



# COMMONWEALTH of VIRGINIA

DEPARTMENT OF  
MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

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JAMES S. REINHARD, M.D.  
COMMISSIONER

## MEMORANDUM

**ACTION:** Community Services Board, Local Government Department, and Behavioral Health Authority Executive Directors

**INFO:** State Hospital and Training Center Directors  
State Mental Health, Mental Retardation and Substance Abuse Services Board  
Mental Health, Mental Retardation, and Substance Abuse Services Advocates

**FROM:** Paul R. Gilding  
Community Contracting Director

**SUBJECT:** **FY 2009 Community Services Performance Contract; Central Office, State Facility, and Community Services Board Partnership Agreement; and Community Services Performance Contract General Requirements Document**

**DATE:** **May 6, 2008**

Attached for your use or information are the FY 2009 contract documents: the Community Services Performance Contract, Partnership Agreement, and General Requirements Document. They are available on the Department's web site at [www.dmhmrzas.virginia.gov](http://www.dmhmrzas.virginia.gov). The Department will distribute Letters of Notification and the CARS-ACCESS contract software electronically this week. Letters of Notification contain initial allocations of state and federal funds to community services boards (CSBs), behavioral health authorities, and local government departments with policy-advisory CSBs, all of which are referred to as Boards or CSBs in the contract documents and this memorandum. The Department will communicate allocations of the new state funds appropriated by the 2008 General Assembly associated with the mental health law reform legislation separately in June.

The attached contract documents reflect comments received during the 60-day public comment period required by § 37.2-508 of the *Code of Virginia*, the work of the Performance Contract Committee established by the Department and the Virginia Association of Community Services Boards, and comments from Department staff. The Office of the Attorney General has reviewed these contract documents. Given the complete rewriting of the performance contract for FY 2004 and positive reaction to the FY 2005, FY 2006, FY 2007, and FY 2008 versions of the contract, the Department and the Performance Contract Committee decided to focus major revisions or changes in the FY 2009 contract in only a few areas. Thus, many parts of the contract documents remain substantially unchanged.

## **FY 2009 Performance Contract Documents**

May 6, 2008

Page 2

### **General Changes in FY 2009 Contract Documents**

The FY 2009 contract documents reflect minor changes in many places, such as improved grammar or syntax, increased clarity, and updated references. Throughout the documents, "mental retardation" is replaced with "intellectual disabilities" when referring to the condition individuals have; mental retardation is retained when referring to the services that address those disabilities. This change mirrors the changes several years ago with substance abuse and substance use disorder.

### **Performance Contract Changes**

1. Revised section 4.c.2.) on page 3 to include inpatient psychiatric hospitals and units in the Linkages with Health Care section.
2. Revised section 4.c.3.) on page 4 to apply this coordination section to involuntary, rather than voluntary, admissions.
3. Revised section 6.b.2.) at the top of page 6 to add private providers participating as signatories in regional partnerships to parties implementing regional utilization management procedures and practices.
4. Added section 6.b.3.) on page 6 to reference Exhibit B: Continuous Quality Improvement Process.
5. Added section 6.b.4.) f.) on page 6 about the Board's recovery orientation.
6. Added section 6.b.6.) on page 7 about Board response to complaints.
7. Added section 6.c.4.) on page 8 about streamlining reporting requirements.
8. Added section 7.b.5.) on page 10 about the recovery orientation of state hospitals.
9. Added language in section 7.c.1.) on page 11 about the Continuous Quality Improvement Process.
10. Added language in section 7.c.3.) on page 11 to include private providers participating as signatories in regional partnerships to parties implementing regional utilization management procedures and practices.
11. Added section 7.c.4.) on page 11 about Central Office's recovery orientation.
12. Added language in section 7.d.4.) on page 12 about the Department complying with Procedures for Approving CSB Surveys, Questionnaires, and Data Collection Instruments and Establishing Reporting Requirements.
13. Added section 7.d.5.) on page 12 about streamlining reporting requirements.
14. Added section 9.d.2.) on page 14 about the Board terminating the performance contract.
15. Added language to the Areas for Future Resolution, section 10.b, on page 16 about developing the second phase of the Mental Health and Substance Abuse Services Performance Expectations and Goals.
16. Added language to section 10.c on page 17 about planning for the implementation of the Health Information Exchange and the Electronic Health Record.
17. Added new section 10.d on page 17 on developing Co-Occurring Disorder Treatment Performance Expectations and Goals.
18. Added new section 10.e on page 17 about developing Regional Management Structures or Processes for Consumers Moving Among Regions or Providers.

## **FY 2009 Community Services Performance Contract**

### **FY 2009 Performance Contract Documents**

May 6, 2008

Page 3

19. Added new section 10.f on page 17 on revising the Discharge Planning Protocols and the Continuity of Care Procedures.
20. Revised Exhibit A (pages 29-32) Forms 11, 21, 31, and 01 to delete projecting service capacities, total units, contract units, and units per capacity in the performance contract.
21. Added new Appendix B: Continuous Quality Improvement Process on pages 33-41 to include the new Emergency Services, Mental Health and Substance Abuse Case Management Services, and Data Quality Performance Expectations and Goals.
22. Added language in Appendix C on page 42 about the Board developing a plan to assess and increase its recovery orientation over time.
23. Revised language in Exhibit E on pages 44-49 to link some semi-monthly payments to submission of monthly CCS 3 extract files and to require Boards to submit plans of correction for audit deficiencies (an Virginia Auditor of Public Accounts requirement).
24. Revised Exhibit H on page 55 to delete reporting Board member characteristics except for the numbers of consumers and family members.
25. Revised Exhibit J on pages 60-63 to separate Regional Program Operating Principles from Regional Programs Procedures (moved to Appendix D of the General Requirements Document) and to delete the regional program models.

### **Partnership Agreement Changes**

1. Added a reference to Critical Success Factors at the bottom of page 1.
2. Added references on page 3 in the first State Facilities item for state facility admission criteria.
3. Added language at the bottom of page 3 in the next to the last paragraph to include other providers involved in the services system through participation in regional partnerships.
4. Added a new section on page 6 to include the Critical Success Factors from the Integrated Strategic Plan.
5. Revised section 9 on page 9 to reflect the current composition of the System Leadership Council and the current role of the System Operations Team.

### **General Requirements Document Changes**

1. Added language on page 15 after section 1.c. regarding single audit requirements.
2. Revised language on page 15 in section III.B.2 to reflect current terminology about disaster response and emergency preparedness requirements.
3. Revised the Crosswalk Between Licensing Regulations and CARF Standards on pages 19-21 to reflect the 2008 CARF Standards.
4. Revised Appendix A: Continuity of Care Procedures on pages 22-23 and 30 to reflect revised state hospital admission criteria in Chapter 8 of Title 37.2 of the *Code of Virginia*.
5. Revised Appendix A on page 28 to reflect use of the Emergency Care Admission Intake Form for state training centers.
6. Revised Appendix A on pages 26 and 27 to reflect *Code* changes regarding assessments required for state hospital admissions.
7. Revised section 5 in Appendix C on page 40 about Services for persons at-risk of HIV/AIDS.

## FY 2009 Community Services Performance Contract

### FY 2009 Performance Contract Documents

May 6, 2008

Page 4

8. Added Appendix D: Regional Program Procedures on pages 43-50 to reflect the work of the Regional Programs Work Group.

All of the contract's Exhibit A will be submitted electronically, using CARS-ACCESS software supplied by the Department. More detailed information about which parts of the contract must be submitted on paper is contained in Exhibit E of the contract, the Performance Contract Process. CARS-ACCESS also contains Table 2: FY 2009 Board Management Salary Costs, which enables CSBs and the Department to respond to requirements in § 37.2-504 of the *Code of Virginia*. This table also collects FTE information by program area. Last year, a column was added to Table 2 to report peer providers. Peer providers are staff who self-identify as consumers and have been hired specifically as peer providers. Staff who have not been hired as peer providers, even if they have a mental illness, mental retardation, or a substance use disorder, should not be reported as peer-providers.

The Department is distributing FY 2009 contract documents electronically, rather than as paper copies by mail. This enables the Department to distribute these contract documents more quickly and easily and allows recipients to distribute the documents to others more rapidly and efficiently. To be accepted for processing by the Department, a performance contract must satisfy the criteria in Exhibits E and I of the contract.

1. Exhibits A and H (first two pages) and Table 2 must be submitted to the Department's Office of Information Technology Services using CARS-ACCESS software and must be complete and accurate.
2. Since the contract is being distributed electronically to CSBs, the parts of the contract that are submitted on paper should be printed, signed where necessary, and mailed to the Office of Community Contracting at the same time that Exhibits A and H are submitted. These parts include: the signature page of the contract body (page 18), the Board's current organization chart (the third page of Exhibit H); Exhibit B, Exhibit D (if applicable), Exhibit F (two pages), the first page of Exhibit G, Exhibit K (if applicable), and the signature page of the Partnership Agreement (page 10). The second page of Exhibit G must be submitted as soon as possible and no later than September 30. The Department must receive all parts of the contract that are submitted on paper before a contract submission will be considered to be complete.
3. Exhibit A must conform to the allocations of state and federal funds in the Letter of Notification enclosures, unless amounts have been revised by or changes negotiated with the Department and confirmed by the Department in writing. Revenues must equal costs on all contract forms or differences must be explained on the Financial Comments form.
4. Contracts must contain actual appropriated amounts of local matching funds. If a CSB cannot include the minimum 10 percent local matching funds in its contract, it must submit a written request for a waiver of the matching funds requirement, pursuant to § 37.2-509 of the *Code of Virginia*, to the Office of Community Contracting with its contract. More information about the waiver request is contained in an attachment to this memorandum.

The FY 2009 contract and other materials described above are due in the Department's Office of Community Contracting by **June 20, 2008**, except for Exhibits A and H (the first two pages), which are submitted to the Department's Office of Information Technology Services by the same date. More detailed information about submitting Exhibits A and H (the first two pages) in CARS-ACCESS will be provided in the Performance Contract Workshops, conducted by Department staff during May.

## FY 2009 Community Services Performance Contract

### FY 2009 Performance Contract Documents

May 6, 2008

Page 5

Section 37.2-508 or 37.2-608 of the *Code of Virginia* requires that the CSB or behavioral health authority make its proposed performance contract available for public review and solicit public comment for a period of 30 days before submitting it for the approval of the operating or administrative policy CSB or behavioral health authority board of directors or the comments of the local government department's policy advisory CSB. That same *Code* section authorizes the Department to provide up to six semi-monthly payments of state and federal funds to allow sufficient time to complete public review and comment, local government approval, and Department negotiation and approval of the contract.

