Localities item in the Appropriation Act and § 37.2-500 or § 37.2-601 of the Code of Virginia, CSBs may use unspent balances of state funds only for mental health, developmental, and substance use disorder services purposes. Any other uses of unspent state fund balances are not acceptable and are a violation of the CSB's performance contract with the Department.

7. **Collective Uses of Unspent Balances**: A group of CSBs may pool amounts of their unspent balances to address one-time issues or needs that are addressed more effectively or efficiently on a collective basis. Any pooled restricted funds must be used in accordance with the terms of the restriction. The use of these pooled unspent balances shall be consistent with the principles and procedures in this Appendix.

B. Reserve Funds: A CSB shall place all unspent balances of unrestricted and restricted state funds that it has accumulated from previous fiscal years in a separate reserve fund. CSBs shall identify and account separately for unspent balances of each type of restricted state funds from previous fiscal years in the

reserve fund. The CSB shall use this reserve fund only for mental health, developmental, and substance use disorder services purposes, as specified in these principles and procedures or by the Department.

1. Reserve funds must not be established using current fiscal year funds, which are appropriated, granted, and disbursed for the provision of services in that fiscal year. This is particularly relevant for funds restricted by funding sources such as the General Assembly, since these funds cannot be used for another purpose. Transferring current fiscal year state funds into a reserve fund or otherwise intentionally not expending them solely for the purpose of accumulating unspent state funds to create or increase a reserve fund is a violation of the legislative intent of the Appropriation Act and is prohibited.
2. **Size of Reserve Funds**: The maximum acceptable amount of unspent state fund balances that a CSB may accumulate in a reserve fund shall be equal to 50 percent of the amount of all state funds received from the Department during the current fiscal year up to a maximum of $7 million. If this amount of all state funds is less than 50 percent of the total amount of state funds received by the CSB during any one of the preceding five fiscal years, then 50 percent of that larger amount shall constitute the acceptable maximum amount of unspent state fund balances that may be accumulated in a reserve account.

    a. If a CSB has accumulated more than this amount, it must expend enough of those reserve funds on allowable uses for mental health, developmental, or substance use disorder services purposes to reduce the amount of accumulated state fund balances to less than 50 percent of the amount of all state funds received from the Department during the current fiscal year.

    b. In calculating the amount of acceptable accumulated state fund balances, amounts of long term capital obligations incurred by a CSB shall be excluded from the calculation. If a CSB has a plan approved by its CSB board and reviewed and approved in advance by the Department to reserve a portion of accumulated balances toward an identified future capital expense such as the purchase, construction, renovation, or replacement of land or buildings used to provide mental health, developmental, or substance use disorder services; purchase or replacement of other capital equipment, including facility-related machinery or equipment; or purchase of information system equipment or software, the reserved amounts of state funds shall be excluded from the maximum acceptable amount of unspent state fund balances.

C. Effective Period of Restrictions on State General Funds

1. Allowable uses of state funds for identified purposes (restricted funds) remain restricted as originally appropriated. After the end of the biennium in which the restricted funds were disbursed to CSB, any unexpended balances of those state funds shall be identified and shall remain restricted for permissible purposes unless the CSB submits and receives approval of a request to unrestrict these funds, in writing, to the Office of Management Services in the Department. Approvals may be granted for unrestricting funds to be used within the same category (MH, SA, DD).

2. The Department may request an accounting of the total amount of accumulated unexpended restricted state funds per funding source. If necessary, the Department may direct the CSBs to repurpose the use of those funds or the Department may re-allocate those funds amongst other CSBs based on need.

D. Performance Contract Exhibit A Documentation

1. All uses of unspent balances of state funds shall be documented in the CSB's performance contract for the year in which the unspent balances are expended. If the balances will be used to support operational costs, the funds shall be shown as state retained earnings in the performance contract and in the CARS mid-year report, if the expense occurs in the first two quarters, and in the end of the fiscal year CARS report.

2. If the balances will be used for major capital expenses, such as the purchase, construction, major renovation, or replacement of land or buildings used to provide mental health, developmental, or substance use disorder services or the CSB's management and administrative operations or the purchase or replacement of information system equipment, these costs shall be shown as state retained earnings and shall be described separately on the Financial Comments page (AF-2) of the performance contract and the CARS reports.
3. Balances used for major capital expenses shall be included in appropriate lines as applicable but shall not be included in the service costs shown in the performance contract or CARS reports because these expenses would distort the ongoing costs of the services in which the major capital expenses would be included. Differences between the financial and service costs related to the inclusion of unspent balances as retained earnings for major capital expenses shall be explained on the Reconciliation of Financial Report and Core Services Costs by Program Area page. However, depreciation of those capital assets can be included in service costs.
4. In either case, for each separate use of unspent balances of state funds, the amount expended and the category from those listed in the expenditure shall be shown on the Financial Comments page of the CARS report. The amount of unspent balances must be shown along with the specific sources of those balances, such as unrestricted state funds or particular restricted state funds. Uses of unspent balances of state funds shall be reviewed and approved by the Department in accordance with the principles and procedures in this document and the Performance Contract Process in Exhibit E of the performance contract.
5. CSBs may maintain their accounting records on a cash or accrual basis for day-to-day accounting and financial management purposes; however its CARS reporting must be in compliance with Generally Accepted Accounting Principles (GAAP). CSBs may submit CARS reports to the Department on a cash or modified accrual basis, but they must report on a consistent basis; and the CARS reports must include all funds contained in the performance contract that are received by the CSB during the reporting period.

E. Department Review of Unspent Balances

In exercising its stewardship responsibility to ensure the most effective, prudent, and accountable uses of state funds, the Department may require CSBs to report amounts of unexpended state funds from previous fiscal years. The Department also may withhold current fiscal year disbursements of state funds from a CSB if amounts of unexpended state funds for the same purposes in the CSB's reserve account exceed the limits in this document. This action would not affect the allocation of those state funds in the following fiscal year. The Department also may review available unspent balances of state funds with a CSB that exhibits a persistent pattern of providing lower levels of services while generating significant balances of unspent state funds, and the Department may take actions authorized by State Board Policy 6005 to address this situation. Finally, the Department may establish other requirements in collaboration with CSBs for the identification, use, reporting, or redistribution of unexpended balances of state funds.

Appendix D: User Acceptance Testing Process

A. ~~User acceptance testing (UAT) is testing used to validate an application against the business requirements. It also provides the opportunity for the end user/client to determine if the application is acceptable or not. UAT is the last step in ensuring that the application is performing as expected and to minimize any future undue costs caused by unexpected errors and decreased data veracity.~~

B. ~~By the time an application has reached the UAT process, the code is expected to work as determined in the business requirements. Unpredictability is one of the least desirable outcomes of using any application. Several factors make UAT necessary for any software development or modification project, especially for complex applications that interface with many IT vendor-supplied data files and are used by many different end users in different ways.~~

C. ~~In the UAT process, end users test the business functionality of the application to determine if it can support day-to-day business practices and user case scenarios.~~ The Community Service Boards (CSB) and Department of Behavioral Health and Developmental Services (DBHDS) will use the following UAT process for major new releases and/or upgrades of applications that involve the addition of new data elements or reporting requirements or other functions that would require significant work by CSB IT staff and vendors.

D. Major changes in complex systems shall primarily occur only once per year at the start of the fiscal year and in accordance with the testing process below. Critical and unexpected changes may occur outside of this annual process for business applications, and under those circumstances DBHDS will follow the established UAT process to implement them. Smaller applications follow the process below at the discretion of the DBHDS with input from the VACSB DMC. (Virginia Community Service Board Data Management Committee).

E. ~~Minor releases of applications will utilize shorter processes that will require a modification to the established UAT process. Minor releases can be described as small modifications of the application and that does not involve collecting new data elements.~~

~~**Department and CSB User Acceptance Testing Process**~~	
~~**Time Frame**~~	~~**Action**~~
~~D Day~~	~~Date data must be received by the Department~~
~~D - 15~~	~~The Department issues the final version of the new release to CSBs for their use.~~
~~D - 20~~	~~UAT is completed and application release is completed.~~
~~D - 35~~	~~UAT CSBs receive the UAT version of the new release and UAT begins.~~
~~D - 50~~	~~CSBs begin collecting new data elements that will be in the new release. Not all releases will involve new data elements, so for some releases, this date would not be applicable.~~
~~D - 140~~	~~The Department issues the final revised specifications that will apply to the new release. The revised specifications will be accompanied by agreed upon requirements specifications outlining all of the other changes in the new release. CSBs use the revised specifications to modify internal business practices and work with their IT vendors to modify their EHRs and extracts.~~
~~Unknown~~	~~The time prior to D-150 in which the Department and CSBs develop and negotiate the proposed application changes. The time needed for this step is unknown and will vary for each new release depending on the content of the release.~~

**Time Frame is based on calendar days*

Department and CSB User Acceptance Testing Process

Time Frame Cal Days	Action
Variable	The time prior to D-150 in which DBHDS and CSBs develop and negotiate the proposed application changes. The time needed for this step is unknown and will vary for each new release depending on the content of the release
D - 140	The Department issues the final revised specifications that will apply to the new release. The revised specifications will be accompanied by agreed upon requirements specifications outlining all changes in the new release.
D - 50	CSBs begin collecting new data elements that will be in the new release. Not all releases will involve new data elements, so for some releases, this date would not be applicable.
D - 35	UAT testers (DBHDS & CSB representatives) receive the beta version of the new release and UAT begins.
D – 20	UAT is completed. Test outcomes are validated and identified errors are mitigated. The application release is completed.
D - 15	The Department issues the final version of the new release to CSBs for their use.
D Day	Initial date data must be received by the Department (

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ADDENDUM I
ADMINISTRATIVE REQUIREMENTS AND PROCESSES AND PROCEDURES

Appendix E: Administrative Requirements for Accounts Receivables

Background

Budget Amendments - HB30 (Conference Report), Item 295#9c – OO.4

The Department of Medical Assistance Services, in cooperation with DBHDS, shall (i) develop and implement a targeted review process to assess the extent to which CSBs are billing for Medicaid-eligible services they provide, (ii) determine if additional technical assistance and training, in coordination with Medicaid managed care organizations, is needed on appropriate Medicaid billing and claiming practices to relevant CSB staff, and (iii) evaluate the feasibility of a central billing entity, similar to the Federally Qualified Health Centers, that would handle all Medicaid claims for the entire system. The Department shall report the results of these targeted reviews, any technical assistance or training provided in response, and on the feasibility of central billing to the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by December 1, 2024.

DBHDS currently looks at the client receivables as part of our CSB reviews, and the data collected shows that some of the CSBs are not billing or processing denials timely. These changes will allow DBHDS to identify causes for these issues and educate CSBs how they can increase collections in the long run. This would also allow DBHDS to have more visibility to the client receivables and deliver specific recommendations to resolve issues. This will also allow CSBs to identify problem areas more closely and the training and resources needed to rectify issues.

As CSBs implement these changes there can be success in timely billing or back billing and recovery of missed revenue opportunities. DBHDS believes this will result in an overall increase in their collections on the receivables.

Effective Date: This Appendix E shall be effective July 1, 2025 through June 30, 2027

A. CSB Responsibilities

1. CSB shall develop and implement systems that are adequate to properly account for and report their client receivables.

2. CSB shall establish and implement receivable collection policy that includes procedures for billing, re-billing, processing denials and write offs. Such procedures should address the frequency of billing, monitoring of denials and frequency of re-billing such denials of client receivables.

3. CSB shall write off client receivable accounts when all collection procedures have been exhausted and categories of such write offs need to be defined in their receivable policy.

4. CSB shall collect minimum prescribed information from clients including their insurance information that aids in collecting receivables.

5. CSB shall strive to consistently pursue client receivables collect its client receivables including Medicaid, Medicare, and third-party insurers and limit the percentage of receivables over 120 days

(excluding self-pay) to 15% or less of the total AR (excluding self-pay) unless actively collecting on those accounts.

B. Department Responsibilities

1. By July 30, 2025 the Department shall work with the CSB to establish the reporting template.
2. The Department shall attend the established VACSB State Steering Committee meetings that address issues around collecting receivables.
3. The Department shall meet quarterly with representation from CEOs & CFOs (small group) to analyze the data and understand the details related to the collected data and what resolutions are reasonable, including the messaging for state-level stakeholders.
4. The Department shall attend VARO (Virginia Association of Reimbursement Officers) conference that address issues around collecting receivables.
5. The Department shall consult with the CSB Executive Director and/or Chief Executive Officer in advance of sharing data with the General Assembly, Behavioral Health Commission, JLARC or posting on any public facing dashboards.

C. **Reporting Requirements**
CSB shall report total client receivables, including accounts aged 30 days, 31-60 days, 61-90 days, 91-120, 120 days and over, by payor type, to DBHDS Finance on a quarterly basis within 30 days of the close of the quarter using the established DBHDS report template. CSB shall send the reports to Eric Billings, Deputy Director of Fiscal Services and Grants Management at eric.billings@dbhds.virginia.gov.

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Appendix F: Regional Program Procedures

A regional program is funded by the Department through the community services board or behavioral health authority, hereafter referred to as the CSB, and operated explicitly to provide services to individuals who receive services from the CSBs participating in the program.

1. Purpose
   The CSB may collaborate and act in concert with other CSBs or with other CSBs and state hospitals or training centers, hereafter referred to as state facilities, to operate regional programs, provide or purchase services on a regional basis, conduct regional utilization management, or engage in regional quality improvement efforts. Regional programs include regional discharge assistance programs (RDAP), local inpatient purchases of services (LIPOS), and other programs such as residential or ambulatory crisis stabilization programs. These procedures apply to all regional programs. While this appendix replaces earlier regional memoranda of agreement (MOAs), CSBs, state facilities, private providers participating in the regional partnership, and other parties may still need to develop MOAs to implement specific policies or procedures to operate regional or sub-regional programs or activities. Also, an MOA must be developed if a regional program intends to established a peer review committee (e.g., a regional utilization review and consultation team) whose records and reviews would be privileged under § 8.01-581.16 of the Code of Virginia. When the CSB receives state or federal funds from the Department for identified regional programs or activities, it shall adhere to the applicable parts of these procedures, which are subject to all applicable provisions of the community services performance contract. In the event of a conflict between any regional program procedures and any provisions of the contract, provisions of the contract shall apply.

2. Regional Management Group (RMG)
   a. The participating CSBs and state facilities shall establish an RMG. The executive director of each participating CSB and the director of each participating state facility shall each serve on or appoint one member of the RMG. The RMC shall manage the regional program and coordinate the use of funding provided for the regional program, review the provision of services offered through the regional program, coordinate and monitor the effective utilization of the services and resources provided through the regional program, and perform other duties that the members mutually agree to carry out. An RMG may deal with more than one regional program.
   b. Although not members of the RMG, designated staff in the Central Office of the Department shall have access to all documents maintained or used by this group, pursuant to applicable provisions of the performance contract, and may attend and participate in all meetings or other activities of this group.
   c. In order to carry out its duties, the RMG may authorize the employment of one or more regional managers to be paid from funds provided for a regional program and to be

employed by a participating CSB. The RMG shall specify the job duties and responsibilities for and supervise the regional manager or managers.

3. Regional Utilization Review and Consultation Team (RURCT)
   a. The RMG shall establish a RURCT pursuant to § 8.01-581.16 of the Code of Virginia to, where applicable:
      1.) review the implementation of the individualized services plans (ISPs) or individualized Discharge Assistance Program plans (IDAPPs) developed through the regional program to ensure that the services are the most appropriate, effective, and efficient services that meet the clinical needs of the individual receiving services and report the results of these reviews to the RMG;
      2.) review individuals who have been on the state facility extraordinary barriers to discharge list for more than 30 days to identify or develop community services and funding appropriate to their clinical needs and report the results of these reviews and subsequent related actions to the RMG;
      3.) review, at the request of the case management CSB, other individuals who have been determined by state facility treatment teams to be clinically ready for discharge and identify community services and resources that may be available to meet their needs;
      4.) facilitate, at the request of the case management CSB, resolution of individual situations that are preventing an individual's timely discharge from a state facility or a private provider participating in the regional partnership or an individual's continued tenure in the community;
      5.) identify opportunities for two or more CSBs to work together to develop programs or placements that would permit individuals to be discharged from state facilities or private providers participating in the regional partnership more expeditiously;
      6.) promote the most efficient use of scarce and costly services; and
      7.) carry out other duties or perform other functions assigned by the RMG.
   b. The RURCT shall consist of representatives from participating CSBs in the region, participating state facilities, private providers participating in the regional partnership, and others who may be appointed by the RMG, such as the regional manager(s) employed pursuant to section II.C. The positions of the representatives who serve on this team shall be identified in local documentation.
   c. The RURCT shall meet monthly or more frequently when necessary, for example, depending upon census issues or the number of cases to be reviewed. Minutes shall be recorded at each meeting. Only members of the team and other persons who are identified by the team as essential to the review of an individual's case, including the individual's treatment team and staff directly involved in the provision of services to the individual, may attend meetings. All proceedings, minutes, records, and reports and any information

discussed at these meetings shall be maintained confidential and privileged, as provided in § 8.01-581.17 of the Code of Virginia.

d. For the regional program, the RURCT or another group designated by the RMG shall maintain current information to identify and track individuals served and services provided through the regional program. This information may be maintained in participating CSB information systems or in a regional data base. For example, for the RDAP, this information shall include the individual's name, social security number or other unique identifier, other unique statewide identifier, legal status, case management CSB, state hospital of origin, discharge date, state re-hospitalization date (if applicable), and the cost of the IDAPP. This team shall maintain automated or paper copies of records for each RDAP-funded IDAPP. Changes in responsibilities of the case management CSB, defined in the core services taxonomy, and the transfer of RDAP funds shall be reported to the Offices of Grants Management and Mental Health Services in the Department as soon as these changes or transfers are known or at least monthly.

e. For RDAP, the RURCT shall conduct utilization reviews of ISPs as frequently as needed to ensure continued appropriateness of services and compliance with approved IDAPPs and reviews of quarterly utilization and financial reports and events related to the individual such as re-hospitalization, as appropriate. This utilization review process may result in revisions of IDAPPs or adjustment to or redistribution of RDAP funds. This provision does not supersede utilization review and audit processes conducted by the Department pursuant to the performance contract.

f. Although not members of the RURCT, designated staff in the Central Office of the Department shall have access to all documents, including ISPs or IDAPPs, maintained or used by this body, pursuant to applicable provisions of the performance contract, and may attend and participate in all meetings as non-voting members and in other activities of this team.

4. **Operating Procedures for Regional Programs:** These operating procedures establish the parameters for allocating resources for and monitoring continuity of services provided to individuals receiving regional program services. Some of the procedures apply to regional programs generally; others apply to particular regional programs, although they may be able to be adapted to other regional programs.

   a. Funding for a regional program shall be provided and distributed by the Department to participating CSBs or to a CSB on behalf of the region through their community services performance contracts in accordance with the conditions specified the contract, often in an Exhibit D.

   b. Each participating CSB or a CSB on behalf of the region shall receive semi-monthly payments of state funds from the Department for the regional program through its community services performance contract, as long as it satisfies the requirements of this

appendix and the performance contract, based upon its total base allocation of previously allotted and approved regional program funds.

c. Participating CSBs and state facilities shall develop agreed-upon procedures that describe how they will implement a regional program and jointly manage the use of regional program funds on a regional basis. These procedures shall be reduced to writing and provided to the Department upon request.

d. Regional program funds may be used to support the activities of the RMG and RURCT.

e. Within the allocation of funds for the regional program, funds may be expended for any combinations of services and supports that assure that the needs of individuals are met in community settings. ISPs or IDAPPs must be updated and submitted, as revisions occur or substitute plans are required, to the RMG for approval according to procedures approved by the RMG.

f. Regional program funds used to support ISPs or IDAPPs shall be identified on a fiscal year basis. Amounts may be adjusted by the RMG to reflect the actual costs of care based on the regional program's experience or as deemed appropriate through a regional management and utilization review process.

g. The CSB responsible for implementing an individual's regional program ISP or IDAPP shall account for and report the funds and expenses associated with the regional program ISP or IDAPP in its community services performance contract and in its quarterly performance contract reports submitted through the Community Automated Reporting System (CARS).

h. The CSB responsible for implementing an individual's regional program ISP or IDAPP shall ensure that the appropriate information about that individual and his or her services is entered into its management information system so that the information can be extracted by the Community Consumer Submission (CCS) and reported in the monthly CCS extracts and applicable CARS reports to the Department.

i. The participating CSBs may use regional program funds to establish and provide regional or sub-regional services when this is possible and would result in increased cost effectiveness and clinical effectiveness.

j. Operation of a RDAP is governed by the Discharge Assistance Program Manual issued by the Department and provisions of Exhibit C of the performance contract.