The Performance Contract Process (Exhibit E in the contract) automatically provides the first two semi-monthly July payments to all CSBs, whether or not a contract has been submitted. The Process conditions the next four semi-monthly payments (two in August and two in September) on the Department's receipt of a complete performance contract. Once a performance contract is received in the Department, the CSB's Community Contracting Administrator will review it and notify the CSB within five working days that it is or is not accepted for review by the Department. Unacceptable contracts will need to be revised before the Department will process them. For CSBs, please call or e-mail your Community Contracting Administrator if you have any questions about this package. If other recipients of this memorandum have any questions about it or the attached documents, please e-mail me at [paul.gilding@co.dmhmrzas.virginia.gov](mailto:paul.gilding@co.dmhmrzas.virginia.gov) or call me at (804) 786-4982. Thank you.

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## FY 2009 Community Services Performance Contract

### Minimum Ten Percent Local Matching Funds Waiver Request Attachment

A Board should maintain its local matching funds at least at the same level as that shown in its FY 2008 final performance contract revision. The 2008 Appropriation Act prohibits using state funds to supplant local governmental funding for existing services. Board includes operating and administrative policy community services boards (CSBs), local government departments with policy-advisory CSBs, and behavioral health authorities.

If a Board is not able to include at least the minimum 10 percent local matching funds, required by § 37.2-509 of the *Code of Virginia* and State Board Policy 4010, in its original performance contract, any subsequent contract revision, or its mid-year or end of the fiscal year performance contract reports, it must submit a written request for a waiver of that requirement, pursuant to § 37.2-509 of the *Code of Virginia* and State Board Policy 4010, to the Office of Community Contracting with the original or revised contract or performance contract reports.

In accordance with sections 7.e.3.), g, and i., if only a Board's participation in the Discharge Assistance Project (DAP), its receipt of reinvestment funds, or its participation in a regional program, as defined in Exhibit J of the contract, causes it to be out of compliance with the 10 percent local matching funds requirement in § 37.2-509 of the *Code of Virginia*, the Department will grant an automatic waiver of that requirement, related to the funds for the DAP, reinvestment program, or regional program. The Board must submit a written request for the waiver, identifying the specific amounts and types of those funds that cause it to be out of compliance with the local matching funds requirement, but without the documentation required below in items 3, 4, and 5, and the Department will approve an automatic waiver in a letter to the Board.

1. State Board Policy 4010 defines acceptable local matching funds as local government appropriations, philanthropic cash contributions from organizations and individuals, in-kind contributions of space, equipment, professional services (for which the Board would otherwise have to pay), and, in certain circumstances, interest revenue. All other revenues, including fees, federal grants, and other funds, as well as uncompensated volunteer services, are not acceptable as local matching funds.
2. Section 37.2-509 of the *Code of Virginia* states that allocations of state funds to any Board for operating expenses, including salaries and other costs, shall not exceed 90 percent of the total amount of state and local matching funds provided for these expenses. This section effectively defines the 10 percent minimum amount of local matching funds as 10 percent of the total amount of state and local matching funds.
3. The written waiver request must include an explanation of each local government's inability to provide sufficient local matching funds at this time. This written explanation could include, among other circumstances, the following factors:
  - a. an unusually high unemployment rate, compared with the statewide or regional average unemployment rate;
  - b. a decreasing tax base or declining tax revenues;
  - c. the existence of local government budget deficits; or
  - d. major unanticipated local government capital or operating expenditures (e.g., for flood damage).
4. Additionally, the waiver request must include information and documentation about the Board's efforts to obtain sufficient local matching funds. Examples of such efforts could include newspaper articles, letters from Board members to local governing bodies outlining statutory matching funds requirements, and Board resolutions.
5. Finally, the waiver request must include a copy of the Board's budget request that was submitted to each local government and a copy or description of the local government's response to the request.

## FY 2009 Community Services Performance Contract

<b>Table of Contents</b>			
1. <b>Contract Purpose</b>	2	f. Individualized Services	12
2. <b>Relationship</b>	2	g. Compliance Requirements	12
3. <b>Contract Term</b>	3	h. Communication	13
4. <b>Scope of Services</b>	3	i. Regional Programs	13
a. Services	3	8. <b>Subcontracting</b>	13
b. Expenses for Services	3	9. <b>Terms and Conditions</b>	13
c. Continuity of Care	3	a. Availability of Funds	13
d. Populations Served	4	b. Compliance	14
5. <b>Resources</b>	4	c. Disputes	14
a. Allocations of Funds	5	d. Termination	14
b. Conditions of the Use of Resources	5	e. Remediation Process	14
6. <b>Board Responsibilities</b>	5	f. Dispute Resolution Process	15
a. State Hospital Bed Utilization	5	g. Contract Amendment	16
b. Quality of Care	5	h. Liability	16
c. Reporting Requirements	7	i. Severability	16
d. Discharge Assistance Project	8	10. <b>Areas for Future Resolution</b>	16
e. Individualized Services	9	a. Evidence-Based Practices	16
f. Compliance Requirements	9	b. MH & SA Service Performance Expectations and Goals	16
g. Regional Programs	10	c. Data Quality and Use	16
h. Joint Agreements	10	d. Co-Occurring Disorder Treatment Goals and Expectations	17
7. <b>Department Responsibilities</b>	10	e. Regional Management Structures or Processes	17
a. Funding	10	f. Discharge Planning Protocols	17
b. State Facility Services	10	11. <b>Signatures</b>	18
c. Quality of Care	10		
d. Reporting Requirements	11		
e. Discharge Assistance Project	12		

<b>Exhibits</b>	
A: Resources and Services	19
B: Continuous Quality Improvement Process	33
C: Statewide Consumer Outcome and Board Performance Measures	42
D: Individual Board Performance Measures	43
E: Performance Contract Process and Contract Revision Instructions	44
F: Federal Compliances	51
G: Local Government Approval of the Contract	53
H: Board Membership	55
I: Administrative Performance Standards	58
J: Regional Program Operating Principles	60
K: Joint Agreements	64

## FY 2009 Community Services Performance Contract

### 1. Contract Purpose

- a. Title 37.2 of the *Code of Virginia* establishes the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (the Department) to ensure delivery of publicly funded services and supports to individuals with mental illnesses, intellectual disabilities (previously identified as mental retardation), or substance use disorders and authorizes the Department to fund community mental health, mental retardation, and substance abuse services. In this contract, intellectual disabilities refer to the conditions individuals have; mental retardation refers to the services that address those disabilities.
- b. Sections 37.2-500 through 37.2-511 of the *Code of Virginia* require cities and counties to establish community services boards for the purpose of providing local public mental health, mental retardation, and substance abuse services; § 37.2-600 through § 37.2-614 authorize certain cities or counties to establish behavioral health authorities that plan and provide those same local public services. In this contract, the community services board, local government department with a policy-advisory community services board, or behavioral health authority named on page 18 of this contract will be referred to as the Board or CSB.
- c. Section 37.2-500 or 37.2-601 of the *Code of Virginia* states that, in order to provide comprehensive mental health, mental retardation, and substance abuse services within a continuum of care, the Board shall function as the single point of entry into publicly funded mental health, mental retardation, and substance abuse services. The Board fulfills this function in accordance with State Board Policy 1035 for any person who is located in the Board's service area and needs mental health, mental retardation, or substance abuse services.
- d. Sections 37.2-508 and 37.2-608 of the *Code of Virginia* establish this contract as the primary accountability and funding mechanism between the Department and the Board.
- e. The Board is applying for the assistance provided under Chapter 5 or 6 of Title 37.2 of the *Code of Virginia* by submitting this performance contract to the Department in accordance with § 37.2-508 or § 37.2-608 of the *Code of Virginia*.
- f. This contract establishes requirements and responsibilities for the Board and the Department that are not established through other means, such as statute or regulation. The General Requirements Document, which, by agreement of the parties, is hereby incorporated into and made a part of this contract by reference, includes or incorporates by reference ongoing statutory, regulatory, policy, and other requirements that are not expected to change frequently.
- g. The Department and the Board enter into this performance contract for the purpose of funding services provided directly or contractually by the Board in a manner that ensures accountability to the Department and quality of care for consumers and implements the vision, articulated in State Board Policy 1036, of a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life, including work, school, family, and other meaningful relationships; and the Board and the Department agree as follows.

2. **Relationship:** The Department functions as the state authority for the public mental health, mental retardation, and substance abuse services system; and the Board functions as the local authority for that system. The relationship between and the roles and responsibilities of the Department and the Board are described more specifically in the current Partnership Agreement between the parties, which, by agreement of the parties, is hereby incorporated into and made a part of this contract by reference. This contract shall not be construed to establish any employer-employee or principal-agent relationship between employees of the Board or its board of directors and the Department.

## FY 2009 Community Services Performance Contract

3. **Contract Term:** This contract shall be in effect for a term of one year, commencing on July 1, 2008 and ending on June 30, 2009.

### 4. Scope of Services

- a. **Services:** Exhibit A of this contract includes all mental health, mental retardation, and substance abuse services provided or contracted by the Board that are supported by the resources described in section 5 of this contract. Services and certain terms used in this contract are defined in the current Core Services Taxonomy, which, by agreement of the parties, is hereby incorporated into and made a part of this contract by reference.
- b. **Expenses for Services:** The Board shall provide to the extent practicable those services that are funded within the revenues and expenses set forth in Exhibit A and documented in the Board's financial management system. The Board shall distribute its administrative and management expenses across some or all of the three program areas on a basis that is in accordance with Uniform Cost Report principles, is auditable, and satisfies Generally Accepted Accounting Principles.
- c. **Continuity of Care:** In order to partially fulfill its responsibility in § 37.2-500 or 37.2-601 of the *Code of Virginia* and State Board Policy 1035 to function as the single point of entry into publicly funded services in its service area, the Board shall follow the *Continuity of Care Procedures*, included in the current General Requirements Document as Appendix A.