5. General Terms and Conditions

a. CSBs, the Department, and any other parties participating in a regional program agree that they shall comply with all applicable provisions of state and federal law and regulations in implementing any regional programs to which these procedures apply. The CSB and the Department shall comply with or fulfill all provisions or requirements, duties, roles, or responsibilities in the current community services performance contract in their implementation of any regional programs pursuant to these procedures.

b. Nothing in these procedures shall be construed as authority for the CSB, the Department, or any other participating parties to make commitments that will bind them beyond the scope of these procedures.

c. Nothing in these procedures is intended to, nor does it create, any claim or right on behalf of any individual to any services or benefits from the CSB or the Department.

6. Project Management

a. The Department shall be responsible for the allocation of regional program state and federal funds and the overall management of the regional program at the state level.

b. The RMG shall be responsible for overall management of the regional program and coordination of the use of funding provided for the regional program in accordance with these procedures.

c. The CSB shall be responsible for managing regional program funds it receives in accordance with these regional program procedures.

d. Payments generated from third party and other sources for any regional program shall be used by the region or CSB to offset the costs of the regional program. The CSB shall collect and utilize all available funds from other appropriate specific sources before using state and federal funds to ensure the most effective use of these state and federal funds. These other sources include Medicare; Medicaid-fee-for service, targeted case management payments, rehabilitation payments, and ID waiver payments; other third party payors; auxiliary grants; SSI, SSDI, and direct payments by individuals; payments or contributions of other resources from other agencies, such as social services or health departments; and other state, local, or Department funding sources.

e. The Department may conduct on-going utilization review and analyze utilization and financial information and events related to individuals served, such as re-hospitalization, to ensure the continued appropriateness of services and to monitor the outcomes of the regional program. The utilization review process may result in adjustment to or reallocation of state general and federal funding allocations for the regional program.

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Addendum II: Central Office, State Facility, and Community Services Board Partnership Agreement

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Addendum II: Central Office, State Facility, and Community Services Board Partnership Agreement

Section 1: Purpose

The Central Office of the Department of Behavioral Health and Developmental Services (Department), state hospitals and training centers (state facilities) operated by the Department, and community services boards (CSBs), which are entities of local governments, are the operational partners in Virginia's public system for providing mental health, developmental, and substance use disorder services. CSBs include operating CSBs, administrative policy CSBs, and policy-advisory CSBs to local government departments and the behavioral health authority that are established pursuant to Chapters 5 and 6, respectively, of Title 37.2 of the Code of Virginia.

Pursuant to State Board Policy 1034, the partners enter into this agreement to implement the vision statement articulated in State Board Policy 1036 and to improve the quality of care provided to individuals receiving services (individuals) and enhance the quality of their lives. The goal of this agreement is to establish a fully collaborative partnership process through which CSBs, the Central Office, and state facilities can reach agreements on operational and policy matters and issues. In areas where it has specific statutory accountability, responsibility, or authority, the Central Office will make decisions or determinations with the fullest possible participation and involvement by the other partners. In all other areas, the partners will make decisions or determinations jointly. The partners also agree to make decisions and resolve problems at the level closest to the issue or situation whenever possible. Nothing in this partnership agreement nullifies, abridges, or otherwise limits or affects the legal responsibilities or authorities of each partner, nor does this agreement create any new rights or benefits on behalf of any third parties.

The partners share a common desire for the system of care to excel in the delivery and seamless continuity of services for individuals and their families and seek similar collaborations or opportunities for partnerships with advocacy groups for individuals and their families and other system stakeholders. We believe that a collaborative strategic planning process helps to identify the needs of individuals and ensures effective resource allocation and operational decisions that contribute to the continuity and effectiveness of care provided across the public mental health, developmental, and substance use disorder services system. We agree to engage in such a collaborative planning process.

This partnership agreement also establishes a framework for covering other relationships that may exist among the partners. Examples of these relationships include regional initiatives such as the regional utilization management teams, regional crisis stabilization programs, regional discharge assistance programs, regional local inpatient purchases of services, and REACH programs.

Section 2: Roles and Responsibilities

Although this partnership philosophy helps to ensure positive working relationships, each partner has a unique role in providing public mental health, developmental, and substance use disorder services. These distinct roles promote varying levels of expertise and create opportunities for identifying the most effective mechanisms for planning, delivering, and evaluating services.

A. Central Office

1. Ensures through distribution of available state and federal funding that an individually focused and community-based system of care, supported by community and state facility resources, exists for the delivery of publicly funded services and supports to individuals with mental health or substance use disorders or developmental disabilities.

2. Promotes the public mental health, developmental, and substance use disorder service delivery system (including the Central Office) quality improvement efforts that focus on individual outcome and provider performance

measures designed to enhance service quality, accessibility, and availability, and provides assistance to the greatest extent practicable with Department-initiated surveys and data requests.

3. Supports and encourages the maximum involvement to ensure that services are not imposed on individuals receiving services. The receiver of services should be an active participant in the planning, delivery, and documentation of services whenever practical participation of individuals receiving services and family members

   of individuals receiving services in policy formulation and services planning, delivery, monitoring, and evaluation.

4. Ensures fiscal accountability that is required in applicable provisions of the Code, relevant state and federal regulations, and policies of the State Board.

5. Promotes identification of state-of-the-art, best or promising practice, or evidence-based programming and resources that exist as models for consideration by other partners.

6. Seeks opportunities to affect regulatory, policy, funding, and other decisions made by the Governor, the Secretary of Health and Human Resources, the General Assembly, the Department of Medical Assistance Services and other state agencies, and federal agencies that interact with or affect the other partners.

7. Encourages and facilitates state interagency collaboration and cooperation to meet the service needs of individuals and to identify and address statewide interagency issues that affect or support an effective system of care.

8. Serves as the single point of accountability to the Governor and the General Assembly for the public system of mental health, developmental, and substance use disorder services.

9. Problem solves and collaborates with a CSB and state facility together on a complex or difficult situation involving an individual who is receiving services when the CSB and state facility have not been able to resolve the situation successfully at their level.

B. Community Services Boards

1. Pursuant to § 37.2-500 and 37.2-600 of the Code and State Board Policy 1035, serve as the single points of entry into the publicly funded system of individually focused and community-based services and supports for individuals with mental health or substance use disorders or developmental disabilities, including individuals with co-occurring disorders in accordance with State Board Policy 1015.

2. Serve as the local points of accountability for the public mental health, developmental, and substance use disorder service delivery system.

3. To the fullest extent that resources allow, promote the delivery of community-based services that address the specific needs of individuals, particularly those with complex needs, with a focus on service quality, accessibility, integration, and availability and on self-determination, empowerment, and recovery.

4. Support and encourage the maximum involvement and participation of individuals receiving services and family members of individuals receiving services in policy formulation and services planning, delivery, monitoring, and evaluation.

5. Establish services and linkages that promote seamless and efficient transitions of individuals between state facility and community services.

6. Promote sharing of program knowledge and skills with other partners to identify models of service delivery that have demonstrated positive outcomes for individuals receiving services.

7. Problem-solve and collaborate with state facilities on complex or difficult situations involving individuals receiving services.

8. Encourage and facilitate local interagency collaboration and cooperation to meet the other services and supports needs, including employment and stable housing, of individuals receiving services.

C. State Facilities

1. Provide psychiatric hospitalization and other services to individuals identified by CSBs as meeting statutory requirements for admission in § 37.2-817 of the Code and criteria in the Continuity of Care Procedures in the CSB Administrative Requirements, including the development of specific capabilities to meet the needs of individuals with co-occurring mental health and substance use disorders in accordance with State Board Policy 1015.

2. Within the resources available, provide residential, training, or habilitation services to individuals with developmental disabilities identified by CSBs as needing those services in a training center and who are certified for admission pursuant to § 37.2-806 of the Code.

3. To the fullest extent that resources allow, provide services that address the specific needs of individuals with a focus on service quality, accessibility, and availability and on self-determination, empowerment, and recovery.

4. Support and encourage the involvement and participation of individuals receiving services and family members of individuals receiving services in policy formulation and services planning, delivery, monitoring, and evaluation.

5. Establish services and linkages that promote seamless and efficient transitions of individuals

6. Promote sharing of program knowledge and skills with other partners to identify models of service delivery that have demonstrated positive outcomes for individuals.

7. Problem-solve and collaborate with CSBs on complex or difficult situations involving individuals receiving services.

Section 3: Vision and Core Values

The Central Office, state facilities, and CSBs share a common desire for the public system of care to excel in the delivery and seamless continuity of services to individuals receiving services and their families. While they are interdependent, each partner works independently with both shared and distinct points of accountability, such as state, local, or federal governments, other funding sources, individuals receiving services, and families. The partners embrace a common vision and core values that guide the Central Office, state facilities, and CSBs in developing and implementing policies, planning services, making decisions, providing services, and measuring the effectiveness of service delivery.

A. Vision Statement

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The vision, as articulated in State Board Policy 1036, is of a system of quality recovery-oriented services and supports that respects the rights and values of individuals with mental illnesses, intellectual disability, other developmental disabilities who are eligible for or are receiving Medicaid developmental disability waiver services, or substance use disorders, is driven by individuals receiving services, and promotes self-determination, empowerment, recovery, resilience, health and overall wellness, and the highest possible level of participation by individuals receiving services in all aspects of community life, including work, school, family, and other meaningful relationships. This vision also includes the principles of inclusion, participation, and partnership.

B. Core Values

1. Underpinning the vision are the core values of accountability, responsiveness, accessibility and localized solution meaning:
2. The Central Office, state facilities, and CSBs are working in partnership; we hold each other accountable for adhering to our core values.
3. As partners, we will focus on fostering a culture of responsiveness and striving for continuous quality improvement.
4. All services should be designed to be welcoming, accessible, and capable of providing interventions properly matched to the needs of individuals with co-occurring disorders.
5. As partners, we will make decisions and resolve problems at the level closest to the issue or situation whenever possible.

Section 4: Indicators Reflecting Core Values

The public system of care in Virginia is guided by simple, cost-effective measures reflecting the core values and expectations identified by the Central Office, state facilities, and CSBs. Subsequently, any indicators or measures should reflect the core values listed in the preceding section. The partners agree to identify, prioritize, collect, and utilize these measures as part of the quality assurance systems mentioned in Section 6 of this agreement and in the quality improvement plan described in Section 6.b of the community services performance contract.

Section 5: Advancing the Vision

The partners agree to engage in activities to advance the achievement of the Vision Statement contained in State Board Policy 1036 and Section 3 of this agreement, including these activities.

1. **Recovery:** The partners agree, to the greatest extent possible, to:
   a. provide more opportunities for individuals receiving services to be involved in decision making,
   b. increase recovery-oriented, peer-provided, and consumer-run services,
   c. educate staff and individuals receiving services about recovery, and
   d. assess and increase the recovery orientation of CSBs, the Central Office, and state hospitals.
2. **Integrated Services:** The partners agree to advance the values and principles in the Charter Agreement signed by the CSB and the Central Office and to increase effective screening and assessment of individuals for co-occurring disorders to the greatest extent possible.
3. **Person-Centered Planning:** The partners agree to promote awareness of the principles of person-centered planning, disseminate and share information about person-centered planning, and participate on work groups focused on implementing person-centered planning.

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Section 6: Critical Success Factors

The partners agree to engage in activities that will address the following seven critical success factors. These critical success factors are required to transform the current service system's crisis response orientation to one that provides incentives and rewards for implementing the vision of a recovery and resilience-oriented and person-centered system of services and supports. Successful achievement of these critical success factors will require the support and collective ownership of all system stakeholders.

1. Virginia successfully implements a recovery and resilience-oriented and person-centered system of services and supports.

2. Publicly funded services and supports that meet growing mental health, developmental, and substance use disorder services needs are available and accessible across the Commonwealth.

3. Funding incentives and practices support and sustain quality care focused on individuals receiving services and supports, promote innovation, and assure efficiency and cost effectiveness.

4. State facility and community infrastructure and technology efficiently and appropriately meet the needs of individuals receiving services and supports.

5. A competent and well-trained mental health, developmental, and substance use disorder services system workforce provides needed services and supports.

6. Effective service delivery and utilization management assures that individuals and their families receive services and supports that are appropriate to their needs.

7. Mental health, developmental, and substance use disorder services and supports meet the highest standards of quality and accountability.

Section 7: Accountability

The Central Office, state facilities, and CSBs agree that it is necessary and important to have a system of accountability. The partners also agree that any successful accountability system requires early detection with faithful, accurate, and complete reporting and review of agreed-upon accountability indicators. The partners further agree that early detection of problems and collaborative efforts to seek resolutions improve accountability. To that end, the partners commit themselves to a problem identification process defined by open sharing of performance concerns and a mutually supportive effort toward problem resolution. Technical assistance, provided in a non-punitive manner designed not to "catch" problems but to resolve them, is a key component in an effective system of accountability.

Where possible, joint work groups, representing CSBs, the Central Office, and state facilities, shall review all surveys, measures, or other requirements for relevance, cost benefit, validity, efficiency, and consistency with this statement prior to implementation and on an ongoing basis as requirements change. In areas where it has specific statutory accountability, responsibility, or authority, the Central Office will make decisions or determinations with the fullest possible participation and involvement by the other partners. In all other areas, the partners will make decisions or determinations jointly.

The partners agree that when accreditation or another publicly recognized independent review addresses an accountability issue or requirement, where possible, compliance with this outside review will constitute adherence to the accountability measure or reporting requirement. Where accountability and compliance rely on affirmations, the partners agree to make

due diligence efforts to comply fully. The Central Office reserves the powers given to the department to review and audit operations for compliance and veracity and upon cause to take actions necessary to ensure accountability and compliance.

Section 8: Involvement and Participation of Individuals Receiving Services and Their Family Members

1. **Involvement and Participation of Individuals Receiving Services and Their Family Members:** CSBs, state facilities, and the Central Office agree to take all necessary and appropriate actions in accordance with State Board Policy 1040 to actively involve and support the maximum participation of individuals receiving services and their family members in policy formulation and services planning, delivery, monitoring, and evaluation.

2. **Involvement in Individualized Services Planning and Delivery by Individuals Receiving Services and Their Family Members:** CSBs and state facilities agree to involve individuals receiving services and, with the consent of individuals where applicable, family members, authorized representatives, and significant others in their care, including the maximum degree of participation in individualized services planning and treatment decisions and activities, unless their involvement is not clinically appropriate.

3. **Language:** CSBs and state facilities agree that they will endeavor to deliver services in a manner that is understood by individuals receiving services. This involves communicating orally and in writing in the preferred languages of individuals, including Braille and American Sign Language when applicable, and at appropriate reading comprehension levels.

4. **Culturally Competent Services:** CSBs and state facilities agree that in delivering services they will endeavor to address to a reasonable extent the cultural and linguistic characteristics of the geographic areas and populations that they serve.

Section 9: Communication

CSBs, state facilities, and the Central Office agree to communicate fully with each other to the greatest extent possible. Each partner agrees to respond in a timely manner to requests for information from other partners, considering the type, amount, and availability of the information requested.

Section 10: Quality Improvement

On an ongoing basis, the partners agree to work together to identify and resolve barriers and policy and procedural issues that interfere with the most effective and efficient delivery of public mental health, developmental, and substance use disorder services.

Section 11: Reviews, Consultation, and Technical Assistance

CSBs, state facilities, and the Central Office agree, within the constraints of available resources, to participate in review, consultation, and technical assistance activities to improve the quality of services provided to individuals and to enhance the effectiveness and efficiency of their operations.

Section 12: Revision

This is a long-term agreement that should not need to be revised or amended annually. However, the partners agree that this agreement may be revised at any time with the mutual consent of the parties. When revisions become necessary, they

will be developed and coordinated through the System Leadership Council. Finally, either party may terminate this agreement with six months written notice to the other party and to the System Leadership Council.

Section 13: Relationship to the Community Services Performance Contract

This partnership agreement by agreement of the parties is hereby incorporated into and made a part of the current community services performance contract by reference.

Effective July 1, 2025 the contents of this Addendum shall sunset except for Appendix F: Regional Program Procedures that will be moved to Addendum I- Administrative Requirements and Processes and Procedures of the performance contract.

Core Services Taxonomy 7.3

June 30, 2014

Core Services Taxonomy 7.3

Introduction

The idea of core services emerged from the General Assembly's Commission on Mental Health and Mental Retardation, chaired by Richard M. Bagley, in 1980. The first list of core services, developed in response to a Commission recommendation, contained five categories of services: emergency, inpatient, outpatient and day support, residential, and prevention and early intervention. The State Board of Behavioral Health and Developmental Services (State Board) approved the original core services definitions in 1981. The General Assembly accepted general definitions of these services and amended § 37.1-194 of the Code of Virginia in 1984 to list the services, requiring the provision of only emergency services. In 1998, the legislature required the provision of case management services, subject to the availability of funds appropriated for them.

The initial description of core services established a useful conceptual framework for Virginia's network of community services board (CSB) and state hospital and training center (state facility) services. However, this description was too general and not sufficiently quantifiable for meaningful data collection and analysis. The initiation of performance contracting in Fiscal Year (FY) 1985 revealed the need for detailed, consistent, and measurable information about services and individuals receiving services. Experience with the first round of contracts reinforced the need for core services definitions that were sufficiently differentiated to reflect the variety of programs and services and yet were general enough to encompass the broad diversity of service modalities and the need for basic, quantified data about services, collected and reported uniformly.

The Virginia Department of Behavioral Health and Developmental Services (Department) and the Virginia Association of Community Services Boards (VACSB) developed the first core services taxonomy, a classification and definition of services, in 1985 to address these needs. The original version of the taxonomy was used with the FY 1986 and 1987 community services performance contracts. State Board Policy 1021 (SYS) 87-9 on core services, adopted in 1987, states that the current version of the taxonomy shall be used to classify, describe, and measure the services delivered directly or through contracts with other providers by all CSBs and state facilities. The Department and the VACSB have revised the core services taxonomy seven times since 1985.

Core Services Taxonomy 7, used in FY 2006 and 2007, added a new core services category, limited services, separated outpatient and case management services into two categories to provide more visibility for case management services, and split day support services into day support services and employment services to reflect the clear differences between them. The limited services category allowed CSBs to capture less information about services that are typically low intensity, infrequent, or short-term (e.g., less than 30 days or four to eight sessions in duration) services. As a result, Taxonomy 7 had nine categories of core services: emergency, inpatient, outpatient, case management, day support, employment, residential, prevention and early intervention, and limited services.

Core Services Taxonomy 7.1, used in FY 2008 and 2009, incorporated changes in the Community Consumer Submission 3 (CCS 3), the new admission and discharge paradigm, and new system transformation initiative services. It reordered core services categories to reflect the new paradigm. Some services were grouped under services available outside of a program area (SAOPA), but most were under services available at admission to a program area. It added a tenth

core services category, consumer-run services, and two subcategories, ambulatory crisis stabilization services and residential crisis stabilization services, and separated prevention and infant and toddler intervention into separate categories.