- 1.) **Coordination of Mental Retardation Waiver Services:** The Board shall provide case management services to consumers who are receiving services under the Medicaid Mental Retardation Home and Community-Based Waiver (MR Waiver). In its capacity as the case manager for these consumers and in order to receive payment for services from the Department of Medical Assistance Services (DMAS), the Board shall develop individual service authorization requests (ISARs) for Waiver services and submit them to the Department for preauthorization, pursuant to the current DMAS/ DMHMRSAS Interagency Agreement (November, 2007), under which the Department preauthorizes ISARs as a delegated function from the DMAS. As part of its specific case management responsibilities for individuals receiving MR Waiver services, the Board shall coordinate and monitor the delivery of all services to its consumers, including monitoring the receipt of services in a consumer's ISAR that are provided by independent vendors, who are reimbursed directly by the DMAS, to the extent that the Board is not prohibited from doing so by such vendors (reference the DMAS *Mental Retardation Community Services Manual*, Chapters II and IV).

The Board may raise issues regarding its efforts to coordinate and monitor services provided by independent vendors to the applicable funding or licensing authority, for example the Department, the DMAS, or the Virginia Department of Social Services. In fulfilling this service coordination responsibility, the Board shall not restrict or seek to influence the consumer's choice among qualified service providers. This prohibition is not intended to restrict the ability of Board case managers to make recommendations, based on their professional judgment, to consumers regarding those available service options that best meet the terms of the consumers' ISPs and allow for the most effective coordination of services. This section does not, nor shall it be construed to, make the Board legally liable for the actions of independent vendors of MR Waiver services who are reimbursed directly by the DMAS.

- 2.) **Linkages with Health Care:** When it arranges for the care and treatment of its consumers in hospitals, inpatient psychiatric facilities, or psychiatric units of hospitals, the Board shall assure its staff's cooperation with those hospitals, inpatient psychiatric facilities, or psychiatric units of hospitals, especially emergency rooms and emergency room physicians, in order to promote continuity of care for those consumers.

## FY 2009 Community Services Performance Contract

- 3.) Coordination with Local Psychiatric Hospitals:** When the Board performed the preadmission screening and referral to the Board is likely upon the discharge of an involuntarily admitted individual, the Board shall coordinate or, if it pays for the service, approve a consumer's admission to and continued stay in a psychiatric unit or hospital and collaborate with that unit or hospital to assure appropriate treatment and discharge planning in the least restrictive setting and to avoid the use of these facilities when the service is no longer needed.
- 4.) Access to Services:** The Board shall not require a consumer to receive case management services in order to receive other services that it provides, directly or contractually, unless it is permitted to do so by applicable regulations or the person is an adult with a serious mental illness, a child with or at risk of serious emotional disturbance, or an individual with an intellectual disability or a substance use disorder, the person is receiving more than one other service from the Board, or a licensed clinician employed or contracted by the Board determines that case management services are clinically necessary for that consumer.
- 5.) PACT Criteria:** If the Board receives state general or federal funds for a Program of Assertive Community Treatment (PACT), it shall satisfy the following criteria:
- a.) Meet PACT state hospital bed use targets.
  - b.) Prioritize providing services to consumers with serious mental illnesses who are frequent recipients of inpatient services or are homeless.
  - c.) Achieve and maintain a caseload of 80 consumers after two years from the date of initial funding by the Department.
  - d.) Participate in technical assistance provided by the Department.

If the Board receives state general or federal funds for a new PACT during the term of this contract or in the fiscal year immediately preceding that term, it also shall satisfy the following conditions:

- a.) Procure individual team training and technical assistance quarterly.
  - b.) Meet bimonthly with other PACT programs (the network of CSB PACTs).
- d. Populations Served:** The Board shall provide needed services to adults with serious mental illnesses, children with or at risk of serious emotional disturbance, and individuals with intellectual disabilities, substance dependence, or substance abuse to the greatest extent possible within the resources available to it for this purpose. In accordance with § 37.2-508 or § 37.2-608 of the *Code of Virginia*, the Board shall report the unduplicated numbers of adults with serious mental illnesses, children with or at risk of serious emotional disturbance, and individuals with intellectual disabilities, substance dependence, or substance abuse that it serves during the term of this contract. These populations are defined in the current Core Services Taxonomy.
- 5. Resources:** Exhibit A of this contract includes the following resources: state general funds and federal funds appropriated by the General Assembly and allocated by the Department to the Board; balances of unexpended or unencumbered state general and federal funds retained by the Board and used in this contract to support services; local matching funds required by § 37.2-509 or § 37.2-611 of the *Code of Virginia* to receive allocations of state general funds; Medicaid Targeted Case Management, State Plan Option, and Mental Retardation Home and Community-Based Waiver fees and any other fees, as required by § 37.2-504 or § 37.2-605 of the *Code of Virginia*; and any other revenues associated with or generated by the services shown in Exhibit A. The Board may choose to include only the minimum 10 percent local matching funds in the contract, rather than all local matching funds.

## FY 2009 Community Services Performance Contract

- a. **Allocations of State General and Federal Funds:** The Department shall inform the Board of its allocations of state general and federal funds in a letter of notification. The Department may adjust allocation amounts during the term of this contract. The Commissioner or his designee shall communicate all adjustments to the Board in writing. Allocations of state general and federal funds shall be based on state and federal statutory and regulatory requirements, provisions of the current Appropriation Act, State Board policies, and previous allocation amounts. Allocations shall not be based on numbers of adults with serious mental illnesses, children with or at risk of serious emotional disturbance, or individuals with mental retardation, substance dependence, or substance abuse who receive services from the Board.
- b. **Conditions on the Use of Resources:** The Department can attach service requirements or specific conditions that it establishes for the use of funds, separate from those established by other authorities, for example, applicable statutory or regulatory requirements such as licensing or human rights regulations or federal anti-discrimination requirements, only to the state general and federal funds that it allocates to the Board and to the 10 percent local matching funds that are required to obtain the Board's state general fund allocations.

### 6. Board Responsibilities

- a. **State Hospital Bed Utilization:** In accordance with § 37.2-508 or § 37.2-608 of the *Code of Virginia*, the Board shall identify or develop jointly with the Department mechanisms, such as the Discharge Protocols, Extraordinary Barriers to Discharge lists, and reinvestment, restructuring, or system transformation projects and activities, and employ these mechanisms collaboratively with state hospitals that serve it to manage the utilization of state hospital beds. Utilization will be measured by bed days received by consumers for whom the Board is the case management board.
- b. **Quality of Care**
  - 1.) **Clinical Consultation:** The Board may request the Department to provide professional consultations for clinically complex or difficult or medically complicated cases within the resources available for this purpose in the Department or its facilities and as permitted under 45 CFR § 164.506 (c) (1) when consumers or their authorized representatives have requested second opinions and with valid authorizations that comply with the Human Rights Regulations and the HIPAA Privacy Rule or when staff of the Board request such consultations for its consumers in the community, if the Board is not able to provide those second opinions or obtain this consultation within its resources.
  - 2.) **Quality Improvement and Risk Management:** The Board shall, to the extent possible, develop and implement quality improvement processes that utilize consumer outcome measures, provider performance measures, and other data or participate in its local government's quality improvement processes to improve services, ensure that services are provided in accordance with current acceptable professional practice, and enable the ongoing review of all major areas of the Board's responsibilities under this contract.

The Board shall, to the extent practicable, develop, implement, and maintain, itself or in affiliation with other Boards, a quality improvement plan incorporating Board provider performance measures, consumer outcome measures, and human rights information. The Board shall, to the extent practicable, develop, implement, and maintain, itself or in affiliation with other Boards, a risk management plan or the Board shall participate in a local government's risk management plan. The Board shall work with the Department through the System Leadership Council to identify how the Board will address quality improvement activities.

## FY 2009 Community Services Performance Contract

The Board shall implement, in collaboration with other Boards in its region, the state hospitals and training centers serving its region, and private providers participating as signatories in the regional partnership, regional utilization management procedures and practices that reflect the Regional Utilization Management Guidance document, adopted by the System Leadership Council on January 10, 2007, which, by agreement of the parties, is hereby incorporated into and made a part of this contract by reference.

- 3.) **Continuous Quality Improvement Process:** The Board shall address and report on the performance expectations and goals in Exhibit B of this contract as part of the Continuous Quality Improvement Process supported by the Department and the Board.
- 4.) **Consumer Outcome and Board Provider Performance Measures**
  - a.) **Measures:** Pursuant to § 37.2-508 or § 37.2-608 of the *Code of Virginia*, the Board shall report the consumer outcome, Board provider performance, consumer satisfaction, and consumer and family member participation and involvement measures in Exhibit C of this contract to the Department. These reporting requirements are contingent on the Department supplying any necessary specifications and software to the Board in time for the Board to make needed changes in its information systems.
  - b.) **Individual Board Performance Measures:** The Department may negotiate specific, time-limited measures with the Board to address identified performance concerns or issues. When negotiated, such measures will be included as Exhibit D of this contract.
  - c.) **Consumer Satisfaction Survey:** Pursuant to § 37.2-508 or § 37.2-608 of the *Code of Virginia*, the Board shall participate in an assessment of consumer satisfaction in accordance with Exhibit C of this contract.
  - d.) **Substance Abuse Youth Surveys:** The Board shall work closely with community-based prevention planning groups, schools, and local governments to support and enable the administration of the Virginia Community Youth Survey and the Virginia Youth Tobacco Survey, which are mandated by federal funding sources and are necessary for continuation of federal block grant funding.
  - e.) **Prevention Services Participants and Program Evaluations:** The Board shall evaluate a minimum of 20 percent of participants in evidence-based prevention programs using program-specific instruments, which are evaluation instruments and processes developed by the program developer for that program. The Board shall conduct program-specific evaluations of all federal Substance Abuse Prevention and Treatment grant-supported prevention programs as agreed in the grant contract with the Department. The Board shall use community-level abstinence data from regional community youth survey data for alcohol, tobacco, and other drug use, perceptions of harm and disapproval, and other indicator data, including archival data listed in the National Outcome Measures, for outcome evaluation of environmental strategies and community-based processes.
  - f.) **Recovery Orientation:** The Board shall develop and implement a plan for assessing and increasing its recovery orientation over time, initially for adults with serious mental illnesses, in accordance with Exhibit C and Section 5, Advancing the Vision, of the Partnership Agreement.
- 5.) **Program and Service Reviews:** The Department may conduct or contract for reviews of programs or services provided or contracted by the Board under this contract to examine their quality or performance at any time as part of its monitoring and review responsibilities or in response to concerns or issues that come to its attention, as permitted under 45 CFR § 164.512 (a), (d), and (k) (6) (ii) and as part of its health oversight functions under § 32.1-127.1:03 (D) (6) and § 37.2-508 or § 37.2-608 of the

## FY 2009 Community Services Performance Contract

*Code of Virginia* or with a valid authorization by the consumer or his authorized representative that complies with the Human Rights Regulations and the HIPAA Privacy Rule.

- 6.) Response to Complaints:** The Board shall implement procedures to respond to complaints from consumers, family members, advocates, or other stakeholders as expeditiously as possible in a manner that seeks to achieve a satisfactory resolution and advises the complainant of any decision and the reason for it. The Board shall acknowledge complaints that the Department refers to it within five days of receipt and provide follow up commentary on them to the Department within 10 days of receipt.

### c. Reporting Requirements

- 1.) Board Responsibilities:** For purposes of reporting to the Department, the Board shall comply with State Board Policy 1037 and:
- a.) provide monthly Community Consumer Submission (CCS) extracts that report individual consumer characteristic and service data to the Department, as required by § 37.2-508 or § 37.2-608 of the *Code of Virginia*, the federal Substance Abuse and Mental Health Services Administration, and Part C of Title XIX of the Public Health Services Act - Block Grants, § 1943 (a) (3) and § 1971 and § 1949, as amended by Public Law 106-310, and as permitted under 45 CFR §§ 164.506 (c) (1) and (3) and 164.512 (a) (1) and (d) and under §32.1-127.1:03.D (6) of the *Code of Virginia*, and as defined in the current CCS Extract Specifications and Design Specifications (including the current Business Rules), which, by agreement of the parties, are hereby incorporated into and made a part of this contract by reference;
  - b.) follow the current Core Services Taxonomy and CCS Extract Specifications and Design Specifications (including the current Business Rules) when responding to reporting requirements established by the Department;
  - c.) complete the National Survey of Substance Abuse Treatment Services (N-SSATS), formerly the Uniform Facility Data Set (UFDS), annually that is used to compile and update the National Directory of Drug and Alcohol Abuse Treatment Programs and the on-line Substance Abuse Treatment Facility Locator;
  - d.) report Inventory of Mental Health Organizations information and data in accordance with federal requests to the greatest extent possible;
  - e.) report KIT Prevention System data on all substance abuse prevention services provided by the Board, including services that are supported by the Substance Abuse Prevention and Treatment (SAPT) Block Grant allocation, LINK prevention and education services funded with the 20 percent SAPT set aside, and prevention services funded by other grants KIT Prevention System and reported under substance abuse in CARS-ACCESS, and enter KIT Prevention System data on goals, objectives, and programs approved by the community prevention planning coalition by June 15;
  - f.) supply information to the Department's Forensics Information Management System for consumers adjudicated not guilty by reason of insanity (NGRI), as required under § 37.2-508 or § 37.2-608 of the *Code of Virginia* and as permitted under 45 CFR §§ 164.506 (c) (1) and (3), 164.512 (d), and 164.512 (k) (6) (ii); and
  - g.) report data and information required by the current Appropriation Act.
- 2.) Routine Reporting Requirements:** The Board shall account for all services, revenues, expenses, and costs accurately and submit reports to the Department in a timely manner using current CARS-ACCESS, CCS, or other software provided by the Department. All reports shall be provided in the form and format prescribed by the

## FY 2009 Community Services Performance Contract

Department. The Board shall provide the following information and meet the following reporting requirements:

- a.) types, amounts, and service capacities of services provided; costs for services provided; and numbers of consumers served by core service and revenues received by source and amount and expenses paid by program area and for services available outside of a program area, reported mid-year and at the end of the fiscal year through CARS-ACCESS, and types and amounts of services provided to each consumer, reported monthly through the current CCS;
- b.) demographic characteristics of individual consumers through the current CCS;
- c.) numbers of adults with serious mental illnesses, children with serious emotional disturbance, children at risk of serious emotional disturbance, and individuals with intellectual disabilities, substance dependence, or substance abuse through the current CCS;
- d.) performance expectations and goals and consumer outcome and Board provider performance measures in Exhibits B and C;
- e.) community waiting list information for the Comprehensive State Plan that is required by § 37.2-315 of the *Code of Virginia*, as permitted under § 32.1-127.1:03 (D) (6) of the *Code of Virginia* and 45 CFR § 164.512 (d) and (k) (6) (ii) (when required);
- f.) State Facility Discharge Waiting List Data Base reports using ACCESS software supplied by the Department;
- g.) Federal Balance Report (October 31);
- h.) Total numbers of consumers served for the Discharge Assistance Project, Mental Health Child and Adolescent Services Initiative, MR Waiver Services, and other Consumer Designation (900) Codes through CARS-ACCESS (mid-year and at the end of the fiscal year) and the current CCS;
- i.) PATH reports (mid-year and at the end of the fiscal year);
- j.) Uniform Cost Report information through CARS-ACCESS (annually) and
- k.) other reporting requirements in the current CCS Extract or Design Specifications.

**3.) Subsequent Reporting Requirements:** In accordance with State Board Policy 1037, the Board shall work with the Department to ensure that current data and reporting requirements are consistent with each other and the current Core Services Taxonomy, the current CCS, and the Treatment Episode Data Set (TEDS) and other federal reporting requirements. The Board also shall work with the Department in planning and developing any additional reporting or documentation requirements beyond those identified in this contract, such as the federal mental health and substance abuse National Outcomes Measures (NOMS) when they become effective, to ensure that such requirements are consistent with the current Core Services Taxonomy, the current CCS, and TEDS and other federal reporting requirements.

**4.) Streamlining Reporting Requirements:** The Board shall work with the Department through the VACSB Data Management Committee to review existing reporting requirements outside of the current CCS to determine if they are still necessary and, if they are, to streamline those reporting requirements as much as possible.

### d. Discharge Assistance Project (DAP)

**1.) Board Responsibilities:** If it participates in any DAP funded by the Department, the Board shall manage, account for, and report DAP funds allocated to it as a restricted fund. The Board shall be responsible for ensuring the effective utilization of those funds, without submitting individualized services plans (ISPs) to the Department for

## FY 2009 Community Services Performance Contract

approval or preauthorization. The Board shall submit all DAP ISPs to the Department for information purposes and shall inform the Department whenever a consumer is admitted to or discharged from a DAP-funded placement.

- 2.) **Department Review:** The Board agrees to participate in any utilization review or utilization management activities conducted by the Department involving services provided under the DAP. Protected health information may be disclosed as permitted under 45 CFR §§ 164.506 (c) (1), (3), and (4) and 164.512 (k) (6) (ii).
- 3.) **Procedures:** The Board shall adhere to the DAP Procedures in the General Requirements Document if it participates in any DAP funded by the Department.

### e. Individualized Services

- 1.) **Board Responsibilities:** If it participates in any individualized services, except the DAP, funded by the Department (e.g., the MH Child and Adolescent Services Initiative), the Board shall manage, account for, and report such individualized services funds allocated to it as a restricted fund. The Board shall be responsible for ensuring the effective utilization of those funds, without submitting individualized services plans to the Department for preauthorization or approval.
- 2.) **Department Review:** The Board agrees to participate in any utilization review or utilization management activities conducted by the Department involving services provided as individualized services. Protected health information may be disclosed as permitted under 45 CFR §§ 164.506 (c) (1) and (3) and 164.512 (k) (6) (ii).
- 3.) **Procedures:** The Board shall develop and maintain individualized services plans (ISPs), which shall be subject to review by the Department, for such individualized services; but the Board shall not be required to submit these ISPs to the Department for information purposes or for prior review or approval.

- f. **Compliance Requirements:** The Board shall comply with all applicable federal, state, and local laws and regulations, including those contained or referenced in the General Requirements Document and in Exhibit F of this contract, as they affect the operation of this contract. Any substantive change in the General Requirements Document, except changes in statutory, regulatory, policy, or other requirements or in other documents incorporated by reference in it, which changes are made in accordance with processes or procedures associated with those statutes, regulations, policies, or other requirements or documents, shall constitute an amendment of this contract, made in accordance with applicable provisions of the Partnership Agreement, that requires a new contract signature page, signed by both parties.

If any laws or regulations that become effective after the execution date of this contract substantially change the nature and conditions of this contract, they shall be binding upon the parties, but the parties retain the right to exercise any remedies available to them by law or other provisions of this contract. The Board shall comply with the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder by their compliance dates, except where the HIPAA requirements and applicable state law or regulations are contrary, and state statutes or regulations are more stringent, as defined in 45 CFR § 160.202, than the related HIPAA requirements.

The Board shall follow the procedures and satisfy the requirements in the Performance Contract Process and the Administrative Performance Standards, contained in Exhibits E and I respectively of this contract. The Board shall document its compliance with §§ 37.2-501, 37.2-504, and 37.2-508 or §§ 37.2-602, 37.2-605, and 37.2-608 of the *Code of Virginia* in Exhibits G and H of this contract.

## FY 2009 Community Services Performance Contract

- g. Regional Programs:** The Board shall manage or participate in the management of, account for, and report on regional programs in accordance with the Regional Program Principles in Exhibit J of this contract and the Regional Program Procedures in Appendix D of the General Requirements Document. The Board agrees to participate in any utilization review or utilization management activities conducted by the Department involving services provided through a regional program. Protected health information may be disclosed as permitted under 45 CFR §§ 164.506 (c) (1) and (3) and 164.512 (k) (6) (ii).
- h. Joint Agreements:** If the Board enters into a joint agreement pursuant to § 37.2-512 or § 37.2-615 of the *Code of Virginia*, the Board shall describe the agreement in Exhibit K of this contract and shall attach a copy of the joint agreement to that Exhibit.