Core Services Taxonomy 7.2, used in FY 2010 through FY 2014, incorporated two new concepts: service subtype, used only for emergency and case management services, and service location to provide more specific information about core services; these changes are reflected in the CCS. It replaced consumer with individual or individual receiving services unless the context requires the use of consumer (e.g., the CCS). It retained infant and toddler services for descriptive purposes only. Information about these services is collected through a separate information system instead of the CCS, and the services are funded through a separate contract. Taxonomy 7.2 added two appendices on regional programs that were previously in the performance contract. It replaced SAOPA with emergency services and ancillary services. Finally, mental health or substance use disorder or intellectual disability were used to refer to a condition experienced by an individual, while mental health, substance abuse, or developmental services referred respectively to the services that address these conditions.

Core Services Taxonomy 7.3, effective for FY 2015 and subsequent years, incorporates all revisions of Taxonomy 7.2 issued since July 1, 2009. It adds a new outpatient services subcategory for intensive outpatient and clarifies that consumer designation code 920 includes all individuals receiving intellectual disability home and community-based Medicaid waiver services.

Taxonomy categories and subcategories are inclusive rather than narrowly exclusive; they are not meant to capture every detail about everything a CSB or state facility does. Categories and subcategories allow meaningful and accurate descriptions and measurements of service delivery activities; this can help produce valid and informative analyses and comparisons of CSBs, state facilities, and regions. Given the diversity and variety of Virginia's localities and the mix and availability of resources and services from other public and private providers, each CSB may not need to provide every subcategory in the taxonomy. The categories and subcategories do not create additional mandates for CSBs; only emergency and case management services are now required.

The relationship of taxonomy core services categories and subcategories to the more traditional community services organizational structure is represented below.

Community Services Board or Behavioral Health Authority (CSB)
Program Area (all mental health, developmental, or substance abuse services)
Core Service Category (e.g., residential services)
Core Service Subcategory (e.g., intensive residential services)
Service Subtype (for emergency and case management services) and
Service Location (for all services)
Services in a Subcategory (e.g.in-home respite in supportive residential)
Individual Program (e.g., a particular group home)
Discrete Service Activity (e.g., meal preparation)

The numbers after some core services categories and all core service subcategories in the definitions section and the matrix are the Community Automated Reporting System (CARS) and CCS codes for those services. Core services categories with subcategories, such as inpatient services, do not have codes because they have subcategories with codes. However, core services categories with no subcategories, such as emergency services, do have codes. Services that have

moved to different categories, such as individual supported employment moving from the day support services to the employment services category, retain the same code numbers that they had in Taxonomy 7 and the original CCS for historical data base continuity purposes. The CARS and CCS do not include details of the bottom three levels (*services in a subcategory*, individual program and discrete service activity) above.

Types of Community Services Boards (CSBs)

A particularly meaningful classification of CSBs is the relationship between the CSB and its local government or governments. While CSBs are agents of the local governments that established them, most CSBs are not city or county government departments. Section 37.2-100 of the Code of Virginia defines three types of CSBs, and Chapter 6 of Title 37.2 authorizes behavioral health authorities (BHAs) to provide community services. Throughout the taxonomy, community services board or CSB refers to all of the following organizations.

Administrative policy CSB or administrative policy board means the public body organized in accordance with the provisions of Chapter 5 (§ 37.2-500 et seq.) that is appointed by and accountable to the governing body of each city and county that established it to set policy for and administer the provision of mental health, developmental, and substance abuse services. The administrative policy CSB or administrative board denotes the board, the members of which are appointed pursuant to § 37.2-501 with the powers and duties enumerated in subsection A of § 37.2504 and § 37.2-505. An administrative policy CSB includes the organization that provides mental health, developmental, and substance abuse services through local government staff or contracts with other organizations and providers, unless the context indicates otherwise. An administrative policy CSB does not employ its staff. There are 11 administrative policy CSBs; nine are city or county government departments; two are not, but use local government staff to provide services.

Behavioral health authority (BHA) or authority means a public body and a body corporate organized in accordance with the provisions of Chapter 6 (§ 37.2-600 et seq.) that is appointed by and accountable to the governing body of the city or county that established it for the provision of mental health, developmental, and substance abuse services. BHA or authority also includes the organization that provides these services through its own staff or through contracts with other organizations and providers, unless the context indicates otherwise. Chapter 6 authorizes Chesterfield County and the cities of Richmond and Virginia Beach to establish a BHA; only Richmond has done so. In many ways, a BHA most closely resembles an operating CSB, but it has several powers or duties in § 37.2-605 of the Code of Virginia that are not given to CSBs.

Operating CSB or operating board means the public body organized in accordance with the provisions of Chapter 5 (§ 37.2-500 et seq.) that is appointed by and accountable to the governing body of each city and county that established it for the direct provision of mental health, developmental, and substance abuse services. The operating CSB or operating board denotes the board, the members of which are appointed pursuant to § 37.2-501 with the powers and duties enumerated in subsection A of § 37.2-504 and § 37.2-505. Operating CSB or operating board also includes the organization that provides such services, through its own staff or through contracts with other organizations and providers, unless the context indicates otherwise. The 27 operating CSBs employ their own staff and are not city or county government departments.

Policy-Advisory CSB or policy-advisory board means the public body organized in accordance with the provisions of Chapter 5 that is appointed by and accountable to the governing body of each city and county that established it to provide advice on policy matters to the local

government department that provides mental health, developmental, and substance abuse services directly or through contracts with other organizations and providers pursuant to subsection A of § 37.2-504 and § 37.2-505. The policy-advisory CSB or policy-advisory board denotes the board, the members of which are appointed pursuant to § 37.2-501 with the powers and duties enumerated in subsection B of § 37.2-504. The CSB has no operational powers or duties; it is an advisory board to a local government department. There is one local government department with a policy-advisory CSB, the Portsmouth Department of Behavioral Healthcare Services.

Core Services Definitions: Categories and Subcategories of Services

Emergency and Ancillary Services (400)**:** If a CSB determines that it can serve a person who is seeking or has been referred for services, the CSB opens a case for the person. Persons needing these services may access them without being admitted to a program area (all mental health, developmental, or substance abuse services). However, individuals who have been admitted to a program area may still access the following services if they need them. These services do not require collecting as many CCS data elements or as much individual service record information as admission to a program area does. If a person receives any of the following services and is subsequently admitted to a program area, the additional CCS program area admission data elements must be collected. The 400 is a pseudo program area code for CCS service file purposes, since this group of services is not a program area. If individuals receive any of the following services after they are admitted to a program area, these services still must be coded with the 400 code, rather than the program area code (100, 200, or 300) to which they have been admitted.

1. **Emergency Services** (100) are unscheduled and sometimes scheduled crisis intervention, stabilization, and referral assistance provided over the telephone or face-to-face, if indicated, 24 hours per day and seven days per week to people seeking such services for themselves or others. Services also may include walk-ins, home visits, and jail interventions. Emergency services include preadmission screening activities associated with admission to a state hospital or training center or other activities associated with the judicial admission process. This category also includes Medicaid crisis intervention and short-term crisis counseling and intellectual disability home and community-based (ID HCB) waiver crisis stabilization and personal emergency response system services. Persons receiving critical incident stress debriefing services are not counted as individuals receiving services, and service units are identified and collected through the z-consumer function in the CCS.

   Service Subtype is a specific activity associated with a particular core service category or subcategory for which a service.txt file is submitted in the CCS. Currently, service subtypes are defined only for emergency services and case management services. The emergency services subtype is collected at every emergency services encounter and reported in the service file; every emergency service encounter is coded with one of these six subtypes in the CCS. a. **Crisis Intervention** is provided in response to an acute crisis episode. This includes counseling, short term crisis counseling, triage, or disposition determination and all emergency services not included in the following service subtypes.

   b. **Crisis Intervention Provided Under an Emergency Custody Order** is clinical intervention and evaluation provided by a certified preadmission screening evaluator in response to an emergency custody order (ECO) issued by a magistrate.

c. **Crisis Intervention Provided Under Law Enforcement Custody (paperless ECO)** is clinical intervention and evaluation provided by a certified preadmission screening evaluator to an individual under the custody of a law enforcement officer without an ECO issued by a magistrate.

d. **Independent Examination** is an examination provided by an independent examiner who satisfies the requirements in and who conducts the examination in accordance with § 37.2815 of the Code of Virginia in preparation for a civil commitment hearing.

e. **Commitment Hearing** is attendance of a certified preadmission screening evaluator at a civil commitment or recommitment hearing conducted pursuant to § 37.2-817.

f. **MOT Review Hearing** is attendance at a review hearing conducted pursuant to §§ 37.2-817.1 through 37.2-817.4 for a person under a mandatory outpatient treatment (MOT) order.

2. **Ancillary Services** consist of the following activities that typically are short term (less than 30 days or four to eight sessions in duration), infrequent, or low-intensity services.

a. ***Motivational Treatment Services*** (318) are generally provided to individuals on an hourly basis, once per week, through individual or group counseling in a clinic. These services are structured to help individuals resolve their ambivalence about changing problematic behaviors by using a repertoire of data gathering and feedback techniques. Motivational treatment services are not a part of another service; they stand alone. Their singular focus on increasing the individual's motivation to change problematic behaviors, rather than on changing the behavior itself, distinguishes motivational treatment services from outpatient services. A course of motivational treatment may involve a single session, but more typically four to eight sessions; and it may be repeated, if necessary, as long as repetition is clinically indicated. Prior to placement in motivational treatment, the individual's level of readiness for change is usually assessed, based on clinical judgment, typically supported by standardized instruments. An assessment may follow a course of motivational treatment to ascertain any changes in the individual's readiness for change. Psycho-educational services are included in this subcategory.

b. ***Consumer Monitoring Services*** (390) are provided to individuals who have not been admitted to a program area but have had cases opened by the CSB. For example, this includes individuals with opened cases whom the CSB places on waiting lists for other services, for example, Medicaid ID wavier services. Individuals receive no interventions or face-to-face contact, but they receive consumer monitoring services that typically consist of service coordination or intermittent emergency contacts. Other examples of consumer monitoring services include individuals who receive only outreach services, such as outreach contacts through projects for assistance in transition from homelessness (PATH), individuals in waiting list groups, and outreach by peers to individuals who are in need of services or have been referred for services.

c. ***Assessment and Evaluation Services*** (720) include court-ordered or psychological evaluations; initial assessments for screening, triage, and referral for individuals who probably will not continue in services; and initial evaluations or assessments that result in placement on waiting lists without receiving other services. An abbreviated individualized services plan and services record may be required.

d. ***Early Intervention Services*** (620) are intended to improve functioning or change behavior in individuals who have been identified as beginning to experience problems, symptoms, or behaviors that, without intervention, are likely to result in the need for treatment. Outpatient service activities should not be included here merely to avoid record keeping or licensing requirements since this is not clinically appropriate and could expose the CSB to increased liability. Services are generally targeted to identified individuals or groups and include case consultation, groups for adolescents who have been suspended for use of alcohol or tobacco, and programs for children or adults exhibiting behavior changes following loss such as divorce, death of a loved one, and job loss. School-based interventions should be included in prevention, early intervention, or outpatient services, as appropriate.

3. ***Consumer-Run Services*** (730) are self-help programs designed, governed, and led by and for people in recovery. Consumer-run services employ peers as staff and volunteers and are often open on weekends and evenings beyond the usual hours traditional services operate. Services are usually open door or drop in, with no required applications, waiting times, or appointments. Services include networking, advocacy, and mutual support groups; drop-in centers; supported housing; hospital liaison; recreation and social activities; arts and crafts and exercise groups; peer counseling, mentorship, and one-on-one consultations; information and referrals; and knowledge and skill-building classes such as employment training, computer training, and other seminars and workshops. Consumer-run centers also may offer the use of washers and dryers, showers, telephones for business calls, mailboxes, and lending libraries. Because of their nature, no information is collected in the CCS about consumer-run services or the individuals participating in them. Instead, the number of persons participating in consumer-run services is reported in the CARS management report. However, core services provided by peers are included and reported where they are delivered, e.g., in outpatient, rehabilitation, or residential services, rather than in consumer-run services; see Appendix G for more information.

Services Available at Admission to a Program Area: If an individual needs other services beyond emergency or ancillary services, the CSB admits the individual to a program area: all mental health (100), developmental (200), or substance abuse (300) services. Depending on his or her needs, the individual may be admitted to two or even three program areas. An individual may be admitted directly to a program area, bypassing case opening, but CCS data elements collected at case opening must still be obtained. Even after admission to a program area, an individual may still receive emergency or ancillary services if he or she needs them.

4. **Inpatient Services** deliver services on a 24-hour-per-day basis in a hospital or training center.

   a. ***Medical/Surgical Care*** provides acute medical treatment or surgical services in state facilities. These services include medical detoxification, orthopedics, oral surgery, urology, care for pneumonia, post-operative care, ophthalmology, ear, nose and throat care, and other intensive medical services.

   b. ***Skilled Nursing Services*** deliver medical care, nursing services, and other ancillary care for individuals with mental disabilities who are in state facilities and require nursing as well as other care. Skilled nursing services are most often required by individuals who are acutely ill or have significant intellectual disability and by older adults with mental health disorders who suffer from chronic physical illnesses and loss of mobility. Services are provided by

professional nurses, licensed practical nurses, and qualified paramedical personnel under the general direction and supervision of a physician.

c. ***Intermediate Care Facility for Individuals with Intellectual Disability (ICF/ID) Services*** are provided in state training centers for individuals with intellectual disability who require active habilitative and training services, including respite and emergency care, but not the degree of care and treatment provided in a hospital or skilled nursing home.

d. ***Intermediate Care Facility/Geriatric Services*** are provided in state geriatric facilities by interdisciplinary teams to individuals who are 65 years of age and older. Services include psychiatric treatment, medical treatment, personal care, and therapeutic programs appropriate to the facility and to the individual's needs.

e. ***Acute Psychiatric or Substance Abuse Inpatient Services*** (250) provide intensive shortterm psychiatric treatment in state hospitals or intensive short-term psychiatric treatment, including services to individuals with intellectual disability, or substance abuse treatment, except medical detoxification, in local hospitals. Services include intensive stabilization, evaluation, psychotropic medications, psychiatric and psychological services, and other supportive therapies provided in a highly structured and supervised setting.

f. ***Community-Based Substance Abuse Medical Detoxification Inpatient Services*** (260) use medication under the supervision of medical personnel in local hospitals to systematically eliminate or reduce the effects of alcohol or other drugs in the body.

g. ***Extended Rehabilitation Services*** offer intermediate or long-term treatment in a state hospital for individuals with severe psychiatric impairments, emotional disturbances, or multiple disabilities (e.g., individuals with mental health disorders who also are deaf). Services include rehabilitation training, skills building, and behavioral management for people who are beyond the crisis stabilization and acute treatment stages.

5. **Outpatient Services** provide clinical treatment services, generally in sessions of less than three consecutive hours, to individuals and groups.

a. ***Outpatient Services*** (310) are generally provided to individuals on an hourly schedule, on an individual, group, or family basis, and usually in a clinic or similar facility or in another location, including a jail or juvenile detention center. Outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services. Medical services include the provision of psychiatric, medical, psychiatric nursing, and medical nursing services by licensed psychiatrists, physicians, 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. These visits are included in outpatient services. The Department has identified a minimum set of information for licensing purposes that would be needed to constitute an individualized services plan (ISP) for individuals receiving only medication visits.

Outpatient services also include *intensive in-home services* that are time-limited, usually between two and six months, family preservation interventions for children and adolescents

with or at risk of serious emotional disturbance, including such individuals who also have a diagnosis of intellectual disability. In-home services are provided typically but not solely in the residence of an individual who is at risk of being moved into or is being transitioned to home from an out-of-home placement. The services provide crisis treatment; individual and family counseling; life, parenting, and communication skills; case management activities and coordination with other required services; and 24 hour per day emergency response.

Outpatient services also include *jail-based habilitation services* that involve daily group counseling, individual therapy, psycho-educational services, 12 step meetings, discharge planning, and pre-employment and community preparation services.

Finally, outpatient services also include Medicaid ID HCB waiver skilled nursing services and therapeutic consultation services. Probation and parole and community corrections day reporting centers also are included in outpatient services, rather than in ancillary services.

b. ***Intensive Outpatient Services*** (313) provide substance abuse treatment in a concentrated manner for two or more consecutive hours per day to groups of individuals in nonresidential settings multiple times per week. This service is provided over a period of time for individuals requiring more intensive services than outpatient services can provide. Intensive substance abuse outpatient services include multiple group therapy sessions during the week, individual and family therapy, individual monitoring, and case management.

c. ***Medication Assisted Treatment*** (335) combines outpatient treatment with administering or dispensing synthetic narcotics, such as methadone or buprenorphine (suboxone), approved by the federal Food and Drug Administration for the purpose of replacing the use of and reducing the craving for opioid substances, such as heroin or other narcotic drugs.

d. ***Assertive Community Treatment*** (350) consists of two modalities: intensive community treatment (ICT) and program of assertive community treatment (PACT). Individuals served by either modality have severe symptoms and impairments that are not effectively remedied by available treatments or, because of reasons related to their mental health disorders, resist or avoid involvement with mental health services. This could include individuals with severe and persistent mental illnesses who also have co-occurring diagnoses of intellectual disability. Assertive community treatment provides an array of services on a 24-hour per day basis to these individuals in their natural environments to help them achieve and maintain effective levels of functioning and participation in their communities. Services may include case management, supportive counseling, symptom management, medication administration and compliance monitoring, crisis intervention, developing individualized community supports, psychiatric assessment and other services, and teaching daily living, life, social, and communication skills.

ICT is provided by a self-contained, interdisciplinary team of at least five full-time equivalent clinical staff, a program assistant, and a psychiatrist. This team (1) assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illnesses, (2) minimally refers individuals to outside service providers, (3) provides services on a long-term care basis with continuity of caregivers over time, (4) delivers 75 percent or more of the services outside of the program's offices, and (5) emphasizes outreach, relationship building, and individualization of services. PACT is provided by a self-contained, inter-disciplinary team of at least 10 full-time equivalent clinical staff, a program assistant, and a psychiatrist, and this team meets the five criteria contained in the definition of ICT.

6. **Case Management Services** (320) assist individuals and their family members to access needed services that are responsive to the individual's needs. 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.

   Service Subtype is a specific activity associated with a particular core service category or subcategory for which a service.txt file is submitted in the CCS. Currently, service subtypes are defined only for emergency and case management services. The case management services subtype is collected at every developmental case management services encounter and reported in the service file with one of the two subtypes in the CCS. CSBs may report these service subtypes for mental health or substance abuse case management services, but this is optional.

a. **Face-to-Face Case Management Services:** These are case management services received by an individual and provided by a case manager during a face-to-face encounter in a case management service licensed by the Department. Examples of service hour activities applicable to face-to-face case management services include case management, individual present and discharge planning, individual present. All other case management services must be reported using non-face-to-face case management.

b. **Non-Face-to-Face Case Management Services:** These are all other case management services provided to or on behalf of an individual by a case manager in a case management service licensed by the Department. This includes telephone contacts with the individual, any contacts (face-to-face or otherwise) with the individual's family members or authorized representative, or any contacts (face-to-face or otherwise) about the individual with other CSB staff or programs or other providers or agencies. Examples of service hour activities applicable to non-face-to-face case management services include:

- case management, individual not present;
- individual-related staff travel; and
- phone consultation with individual;
- discharge planning, individual not present.
- report writing re: individual;

7. **Day Support Services** provide structured programs of treatment, activity, or training services, generally in clusters of two or more continuous hours per day, to groups or individuals in nonresidential settings.

a. ***Day Treatment or Partial Hospitalization*** (410) is a treatment program that includes the major diagnostic, medical, psychiatric, psychosocial, and prevocational and educational treatment modalities designed for adults with serious mental health, substance use, or cooccurring disorders who require coordinated, intensive, comprehensive, and multidisciplinary treatment that is provided several hours per day for multiple days each week and is not provided in outpatient services.