### 7. Department Responsibilities

- a. Funding:** The Department shall disburse the state general funds displayed in Exhibit A, subject to the Board's compliance with the provisions of this contract, prospectively on a semi-monthly basis to the Board. Payments may be revised to reflect funding adjustments. The Department shall disburse federal grant funds that it receives to the Board in accordance with the requirements of the applicable federal grant and, wherever possible, prospectively on a semi-monthly basis. The Department shall make these payments in accordance with Exhibit E of this contract.
- b. State Facility Services**

  - 1.) The Department shall make state facility services available, if appropriate, through its state hospitals and training centers, when individuals located in the Board's service area meet the admission criteria for these services.
  - 2.) The Department shall track, monitor, and report on the Board's utilization of state hospital beds and provide data to the Board about consumers from its service area who are served in state hospitals as permitted under 45 CFR §§ 164.506 (c) (1), (2), and (4) and 164.512 (k) (6) (ii). The Department shall post state hospital bed utilization by the Board for all types of beds (adult, geriatric, child and adolescent, and forensic) on its Internet web site for information purposes.
  - 3.) The Department shall manage its state hospitals and training centers in accordance with State Board Policy 1035 to support service linkages with the Board, including adherence to the applicable provisions of the *Continuity of Care Procedures*, attached to the General Requirements Document as Appendix A, and the *Discharge Planning Protocols*. The Department shall assure that its state hospitals and training centers use teleconferencing technology to the extent practicable and whenever possible to facilitate the Board's participation in treatment planning activities and the Board's fulfillment of its discharge planning responsibilities for its consumers in state hospitals and training centers.
  - 4.) The Department shall involve the Board, as applicable and to the greatest extent possible, in collaborative planning activities regarding the future role and structure of state hospitals and training centers.
  - 5.) **Recovery Orientation:** Each state hospital shall develop and implement a plan for assessing and increasing its recovery orientation over time, initially for adults with serious mental illnesses, in accordance with Section 5, *Advancing the Vision*, of the Partnership Agreement.
- c. Quality of Care**

  - 1.) The Department with participation from the Board shall identify consumer outcome, Board provider performance, consumer satisfaction, and consumer and family member participation and involvement measures and emergency services and case

## FY 2009 Community Services Performance Contract

management services performance expectations and goals for inclusion in this contract, pursuant to § 37.2-508 or § 37.2-608 of the *Code of Virginia*, and shall collect information about these measures and performance expectations and goals and work with the Board to use them as part of the Continuous Quality Improvement Process described in Exhibit B to improve services.

- 2.) The Department may provide professional consultations to the Board upon request for clinically complex or difficult or medically complicated cases within the resources available for this purpose in the Department or its facilities and as permitted under 45 CFR § 164.506 (c) (1) when consumers or their authorized representatives have requested second opinions and with valid authorizations that comply with the Human Rights Regulations and the HIPAA Privacy Rule or when staff of the Board request such consultations for its consumers in the community, if the Board is not able to provide those second opinions or obtain this consultation within its resources.
- 3.) The Department shall work with the Board, the state hospitals and training centers serving it, and private providers participating as signatories in the regional partnership, to implement regional utilization management procedures and practices that reflect the Regional Utilization Management Guidance document, adopted by the System Leadership Council on January 10, 2007, which, by agreement of the parties, is hereby incorporated into and made a part of this contract by reference.
- 4.) **Recovery Orientation:** The Department shall develop and implement a plan for assessing and increasing its recovery orientation over time, initially for adults with serious mental illnesses, in accordance with Exhibit C and Section 5, Advancing the Vision, of the Partnership Agreement. It shall work with the Board through the Virginia Association of Community Services Boards to identify one or more standardized instruments for the Board, the Department, and state hospitals to use periodically to assess their consumer orientation; work with the Board within the resources available to support the Board's efforts to assess and increase its consumer orientation over time; and review and provide feedback to the Board on its efforts in this area.

### d. Reporting Requirements

- 1.) In accordance with State Board Policy 1037, the Department shall work with representatives of Boards, including the Virginia Association of Community Services Boards' Data Management Committee (DMC), to ensure that current data and reporting requirements are consistent with each other and with the current Core Services Taxonomy, the current Community Consumer Submission (CCS), and TEDS and other federal reporting requirements. The Department also shall work with representatives of Boards, including the DMC, in planning and developing any additional reporting or documentation requirements beyond those identified in this contract, such as the federal mental health and substance abuse National Outcomes Measures (NOMS) when they become effective, to ensure that such requirements are consistent with the current Core Services Taxonomy, the current CCS, and TEDS and other federal reporting requirements.
- 2.) The Department shall collaborate with representatives of the Boards, including the DMC, in the implementation and modification of the current Community Consumer Submission (CCS), which reports individual consumer characteristic and service data that is required under § 37.2-508 or § 37.2-608 of the *Code of Virginia*, the federal Substance Abuse and Mental Health Services Administration, and Part C of Title XIX of the Public Health Services Act – Block Grants, §1943 (a) (3) and § 1971 and § 1949, as amended by Public Law 106-310, to the Department and is defined in the current CCS Extract Specifications and Design Specifications (including the current Business Rules). The Department will receive and use individual consumer characteristic and service data disclosed by the Board through the CCS as permitted under 45 CFR §§ 164.506

## FY 2009 Community Services Performance Contract

(c) (1) and (3) and 164.512 (a) (1) and under § 32.1-127.1:03.D (6) of the *Code of Virginia* and shall implement procedures to protect the confidentiality of this information pursuant to § 37.2-504 or § 37.2-605 of the *Code of Virginia* and HIPAA.

- 3.) The Department shall work with representatives of the Boards, including the DMC, to reduce the number of data elements required whenever this is possible.
- 4.) The Department shall ensure that all surveys and requests for data have been reviewed for cost effectiveness and developed through a joint Department and Board process. The Department shall comply with the Procedures for Approving CSB Surveys, Questionnaires, and Data Collection Instruments and Establishing Reporting Requirements, issued by Commissioner Reinhard on November 9, 2007.
- 5.) The Department shall work with representatives of the Boards, including the DMC, to review existing reporting requirements outside of the current CCS to determine if they are still necessary and, if they are, to streamline those reporting requirements as much as possible.

### e. Discharge Assistance Project

- 1.) **Department Responsibilities:** If the Board participates in any DAP funded by the Department, the Department shall fund and monitor the DAP as a restricted fund. The Department agrees that the Board shall be responsible for ensuring the effective utilization of those funds, without submitting individualized services plans to the Department for preauthorization or approval.
- 2.) **Department Review:** The Department may conduct utilization review or utilization management activities involving services provided by the Board under the DAP. If such activities involve the disclosure of protected health information, the information may be used and disclosed as permitted under 45 CFR §§ 164.506 (c) (1), (3), and (4) and 164.512 (k) (6) (ii).
- 3.) **Procedures:** The Department shall adhere to the DAP Procedures in the General Requirements Document. If the Board's participation in the DAP causes it to be out of compliance with the 10 percent local matching funds requirement in § 37.2-509 of the *Code of Virginia*, the Department shall grant an automatic waiver of that requirement, related to the DAP funds, as authorized by that *Code* section and State Board Policy 4010.

### f. Individualized Services

- 1.) **Department Responsibilities:** If the Board participates in any individualized services, except DAP, funded by the Department (e.g., the MH Child and Adolescent Services Initiative), the Department shall fund and monitor those services as a restricted fund. The Department agrees that the Board shall be responsible for ensuring the effective utilization of those funds, without submitting individualized services plans to the Department for preauthorization, approval, or information.
- 2.) **Department Review:** The Department may conduct utilization review or utilization management activities involving services provided by the Board as individualized services. If such activities involve the disclosure of protected health information, the information may be used and disclosed as permitted under 45 CFR §§ 164.506 (c) (1) and (3) and 164.512 (k) (6) (ii).

- g. **Compliance Requirements:** The Department shall comply with all applicable state and federal statutes and regulations, including those contained or referenced in the General Requirements Document and in Exhibit F of this contract, as they affect the operation of this contract. Any substantive change in the General Requirements Document, except changes in statutory, regulatory, policy, or other requirements or in other documents incorporated by reference in it, which changes are made in accordance with processes or procedures

## FY 2009 Community Services Performance Contract

associated with those statutes, regulations, policies, or other requirements or documents, shall constitute an amendment of this contract, made in accordance with applicable provisions of the Partnership Agreement, that requires a new contract signature page, signed by both parties.

If any laws or regulations that become effective after the execution date of this contract substantially change the nature and conditions of this contract, they shall be binding upon the parties, but the parties retain the right to exercise any remedies available to them by law or other provisions of this contract. The Department and its state hospitals and training centers shall comply with the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder by their compliance dates, except where the HIPAA requirements and applicable state law or regulations are contrary, and state statutes or regulations are more stringent, as defined in 45 CFR § 160.202, than the related HIPAA requirements.

If the Board's receipt of state facility reinvestment project funds causes it to be out of compliance with the 10 percent local matching funds requirement in § 37.2-509 of the *Code of Virginia*, the Department shall grant an automatic waiver of that requirement, related to the state facility reinvestment project funds, as authorized by that *Code* section and State Board Policy 4010.

- h. Communication:** The Department shall provide technical assistance and written notification regarding changes in funding source requirements, such as regulations, policies, procedures, and interpretations, to the extent that those changes are known to the Department. The Department shall resolve, to the extent practicable, inconsistencies in state agency requirements that affect requirements in this contract. The Department shall respond in a timely manner to written correspondence from the Board that requests information or a response.
  - i. Regional Programs:** The Department may conduct utilization review or utilization management activities involving services provided by the Board through a regional program. If such activities involve the disclosure of protected health information, the information may be used and disclosed as permitted under 45 CFR §§ 164.506 (c) (1) and (3) and 164.512 (k) (6) (ii). If the Board's participation in a regional program, as defined in the Regional Program Principles in Exhibit J of this contract and the Regional Program Procedures in Appendix D of the General Requirements Document, causes it to be out of compliance with the 10 percent local matching funds requirement in § 37.2-509 of the *Code of Virginia*, the Department shall grant an automatic waiver of that requirement, related to the funds for that regional program, as authorized by that *Code* section and State Board Policy 4010.
- 8. Subcontracting:** The Board may subcontract any of the requirements in this contract. The Board shall remain fully and solely responsible and accountable for meeting all of its obligations and duties under this contract, including all services, terms, and conditions, without regard to its subcontracting arrangements. Subcontracting must comply with applicable statutes, regulations, and guidelines, including the Virginia Public Procurement Act. All subcontracted activities shall be formalized in written contracts between the Board and subcontractors. The Board agrees to provide copies of such contracts or other documents to the Department upon request. The Board shall satisfy the subcontracting provisions in the General Requirements Document.
- 9. Terms and Conditions**
- a. Availability of Funds:** The Department and the Board shall be bound by the provisions of this contract only to the extent of the funds available or that may hereafter become available for the purposes of the contract.

## FY 2009 Community Services Performance Contract

- b. Compliance:** The Department may utilize a variety of remedies, including requiring a corrective action plan, delaying payments, and terminating the contract, to assure Board compliance with this contract. Specific remedies, described in Exhibit I of this contract, may be taken if the Board fails to satisfy the reporting requirements in this contract.
- c. Disputes:** Resolution of disputes arising from Department contract compliance review and performance management efforts or from actions by the Board related to this contract may be pursued through the dispute resolution process in section 9.f, which may be used to appeal only the following conditions:
- 1.) reduction or withdrawal of state general or federal funds, unless funds for this activity are withdrawn by action of the General Assembly or federal government, or adjustment of allocations or payments pursuant to section 5 of this contract;
  - 2.) termination or suspension of the performance contract, unless funding is no longer available;
  - 3.) refusal to negotiate or execute a contract modification;
  - 4.) disputes arising over interpretation or precedence of terms, conditions, or scope of the performance contract;
  - 5.) determination that an expenditure is not allowable under this contract; and
  - 6.) determination that the performance contract is void.
- d. Termination**
- 1.) The Department may terminate this contract immediately, in whole or in part, at any time during the contract period if funds for this activity are withdrawn or not appropriated by the General Assembly or are not provided by the federal government. In this situation, the obligations of the Department and the Board under this contract shall cease immediately. The Board and the Department shall make all reasonable efforts to ameliorate any negative consequences or effects of contract termination on consumers and Board staff.
  - 2.) The Board may terminate this contract immediately, in whole or in part, at any time during the contract period if funds for this activity are withdrawn or not appropriated by its local government(s) or other funding sources. In this situation, the obligations of the Board and the Department under this contract shall cease immediately. The Board and the Department shall make all reasonable efforts to ameliorate any negative consequences or effects of contract termination on consumers and Board staff.
  - 3.) In accordance with § 37.2-508 or § 37.2-608 of the *Code of Virginia*, the Department may terminate all or a portion of this contract, after unsuccessful use of the remediation process described in section 9.e and after affording the Board an adequate opportunity to use the dispute resolution process described in section 9.f of this contract. A written notice specifying the cause must be delivered to the Board's board chairman and executive director at least 75 days prior to the date of actual termination of the contract. In the event of contract termination under these circumstances, only payment for allowable services rendered by the Board shall be made by the Department.
- e. Remediation Process:** The remediation process mentioned in § 37.2-508 or § 37.2-608 of the *Code of Virginia* is an informal procedure that shall be used by the Department and the Board to address a particular situation or condition identified by the Department or the Board that may, if unresolved, result in termination of the contract, in accordance with the provisions of section 9.d of this contract. The details of this remediation process shall be developed by the parties and added as an exhibit of this contract. This exhibit shall describe the situation or condition and include the performance measures that shall document a satisfactory resolution of the situation or condition.

## FY 2009 Community Services Performance Contract

- f. **Dispute Resolution Process:** Disputes arising from any of the conditions in section 9.c of this contract shall be resolved using the following process.
- 1.) Within 15 days of the Board's identification or receipt of a disputable action taken by the Department or of the Department's identification or receipt of a disputable action taken by the Board, the party seeking resolution of the dispute shall submit a written notice to the Department's Director of Community Contracting, stating its desire to use the dispute resolution process. The written notice must describe the condition, nature, and details of the dispute and the relief sought by the party.
  - 2.) The Director of Community Contracting shall review the written notice and determine if the dispute falls within the conditions listed in section 9.c. If it does not, the Director of Community Contracting shall notify the party in writing within seven days of receipt of the written notice that the dispute is not subject to this dispute resolution process. The party may appeal this determination to the Commissioner in writing within seven days of its receipt of the Director's written notification.
  - 3.) If the dispute falls within the conditions listed in section 9.c, the Director of Community Contracting shall notify the party within seven days of receipt of the written notice that a panel will be appointed within 15 days to conduct an administrative hearing.
  - 4.) Within 15 days of notification to the party, a panel of three or five disinterested individuals shall be appointed to hear the dispute. The Board shall appoint one or two members; the Commissioner shall appoint one or two members; and the appointed members shall appoint the third or fifth member. Each panel member will be informed of the nature of the dispute and be required to sign a statement indicating that he has no interest in the dispute. Any person with an interest in the dispute shall be relieved of panel responsibilities and another person shall be selected as a panel member.
  - 5.) The Director of Community Contracting will contact the parties by telephone and arrange for a panel hearing at a mutually convenient time, date, and place. The panel hearing shall be scheduled not more than 15 days after the appointment of panel members. Confirmation of the time, date, and place of the hearing will be communicated to all parties at least seven days in advance of the hearing.
  - 6.) The panel members shall elect a chairman and the chairman shall convene the panel. The party requesting the panel hearing shall present evidence first, followed by the presentation of the other party. The burden shall be on the party requesting the panel hearing to establish that the disputed decision or action was incorrect and to present the basis in law, regulation, or policy for its assertion. The panel may hear rebuttal evidence after the initial presentations by the Board and the Department. The panel may question either party in order to obtain a clear understanding of the facts.
  - 7.) Subject to provisions of the Freedom of Information Act, the panel shall convene in closed session at the end of the hearing and shall issue written recommended findings of fact within seven days of the hearing. The recommended findings of fact shall be submitted to the Commissioner for a final decision.
  - 8.) The findings of fact shall be final and conclusive and shall not be set aside by the Commissioner unless they are (1) fraudulent, arbitrary, or capricious; (2) so grossly erroneous as to imply bad faith; (3) in the case of termination of the contract due to failure to perform, the criteria for performance measurement are found to be erroneous, arbitrary, or capricious; or (4) not within the Board's purview.
  - 9.) The final decision shall be sent by certified mail to both parties no later than 60 days after receipt of the written notice from the party invoking the dispute resolution process.
  - 10.) Multiple appeal notices shall be handled independently and sequentially so that an initial appeal will not be delayed by a second appeal.

## FY 2009 Community Services Performance Contract

11.) The Board or the Department may seek judicial review of the final decision as provided in § 2.2-4365 of the *Code of Virginia* in the Circuit Court for the City of Richmond within 30 days of receipt of the final decision.

- g. Contract Amendment:** This contract, including all exhibits and incorporated documents, constitutes the entire agreement between the Department and the Board. The services identified in Exhibit A of this contract may be revised in accordance with the performance contract revision instructions, contained in Exhibit E of this contract. Other provisions of this contract may be amended only by mutual agreement of the parties, in writing and signed by the parties hereto.
- h. Liability:** The Board shall defend or compromise, as appropriate, all claims, suits, actions, or proceedings arising from its performance of this contract. The Board shall obtain and maintain sufficient liability insurance to cover claims for bodily injury and property damage and suitable administrative or directors and officers liability insurance. These responsibilities may be discharged by means of a proper and sufficient self-insurance program operated by the state or a city or county government. The Board shall provide a copy of any such policy or program to the Department upon request. This contract is not intended to, and does not, create by implication or otherwise any basis for any claim or cause of action by a person or entity not a party to this contract, arising out of any claimed violation of any provision of this contract, nor does it create any claim or right on behalf of any individual to services or benefits from the Board or the Department.
- i. Severability:** Each paragraph and provision of this contract is severable from the entire contract, and the remaining provisions shall nevertheless remain in full force and effect if any provision is declared invalid or unenforceable.

**10. Areas for Future Resolution:** On an ongoing basis, the Board and the Department 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 services. This section identifies issues and topics that the Board and the Department agree to work on collaboratively during the term of this contract in order to resolve them during that period or later, if necessary. Issues and topics may be added at any time by mutual agreement through amendment of this contract. The Board or representatives of the Board and the Department will establish work groups where appropriate to address these issues and topics. The Department and the Board also may address issues and topics through the System Leadership Council and the System Operations Team, which are described in the Partnership Agreement.

- a. Evidence-Based or Best Clinical Practices:** Identify evidence-based practices or best clinical practices that will improve the quality of mental health, mental retardation, or substance abuse services and address the service needs of individuals with co-occurring disorders and develop strategies for the implementation of these practices to the extent practicable.
- b. Mental Health and Substance Abuse Services Performance Expectations and Goals:** Develop the second phase of performance expectations and goals that will address service quality issues for emergency services and case management services and expand this continuous quality improvement approach to other services provided by the Board, including preadmission screening and discharge planning, to local, regional, and statewide utilization management, and to state facility operations.
- c. Data Quality and Use:** Through the Moving Forward Work Group, the VACSB Data Management Committee, and similar mechanisms, work collaboratively to (i) monitor and increase the timeliness and quality of data submitted through the current Community Consumer Submission in accordance with the current CCS Extract Specifications and Design Specifications (including the current Business Rules); (ii) address current and future

## FY 2009 Community Services Performance Contract

data and information needs, including communicating more effectively about the volume of services provided and how these services affect the lives of individual consumers; (iii) achieve the values and benefits of interoperability or the ability to reliably exchange information without error, in a secure fashion, with different information technology systems, software applications, and networks in various settings; to exchange this information with its clinical or operational meaning preserved and unaltered; and to do so in the course of the process of service delivery to promote the continuity of that process and (iv) plan for the implementation of electronic Health Information Exchange and Electronic Health Records by July 1, 2012 to improve the quality and accessibility of services and streamline and reduce reporting and documentation requirements.

- d. **Co-Occurring Disorder Treatment Performance Expectations and Goals:** As part of the continuous quality improvement process described in Exhibit B, develop co-occurring disorder treatment performance expectations, goals, and benchmarks in areas such as Board self-assessment, consumer screening and assessment, service integration, and reporting, for possible inclusion in the FY 2010 performance contract. As part of this activity, reference or develop CCS data elements and Core Services Taxonomy definitions that identify consumers with co-occurring disorders and services that treat those disorders.
- e. **Regional Management Structures or Processes for Consumers Moving Among Regions or Providers:** Through the Regional Utilization Management/Continuous Quality Improvement (RUM/CQI) Work Group, develop clear regional management structures or processes to deal with consumers transferring between private providers participating as signatories in regional partnerships and Boards or state facilities within a region or across regions or consumers transferring from Boards or state facilities in one region to Boards or state facilities in another region. The structures or processes should focus on behavioral rather than diagnostic criteria, individuals and their unique situations rather than population groupings, shared responsibilities and joint ownership, and problem solving. The structures or processes should be as consistent as possible among regions, while allowing variations needed to accommodate particular or unique circumstances in regions. The RUM/CQI Work Group shall develop these structures or processes for consideration and possible adoption in FY 2010 and, where appropriate, inclusion in the FY 2010 contract.
- f. **Discharge Planning Protocols and Continuity of Care Procedures:** Through the RUM/CQI Work Group or a separate group established for this purpose, revise the current Discharge Planning Protocols, Continuity of Care Procedures, and Procedures for Continuity of Care Between Community Services Boards and State Psychiatric Facilities (February 3, 1997), integrating or combining them to the greatest extent possible, in time for the revised document(s) to be included in or incorporated by reference into the FY 2010 performance contract. The revised document(s) shall be consistent with applicable *Code of Virginia* requirements and with the regional structures or processes developed pursuant to section 10.e of this contract and also shall include admission protocols or procedures. The revised document(s) or the regional structures or processes also shall address a process for resolving disagreements or problems among Boards and state facilities which they cannot resolve locally.