This subcategory also includes *therapeutic day treatment for children and adolescents*, a treatment program that serves children and adolescents (birth through age 17) with serious emotional disturbances or substance use or co-occurring disorders or children (birth through age 7) at risk of serious emotional disturbance in order to combine psychotherapeutic interventions with education and mental health or substance abuse treatment. Services include: evaluation, medication education and management, opportunities to learn and use daily living skills and to enhance social and interpersonal skills, and individual, group, and family counseling.

b. ***Ambulatory Crisis Stabilization Services*** (420) provide direct care and treatment to nonhospitalized individuals experiencing an acute crisis related to mental health, substance use, or co-occurring disorders that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization, provide normative environments with a high assurance of safety and security for crisis intervention, stabilize individuals in crisis, and mobilize the resources of the community support system, family members, and others for ongoing rehabilitation and recovery. Ambulatory crisis stabilization services may be provided in an individual's home or in a community-based program licensed by the Department. These services are planned for and provide services for up to 23 hours per day. Services that are integral to and provided in ambulatory crisis stabilization programs, such

as outpatient or case management services, should not be reported separately in those core services since they are included in the ambulatory crisis stabilization day support hours.

c. ***Rehabilitation or Habilitation*** (425) consists of training services in two modalities.

Psychosocial rehabilitation provides assessment, medication education, opportunities to learn and use independent living skills and to enhance social and interpersonal skills, family support and education, vocational and educational opportunities, and advocacy to individuals with mental health, substance use, or co-occurring disorders in a supportive community environment focusing on normalization. It emphasizes strengthening the individual's abilities to deal with everyday life rather than focusing on treating pathological conditions.

Habilitation provides planned combinations of individualized activities, supports, training, supervision, and transportation to individuals with intellectual disability to improve their condition or maintain an optimal level of functioning. Specific components of this service develop or enhance the following skills: self-care and hygiene, eating, toileting, task learning, community resource utilization, environmental and behavioral skills, medication management, and transportation. Habilitation also includes Medicaid ID HCB waiver day support (center-based and non-center-based) and prevocational services.

8. **Employment Services** provide work and support services to groups or individuals in nonresidential settings.

a. ***Sheltered Employment*** (430) programs provide work in a non-integrated setting that is compensated in accordance with the Fair Labor Standards Act for individuals with disabilities who are not ready, are unable, or choose not to enter into competitive employment in an integrated setting. This service includes the development of social, personal, and work-related skills based on an individualized services plan.

b. ***Group Supported Employment*** (465) provides work to small groups of three to eight individuals at job sites in the community or at dispersed sites within an integrated setting. Integrated setting means opportunities exist for individuals receiving services in the immediate work setting to have regular contact with non-disabled persons who are not providing support services. The employer or the vendor of supported employment services employs the individuals. An employment specialist, who may be employed by the employer or the vendor, provides ongoing support services. Support services are provided in accordance with the individual's written rehabilitation plan. Models include mobile and stationary crews, enclaves, and small businesses. Group supported employment includes Medicaid ID HCB waiver supported employment - group model.

c. ***Individual Supported Employment*** (460) provides paid employment to an individual placed in an integrated work setting in the community. The employer employs the individual. Ongoing support services that may include transportation, job-site training, counseling, advocacy, and any other supports needed to achieve and to maintain the individual in the supported placement are provided by an employment specialist, co-workers of the supported employee, or other qualified individuals. Support services are provided in accordance with the individual's written rehabilitation plan. Individual supported employment includes Medicaid ID HCB waiver supported employment - individual model.

9. **Residential Services** provide overnight care with an intensive treatment or training program in a setting other than a hospital or training center, overnight care with supervised living, or other supportive residential services.

   a. ***Highly Intensive Residential Services*** (501) provide overnight care with intensive treatment or training services. These services include:

      Mental Health Residential Treatment Centers such as short term intermediate care, residential alternatives to hospitalization such as community gero-psychiatric residential services[1], and residential services for individuals with co-occurring diagnoses (e.g., mental health and substance use disorders, intellectual disability and mental health disorders) where intensive treatment rather than just supervision occurs;

      Community Intermediate Care Facilities for Individuals With Intellectual Disability (ICF/ID) that provide care to individuals who have intellectual disability and need more intensive training and supervision than may be available in an assisted living facility or group home, comply with Title XIX of the Social Security Act standards and federal certification requirements, provide health and habilitation services, and provide active treatment to individuals receiving services toward the achievement of a more independent level of functioning or an improved quality of life; and

      Substance Abuse Medically Managed Withdrawal Services that provide detoxification services with physician services available when required to eliminate or reduce the effects of alcohol or other drugs in the individual's body and that normally last up to seven days, but this does not include medical detoxification services provided in community-based substance abuse medical detoxification inpatient services (260) or social detoxification services.

   b. ***Residential Crisis Stabilization Services*** (510) provide direct care and treatment to nonhospitalized individuals experiencing an acute crisis related to mental health, substance use, or co-occurring disorders that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization, provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in crisis, and mobilize the resources of the community support system, family members, and others for ongoing rehabilitation and recovery. Residential crisis stabilization services are provided in a community-based program licensed by the Department. These services are planned for and provide overnight care; the service unit is a bed day. Services that are integral to and provided in residential crisis stabilization programs, such as outpatient and case management services, should not be reported separately in those core services since they are included in the bed day.

[1] Community gero-psychiatric residential services that provide 24-hour non-acute care with treatment in a setting that offers less intensive services than a hospital, but more intensive mental health services than a nursing home or group home. Individuals with mental health disorders, behavioral problems, and concomitant health problems, usually age 65 and older, who are appropriately treated in a geriatric setting, receive intensive supervision, psychiatric care, behavioral treatment planning, nursing, and other health-related services.

c. ***Intensive Residential Services*** (521) provide overnight care with treatment or training that is less intense than highly intensive residential services. It includes the following services and Medicaid ID HCB waiver congregate residential support services.

Group homes or *halfway houses* provide identified beds and 24 hour supervision for individuals who require training and assistance in basic daily living functions such as meal preparation, personal hygiene, transportation, recreation, laundry, and budgeting. The expected length of stay normally exceeds 30 days.

Primary care offers substance abuse rehabilitation services that normally last no more than 30 days. Services include intensive stabilization, daily group therapy and psychoeducational services, consumer monitoring, case management, individual and family therapy, and discharge planning.

Intermediate rehabilitation is a substance abuse psychosocial therapeutic milieu with an expected length of stay up to 90 days. Services include supportive group therapy, psychoeducation, consumer monitoring, case management, individual and family therapy, employment services, and community preparation services.

Long-term habilitation is a substance abuse psychosocial therapeutic milieu with an expected length of stay of 90 or more days that provides a highly structured environment where residents, under staff supervision, are responsible for daily operations of the facility. Services include intensive daily group and individual therapy, family counseling, and psycho-education. Daily living skills and employment opportunities are integral components of the treatment program. Jail-based habilitation services, previously reported here, should be reported in outpatient services (310).

d. ***Supervised Residential Services*** (551) offer overnight care with supervision and services. This subcategory includes the following services and Medicaid ID HCB waiver congregate residential support services.

Supervised apartments are directly-operated or contracted, licensed residential programs that place and provide services to individuals in apartments or other residential settings. The expected length of stay normally exceeds 30 days.

Domiciliary care provides food, shelter, and assistance in routine daily living but not treatment or training in facilities of five or more beds. This is primarily a long-term setting with an expected length of stay exceeding 30 days. Domiciliary care is less intensive than a group home or supervised apartment; an example would be a licensed assisted living facility (ALF) operated, funded, or contracted by a CSB.

Emergency shelter or *residential respite* programs provide identified beds, supported or controlled by a CSB, in a variety of settings reserved for short term stays, usually several days to no more than 21 consecutive days.

Sponsored placements place individuals in residential settings and provide substantial amounts of financial, programmatic, or service support. Examples include individualized therapeutic homes, specialized foster care, family sponsor homes, and residential services contracts for specified individuals. The focus is on individual residential placements with expected lengths of stay exceeding 30 days rather than on organizations with structured staff support and set numbers of beds.

e. ***Supportive Residential Services*** (581) are unstructured services that support individuals in their own housing arrangements. These services normally do not involve overnight care delivered by a program. However, due to the flexible nature of these services, overnight care may be provided on an hourly basis. It includes the following services and Medicaid ID HCB waiver supported living/in-home supports, respite (agency and consumer-directed) services, companion services (agency and consumer-directed), and personal assistance services (agency and consumer-directed).

In-Home respite provides care in the homes of individuals with mental disabilities or in a setting other than that described in residential respite services above. This care may last from several hours to several days and allows the family member care giver to be absent from the home.

Supported living arrangements are residential alternatives that are not included in other types of residential services. These alternatives assist individuals to locate or maintain residential settings where access to beds is not controlled by a CSB and may provide program staff, follow-along, or assistance to these individuals. The focus may be on assisting an individual to maintain an independent residential arrangement. Examples include homemaker services, public-private partnerships, and non-CSB subsidized apartments (e.g., HUD certificates).

Housing subsidies provide cash payments only, with no services or staff support, to enable individuals to live in housing that would otherwise not be accessible to them. These cash subsidies may be used for rent, utility payments, deposits, furniture, and other similar payments required to initiate or maintain housing arrangements for individuals. This is used only for specific allocations of funds from the Department earmarked for housing subsidies. Numbers of individuals receiving services and expense information should be included in supportive residential services in performance contract reports. Information associated with other housing subsidies should be included in the services of which they are a part.

10. **Prevention Services** (610) are designed to prevent mental health or substance use disorders. Activities that are really outpatient services should not be included in prevention services to avoid record keeping or licensing requirements, since this exposes the CSB to increased liability, is not clinically appropriate, and violates the regulatory requirements of the federal Substance Abuse Prevention and Treatment block grant. Prevention services promote mental health through individual, community, and population-level change strategies. Prevention services are identified through the implementation of the Strategic Prevention Framework, an evidenced-based and community-based needs assessment-focused planning model. This model involves data-driven needs assessment, planning and evaluation, capacity building, and implementation of evidenced-based programs, strategies, and practices. Overlaying all these components are cultural competence and sustainability of effective outcomes. To achieve community level strategies, CSBs must be a part of a community coalition. Emphasis is on enhancement of protective factors and reduction of risk factors in individuals and the community. Information on substance abuse prevention services is collected and reported separately through the Department's contracted prevention services information system, instead of being included in the CCS. The following six strategies comprise prevention services.

Information Dissemination provides awareness and knowledge of the nature and extent of mental health and substance use disorders and intellectual disability. It also provides awareness

and knowledge of available prevention programs and services. Examples of information dissemination include media campaigns, public service announcements, informational brochures and materials, community awareness events, and participation on radio or TV talk shows. Information dissemination is characterized by one-way communication from the source to the audience.

Prevention Education aims to affect critical life and social skills, including general competency building, specific coping skills training, support system interventions, strengthening caregivers, and decision-making skills training. Prevention education is characterized by two-way communication with close interaction between the facilitator or educator and program participants. Examples of prevention education include children of alcoholics groups and parenting classes.

Alternatives provide for the participation of specific populations in activities that are constructive, promote healthy choices, and provide opportunities for skill building. Examples of prevention alternatives include leadership development, community service projects, alcohol, tobacco, and other drug free activities, and youth centers.

Problem Identification and Referral aims at the identification of those individuals who are most at risk of developing problematic behaviors in order to assess if their behaviors can be changed though prevention education. Examples include student and employee assistance programs.

Community-Based Process aims at enhancing the ability of the community to provide prevention and treatment services more effectively. Activities include organizing, planning, enhancing efficiency and effectiveness of service implementation, interagency collaboration, coalition building, and networking. Examples include community and volunteer training, multi-agency coordination and collaboration, accessing services and funding, and community team-building.

Environmental Prevention Activities establish or change written and unwritten community standards, codes, and attitudes, thereby influencing the development of healthy living conditions. Examples include modifying advertising practices and promoting the establishment and review of alcohol, tobacco, and other drug use policies.

11. ***Infant and Toddler Intervention Services*** (625) provides family-centered, community-based early intervention services designed to meet the developmental needs of infants and toddlers and the needs of their families as these needs relate to enhancing the child's development. These services prevent or reduce the potential for developmental delays in infants and toddlers and increase the capacity of families to meet the needs of their at-risk infants and toddlers. Infant and toddler intervention is delivered through a comprehensive, coordinated, interagency, and multidisciplinary services system. Infant and toddler intervention includes: a. assistive technology, j. special instruction,

b. audiology,
c. family training, counseling, and home visits, l. service coordination,
d. health services,
e. nursing services,
f. nutrition services,
g. occupational therapy,
h. physical therapy,
k. psychological services,
m. social work services,
n. speech-language pathology,
o. transportation services, and
p. vision services.

i. medical services (for diagnostic or evaluation purposes only),

The identified individual receiving services is the infant or toddler. Information about infant and toddler intervention services, including funds, expenditures, costs, service units, and the individuals receiving them is collected and reported to the Department through a separate contract and automated information system, rather than through CARS reports and the CCS. Consequently, this service is not included in the Core Services Category and Subcategory Matrix in the taxonomy. This infant and toddler intervention services definition is included in the taxonomy for information and reference purposes.

Community Consumer Submission (CCS) Consumer Designation Codes

The CCS consumer designation codes for specialized initiatives or projects (consumer designation codes for short) identify individuals who are served in certain specific initiatives or projects; these codes are not service codes *per se*, like 310 is the core services code for Outpatient Services, instead, these codes reflect a particular status of those individuals. Consumer designation codes may encompass more than special projects or initiatives.

The component services of these projects or initiatives are included in the appropriate core services and numbers of individuals in these initiatives are counted in the CCS in the following manner. When an individual receives services in any of the following initiatives, the consumer designation code for the initiative will be entered in the type of care file for the individual. Units of service for these initiatives will be recorded and accumulated in the applicable core services associated with the initiative, such as outpatient, case management, day treatment or partial hospitalization, rehabilitation or habilitation, or various residential services.

905 - Mental Health Mandatory Outpatient Treatment (MOT) Orders
910 - Discharge Assistance Program (DAP)
915 - Mental Health Child and Adolescent Services Initiative,
916 - Mental Health Services for Children and Adolescents in Juvenile Detention Centers
918 - Program of Assertive Community Treatment (PACT),
919 - Projects for Assistance in Transition from Homelessness (PATH), and
920 - Medicaid Intellectual Disability (ID) Home and Community-Based Waiver Services.
933 - Substance Abuse Medication Assisted Treatment
935 - Substance Abuse Recovery Support Services

Additional CCS consumer designation codes may be used to identify individuals involved in special projects and to gather information about those individuals and the services associated with those projects. The Department and the VACSB Data Management Committee will designate and approve additional consumer designation codes for such purposes.

Descriptions of Some Consumer Designation Codes

Consumer Designation Code 905 - Mental Health Mandatory Outpatient Treatment (MOT) Orders is used only for individuals for whom a judge or special justice has issued a mandatory outpatient treatment order pursuant to § 37.2-817.D of the Code of Virginia and for whom the CSB has developed an initial mandatory outpatient treatment plan pursuant to § 37.2-817.F and a comprehensive mandatory outpatient treatment plan pursuant to § 37.2-817.G. Individuals receiving services from the CSB as a result of any other court orders (e.g., court-ordered

evaluations, forensic evaluations, or competency restoration services) shall not be assigned this consumer designation code. If an individual who is the subject of an MOT order will be receiving mental health services under that order from or through the CSB and has not been admitted to the mental health services program area (100) previously, the individual must be admitted to that program area, with two CCS TypeOfCare records submitted in the next monthly CCS extract file submission: first, one record for the admission, and second, one record for the 905 consumer designation code. The ServiceFromDate on the second record must be the date of the MOT order and must be the same or a later date than the ServiceFromDate on the TypeOfCare record for the admission to the mental health services program area. When the MOT order expires or is rescinded, the date of that expiration or rescission must be entered as the ServiceThroughDate on a TypeOfCare record to end the MOT consumer designation code.

If an individual who is the subject of an MOT order will not be receiving mental health services under that order from or through the CSB, for example, the individual will receive services from non-contracted private providers and the CSB will only be monitoring the individual's compliance with the comprehensive MOT plan, then admission to the mental health services program area (100) is not necessary. The CSB's monitoring of compliance with the MOT plan should be recorded as consumer monitoring services (390), an ancillary service, and, if the CSB did not perform the preadmission screening or provide emergency services to the individual, the CSB still must open a case on the individual, collecting the applicable CCS 3 data elements associated with case opening. A TypeOfCare record for the initiation of the MOT must still be submitted by the CSB to start the MOT consumer designation code. When the MOT order expires or is rescinded, the date of that expiration or rescission must be entered as the ServiceThroughDate on a TypeOfCare record to end the MOT consumer designation code.

The duration of the MOT order is specified in the order, per § 37.2-817.E of the Code of Virginia. The clerk of the court must provide a copy of the order, per § 37.2-817.I, to the person who is the subject of the order and to the CSB that is required to monitor the individual's compliance with the MOT plan pursuant to § 37.2-817.1. Sections 37.2-817.3 and 37.2-817.4 contain provisions for the rescission or continuation of MOT orders.

Consumer Designation Code 910 - Discharge Assistance Program (DAP) is used for individuals receiving services supported with mental health state DAP funds. Since the state hospital discharge date and related DAP TypeOfCareFromDate may precede the TypeOfCareFromDate for admission to the mental health services program area, the individual does not have to be admitted to the mental health services program area (100) before being given a 910 consumer designation code.

Consumer Designation Code 915 - Mental Health Child and Adolescent Services Initiative is used for children and adolescents with serious emotional disturbance (SED) or related disorders who are not mandated to receive services funded through the Comprehensive Services Act. Initiative services are funded with restricted mental health state funds that are used exclusively for this purpose. Related disorders are not defined in the Appropriations Act, but the term allows sufficient flexibility to serve children with mental health or co-occurring mental health and substance use disorders who may not fit the definition of SED but may need services that can only be provided with these Initiative funds.

Consumer Designation Code 916 - Mental Health Services for Children and Adolescents in Juvenile Detention Centers is used for children and adolescents in juvenile detention centers receiving CSB services that are funded with restricted mental health state funds identified for this purpose. The use of this consumer designation code will eliminate the separate paper reporting mechanism for these services by CSBs maintained by the Department's Office of Child and Family Services. A CSB's primary role in a juvenile detention center is providing short-term services to juveniles with mental health disorders or co-occurring mental health and substance use disorders who are incarcerated in the center. As part of this role, a CSB also consults with juvenile detention center staff on the needs and treatment of these juveniles. Since the juveniles have been court ordered to the center, they are under the jurisdiction of the center for care. A CSB provides consultation and behavioral health services in support of the center's care of these juveniles. If the CSB provides consultation to the center's staff about groups of children, rather than about specific individuals, the CSB should report the service hours using the z-consumer function in the CCS.

A CSB typically provides the following core services to most of the juveniles it serves in juvenile detention centers: emergency, consumer monitoring, assessment and evaluation, or early intervention services. Since these services are being provided in a consultative mode within the juvenile detention center and the CSB will not have an ongoing clinical relationship with most of these juveniles once they are released, CSB staff should enter information about these services in the juvenile's record at the detention center, rather than initiating an individualized services plan (ISP) or service record at the CSB. Less frequently, a CSB may provide outpatient services to juveniles whose needs and lengths of stay warrant them and case management services for juveniles who are near discharge to their home CSBs. These services are typically more intensive and of longer duration, and staff must initiate ISPs at the CSB for juveniles receiving them. Except for outpatient and case management services, the other services that can be provided are emergency or ancillary services and, therefore, require limited CCS 3 data to be collected. However, if it provides outpatient or case management services, a CSB must admit the juvenile to the mental health services program area with a Type Of Care record prior to assigning a 916 consumer designation code, according to instructions in the CCS 3 Extract Specifications. The CSB must collect a full data set consistent with the CCS 3 requirements, as well as conform to the licensing requirements for the provision of those services.