**FY 2009 Community Services Performance Contract**

**11. Signatures:** In witness thereof, the Department and the Board have caused this performance contract to be executed by the following duly authorized officials.

**Virginia Department of Mental Health,  
Mental Retardation and Substance  
Abuse Services**

\_\_\_\_\_  
\_\_\_\_\_  
**Board**

By: \_\_\_\_\_

By: \_\_\_\_\_

Name: James S. Reinhard, M.D.

Name: \_\_\_\_\_

Title: Commissioner

Title: Chairman of the Board

Date: \_\_\_\_\_

Date: \_\_\_\_\_

By: \_\_\_\_\_

Name: \_\_\_\_\_

Title: Executive Director

Date: \_\_\_\_\_

**FY 2009 Community Services Performance Contract**

**Exhibit A**

CSB: \_\_\_\_\_

<b>Consolidated Budget</b>				
<b>Revenue Source</b>	<b>Mental Health</b>	<b>Mental Retardation</b>	<b>Substance Abuse</b>	<b>TOTAL</b>
State Funds				
State Restricted Funds				
Local Matching Funds				
Total Fees				
Transfer Fees (To)/From				
Federal Funds				
Other Funds				
State Retained Earnings				
Federal Retained Earnings				
Other Retained Earnings				
<b>Subtotal: Ongoing Funds</b>				
State Funds One -Time				
State Restricted Funds One-Time				
Federal Funds One-Time				
<b>Subtotal: One-Time Funds</b>				
<b>Total: All Funds</b>				

<b>Cost for MH, MR, SA Services</b>				
<b>Cost for Services Available Outside of a Program Area (AP-4)</b>				
<b>Total Costs</b>				

<b>Local Match Computation</b>	
<b>Total State and State Restricted Funds</b>	
<b>Total Local Matching Funds</b>	
<b>Total State and Local Funds</b>	
<b>Total Local Match Percent (Local/Total State + Local)</b>	

<b>Administrative Expenses</b>	
Administrative Expenses	
Total Expenses	
Administrative Percent	

**FY 2009 Community Services Performance Contract**

**Exhibit A**

**CSB:** \_\_\_\_\_

**Financial Comments**

Comment 1	
Comment 2	
Comment 3	
Comment 4	
Comment 5	
Comment 6	
Comment 7	
Comment 8	
Comment 9	
Comment 10	
Comment 11	
Comment 12	
Comment 13	
Comment 14	
Comment 15	
Comment 16	
Comment 17	
Comment 18	
Comment 19	
Comment 20	
Comment 21	
Comment 22	
Comment 23	
Comment 24	
Comment 25	

**FY 2009 Community Services Performance Contract**

**Exhibit A**

**Mental Health**

**CSB:** \_\_\_\_\_

<b>Revenue Sources</b>	<b>Revenue</b>
<b><u>Fees</u></b>	
MH Medicaid Fees	
MH Fees: Other	_____
<b>Total MH Fees</b>	
MH Transfer Fees (To)/From	_____
<b>Net MH Fees</b>	
<b><u>Restricted Funds</u></b>	
<b>Federal</b>	
<b><i>MH FBG SED Child &amp; Adolescent</i></b>	
MH FBG SMI	
MH FBG PACT	
MH FBG Geriatrics	
MH FBG Consumer Services	
MH FBG PATH	
MH Other Federal – DMHMRSAS	
MH Other Federal – CSB	_____
<b>Total Restricted Federal MH Funds</b>	
<b>State</b>	
MH Acute Care (Fiscal Agent)	
MH Transfer In/(Out) Acute Care	_____
<b>MH Net Acute Care</b>	
MH Regional DAP (Fiscal Agent)	
MH Transfer In/(Out) Regional DAP	_____
<b>MH Net Regional DAP</b>	
MH Facility Reinvestment (Fiscal Agent)	
MH Transfer In/(Out) Facility Reinvestment	_____
<b>MH Net Facility Reinvestment</b>	
MH Regional DAD/Wintex (Fiscal Agent)	
MH Transfer In/(Out) DAD/Wintex	_____
<b>MH Net Regional DAD/Wintex</b>	
MH Crisis Stabilization (Fiscal Agent)	
MH Transfer In/(Out) Crisis Stabilization	_____
<b>MH Net Crisis Stabilization</b>	
MH Recovery (Fiscal Agent)	
MH Transfer In/(Out) Recovery	_____
<b>MH Net Recovery</b>	
MH Transformation (Fiscal Agent)	
MH Transfer In/(Out) Transformation	_____
<b>MH Net Transformation</b>	

# FY 2009 Community Services Performance Contract

## Exhibit A Mental Health

CSB: \_\_\_\_\_

<b>Revenue Sources</b>	<b>Revenue</b>
MH DAD/Wintex	
MH PACT	
MH Discharge Assistance Project (DAP)	
MH Child & Adolescent Services Initiative	
MH Pharmacy (Blue Ridge)	
MH Demo Proj-System of Care (Child)	
MH Juvenile Detention	
MH Jail Diversion/Service	
MH Geriatric Services	
MH Civil Commitment Law Reforms	_____
<b>Total Restricted State MH Funds</b>	
<b><u>Other Funds</u></b>	
MH Other Funds	
MH Federal Retained Earnings	
MH State Retained Earnings	
MH State Retained Earnings - Regional Programs	
MH Other Retained Earnings	_____
<b>Total Other MH Funds</b>	
<b><u>State Funds</u></b>	
MH State General Funds	
MH State Regional Deaf Services	
MH State NGRI Funds	
MH State Children's Services	_____
<b>Total State MH Funds</b>	
<b><u>Local Matching Funds</u></b>	
MH In-Kind	
MH Contributions	
MH Local Other	
MH Local Government	_____
<b>Total Local MH Funds</b>	
<b>Total MH Revenue</b>	_____
<b><u>One-Time MH Funds</u></b>	
MH FBG SWVMH Board	
MH FBG SMI	
MH FBG SED Child & Adolescent	
MH FBG Consumer Services	
MH Fed Emergency Preparedness & Response	
MH Fed SERG	
MH State General Funds	_____
<b>Total One-Time MH Funds</b>	
<b>Total All MH Revenue</b>	_____

AF-4

FY 2009 Community Services Performance Contract

Exhibit A

Mental Retardation

CSB: \_\_\_\_\_

Revenue Sources	Revenue
<b><u>Fees</u></b>	
MR Medicaid Fees	
MR Medicaid ICF/MR	
MR Fees: Other	
MR Fees: Part C	_____
<b>Total MR Fees</b>	
MR Transfer Fees (To)/From	_____
<b>Net MR Fees</b>	
<b><u>Restricted Funds</u></b>	
<b>Federal</b>	
MR Other Federal – DMHMRSAS	
MR Other Federal – CSB	_____
<b>Total Restricted Federal MR Funds</b>	
<b>State</b>	
MR Facility Reinvestment (Fiscal Agent)	
MR Transfer In/(Out) Facility Reinvestment	_____
<b>MR Net Facility Reinvestment</b>	
MR Transformation	_____
<b>Total Restricted State MR Funds</b>	
<b><u>Other Funds</u></b>	
MR Workshop Sales	
MR Other Funds	
MR Other Funds- Part C	
MR State Retained Earnings	
MR Other Retained Earnings	_____
<b>Total Other MR Funds</b>	
<b><u>State Funds</u></b>	
MR State General Funds	
MR OBRA	
MR Family Support	
MR Children’s Family Support	_____
<b>Total State MR Funds</b>	

FY 2009 Community Services Performance Contract

Exhibit A

Mental Retardation

CSB: \_\_\_\_\_

<b>Revenue Sources</b>	<b>Revenue</b>
<b><u>Local Matching Funds</u></b>	
MR In-Kind	
MR Contributions	
MR Local Other	
MR Local Government	_____
<b>Total Local MR Funds</b>	_____
<b>Total MR Revenue</b>	_____
<b><u>One-Time MR Funds</u></b>	
MR Waiver Start Up	_____
<b>Total One-Time MR Funds</b>	_____
<b>Total All MR Revenue</b>	_____

FY 2009 Community Services Performance Contract

Exhibit A

Substance Abuse

CSB: \_\_\_\_\_

Revenue Sources	Revenue
<b><u>Fees</u></b>	
SA Medicaid Fees	
SA Fees: Other	_____
<b>Total SA Fees</b>	
SA Transfer Fees (To)/From	_____
<b>SA Net Fees</b>	
<b><u>Restricted Funds</u></b>	
<b>Federal</b>	
SA FBG Alcohol/Drug Treatment	
SA FBG Women	
SA FBG Prevention-Women	
SA FBG SARPOS	
SA FBG Facility Diversion	
SA FBG Jail Services	
SA FBG Crisis Intervention	
SA FBG Prevention	
SA FBG Co-Occurring	
SA FBG Prev-Strengthening Families	
SA FBG New Directions	
SA Fed VASIP/COSIG (Fiscal Agent)	
SA Fed Transfer In/(Out) VASIP/COSIG	_____
<b>SA Net VASIP/COSIG</b>	
SA Fed Project REMOTE	
SA Fed Project TREAT	
SA Other Federal - DMHMRSAS	
SA Other Federal - CSB	_____
<b>Total Restricted Federal SA Funds</b>	
<b>State</b>	
SA Facility Reinvestment (Fiscal Agent)	
SA Transfer In/(Out) Facility Reinvestment	_____
<b>SA Net Facility Reinvestment</b>	
SA Facility Diversion	
SA Women	
SA Crisis Stabilization	
SA Medically Assisted Treatment (MAT)	
SA Transformation	
SA SARPOS	
SA Recovery	
SA HIV/AIDS	_____
<b>Total Restricted State SA Funds</b>	

FY 2009 Community Services Performance Contract

Exhibit A

Substance Abuse

CSB: \_\_\_\_\_

Revenue Sources	Revenue
<b><u>Other Funds</u></b>	
SA Other Funds	
SA Federal Retained Earnings	
SA State Retained Earnings	
SA State Retained Earnings - Regional Programs	
SA Other Retained Earnings	_____
<b>Total Other SA Funds</b>	
<b><u>State Funds</u></b>	
SA State General Funds	
SA Region V Residential	
SA Postpartum - Women	
SA Jail Services/Juv Detention	_____
<b>Total State SA Funds</b>	
<b><u>Local Matching Funds</u></b>	
SA In-Kind	
SA Contributions	
SA Local Other	
SA Local Government	_____
<b>Total Local SA Funds</b>	
<b>Total SA Revenue</b>	_____
<b><u>One-Time SA Funds</u></b>	
SA FBG Alcohol/Drug Treatment	
SA FBG Women	
SA FBG Prevention	_____
<b>Total One-Time SA Funds</b>	
<b>Total All SA Revenue</b>	_____