A CSB must assign a 916 consumer designation code to each juvenile served in a juvenile detention center when his or her case is opened for CCS 3 purposes, so the services that he or she receives while in the juvenile detention center and upon discharge from it can be identified with this initiative. Normally, an individual must be admitted to a program area in order to assign a consumer designation code. However, an exception exists in the CCS 3 Extract Specifications for juveniles who receive only emergency or ancillary services; the CSB can submit a TypeOfCare record to assign the 916 consumer designation code without an admission to a program area. Refer to the *Revised Guidance for CSB Services in Juvenile Detention Centers*, March 3, 2008, for further information about collecting and reporting information about these services.

Consumer Designation Code 920 - Medicaid ID Home and Community-Based (HCB) Waiver Services is used only for individuals who have been admitted to the developmental services program area (200) and are receiving any Medicaid ID HCB waiver services from a CSB, directly or through CSB contracts with other agencies or individuals where the CSB remains the provider for DMAS purposes, or from any other provider of Medicaid ID HCB waiver services. Admission to the developmental services program area (200) is a prerequisite for assigning this consumer

designation code. Assigning the 920 consumer designation code to individuals who do not receive Medicaid ID HCB waiver services from the CSB should not be a problem since the CSB provides case management services, a non-waiver service, to all individuals receiving Medicaid ID HCB waiver services, even if the CSB does not provide those waiver services.

Consumer Designation Code 933 – Substance Abuse Medication Assisted Treatment is used only for individuals who have been admitted to the substance abuse services program area (300) and are receiving buprenorphine (suboxone) that is provided by the CSB or prescribed by a private physician who has a formal agreement with the CSB to provide medical oversight for medication assisted treatment to individuals for whom the CSB is providing support services, including counseling and case management. Medication assisted treatment is reported in outpatient services. Admission to the substance abuse services program area (300) is a prerequisite for assigning this consumer designation code.

Consumer Designation Code 935 – Substance Abuse Recovery Support Services is used only for individuals receiving recovery support at a program funded specifically for this purpose by the Department. Because of the mix of services (some emergency or ancillary services) that individuals will receive, admission to the substance abuse services program area (300) is not a prerequisite for assigning this consumer designation code.

Recovery support services are designed and delivered by peers in recovery and in coordination with clinical staff. However, recovery support services are designed and provided primarily by individuals in recovery; although supportive of formal treatment, recovery support services are not intended to replace treatment services in the commonly understood clinical sense of that term. Recovery support services include:

1. **emotional support** that offers demonstrations of empathy, caring, and concern that bolster one's self-esteem and confidence and include peer mentoring, peer coaching, and peer-led support groups;
2. **informational support** that involves assistance with knowledge, information, and skills and includes peer-led life skills training, job skills training, citizenship restoration, educational assistance, and health and wellness information;
3. **instrumental support** that provides concrete assistance in helping others do things or get things done, especially stressful or unpleasant tasks, and includes connecting people to treatment services, providing transportation to get to support groups, child care, clothing closets, and filling our applications or helping people obtain entitlements; and
4. **affiliational support** that offers the opportunity to establish positive social connections with other recovering people.

CSB services associated with recovery support include emergency, motivational treatment, and assessment and evaluation services in addition to needed substance abuse services.

Core Services Taxonomy 7.3

Core Services Category and Subcategory Matrix

Emergency and Ancillary Services

	Unit of Service	Capacity
1. **Emergency Services** (100)	Service Hour	NA
2. **Ancillary Services**		
a. Motivational Treatment Services (318)	Service Hour	NA
b. Consumer Monitoring Services (390)	Service Hour	NA
c. Assessment and Evaluation Services (720)	Service Hour	NA
d. Early Intervention Services (620)	Service Hour	NA
3. **Consumer-Run Services** (730)	NA	NA

Core Services Category and Subcategory Matrix

Services Available at Admission to a Program Area

	MH	DV	SA	Unit of Service	Capacity
4. **Inpatient Services**					
a. Medical/Surgical Care (State Facility)	x	x	NA	Bed Day	Bed
b. Skilled Nursing Services (State Facility)	x	x	NA	Bed Day	Bed
c. ICF/ID Services (State Facility)	NA	x	NA	Bed Day	Bed
d. ICF/Geriatric Services (State Facility)	x	x	NA	Bed Day	Bed
e. Acute Psychiatric or Substance Abuse Inpatient Services (250)	x	NA	x	Bed Day	Bed
f. Community-Based Substance Abuse Medical Detoxification Inpatient Services (260)	NA	NA	x	Bed Day	Bed
g. Extended Rehabilitation Services (St. Facility)	x	NA	NA	Bed Day	Bed
5. **Outpatient Services**					
a. Outpatient Services (310)	x	x	x	Service Hour	NA
b. Intensive Outpatient (313)	NA	NA	x	Service Hour	NA
c. Medication Assisted Treatment (335)	NA	NA	x	Service Hour	NA
d. Assertive Community Treatment (350)	x	NA	NA	Service Hour	NA
6. **Case Management Services** (320)	x	x	x	Service Hour	NA
7. **Day Support Services**					
a. Day Treatment or Partial Hospitalization (410)	x	NA	x	Day Support Hour	Slot
b. Ambulatory Crisis Stabilization Services (420)	x	x	x	Day Support Hour	Slot

c. Rehabilitation (MH, SA) or Habilitation (425)	x	x	x	Day Support Hour	Slot
8. **Employment Services**					
a. Sheltered Employment (430)	x	x	x	Day of Service	Slot
b. Group Supported Employment (465)	x	x	x	Day of Service	Slot
c. Individual Supported Employment (460)	x	x	x	Service Hour	NA
9. **Residential Services**					
a. Highly Intensive Residential Services (501)	x	x	x	Bed Day	Bed
b. Residential Crisis Stabilization Services (510)	x	x	x	Bed Day	Bed
c. Intensive Residential Services (521)	x	x	x	Bed Day	Bed
d. Supervised Residential Services (551)	x	x	x	Bed Day	Bed
e. Supportive Residential Services (581)	x	x	x	Service Hour	NA
10. **Prevention Services** (610)	x	x	x	Service Hour	NA

Core Services Definitions: Units of Service

There are four kinds of service units in this core services taxonomy: service hours, bed days, day support hours, and days of service. These units are related to different kinds of core services and are used to measure and report delivery of those services. The unit of service for each core service category or subcategory is shown in the Core Services Category and Subcategory Matrix on the preceding pages. Units of service are collected and reported in the Community Consumer Submission (CCS) for all services provided by CSBs directly or through contracts with other providers.

1. ***Service Hours***

A service hour is a continuous period measured in fractions or multiples of an hour during which an individual or a family member, authorized representative, care giver, health care provider, or significant other through in-person or electronic (audio and video or telephonic) contact on behalf of the individual receiving services or a group of individuals participates in or benefits from the receipt of services. This definition also includes significant electronic contact with the individual receiving services and activities that are reimbursable by third party payers. The following table, developed by the Department and the VACSB Data Management Committee, contains examples of activities received during service hour services directly by or on behalf of individuals or groups of individuals.

Examples of Service Hour Activities	
Individual, group, family, or marital, counseling or therapy	Phone consultation with individual
Psychological testing and evaluations	Follow up and outreach
Medication visit or physician visit	Social security disability evaluation
Crisis intervention	Case management, individual present
Intake, psychiatric, forensic, court, and jail evaluations	Case management, individual not present
	Peer self help or support

Emergency telephone contacts with individual	Individual or group training
Preadmission screening evaluations	Job development for individuals
Independent examinations	Report writing re: individual
Commitment and MOT hearings	Individual-related staff travel
Attending court with the individual	Activity or recreation therapy
Discharge planning, individual present	Education of individuals
Discharge planning, individual not present	Early intervention activities

Service hours measure the amounts of services received by or on behalf of individuals or groups of individuals. For example, if nine individuals received one hour of group therapy, one service hour of outpatient services would be reported for each individual in a service.txt record in the CCS. Service hours are reported in the CCS service file only for the following core services:

- Emergency services,
- Motivational treatment services,
- Consumer monitoring services,
- Assessment and evaluation services,
- Early intervention services,
- Outpatient services,
- Intensive outpatient services,
- Medication assisted treatment,
- Assertive community treatment,
- Case management services,
- Individual supported employment, and
- Supportive residential services.

Mental health and developmental prevention services are discussed on the next page.

Z-Consumers: Service hours that are not received by or associated directly with individuals or groups of individuals also are collected and reported for the core services listed at the bottom of the previous page through the CCS using the z-consumer (unidentified individual receiving services) function (NC Service file). In addition, mental health and developmental prevention services are collected and reported using the z-consumer function, since individuals receiving services are not counted for prevention services. All information about Substance Abuse Prevention Services is collected and reported through the KIT Prevention System. Examples of z-consumer activities are listed below.

Examples of Z-Consumer Activities for Service Hours	
Case-specific clinical supervision	Employee, student, or peer assistance
Record charting	Staff preparation for individual, group, family, or marital counseling or therapy
Case consultation	
Treatment planning conference	Healthy pregnancies and fetal alcohol syndrome education
Phone Calls in emergency services	
Participation in FAPT	Child abuse and neglect prevention and positive parenting programs
Coordination of multidisciplinary teams	
Consultation to service providers	Neighborhood-based high risk youth programs
Application for admission to facility	Competency building programs
Preparing for workshops and training	Skill-building group training

Service hours received by groups of identifiable individuals (e.g., individuals participating in group outpatient services) must not be reported using the z-consumer function (NC service file); they must be reported in the service file as service hours received by each individual participating in the group. Similarly, service hours directly associated with individuals, such as

case management without the individual present, discharge planning without the individual present, phone consultation with the individual, or report writing re: individual, must not be reported using the z-consumer function. Finally, units of service for core services measured with bed days, days of service, or day support hours must not be reported in the CCS using the z-consumer function (NC service file).

2. ***Bed Days***

A bed day involves an overnight stay by an individual in a residential or inpatient program, facility, or service. Given the unique nature of residential SA medically managed withdrawal services, CSBs may count partial bed days for this service. If an individual is in this program for up to six hours, this would equal ¼ bed day, six to 12 hours would equal ½ bed day, 12 to 18 hours would equal ¾ bed day, and 18 to 24 hours would equal one bed day.

3. ***Day Support Hours***

Many day support services provided to groups of individuals are offered in sessions of two or more consecutive hours. However, Medicaid billing units for State Plan Option and ID waiver services vary by service. Therefore, counting service units by the smallest reasonable unit, a day support hour, is desirable and useful. Medicaid service units, if different from taxonomy units of service, need to be converted to taxonomy units for Medicaid services included in the CCS. The day support hour is the unit of service for day treatment or partial hospitalization, ambulatory crisis stabilization, and rehabilitation or habilitation and measures hours received by individuals in those services.

This unit allows the collection of more accurate information about services and will facilitate billing various payors that measure service units differently. At a minimum, day support programs that deliver services on a group basis must provide at least two consecutive hours in a session to be considered a day support program.

4. ***Days of Service***

Two employment services provided to groups of individuals are offered in sessions of three or more consecutive hours. Day of service is the unit of service for sheltered employment and group supported employment. A day of service equals five or more hours of service received by an individual. If a session lasts three or more but less than five hours, it should be counted as a half day. Since the unit of service is a day, fractional units should be aggregated to whole days in the CCS. Also, Medicaid service units, if different from taxonomy units, need to be converted to taxonomy units for Medicaid services included in the CCS.

Core Services Definitions: Static Capacities

Static capacities are reported through performance contract reports in the Community Automated Reporting System (CARS) for those services shown in the Core Services Category and Subcategory Matrix with a static capacity that are provided by CSBs directly or through contracts with other providers.

1. ***Number of Beds***

The number of beds is the total number of beds for which the facility or program is licensed and staffed or the number of beds contracted for during the performance contract period. If the CSB contracts for bed days without specifying a number of beds, convert the bed days to a static capacity by dividing the bed days by the days in the term of the CSB's contract (e.g., 365 for an annual contract, 183 for a new, half-year contract). If the CSB contracts for the placement of a specified number of individuals, convert this to the number of beds by multiplying the number of individuals by their average length of stay in the program and then dividing the result by the number of days in the term of the CSB's contract.

2. ***Number of Slots***

Number of slots means the maximum number of individuals who could be served during a day or a half-day session in most day support programs. It is the number of slots for which the program or service is staffed. For example, in psychosocial rehabilitation programs, the number of slots is not the total number of members in the whole program; it is the number of members who can be served by the program at the same time during a session. If the CSB contracts for days of service without specifying a number of slots, convert the days of service to a static capacity by dividing the days of service by the days in the term of the CSB's contract (e.g., 248 for an annual contract based on 365 days minus 105 weekend and 12 holiday days). If the CSB contracts for the placement of a specified number of individuals, convert this to days of service by multiplying the number of individuals by the average units of service they receive and then convert the resulting days of service to slots, per the preceding example. If the CSB contracts for day support hours without specifying a number of slots, convert the hours to a static capacity by dividing the day support hours by the number of hours the program is open daily and dividing the result by the number of days the program is open during the CSB's contract period.

Core Services Definitions: Individuals Receiving Services

Section 37.2-100 of the Code of Virginia defines an individual receiving services as a current direct recipient of public or private mental health, developmental, or substance abuse treatment or habilitation services. The term individual or individual receiving services will always be those individuals who have been admitted to a program area or for whom a CSB has opened a case and who have received valid services during a reporting period or the contract period. However, persons participating in prevention services are not counted as individuals receiving services.

If a CSB has opened a case for an individual or admitted an individual to a program area, but the individual has not received any valid services during the reporting period or the contract period, the CSB must not report that individual as a consumer in the CCS. Information about all individuals receiving valid services from CSBs through directly operated services or contracts with other providers must be collected and reported through the CCS.

Inpatient Core Service and State Facility Cost Centers Crosswalk

The following table crosswalks the inpatient services in the core services taxonomy (4.a through g) with the state facility cost centers and codes.

Core Service and State Facility Cost Accounting Crosswalk		
4.	**Inpatient Services** (Core Service)	
	State Facility Cost Center	**Code**
a.	**Medical/Surgical**	
b.	Acute Medical/Surgical (Certified)	411
	Skilled Nursing	
c.	Skilled Nursing - ID (Certified)	421
	Skilled Nursing - General (Certified)	423
d.	**Intermediate Care Facility/Intellectual Disability (ID)**	
	ICF/ID Certified (General)	529
e.	**Intermediate Care Facility/Geriatric**	
	ICF (Certified)	441
	Chronic Disease (Certified)	443
g.	**Acute Intensive Psychiatric**	
	Acute Admissions (Certified)	457
	Extended Rehabilitation	
	Community Preparation/Psychosocial	481
	Long Term Rehabilitation	482
	Child and Adolescent Services (General)	487
	Clinical Evaluation	488
	Forensic Medium Security	490
	Forensic Maximum Security	491
	Forensic Intermediate Security	493

Performance Contract Definitions

Administrative Expenses means the expenses incurred by the CSB for its administrative functions. Administrative expenses are incurred for common or joint activities that cannot be identified readily with a particular organizational activity or cost objective. Expenses may include overall leadership and supervision of the CSB organization (e.g., expenses for the executive director, deputy director or director of administration, and support staff), financial management, accounting, reimbursement, procurement, human resources management, information technology services, policy development, strategic planning, resource development and acquisition, quality improvement, risk management, intergovernmental relations, board member support, and media relations.

Administrative functions and expenses may be centralized or included in programs and services, depending on the CSB's organizational structure. However, in either alternative, administrative and management expenses must be identified and allocated on a basis that is auditable and satisfies generally accepted accounting principles among service costs across the three program areas and emergency and ancillary services on financial and service forms in the performance contract and reports, and administrative costs must be displayed separately on the Consolidated Budget form

(page AF-1) in the performance contract and reports. CSB administrative and management expenses shall be reasonable and subject to review by the Department.

Admission means the process by which a CSB accepts a person for services in one or more program areas (all mental health, developmental, or substance abuse services). If a person is only interviewed regarding services or triaged and referred to another provider or system of care, that activity does not constitute an admission. The staff time involved in that activity should be recorded in the core service category or subcategory (e.g., emergency or outpatient services) where the activity occurred as a z-consumer, a service with no associated individual receiving services, for Community Consumer Submission (CCS) purposes. Admission is to a program area, not to a specific program or service. A clinical record is opened on all persons seen face-to-face for an assessment. Individuals who will be receiving services through a CSB-contracted program or service are admitted to a program area, based upon a face-to-face clinical assessment. In order for a person to be admitted to a program area, all of the following actions are necessary:

1. an initial contact has been made,
2. a clinical screening or initial assessment was conducted,
3. a unique identifier for the individual was assigned or retrieved from the management information system if the person has been admitted for a previous episode of care, and
4. the person is scheduled to receive services in a directly-operated or contractual service in the program area.

Admission is to a program area. An individual is not admitted to a program area for emergency services or ancillary (motivational treatment, consumer monitoring, assessment and evaluation, or early intervention) services; the CSB opens a case for that individual. The CCS requires collection of an abbreviated set of data elements, rather than a full set, for these services. However, all of the CCS data elements that were not collected then must be collected if an individual subsequently is admitted to a program area. It is possible that an individual may be admitted to more than one program area concurrently. A case is not opened for an individual participating in consumer-run services. CSBs providing consumer-run services directly or contractually must report the number of individuals participating in those services separately in the CARS management report.

Case Management CSB means the CSB that serves the area in which the individual receiving services lives. The case management CSB is responsible for case management, liaison with the state facility when a person is admitted to it, and discharge planning. Any change in case management CSB for an individual shall be implemented in accordance with the current *Discharge Planning Protocols* to ensure a smooth transition for the individual and the CSB. Case management CSB also means the CSB to which bed day utilization is assigned, beginning on the day of admission, for an episode of care and treatment when an individual is admitted to a state facility.

Case Opening means the process by which the CSB opens a case for a person. The CSB has determined that it can serve the person who has sought or been referred to it for services. This does not constitute an admission to a program area. When the CSB opens a case for a person, he or she can access the following services without being admitted to a program area: emergency services or ancillary (motivational treatment, consumer monitoring, assessment and evaluation, and early intervention) services. The CSB collects only minimal CCS data elements at case opening. If the person needs other services, he or she is admitted to a program area. A person can be admitted

directly to a program area without going through case opening; however, CCS data and other information collected at case opening must still be collected and reported.

Case Closing means the process by which the CSB closes a case for an individual who received services.

Cognitive Delay means a child is at least three but less than six years old and has a confirmed cognitive developmental delay. Documentation of a confirmed cognitive developmental delay must be from a multidisciplinary team of trained personnel, using a variety of valid assessment instruments. A confirmed delay will be noted on the test with a score that is at least 25 percent below the child's chronological age in one or more areas of cognitive development. A developmental delay is defined as a significant delay in one of the following developmental areas: cognitive ability, motor skills, social/adaptive behavior, perceptual skills, or communication skills. A multidisciplinary team of trained personnel will measure developmental delay (25 percent below the child's chronological age) by a using a variety of valid assessment instruments. The most frequently used instruments in Virginia's local school systems are the Battelle Developmental Inventory, Learning Accomplishments Profile - Diagnostic Edition (LAP-D), the Early Learning Accomplishment Profile (ELAP), and the Hawaiian Early Learning Profile (HELP). For infants and toddlers born prematurely (gestation period of less than 37 weeks), the child's actual adjusted age is used to determine his or her developmental status. Chronological age is used once the child is 18 months old.

Co-Occurring Disorders means individuals are diagnosed with more than one, and often several, of the following disorders: mental health or substance use disorders or intellectual disability. Individuals may have more than one substance use disorder and more than one mental health disorder. At an individual level, co-occurring disorders exist when at least one disorder of each type (e.g., mental health and substance use disorder or intellectual disability and mental health disorder) can be identified independently of the other and are not simply a cluster of symptoms resulting from a single disorder. The mental health and substance use disorders of some individuals may not, at a given point in time, fully meet the criteria for diagnoses in DSM IV categories. While conceptually ideal, diagnostic certainty cannot be the sole basis for system planning and program implementation.

A service definition of co-occurring disorders includes individuals who are pre-diagnosis in that an established diagnosis in one domain (mental health disorder, intellectual disability, or substance use disorder) is matched with signs or symptoms of an evolving disorder in another domain. Similarly, the service definition also includes individuals who are post-diagnosis in that one or both of their substance use disorder and their mental health disorder may have resolved for a substantial period of time, but who present for services with a unitary disorder and acute signs or symptoms of a cooccurring condition. For example, an individual with a substance use disorder who is now suicidal may not meet the formal criteria for a DSM IV diagnosis but is clearly in need of services that address both conditions. Refer to State Board Policy 1015 (SYS) 86-22 for more information about providing services to individuals with co-occurring mental health disorders, intellectual disability, or substance use disorders.

The definition of co-occurring disorders for the Community Consumer Submission data set is individuals shall be identified as having co-occurring mental health and substance use disorders if

there is (1) an Axis I or Axis II mental health diagnosis and (a) an Axis I substance use disorder diagnosis or (b) admission to the substance abuse program area (denoted in a type of care record) or (2) an Axis I substance use disorder diagnosis and (a) an Axis I or Axis II mental health diagnosis or (b) admission to the mental health program area (denoted in a type of care record).

Discharge means the process by which a CSB documents the completion of a person's episode of care in a program area. Discharge occurs at the program area level, as opposed to a specific service. When an individual has completed receiving all services in the program area to which he or she was admitted, the person has completed the current episode of care and is discharged from that program area. A person is discharged from a program area if any of the following conditions exists; the individual has:

1. been determined to need no further services in that program area,
2. completed receiving services from all CSB and CSB-contracted services in that program area,
3. received no program area services in 90 days from the date of the last face-to-face service or service-related contact or indicated that he no longer desires to receive services, or
4. relocated or died.

Persons may be discharged in less than the maximum time since the last face-to-face contact (i.e., less than 90 days) at the CSB's discretion, but the person must be discharged if no face-to-face services have been received in the maximum allowable time period for that episode of care. Once discharged, should an individual return for services in a program area, that person would be readmitted to that program area; the subsequent admission would begin a new episode of care. If the person is discharged because he or she has received no services in 90 days, the discharge date must be the date of the last face-to-face or other contact with the person, not the 90th day.

In the rare circumstance in which services are provided for an individual after he or she has been discharged (e.g., completing a discharge summary), the units of service should be collected and reported in the core service category or subcategory (e.g., outpatient or case management services) where the activity occurred using the z-consumer function (NC service file), a service with no associated individual receiving services, for CCS purposes.

Episode of Care means all of the services provided to an individual to address an identified condition or support need over a continuous period of time between an admission and a discharge. An episode of care begins with admission to a program area, and it ends with the discharge from that program area. An episode of care may consist of a single face-to-face encounter or multiple services provided through one or more programs. A person is not admitted to emergency services or ancillary services; those services are outside of an episode of care. If a person has received his or her last service but has not yet been discharged from a program area, and he or she returns for services in that program area within 90 days, the person is not readmitted, since he or she has not been discharged; the person is merely accepted into that program area for the needed services.

Intellectual Disability means a disability, originating before the age of 18 years, characterized concurrently by (i) significantly sub average intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at least two standard deviations below the mean and (ii)

significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills (§ 37.2-100 of the Code of Virginia).

Mental Illness means a disorder of thought, mood, emotion, perception, or orientation that significantly impairs judgment, behavior, capacity to recognize reality, or ability to address basic life necessities and requires care and treatment for the health, safety, or recovery of the individual or for the safety of others (§ 37.2-100 of the Code of Virginia).

Serious Mental Illness means a severe and persistent mental or emotional disorders that seriously impair the functioning of adults, 18 years of age or older, in such primary aspects of daily living as personal relations, self-care skills, living arrangements, or employment. Individuals with serious mental illness who have also been diagnosed as having a substance abuse disorder or developmental disability are included in this definition. Serious mental illness is defined along three dimensions: diagnosis, level of disability, and duration of illness. All three dimensions must be met to meet the criteria for serious mental illness.

a. Diagnosis: The person must have a major mental disorder diagnosed using the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). These disorders are: schizophrenia, major affective disorders, paranoia, organic or other psychotic disorders, personality disorders, or other disorders that may lead to chronic disability. A diagnosis of adjustment disorder or a V-Code diagnosis cannot be used to satisfy these criteria.

b. Level of Disability: There must be evidence of severe and recurrent disability resulting from mental illness. The disability must result in functional limitations in major life activities. Individuals should meet at least two of the following criteria on a continuing or intermittent basis. The person:

   1.) Is unemployed; is employed in a sheltered setting or supportive work situation; has markedly limited or reduced employment skills; or has a poor employment history;

   2.) Requires public financial assistance to remain in the community and may be unable to procure such assistance without help;

   3.) Has difficulty establishing or maintaining a personal social support system;

   4.) Requires assistance in basic living skills such as personal hygiene, food preparation, or money management; or

   5.) Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.

c. Duration of Illness: The individual is expected to require services of an extended duration, or the individual's treatment history meets at least one of the following criteria.

   1.) The individual has undergone psychiatric treatment more intensive than outpatient care more than once in his or her lifetime (e.g., crisis response services, alternative home care, partial hospitalization, and inpatient hospitalization), or

   2.) The individual has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.

Serious Emotional Disturbance means a serious mental health problem that can be diagnosed under the DSM-IV in children ages birth through 17 (until the 18th birthday), or the child must exhibit all of the following:

a. Problems in personality development and social functioning that have been exhibited over at least one year's time, and

b. Problems that are significantly disabling based upon the social functioning of most children that age, and

c. Problems that have become more disabling over time, and

d. Service needs that require significant intervention by more than one agency.

At Risk of Serious Emotional Disturbance means children aged birth through seven are considered at risk of developing serious emotional disturbances if they meet at least one of the following criteria.

a. The child exhibits behavior or maturity that is significantly different from most children of that age and is not primarily the result of developmental disabilities; or

b. Parents or persons responsible for the child's care have predisposing factors themselves that could result in the child developing serious emotional or behavioral problems (e.g., inadequate parenting skills, substance abuse, mental illness, or other emotional difficulties, etc.); or

c. The child has experienced physical or psychological stressors that have put him or her at risk for serious emotional or behavioral problems (e.g., living in poverty, parental neglect, physical or emotional abuse, etc.).

Please refer to Appendix A that contains detailed criteria in checklists for serious mental illness, serious emotional disturbance, and at risk of serious emotional disturbance. Those criteria are congruent with these definitions and will ensure consistent screening for and assessment of these conditions.

Program Area means the general classification of service activities for one of the following defined conditions: a mental health disorder, intellectual disability, or a substance use disorder. The three program areas in the public services system are mental health, developmental, and substance abuse services. In the taxonomy, mental health or substance use disorder or intellectual disability refers to a condition experienced by an individual; and mental health, substance abuse, or developmental refers respectively to the services that address that condition.

Service Area means the city or county or any combination of cities and counties or counties or cities that established and is served by the CSB.

Service Location means the location in which the service for which a service.txt file is submitted in the Community Consumer Submission (CCS) was provided to an individual. Service location is reported in the service file for every service in all program areas (100, 200, and 300) and for emergency and ancillary services (400). Service location is collected at every service encounter. Service locations are defined in CCS data element 65.

Service Subtype is a specific activity associated with a particular core service category or subcategory for which a service.txt file is submitted in the Community Consumer Submission. Service Subtypes now are defined only for emergency services and case management services. Service subtypes are defined in CCS data element 64.

Substance Abuse means the use of drugs, enumerated in the Virginia Drug Control Act (§ 54.013400 et seq.), without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior and (iii), because of such substance abuse, requires care and treatment for the health of the individual. This care and treatment may include counseling, rehabilitation, or medical or psychiatric care (§ 37.2-100 of the Code of Virginia). Substance abuse is now beginning to be defined and described as substance use disorder. There are two levels of substance use disorder: substance addiction (dependence) and substance abuse.

Substance Addiction (Dependence), as defined by ICD-9, means uncontrollable substance-seeking behavior involving compulsive use of high doses of one or more substances resulting in substantial impairment of functioning and health. Tolerance and withdrawal are characteristics associated with dependence. ICD-9 defines substance dependence as a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. tolerance, as defined by a need for markedly increased amounts of the substance to achieve intoxification or desired effect or markedly diminished effect with continued use of the same amount of the substance;
2. withdrawal, as manifested by the characteristic withdrawal syndrome for the substance or the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms;
3. the substance is often taken in larger amounts or over a longer period than was intended;
4. there is a persistent desire or unsuccessful efforts to cut down or control substance use;
5. a great deal of time is spent on activities necessary to obtain the substance, use the substance, or recover from its effects;
6. important social, occupational, or recreational activities are given up or reduced because of substance use; and
7. the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

Substance Abuse, as defined by ICD-9, means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. It leads to clinically significant impairment or distress, as manifested by one (or more) of the following occurring within a 12-month period:

1. recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substancerelated absences, suspensions, or expulsions from school; neglect of children or household);
2. recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
3. recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); and

4. ~~continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxification, physical fights).~~

Appendix A: Diagnostic Criteria Checklists

Serious Mental Illness Criteria Checklist		
Yes	**No**	**Criteria**
		1. Age: The individual is 18 years of age or older.
		2. DIAGNOSIS: The individual has a major mental disorder diagnosed using the DSM IV. **At least one of the following diagnoses must be present.** Adjustment disorder or V Code diagnoses do not meet this criterion.
		Schizophrenia, all types
		Major Affective Disorder
		Paranoid Disorder
		Organic Disorder
		Other Psychotic Disorder
		Personality Disorder
		Other mental health disorder that may lead to chronic disability
		3. Level Of Disability: There must be evidence of severe and recurrent disability resulting from mental illness. The disability must result in functional limitations in major life activities. **The individual must meet at least two of these criteria on a continuing or intermittent basis.** The individual:
		Is unemployed; employed in a sheltered setting or a supportive work situation; has markedly limited or reduced employment skills; or has a poor employment history.
		Requires public financial assistance to remain in the community and may be unable to procure such assistance without help.
		Has difficulty establishing or maintaining a personal social support system.
		Requires assistance in basic living skills such as personal hygiene, food preparation, or money management.
		Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.
		4. Duration Of Illness: The individual's treatment history must meet at least one of these criteria. The individual:
		Is expected to require services of an extended duration.
		Has undergone psychiatric treatment more intensive than outpatient care more than once in his or her lifetime (e.g., crisis response services, alternative home care, partial hospitalization, and inpatient hospitalization).
		Has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.
		If Yes is checked for criterion 1, and for at least one response in criterion 2, and for at least two responses in criterion 3, and for at least one response in criterion 4, then check Yes here to indicate that the individual has serious mental illness.

NOTE: Any diagnosis checked in 2 above must be documented in the individual's clinical record and in the CSB's information system, and the individual's clinical record also must contain documentation that he or she meets any criteria checked in 3 and 4 above.

Appendix A: Diagnostic Criteria Checklists

Serious Emotional Disturbance Criteria Checklist		
Yes	**No**	**Criteria**
		1. Age: The individual is a child, age birth through 17 (until the 18th birthday).
		2. Diagnosis: The child has a serious mental health problem that can be diagnosed under the DSM IV. Specify the diagnosis: _____
		3. Problems And Needs: The child must exhibit all of the following:
		Problems in personality development and social functioning that have been exhibited over at least one year's time, and
		Problems that are significantly disabling based upon the social functioning of most children that child's age, and
		Problems that have become more disabling over time, and
		Service needs that require significant intervention by more than one agency.
		If Yes is checked for criterion 1 and for criterion 2 **OR** for all four responses in criterion 3, then check Yes here to indicate that the child has serious emotional disturbance.
NOTE: Any diagnosis in criterion 2 above must be documented in the child's clinical record and in the CSB's information system, and the child's clinical record also must contain documentation of any of the problems or needs checked in criterion 3 above.		

At Risk Of Serious Emotional Disturbance Criteria Checklist		
Yes	**No**	**Criteria**
		1. Age: The person is a child, age birth through 7.
		2. Problems: The child must meet at least one of the following criteria.
		The child exhibits behavior or maturity that is significantly different from most children of that age and which is not primarily the result of developmental disabilities; or
		Parents or persons responsible for the child's care have predisposing factors themselves that could result in the child developing serious emotional or behavioral problems (e.g., inadequate parenting skills, substance use disorder, mental illness, or other emotional difficulties, etc.); or
		The child has experienced physical or psychological stressors that have put him or her at risk for serious emotional or behavioral problems (e.g., living in poverty, parental neglect, or physical or emotional abuse, etc,).

		If Yes is checked for criterion 1 and for any problem in criterion 2, then check Yes here to indicate that the child is at risk of serious emotional disturbance.
NOTES: These criteria should be used only if the child does not have serious emotional disturbance. The child's clinical record must contain documentation of any of the problems checked in criterion 2 above.		

Appendix B: Core Services Taxonomy and Medicaid Intellectual Disability Home and Community-Based Waiver (ID Waiver) Services Crosswalk

Core Services Taxonomy Service	ID Home and Community-Based Waiver Service
Emergency Services	Crisis Stabilization/Crisis Supervision Personal Emergency Response System [1]
Inpatient Services	None
Outpatient Services	Skilled Nursing Services [2] Therapeutic Consultation [3]
Case Management Services	None. Case Management is not a Waiver service.
Day Support: Habilitation	Day Support (Center-Based and Non-Center-Based) and Prevocational
Sheltered Employment	None
Group Supported Employment	Supported Employment - Group Model
Individual Supported Employment	Supported Employment - Individual Placement
Highly Intensive Residential Services	None, this is ICF/ID services in the taxonomy.
Intensive Residential Services	Congregate Residential Support Services [5]
Supervised Residential Services	Congregate Residential Support Services [5]
Supportive Residential Services	Supported Living/In-Home Residential Supports Agency and Consumer-Directed Respite Services, Personal Assistance Services [4], and Companion Services
Early Intervention, Ancillary Services	None

This crosswalk is included for information purposes. When there is an inconsistency between Medicaid service units and taxonomy units of service, taxonomy units of service will be used for uniform cost report and CCS purposes. Medicaid service definitions can be accessed at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManuals

[1] **Personal Emergency Response System** will be counted in the taxonomy and performance contract in terms of numbers of individuals served and expenses; there are no core services taxonomy units of service for this Medicaid service.

[2] **Skilled Nursing Services** are available to individuals with serious medical conditions and complex health care needs that require specific skilled nursing services that are long term and

maintenance in nature ordered by a physician and which cannot be accessed under the Medicaid State Plan. Services are provided in the individual's home or a community setting on a regularly scheduled or intermittent need basis. The Medicaid service unit is one hour.

3

Therapeutic Consultation provides expertise, training, and technical assistance in a specialty area (psychology, behavioral consultation, therapeutic recreation, rehabilitation engineering, speech therapy, occupational therapy, or physical therapy) to assist family members, care givers, and other service providers in supporting the individual receiving services. ID Waiver therapeutic consultation services may not include direct therapy provided to Waiver recipients or duplicate the activities of other services available to the person through the State Plan for Medical Assistance. This service may not be billed solely for monitoring purposes. The Medicaid service unit is one hour. Therapeutic consultation is included under outpatient services in the crosswalk, instead of case management services, to preserve the unique nature of case management services and because it seemed to fit most easily in outpatient services. This also is the preference expressed by the VACSB Developmental Services Council.

4

Personal Assistance Services are available to ID Waiver recipients who do not receive congregate residential support services or live in an assisted living facility and for whom training and skills development are not primary objectives or are received in another service or program. Personal assistance means direct assistance with personal care, activities of daily living, medication or other medical needs, and monitoring physical condition. It may be provided in residential or non-residential settings to enable an individual to maintain health status and functional skills necessary to live in the community or participate in community activities. Personal assistance services may not be provided during the same hours as Waiver supported employment or day support, although limited exceptions may be requested for individuals with severe physical disabilities who participate in supported employment. The Medicaid service unit is one hour. Personal Assistance Services and Companion Services are included under supportive residential services because they are more residentially based than day support based. The credentials for both include Department residential services licenses. This is the preference expressed by the VACSB Developmental Services Council. The Medicaid service unit and taxonomy unit are the same, a service hour.

5

Congregate Residential Support Services have a Medicaid service unit measured in hours; this is inconsistent with the taxonomy bed day unit of service for intensive and supervised residential services. Therefore, congregate residential support services will be counted in the taxonomy and performance contract reports in terms of numbers of individuals served and expenses; there are no taxonomy units of service for these Medicaid services.

Environmental Modifications are available to individuals who are receiving at least one other ID Waiver service along with Medicaid targeted case management services. Modifications are provided as needed only for situations of direct medical or remedial benefit to the individual. These are provided primarily in an individual's home or other community residence. Modifications may not be used to bring a substandard dwelling up to minimum habitation standards. Environmental modifications include physical adaptations to a house or place of residence necessary to ensure an individual's health or safety or to enable the individual to live in a non-institutional setting, environmental modifications to a work site that exceed reasonable accommodation requirements of the Americans with Disabilities Act, and modifications to the primary vehicle being used by the

individual. The Medicaid service unit is hourly for rehabilitation engineering, individually contracted for building contractors, and may include supplies. Environmental Modifications are included in the core service in which they are implemented (e.g., various residential services or case management services).

Assistive Technology is available to individuals who are receiving at least one other ID Waiver service along with Medicaid targeted case management services. It includes specialized medical equipment, supplies, devices, controls, and appliances not available under the State Plan for Medical Assistance that enable individuals to increase their abilities to perform activities of daily living or to perceive, control or communicate with the environment in which they live or that are necessary to their proper functioning. It may be provided in a residential or non-residential setting. The Medicaid service unit is hourly for rehabilitation engineering or the total cost of the item or the supplies. Assistive technology is included in the core service in which it is implemented (e.g., various residential services or case management services).

Appendix C: Retired Core Services Service Codes

The following core services service codes have been retired from use. The codes are listed in this appendix so that when core service categories or subcategories are added to the taxonomy in the future, none of these retired codes will be assigned to those new services.

Retired Core Services Service Codes		
Core Service Category	**Former Core Services Subcategory**	**Service Code**
Outpatient Services	Medical Services	311
Outpatient Services	Intensive In-Home Services	315
Outpatient Services	Opioid Detoxification Services	330
Outpatient Services	Opioid Treatment Services	340
Day Support	Therapeutic Day Treatment for Children and Adolescents	415
Day Support	Alternative Day Support Arrangements	475
Residential Services	Jail-Based Habilitation Services	531
Residential Services	Family Support Services	587
Limited Services	Substance Abuse Social Detoxification Services	710

Appendix D: Reserved for Future Use

Appendix E: Regional Program Operating Principles

A regional program is funded by the Department through the community services board or behavioral health authority, hereafter referred to as the CSB, and operated explicitly to provide services to individuals who receive services from the CSBs participating in the program. A regional program may be managed by the participating CSBs or by one CSB, have single or multiple service sites, and provide one or more types of service. A regional program also may include selfcontained, single purpose programs (e.g., providing one type of core service, usually residential) operated by one CSB for the benefit of other CSBs or programs contracted by one CSB that serve individuals from other CSBs.

A regional program can be a highly effective way to allocate and manage resources, coordinate the delivery and manage the utilization of high cost or low incidence services, and promote the development of services where economies of scale and effort could assist in the diversion of individuals from admission to state facilities. Each individual receiving services provided through a regional program must be identified as being served by a particular CSB. That CSB will be responsible for contracting for and reporting on the individuals that it serves and the services that it provides; and each individual will access services through and have his or her individualized services plan managed by that particular CSB. CSBs are the single points of entry into publicly funded mental health, developmental, and substance abuse services, the local points of accountability for coordination of those services, and the only entities identified in the Code of Virginia that the Department can fund for the delivery of community mental health, developmental, or substance abuse services.

The regional program operating principles provide guidance for CSBs to implement and manage identified regional programs and to account for services provided by the programs. The principles also provide guidance for the Department to monitor regional programs on a more consistent basis. Adherence to these principles will ensure that performance contracts and reports, including the Community Automated Reporting System (CARS) and the Community Consumer Submission (CCS) reports, contain complete and accurate information about individuals receiving services, services, funding, and expenses.

Regional Program Operating Principles

1. **Individual CSB Reporting:** The CCS, a secure and HIPAA-compliant individual data reporting system, is the basis for all statewide individual and service data. Therefore, every individual served in any manner must be included in some CSB's information system, so that necessary individual and service information can be extracted by CSBs and provided to the Department using the CCS. If a CSB does not collect information about all of the individuals it serves and services, including those served by regional programs, in its information system, it will not be able to report complete information about its operations to the Department.
    a. Unless subsection b. is applicable, each CSB participating in a regional program shall admit individuals that it serves through the regional program to the applicable program area(s) and maintain CCS data about them in its information system. For performance contract and report purposes (CARS and CCS), each participating CSB shall maintain and report

funding, expense, cost, individual, and service information associated with the regional program for each individual that it serves through the regional program.

b. If one CSB operates a regional program on behalf of other CSBs in a region, it shall admit all individuals for services provided by the regional program, maintain CCS data about these individuals in its information system, and maintain and report funding, expense, cost, individual, and service information associated with those individuals, or, if the participating CSBs elect, each referring CSB may report on the individuals it serves.

2. **Regional Program Funding:** Depending on the design of a regional program, the Department may disburse state or federal funds for a regional program to each participating CSB or to one CSB that operates a regional program or agrees to serve as the fiscal agent for a regional program. Sections 37.2 -504 and 37.2-508 of the Code of Virginia establish the community services performance contract as the mechanism through which the Department provides state and federal funds to CSBs for community services and through which CSBs report on the use of those and other funds. All regional programs shall be included in the performance contract and reflected in CARS and CCS reports.

   a. If the Department disburses regional program funds to each participating CSB, each participating CSB shall follow existing performance contract and report requirements and procedures for that portion of the regional program funded by that CSB.

   b. If the Department disburses regional program funds to a CSB that operates a regional program on behalf of the other CSBs in a region, the operating CSB shall follow existing performance contract and report requirements and procedures, as if the regional program were its own program.

   c. If the Department disburses regional program funds to a CSB that has agreed to serve as the fiscal agent (fiscal agent CSB) for the regional program, disbursements will be based on, accomplished through, and documented by appropriate procedures, developed and implemented by the region.

   d. When funds are disbursed to a fiscal agent CSB, each participating CSB shall identify, track, and report regional program funds that it receives and spends as funds for that regional program. Each participating CSB, including the fiscal agent CSB, shall reflect in its CARS reports and CCS 3 extracts only its share of the regional program, in terms of individuals served, services provided, funds received, expenses made, and costs of the services. Any monitoring and reporting of and accountability for the fiscal agent CSB's handling of state or federal funds for a regional program shall be accomplished through the performance contract and reports. Alternately, if the participating CSBs elect, each CSB may perform these functions for its share of the regional program.

   e. When funds are disbursed to a fiscal agent CSB that pays a contract agency to deliver regional program services, the fiscal agent CSB and participating CSBs may elect to establish an arrangement in which the fiscal agent CSB reports all of the funds and expenditures in the fiscal pages of Exhibit A while the participating CSBs and the fiscal agent CSB report information about individuals served, units of services, and expenses for those units only for the individuals it serves on the program pages of Exhibit A, with a note on the Comments page of Exhibit A explaining the differences between the fiscal and program pages. Alternately, if the participating CSBs elect, the fiscal agent CSB may admit

the individuals served by other participating CSBs and, for purposes of this regional program, treat those individuals as its own for documentation and reporting purposes.

3. **Financial Reporting:** All funds, expenses, and costs for a regional program shall be reported to the Department only once; they may be reported by individual CSBs, the CSB that serves as the fiscal agent, or both, depending on how the regional program is designed and operates. For example, the fiscal agent CSB might report the revenues and expenses for a regional program provided by a contract agency, and a CSB that refers individuals it serves to that regional program may report the service and cost information related to those individuals.

4. **Consumer Reporting:** Each individual who receives services through a regional program shall be reported to the Department only once for a particular service. However, an individual who receives services from more than one CSB should be reported by each CSB that provides a service to that individual. For example, if an individual receives outpatient mental health services from one CSB and residential crisis stabilization services from a second CSB operating that program on behalf of a region, the individual would be admitted to each CSB and each CSB would report information about the individual and the service it provided to the individual.

5. **Service Reporting:** Each service provided by a regional program shall be reported only once, either by the CSB providing or contracting for the service or the CSB that referred individuals it served to the regional program operated or contracted by another CSB or by the region.

6. **Contracted Regional Programs:** When the case management CSB refers an individual to a regional program that is operated by a contract agency and paid for by the regional program's fiscal agent CSB, the case management CSB shall report the service and cost information, but not the funding and expense information, even though it did not provide or pay for it, since there would be no other way for information about it to be extracted through the CCS. Alternately, if the participating CSBs elect, the fiscal agent CSB could admit the individual for this service and report information about the individual receiving services, services, costs, funds, and expenses itself; in this situation, the case management CSB would report nothing about this service.

7. **Transfers of Resources Among CSBs:** CSBs should be able to transfer state, local, and federal funds to each other to pay for services that they purchase from each other.

8. **Use of Existing Reporting Systems:** Existing reporting systems (the CCS and CARS) shall be used wherever possible, rather than developing new reporting systems, to avoid unnecessary or duplicative data collection and entry. Any new service or program shall be implemented as simply as possible regarding reporting requirements.

9. **Regional Administrative and Management Expenses:** CSBs and the Department have provider and local or state authority roles that involve non-direct services tasks such as utilization management and regional authorization committees. These roles incur additional administrative and management expenses for the programs. CSBs shall report these expenses as part of their costs of delivering regional services. The Department shall factor in and accept reasonable administrative and management expenses as allowable costs in regional programs.

10. **Local Supplements:** If a CSB participating in a regional program supplements the allocation of state or federal funds received by the CSB operating that program through transferring resources to the operating CSB, the participating CSB shall show the transfer as an expense on financial forms but not as a cost on service forms in its performance contract and reports. Then, the participating CSB will avoid displaying an unrealistically low service cost in its reports for the regional program and double counting individuals served by and service units delivered in the regional program, since the operating CSB already reports this information.

11. **Balances:** Unexpended balances of current or previous fiscal year regional program funds should not be retained by the participating CSBs to which the regional fiscal agent CSB or the Department disbursed the funds, unless this is approved by the region for purposes that are consistent with the legislative intent of the Appropriation Act item that provided the funds. Otherwise, the balances should be available for redistribution during the fiscal year among participating CSBs to ensure maximum utilization of these funds. Each region should establish procedures for monitoring expenditures of regional program funds and redistributing those unexpended balances to ensure that uses of those funds are consistent with the legislative intent of the Appropriation Act item that provided the funds.

12. **Issue Resolution:** Regional program funding issues, such as the amount, sources, or adequacy of funding for the program, the distribution of state allocations for the regional program among participating CSBs, and financial participation of each CSB whose individuals receive services from the regional program, should be resolved at the regional level among CSBs participating in the program, with the Department providing information or assistance upon request.

13. **Local Participation:** Whenever possible, regional funding and reporting approaches should encourage or provide incentives for the contribution of local dollars to regional activities.

Four Regional Program Models

The following models have been developed for CSBs and the Department to use in designing, implementing, operating, monitoring, and evaluating regional programs. These models are paradigms that could be altered by mutual agreement among the CSBs and the Department as regional circumstances warrant. However, to the greatest extent possible, CSBs and the Department should adhere to these models to support and reinforce more consistent approaches to the operation, management, monitoring, and evaluation of regional programs. CSBs should review these models and, in consultation with the Department, implement the applicable provisions of the model or models best suited to their particular circumstances, so that the operations of any regional program will be congruent with one of these models.

1. Operating CSB-Funded Regional Program Model

1. The CSB that operates a regional program receives state and sometimes other funds from the Department for the program. The operating CSB provides the services, projects the total funding and cost for the regional program in its performance contract and contract revision(s), and reports total actual individuals served and units of service(s) delivered in its Community Consumer Submission 3 (CCS 3) extracts and reports funding, expenses, costs, and static capacities in its CARS. Other CSBs, which refer individuals to the regional program for

services, project and report nothing for the regional program in their contracts, CARS reports, or CCS 3 extracts.

2. The operating CSB admits individuals receiving services from the regional program to the applicable program area (all MH, DV, or SA services) and develops individualized services plans (ISPs) for them for service(s) provided by the regional program. When individuals complete receiving all services from the regional program, they are discharged from the applicable program area by the operating CSB, unless they are receiving other services in that program area from that operating CSB. If individuals also are receiving services from the operating CSB in another program area, the CSB admits them to that program area. The operating CSB provides appropriate information about the services provided and other clinical information to the CSB that referred the individual to the regional program for clinical record keeping purposes at the referring CSB.
3. The operating CSB ensures that the appropriate information about individuals and services in the regional program is entered into its information system, so that the information can be extracted by the CCS 3 and reported in the CCS 3 and applicable CARS reports. Thus, for performance contract and reporting purposes, individuals receiving services from a regional program operated by that CSB are reported by that operating CSB.
4. Each of the other CSBs with individuals receiving services from this regional program admits those individuals to the applicable program area and provides a service, such as case management, consumer monitoring, or another appropriate service, but not in service(s) provided by the regional program. Thus, individuals receiving services from a regional program will appear in the CCS 3 extracts for two CSBs, but not for the same services.
5. If the other CSBs with individuals receiving services from this regional program provide additional funds to the operating CSB to supplement the funds that the operating CSB receives from the Department for the regional program, these other CSBs show the revenues and expenses for this supplement on the financial forms in their performance contracts, contract revisions, and reports. However, these other CSBs do not show any services provided, individuals served, or costs for the regional program's services on the service forms in their contracts, revisions, or reports. These other CSBs include an explanation on the Financial Comments page of the difference between the expenses on the financial forms and the costs on the service forms. The operating CSB shows the services provided, individuals served, and total costs (including costs supported by supplements from the other CSBs) for the regional program's services on its service forms, but it does not show any revenues or expenses associated with the supplements on the financial pages in its contract, contract revision(s), and reports. The operating CSB includes an explanation of the difference between the expenses on the financial forms and the costs on the service forms on the Financial Comments page.
6. All of the CSBs, to the extent practicable, determine individual CSB allocations of the state and sometimes other funds received from the Department, based on service utilization or an agreedupon formula.
7. Regional programs should receive the same state funding increases as regular CSB grant-funded activities, such as the salary increases for community services provided from time to time by the General Assembly in the Appropriation Act.

This model also could be adapted by a region to handle its LIPOS services, if one CSB receives all of the LIPOS funds, admits all of the individuals receiving LIPOS services, and pays all of the LIPOS providers. Participating CSBs should negotiate this adaptation with the Department.

2. All Participating CSBs-Funded Regional Program Model

1. Each CSB that participates in a regional program that is operated by one of those CSBs receives state and sometimes other funds from the Department for that program. Each participating CSB may supplement this amount with other funds available to it if the funds received from the Department are not sufficient to cover the regional program's expenses. Each participating CSB uses those funds to purchase services from the regional program for the individuals it serves, projects the funding and cost for the regional program in its performance contract) and reports actual individuals served and units of service(s) delivered in its Community Consumer Submission 3 (CCS 3) extracts and reports funding, expenses, costs, and static capacities in its performance contract reports (CARS) only for the individuals it serves.
2. The regional program operated by one of the participating CSBs functions like a contract agency provider. All of the individual, service, static capacity, funding, expense, and cost information for the whole program is maintained separately and is not included in the contract, contract revision(s), reports (CARS), and CCS 3 extracts of the CSB operating the program. The participating CSBs, including the CSB operating the program, include only the parts of this information that apply to the individuals it serves in their contracts, contract revisions, reports, and extracts. The regional program is licensed by the Department, when applicable, and develops and maintains individualized services plans (ISPs) for individuals that it serves.
3. Each participating CSB admits individuals receiving services from the regional program to the applicable program area (all MH, DV, or SA services) for the services provided by the regional program. The services provided by the regional program are listed in the ISPs maintained by the participating CSBs for these individuals. When individuals complete receiving all services from the regional program, they are discharged from the applicable program area by the participating CSB, unless they continue to receive other services in that program area from that participating CSB. The regional program provides appropriate information about the services provided and other clinical information to the CSB that referred the individual to the program, as any contract agency would provide such information to the contracting CSB.
4. Each participating CSB, including the CSB operating the regional program, ensures that the appropriate information about the individuals it serves and their services is entered into its information system, so that the information can be extracted by the CCS 3 and reported in the CCS 3 submissions and applicable CARS reports for that participating CSB.
5. Regional programs should receive the same state funding increases as regular CSB grant-funded activities, such as the salary increases for community services provided from time to time by the General Assembly in the Appropriation Act.

3. Fiscal Agent CSB-Funded Regional Program Model

1. One CSB receives state and sometimes other funds from the Department and acts as the fiscal agent for a regional program. The Department disburses the regional allocation to the fiscal agent CSB on behalf of all CSBs participating in the regional program.

2. The fiscal agent CSB, in collaboration with the other participating CSBs, develops agreed-upon procedures that describe how the CSBs implement the regional program and jointly manage the use of these funds on a regional basis. The procedures also establish and describe how unused funds can be reallocated among the participating CSBs to ensure the greatest possible utilization of the funds. These procedures should be documented in a regional memorandum of agreement (MOA) that is available for review by the Department.
3. The fiscal agent CSB receives the semi-monthly payments of funds from the Department for the regional program. The fiscal agent CSB disburses the regional program funds to individual CSBs, including itself when applicable, in accordance with the procedures in paragraph 2. The fiscal agent CSB displays such disbursements on a Transfer In/Out line of the applicable resources page in its final performance contract revision and its reports. The other CSBs receiving the transferred funds show the receipt of these funds on the same line. CSBs provide more detailed information about these transfers on the Financial Comments pages of contract revisions and reports.
4. Each CSB implementing a regional program accounts for and reports the funds and expenses associated with the program in its final performance contract revision and CARS reports. The fiscal agent CSB displays the total amount of the allocation as funding and all Transfers Out in its CARS reports, but it only displays in its reports the expenses for any regional program that it implements.
5. As an alternative to paragraphs 1 through 4 for some kinds of programs, such as the Discharge Assistance Program, and with the concurrence of the Department, instead of one CSB acting as a fiscal agent, all CSBs participating in that program establish a regional mechanism for managing the use of the regional program funds. The CSBs decide through this regional management mechanism how the total amount of funds for the program should be allocated among them on some logical basis (e.g., approved regional discharge assistance program ISPs). The region informs the Department of the allocations, and the Department adjusts the allocation of each participating CSB and disburses these allocations directly to the participating CSBs. Those CSBs agree to monitor and adjust allocations among themselves during the fiscal year through this regional management mechanism to ensure the complete utilization of these regional program funds, in accordance with the MOA in paragraph 2.
6. Each CSB implementing a regional program ensures that appropriate information about the individuals it serves and their services is entered into its information system, so that the CCS 3 can extract the information and report it in the CCS 3 submissions and applicable CARS reports.
7. Regional programs should receive the same state funding increases as regular CSB grant-funded activities, such as the salary increases for community services provided from time to time by the General Assembly in the Appropriation Act.

A variation of this model, the Fiscal Agent CSB-Funded Regional Local Inpatient POS Program Model, can be used to implement and manage regional local acute psychiatric inpatient bed purchases.

3.a. Fiscal Agent CSB-Funded Regional Local Inpatient POS Program Model

1. One CSB agrees to act as the fiscal agent for the regional Local Inpatient Purchase of Services (LIPOS) program. The Department disburses the regional LIPOS allocation to the fiscal agent CSB on behalf of all of the CSBs participating in the regional LIPOS program.
2. The fiscal agent CSB, in collaboration with all of the participating CSBs and with consultation from the Department, develops procedures that describe how the CSBs will implement the regional LIPOS program and jointly manage the use of these funds on a regional basis. The procedures include regional utilization management mechanisms, such as regional authorization committees (RACs) and regional procurements of beds through contracts with private providers. Such contracts may reserve blocks of beds for use by the region or purchase beds or bed days on an as available basis. The procedures also establish and describe how unused funds can be reallocated among the participating CSBs to ensure the greatest possible utilization of the funds. These procedures should be documented in a regional memorandum of agreement (MOA) that is available for review by the Department.
3. The fiscal agent CSB receives the semi-monthly payments of funds from the Department for the regional LIPOS program. The fiscal agent CSB disburses regional LIPOS funds to individual CSBs or uses such funds itself to pay for the costs of local inpatient hospitalizations that have been approved by a regional review and authorization body established by and described in the MOA in paragraph 2. The fiscal agent CSB displays such disbursements on a Transfer In/Out line of the mental health resources page in its final performance contract revision and reports, and the CSB receiving the transferred funds shows the receipt of these funds on the same line. CSBs provide more detailed information about these transfers on the Financial Comments page of contract revisions and reports.
4. The CSB that purchases local inpatient services accounts for and reports the funds and expenses associated with its LIPOS in its final performance contract revision and CARS reports. The fiscal agent CSB displays the total amount of the allocation as funds and all Transfers Out in its CARS reports, but it displays in its reports only the expenses for its own LIPOS.
5. The CSB that purchases the local inpatient services ensures that appropriate information about individuals, services, and costs is entered into its management information system, so that the CCS 3 can extract the information and report it in the CCS 3 submissions and applicable CARS reports.
6. Regional programs should receive the same state funding increases as regular CSB grant-funded activities, such as the salary increases for community services provided from time to time by the General Assembly in the Appropriation Act.

4. Fiscal Agent CSB-Funded Contract Agency Regional Program Model

1. One CSB receives state and sometimes other funds from the Department and acts as the fiscal agent for a regional program that is contracted by this fiscal agent CSB to a public or private agency. The Department disburses the regional allocation to the fiscal agent CSB on behalf of all CSB participating in the contracted regional program.

2. The fiscal agent CSB contracts with and provides set monthly payments to a regional program provided by a public or private contract agency on behalf of all of the CSB participating in this regional program. The contract may purchase a pre-set amount of specified services from the contract agency and pay the agency a predetermined cost, whether or not the participating CSBs use the services.

3. Each participating CSB referring one of the individuals it serves to this contracted regional program admits the individual, enrolls him in the regional program service, and refers him to the contract agency. The contract agency provides information to the referring (case management) CSB, and that CSB maintains information about the individual and the service units in its information system, where the CCS 3 can extract the information.

4. The fiscal agent CSB provides program cost information to each referring CSB, based on its use of the regional program, and the referring CSB enters this information in the cost column of the program services form (pages AP-1 through AP-4) but does not enter any funding or expenditure information in its performance contract report (CARS). The fiscal agent CSB enters the funding and expenditure information associated with the regional program on the financial forms in its performance contract report, but it enters cost information on the program services form only for the individuals that it referred to the regional program. Each CSB will explain the differences between the financial and program service forms in its performance contract report on the Financial Comments page. The Department will reconcile the differences among the participating CSBs' reports using these comments. Because of the difficulty in calculating the program cost information for each participating CSB, program cost information would only need to be included in end of the fiscal year performance contract (CARS) reports.

5. All of the participating CSBs, to the extent practicable, determine individual CSB allocations of the state and sometimes other funds received from the Department, based on service utilization or an agreed-upon formula.

6. Regional programs should receive the same state funding increases as regular CSB grant-funded activities, such as the salary increases for community services provided from time to time by the General Assembly in the Appropriation Act.

This model also could be adapted by a region to handle its LIPOS services, if one CSB acts as the fiscal agent and pays all of the LIPOS providers. This adaptation should be negotiated with the Department by the participating CSBs.

Core Services Taxonomy 7.3

Appendix F: Regional Program Procedures

A regional program is funded by the Department through the community services board or behavioral health authority, hereafter referred to as the CSB, and operated explicitly to provide services to individuals who receive services from the CSBs participating in the program.

1. Purpose

The CSB may collaborate and act in concert with other CSBs or with other CSBs and state hospitals or training centers, hereafter referred to as state facilities, to operate regional programs, provide or purchase services on a regional basis, conduct regional utilization management, or engage in regional quality improvement efforts. Regional programs include regional discharge assistance programs (RDAP), local inpatient purchases of services (LIPOS), and other programs such as residential or ambulatory crisis stabilization programs. These procedures apply to all regional programs. While this appendix replaces earlier regional memoranda of agreement (MOAs), CSBs, state facilities, private providers participating in the regional partnership, and other parties may still need to develop MOAs to implement specific policies or procedures to operate regional or sub-regional programs or activities. Also, an MOA must be developed if a regional program intends to established a peer review committee (e.g., a regional utilization review and consultation team) whose records and reviews would be privileged under § 8.01-581.16 of the Code of Virginia. When the CSB receives state or federal funds from the Department for identified regional programs or activities, it shall adhere to the applicable parts of these procedures, which are subject to all applicable provisions of the community services performance contract. In the event of a conflict between any regional program procedures and any provisions of the contract, provisions of the contract shall apply.

2. Regional Management Group (RMG)

a. The participating CSBs and state facilities shall establish an RMG. The executive director of each participating CSB and the director of each participating state facility shall each serve on or appoint one member of the RMG. The RMC shall manage the regional program and coordinate the use of funding provided for the regional program, review the provision of services offered through the regional program, coordinate and monitor the effective utilization of the services and resources provided through the regional program, and perform other duties that the members mutually agree to carry out. An RMG may deal with more than one regional program.

b. Although not members of the RMG, designated staff in the Central Office of the Department shall have access to all documents maintained or used by this group, pursuant to applicable provisions of the performance contract, and may attend and participate in all meetings or other activities of this group.

c. In order to carry out its duties, the RMG may authorize the employment of one or more regional managers to be paid from funds provided for a regional program and to be employed by a participating CSB. The RMG shall specify the job duties and responsibilities for and supervise the regional manager or managers.

3. Regional Utilization Review and Consultation Team (RURCT)

a. The RMG shall establish a RURCT pursuant to § 8.01-581.16 of the Code of Virginia to, where applicable:

1.) review the implementation of the individualized services plans (ISPs) or individualized Discharge Assistance Program plans (IDAPPs) developed through the regional program to ensure that the services are the most appropriate, effective, and efficient services that meet the clinical needs of the individual receiving services and report the results of these reviews to the RMG;

2.) review individuals who have been on the state facility extraordinary barriers to discharge list for more than 30 days to identify or develop community services and funding appropriate to their clinical needs and report the results of these reviews and subsequent related actions to the RMG;

3.) review, at the request of the case management CSB, other individuals who have been determined by state facility treatment teams to be clinically ready for discharge and identify community services and resources that may be available to meet their needs;

4.) facilitate, at the request of the case management CSB, resolution of individual situations that are preventing an individual's timely discharge from a state facility or a private provider participating in the regional partnership or an individual's continued tenure in the community;

5.) identify opportunities for two or more CSBs to work together to develop programs or placements that would permit individuals to be discharged from state facilities or private providers participating in the regional partnership more expeditiously;

6.) promote the most efficient use of scarce and costly services; and

7.) carry out other duties or perform other functions assigned by the RMG.

b. The RURCT shall consist of representatives from participating CSBs in the region, participating state facilities, private providers participating in the regional partnership, and others who may be appointed by the RMG, such as the regional manager(s) employed pursuant to section II.C. The positions of the representatives who serve on this team shall be identified in local documentation.

c. The RURCT shall meet monthly or more frequently when necessary, for example, depending upon census issues or the number of cases to be reviewed. Minutes shall be recorded at each meeting. Only members of the team and other persons who are identified by the team as essential to the review of an individual's case, including the individual's treatment team and staff directly involved in the provision of services to the individual, may attend meetings. All proceedings, minutes, records, and reports and any information discussed at these meetings shall be maintained confidential and privileged, as provided in § 8.01-581.17 of the Code of Virginia.

d. For the regional program, the RURCT or another group designated by the RMG shall maintain current information to identify and track individuals served and services provided through the regional program. This information may be maintained in participating CSB information systems or in a regional data base. For example, for the RDAP, this information shall include the individual's name, social security number or other unique

identifier, other unique statewide identifier, legal status, case management CSB, state hospital of origin, discharge date, state re-hospitalization date (if applicable), and the cost of the IDAPP. This team shall maintain automated or paper copies of records for each RDAP-funded IDAPP. Changes in responsibilities of the case management CSB, defined in the core services taxonomy, and the transfer of RDAP funds shall be reported to the Offices of Grants Management and Mental Health Services in the Department as soon as these changes or transfers are known or at least monthly.

e. For RDAP, the RURCT shall conduct utilization reviews of ISPs as frequently as needed to ensure continued appropriateness of services and compliance with approved IDAPPs and reviews of quarterly utilization and financial reports and events related to the individual such as re-hospitalization, as appropriate. This utilization review process may result in revisions of IDAPPs or adjustment to or redistribution of RDAP funds. This provision does not supersede utilization review and audit processes conducted by the Department pursuant to the performance contract.

f. Although not members of the RURCT, designated staff in the Central Office of the Department shall have access to all documents, including ISPs or IDAPPs, maintained or used by this body, pursuant to applicable provisions of the performance contract, and may attend and participate in all meetings as non-voting members and in other activities of this team.

4. **Operating Procedures for Regional Programs:** These operating procedures establish the parameters for allocating resources for and monitoring continuity of services provided to individuals receiving regional program services. Some of the procedures apply to regional programs generally; others apply to particular regional programs, although they may be able to be adapted to other regional programs.

   a. Funding for a regional program shall be provided and distributed by the Department to participating CSBs or to a CSB on behalf of the region through their community services performance contracts in accordance with the conditions specified the contract, often in an Exhibit D.

   b. Each participating CSB or a CSB on behalf of the region shall receive semi-monthly payments of state funds from the Department for the regional program through its community services performance contract, as long as it satisfies the requirements of this appendix and the performance contract, based upon its total base allocation of previously allotted and approved regional program funds.

   c. Participating CSBs and state facilities shall develop agreed-upon procedures that describe how they will implement a regional program and jointly manage the use of regional program funds on a regional basis. These procedures shall be reduced to writing and provided to the Department upon request.

   d. Regional program funds may be used to support the activities of the RMG and RURCT.

   e. Within the allocation of funds for the regional program, funds may be expended for any combinations of services and supports that assure that the needs of individuals are met in community settings. ISPs or IDAPPs must be updated and submitted, as revisions occur or substitute plans are required, to the RMG for approval according to procedures approved by the RMG.

f. Regional program funds used to support ISPs or IDAPPs shall be identified on a fiscal year basis. Amounts may be adjusted by the RMG to reflect the actual costs of care based on the regional program's experience or as deemed appropriate through a regional management and utilization review process.

g. The CSB responsible for implementing an individual's regional program ISP or IDAPP shall account for and report the funds and expenses associated with the regional program ISP or IDAPP in its community services performance contract and in its quarterly performance contract reports submitted through the Community Automated Reporting System (CARS).

h. The CSB responsible for implementing an individual's regional program ISP or IDAPP shall ensure that the appropriate information about that individual and his or her services is entered into its management information system so that the information can be extracted by the Community Consumer Submission (CCS) and reported in the monthly CCS extracts and applicable CARS reports to the Department.

i. The participating CSBs may use regional program funds to establish and provide regional or sub-regional services when this is possible and would result in increased cost effectiveness and clinical effectiveness.

j. Operation of a RDAP is governed by the Discharge Assistance Program Manual issued by the Department and provisions of Exhibit C of the performance contract.

5. ~~General Terms and Conditions~~

a. ~~CSBs, the Department, and any other parties participating in a regional program agree that they shall comply with all applicable provisions of state and federal law and regulations in implementing any regional programs to which these procedures apply. The CSB and the Department shall comply with or fulfill all provisions or requirements, duties, roles, or responsibilities in the current community services performance contract in their implementation of any regional programs pursuant to these procedures.~~

b. ~~Nothing in these procedures shall be construed as authority for the CSB, the Department, or any other participating parties to make commitments that will bind them beyond the scope of these procedures.~~

c. ~~Nothing in these procedures is intended to, nor does it create, any claim or right on behalf of any individual to any services or benefits from the CSB or the Department.~~

6. ~~Privacy of Personal Information~~

a. ~~The CSB, the Department, and any other parties participating in a regional program agree to maintain all protected health information (PHI) learned about individuals receiving services confidential and agree to disclose that information only in accordance with applicable state and federal law and regulations, including the regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 CFR Part 2, the Virginia Health Records Privacy Act, the Department's human rights regulations, and each party's own privacy policies and practices. The organization operating the regional program shall provide a notice to individuals participating in or receiving services from the regional program that it may share protected information about them and the services they receive, as~~

~~authorized by HIPAA and other applicable federal and state statutes and regulations. The organization shall seek the authorization of the individual to share this information whenever possible.~~

b. ~~Even though each party participating in a regional program may not provide services directly to each of the individuals served through the regional program, the parties may disclose the PHI of individuals receiving services to one another under 45 C.F.R. § 164.512(k)(6)(ii) in order to perform their responsibilities related to this regional program, including coordination of the services and functions provided under the regional program and improving the administration and management of the services provided to the individuals served in it.~~

c. ~~In carrying out their responsibilities in the regional program, the CSB, the Department, and any other parties involved in this regional program may use and disclose PHI to one another to perform the functions, activities, or services of the regional program on behalf of one another, including utilization review, financial and service management and coordination, and clinical case consultation. In so doing, the parties agree to:~~

1.) ~~Not use or further disclose PHI other than as permitted or required by the performance contract or these procedures or as required by law;~~

2.) ~~Use appropriate safeguards to prevent use or disclosure of PHI other than as permitted by the performance contract or these procedures;~~

3.) ~~Report to the other parties any use or disclosure of PHI not provided for by the performance contract or these procedures of which they become aware;~~

4.) ~~Impose the same requirements and restrictions contained in the performance contract or these procedures on their subcontractors and agents to whom they provide PHI received from or created or received by the other parties to perform any services, activities, or functions on behalf of the other parties;~~

5.) ~~Provide access to PHI contained in a designated record set to the other parties in the time and manner designated by the other parties or at the request of the other parties to an individual in order to meet the requirements of 45 CFR 164.524;~~

6.) ~~Make available PHI in its records to the other parties for amendment and incorporate any amendments to PHI in its records at the request of the other parties;~~

7.) ~~Document and provide to the other parties information relating to disclosures of PHI as required for the other parties to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528;~~

8.) ~~Make their internal practices, books, and records relating to use and disclosure of PHI received from or created or received by the other parties on behalf of the other parties, available to the Secretary of the U.S. Department of Health and Human Services for the purposes of determining compliance with 45 CFR Parts 160 and 164, subparts A and E;~~

9.) ~~Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that they create, receive, maintain, or transmit on behalf of the other parties as required by the HIPAA Security Rule, 45 C.F.R. Parts 160, 162, and 164;~~

10.) ~~Ensure that any agent, including a subcontractor, to whom they provide electronic PHI agrees to implement reasonable and appropriate safeguards to protect it;~~

11.) ~~Report to the other parties any security incident of which they become aware; and~~

12.) ~~At termination of the regional program, if feasible, return or destroy all PHI received from or created or received by the parties on behalf of the other parties that the parties still maintain in any form and retain no copies of such information or, if such return or destruction is not feasible, extend the protections in this appendix to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.~~

~~d. Each of the parties may use and disclose PHI received from the other parties, if necessary, to carry out its legal responsibilities and for the proper management and administration of its business. Each of the parties may disclose PHI for such purposes if the disclosure is required by law, or if the party obtains reasonable assurances from the person to whom the PHI is disclosed that it will be held confidentially, that it will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and that the person will notify the party of any instances of which it is aware in which the confidentiality of the information has been breached.~~

~~**7. Reporting:** The CSB shall provide all required information (e.g., the number of individuals receiving services, the total expenditures for the regional program, and the total amount of regional program restricted funds expended) to the Department about the regional programs in which it participates, principally through CCS and CARS reports. CSBs shall not be required to submit more frequent standard reports or reports on individuals, unless such requirements have been established in accordance with the applicable sections of the performance contract. The CSB also shall identify all individuals in regional programs that it serves in its CCS extract submissions using the applicable consumer designation codes.~~

8. Project Management

a. The Department shall be responsible for the allocation of regional program state and federal funds and the overall management of the regional program at the state level.

b. The RMG shall be responsible for overall management of the regional program and coordination of the use of funding provided for the regional program in accordance with these procedures.

c. The CSB shall be responsible for managing regional program funds it receives in accordance with these regional program procedures.

d. Payments generated from third party and other sources for any regional program shall be used by the region or CSB to offset the costs of the regional program. The CSB shall collect and utilize all available funds from other appropriate specific sources before using state and federal funds to ensure the most effective use of these state and federal funds. These other sources include Medicare; Medicaid-fee-for service, targeted case management payments, rehabilitation payments, and ID waiver payments; other third party payors; auxiliary grants; SSI, SSDI, and direct payments by individuals; payments or contributions of other resources from other agencies, such as social services or health departments; and other state, local, or Department funding sources.

e. The Department may conduct on-going utilization review and analyze utilization and financial information and events related to individuals served, such as re-hospitalization, to ensure the continued appropriateness of services and to monitor the outcomes of the regional program. The utilization review process may result in adjustment to or reallocation of state general and federal funding allocations for the regional program.

9. ~~**Compensation and Payment:** The Department shall disburse semi-monthly payments of state general and federal funds to the CSB for the regional program as part of its regular semimonthly disbursements to the CSB.~~

~~Appendix G: Core Services Taxonomy Work Group Commentary~~

~~The following comments reflect the deliberations and decisions of the Core Services Taxonomy Work Group and the VACSB Data Management Committee. These comments are included for information or historical background purposes.~~

~~Peer-provided services are included and reported where they are delivered, for example, in outpatient, rehabilitation, or residential services, rather than in consumer-run services. Peerprovided services are provided by individuals who identify themselves as having mental health, substance use, or co-occurring disorders and are receiving or have received mental health, substance abuse, or co-occurring services. The primary purpose of peer-provided services is to help others with mental health, substance use, or co-occurring disorders. Peer-provided services involve partnering with non-peers, such as being hired by community mental health or substance abuse programs in designated peer positions or traditional clinical positions. Peers may serve as recovery coaches, peer counselors, case managers, outreach workers, crisis workers, and residential staff, among other possibilities. Units of service provided by peers in core services should be included with all service units collected and reported through the CCS. CSBs will report the numbers of peers they employ in each program area to provide core in their CARS management reports.~~

~~*Family Support* was a separate core services subcategory in Taxonomy 6; however, it was eliminated as a separate subcategory in Taxonomy 7. Family support offers assistance for families who choose to provide care at home for family members with mental disabilities. Family support is a combination of financial assistance, services, and technical supports that allows families to have control over their lives and the lives of their family members. Family is defined as the natural, adoptive, or foster care family with whom the person with a mental disability resides. Family can also mean an adult relative (i.e., sister, brother, son, daughter, aunt, uncle, cousin, or grandparent) or interested person who has been appointed full or limited guardian and with whom the person with the mental disability resides. The family defines the support. While it will be different for each family, the support should be flexible and individualized to meet the unique needs of the family and the individual with the mental disability. Family support services include respite care, adaptive equipment, personal care supplies and equipment, behavior management, minor home adaptation or modification, day care, and other extraordinary needs. Funds and expenses for family support activities should be included in the applicable core service subcategories, but numbers of individuals would not be included separately, since those individuals are already receiving the service in the category or subcategory. If an individual is receiving nothing but family support, he or she should be opened to consumer monitoring and the family member with a mental disability would be counted and reported as an individual receiving services in consumer monitoring.~~

~~*Consultations* include professional and clinical consultations with family assessment and planning teams (CSA), other human services agencies, and private providers. No ISPs are developed, and~~

Department licensing is not required. In consultations, CSB staff members are not providing services or care coordination to individuals; the staff are only consulting with service providers and other agencies about individuals who are receiving services from other organizations. Since there are no individuals receiving services counted for consultations, service units will be collected through the z-consumer function in the CCS. Traditionally, consultations have been and will continue to be included in outpatient or case management services. However, if a CSB is providing other services, this is not a consultation situation; the CSB opens a case for the individual or admits the individual to a program area, depending on the other services received. For example, if a CSB is providing significant amounts of staff support associated with FAPT or Title IV-E activities, it may include this support as part of consumer monitoring services.

Appendix H: REACH Services Crosswalk and Reporting Requirements

This exhibit provides guidance to the CSBs providing Regional Education Assessment Crisis Services and Habilitation (REACH) program services about how to report those services in their monthly CCS 3 submissions to the Department. REACH program services must be reported only in emergency services, ancillary services and the developmental services program area; they must not be reported in the mental health services or substance abuse services program areas. There are only seven services that CSBs providing REACH program services directly or contractually must include in their information systems in a way that information about them can be extracted and exported to the Department through CCS 3. These services are:

1. **100 Emergency Services,** licensed by the Department as crisis intervention services;
2. **390 Consumer Monitoring Services** (ancillary services), not licensed by the Department;
3. **720 Assessment and Evaluation Services** (ancillary services), not licensed by the Department;
4. **420 Ambulatory Crisis Stabilization Services** (in the developmental services program area), licensed by the Department as mental health non-residential crisis stabilization;
5. **510 Residential Crisis Stabilization Services** (in the developmental services program area), licensed by the Department as mental health residential crisis stabilization services for adults;
6. **521 Intensive Residential Services** (in the developmental services program area),licensed by the Department as intellectual disability residential therapeutic respite group home services for adults – includes ID assessment/treatment beds; and
7. **581 Supportive Residential Services** (in the developmental services program area), licensed by the Department as REACH intellectual disability supportive in-home services for adults.

These are the only services provided to individuals who have been determined to be served in the REACH program that should be included in CCS 3 submissions to the Department. When they provide them, CSBs that operate or contract for REACH program services must include the following information about these seven services in their CCS 3 submissions.

Consumer File: Include all applicable CCS 3 consumer data elements on an individual receiving REACH program services if the individual has not already been admitted to the developmental services program area (for services 4 through 7 above) or if the CSB has not opened a case on the individual for emergency services or ancillary services (for services 1 through 3 above).

~~**Type of Care File:** Include a type of care file on the individual if he or she receives services 4 through 7 above and has not already been admitted to the developmental services program area.~~

~~**Service Files:** Include service files to report receipt of:~~

1. ~~Emergency services (pseudo program area code 400 and service code 100) if the individual receives crisis intervention services,~~
2. ~~Consumer monitoring (pseudo program area code 400 and service code 390) if the individual receives consumer monitoring services,~~
3. ~~Assessment and evaluation (pseudo program area code 400 and service code 720) if the individual receives assessment and evaluation services,~~
4. ~~Ambulatory crisis stabilization (developmental services program area code 200 and service code 420) if the individual receives mental health non-residential crisis stabilization,~~
5. ~~Residential crisis stabilization (developmental services program area code 200 and service code 510) if the individual receives mental health residential crisis stabilization services for adults,~~
6. ~~Intensive residential services (developmental services program area code 200 and service code 521) if the individual receives intellectual disability residential therapeutic respite group home services for adults, or~~
7. ~~Supportive residential services (developmental services program area code 200 and service code 581) if the individual receives REACH intellectual disability supportive in-home services for adults.~~

~~When they provide these services, CSBs that operate or contract for REACH program services also must include funding, expenditure, cost, and static capacity information about these seven services in their quarterly CARS Reports submitted to the Department.~~