FY 2009 Community Services Performance Contract

Exhibit A

Supplemental Information

Reconciliation of Financial Report and Utilization Data (Core Services) Expenses

CSB: \_\_\_\_\_

	MH	MR	SA	Services Outside of a Prog. Area	Total
Financial Report Revenue					
Utilization Data Expenses					
Difference					

Difference results from

Other

Explanation of Other:

**FY 2009 Community Services Performance Contract**

**Exhibit A**

CSB: \_\_\_\_\_

<b>Form 11: Mental Health Services Program Area (100)</b>		
<b>Core Services or Consumer Designation Codes</b>	<b>Consumers Served</b>	<b>Costs</b>
250 Acute Psychiatric Inpatient Services		
310 Outpatient Services		
350 Assertive Community Treatment		
320 Case Management Services		
410 Day Treatment/Partial Hospitalization		
420 Ambulatory Crisis Stabilization Services		
425 Rehabilitation		
430 Sheltered Employment		
465 Group Supported Employment		
460 Individual Supported Employment		
501 Highly Intensive Residential Services		
510 Residential Crisis Stabilization Services		
521 Intensive Residential Services		
551 Supervised Residential Services		
581 Supportive Residential Services		
610 Prevention Services		
910 Discharge Assistance Project (DAP)		
915 Mental Health Child and Adolescent Services Initiative		
916 Mental Health Services for Children & Adolescents in Juvenile Detention Centers		
918 Program of Assertive Community Treatment (PACT)		
919 Project for Assistance in Transition from Homelessness (PATH)		
<b>Total Costs</b>		

**FY 2009 Community Services Performance Contract**

**Exhibit A**

CSB: \_\_\_\_\_

<b>Form 21: Mental Retardation Services Program Area (200)</b>		
<b>Core Services or Consumer Designation Code</b>	<b>Consumers Served</b>	<b>Costs</b>
310 Outpatient Services		
320 Case Management Services		
425 Habilitation		
430 Sheltered Employment		
465 Group Supported Employment		
460 Individual Supported Employment		
501 Highly Intensive Residential (Community-Based ICF/MR) Services		
521 Intensive Residential Services		
551 Supervised Residential Services		
581 Supportive Residential Services		
610 Prevention Services		
625 Infant and Toddler Intervention Services		
920 Medicaid Mental Retardation Home and Community-Based Waiver Services		
<b>Total Costs</b>		

**FY 2009 Community Services Performance Contract**

**Exhibit A**

CSB: \_\_\_\_\_

<b>Form 31: Substance Abuse Services Program Area (300)</b>		
<b>Core Services or Consumer Designation Codes</b>	<b>Consumers Served</b>	<b>Costs</b>
250 Acute Substance Abuse Inpatient Services		
260 Community-Based SA Medical Detoxification Inpatient (Hospital) Services		
310 Outpatient Services		
330 Opioid Detoxification Services		
340 Opioid Treatment Services		
320 Case Management Services		
410 Day Treatment/Partial Hospitalization		
420 Ambulatory Crisis Stabilization Services		
425 Rehabilitation		
430 Sheltered Employment		
465 Group Supported Employment		
460 Individual Supported Employment		
501 Highly Intensive Residential (Community-Based SA Detoxification) Services		
510 Residential Crisis Stabilization Services		
521 Intensive Residential Services		
531 Jail-Based Habilitation Services		
551 Supervised Residential Services		
581 Supportive Residential Services		
610 Prevention Services		
933 <i>Substance Abuse Medically Assisted Treatment</i>		
934 <i>Project REMOTE</i>		
935 <i>Recovery Support Services</i>		
<b>Total Costs</b>		

FY 2009 Community Services Performance Contract

Exhibit A

CSB: \_\_\_\_\_

<b>Form 01: Services Available Outside of a Program Area (400)</b>		
<b>Core Services</b>	<b>Consumers Served</b>	<b>Costs</b>
100 Emergency Services		
318 Motivational Treatment Services		
390 Consumer Monitoring Services		
720 Assessment and Evaluation Services		
620 Early Intervention Services		
730 Consumer-Run Services		
<b>Total Costs</b>		

## FY 2009 Community Services Performance Contract

### Exhibit B: Continuous Quality Improvement Process

**Introduction:** Meaningful performance expectations are part of a continuous quality improvement (CQI) process being developed and supported by the Department and the Board that will monitor the Board's progress in achieving those expectations to improve the quality, accessibility, and responsiveness of services locally and to provide a platform for system wide improvement efforts. Generally, performance expectations reflect established requirements based in statute, regulation, or policy. Performance goals are developmental; once baseline measures are established and implemented, they will become expectations. The initial performance expectations and goals focus on the areas of the public mental health, mental retardation, and substance abuse services system that have the primary interactions with individuals who are at risk of involvement in the civil admissions process established in Chapter 8 of Title 37.2 of the Code of Virginia, are directly involved in that process, are receiving case management services from the Board, or require service linkages between state facility or local inpatient services and other community services. This emphasis is consistent with the Department's and the Board's interest in assuring that consumers receive the services and supports necessary to link them with the most appropriate resources needed to support their recovery, empowerment, and self-determination. The capacity to measure progress in achieving performance expectations and goals, provide feedback, and plan and implement CQI strategies shall exist at local, regional, and state levels. Implementing the CQI process will be a multi-year, iterative, and collaborative effort to assess and enhance individual Board and system wide performance over time. In this process, Boards and the Department evaluate current operations, determine relevant CQI performance expectations and goals, and establish benchmarks for goals, determined by baseline performance, to convert those goals to expectations. Then, each Board assesses and reports to the Department on its progress toward achieving these expectations and goals and develops and implements a CQI plan to meet them. As benchmarks are attained and expectations and goals are achieved, Boards and the Department review and revise the performance expectations, goals, and benchmarks or establish new ones. Because this CQI process focuses on improving services and to strengthen the engagement of Boards in this process and preserve essential services for consumers, funding will not be based on or associated with Board performance in achieving these expectations and goals. The Department and the Board may negotiate individual Board performance measures in Exhibit D reflecting actions or requirements to meet expectations and goals in the Board's CQI plan. As this joint CQI process evolves and expands, the Department and the VACSB will utilize data and reports submitted by Boards to conduct a broader scale evaluation of service system performance and to identify opportunities for CQI activities across all program areas.

#### I. CQI Performance Expectations and Goals for Emergency Services and Mental Health and Substance Abuse Case Management Services

##### A. General Performance Goals

1. For consumers currently receiving services, the Board shall have a protocol in effect 24 hours per day, seven days per week (a) for service providers to alert emergency services staff about consumers deemed to be at risk of needing an emergency intervention, (b) for service providers to provide essential clinical information, which should include advance directives, wellness recovery action plans, or safety and support plans to the extent they are available, that would assist in facilitating the disposition of the emergency intervention, and (c) for emergency services staff to inform the case manager of the disposition of the emergency intervention.
2. For individuals hospitalized through the civil involuntary admission process in a state hospital, a private psychiatric hospital, or a psychiatric unit in a public or private hospital, the Board that will provide services upon the consumer's discharge shall have in place a protocol to engage those individuals in appropriate Board services and supports upon their return to the community. The Board shall monitor and strive to increase the rate at

## **FY 2009 Community Services Performance Contract**

which these consumers keep scheduled face-to-face (non-emergency) service visits within seven days after discharge from the hospital or unit.

### **B. Emergency Services Performance Expectations**

1. Every preadmission screening evaluator hired after July 1, 2008 shall meet the educational qualifications endorsed in October 2007 by the Department and the Virginia Association of Community Services Boards.
2. Every preadmission screening evaluator shall complete the certification program approved by the Department, and documentation of satisfactory completion shall be accessible for review.
3. Pursuant to subsection B of § 37.2-815 of the *Code of Virginia*, a preadmission screening evaluator or, through a mutual arrangement, an evaluator from another Board shall attend each commitment hearing held in the Board's service area or for a Board's consumer outside of its service area in person, or, if that is not possible, the preadmission screening evaluator shall participate in the hearing through two-way electronic video and audio or telephonic communication systems, as authorized by subsection B of § 37.2-804.1 of the *Code of Virginia*, for the purposes of presenting preadmission screening reports and recommended treatment plans and facilitating least restrictive dispositions.
4. In preparing preadmission screening reports, the preadmission screening evaluator shall consider all available relevant clinical information, including a review of clinical records, wellness recovery action plans, advance directives, and information or recommendations provided by other current service providers or appropriate significant persons (e.g., family members or partners). Reports shall reference the relevant clinical information used by the preadmission screening evaluator.
5. If the emergency services intervention occurs in a hospital or clinic setting, the preadmission screening evaluator shall inform the charge nurse or requesting medical doctor of the disposition, including leaving a written clinical note describing the assessment and recommended disposition or a copy of the preadmission screening form containing this information.

### **C. Emergency Services Performance Goals**

1. Telephone access to individuals employed or contracted by the Board to provide emergency services shall be available 24 hours per day, seven days per week. Initial responders shall triage calls and, for callers with emergency needs, shall be able to link the caller with a preadmission screening evaluator within 15 minutes.
2. When an immediate face-to-face intervention by a certified preadmission screening evaluator is appropriate to determine the possible need for involuntary hospitalization, the intervention shall be completed by a certified preadmission screening evaluator who shall be available within one hour of initial contact for urban Boards and within two hours for rural Boards. Urban and rural Boards are defined and listed in the current Overview of Community Services in Virginia, available on the Department's web site.

### **D. Mental Health and Substance Abuse Case Management Services Performance Expectations**

1. Case managers employed or contracted by the Board shall meet the knowledge, skills, and abilities qualifications in the Case Management Licensing Regulations, 12 VAC 35-105-1250.
2. Consumers of case management services shall be offered a choice of case managers to the extent possible, and this shall be documented by a procedure to address requests for changing a case manager.

## **FY 2009 Community Services Performance Contract**

3. Reviews of the individualized services plan (ISP), including necessary assessment updates, shall be conducted face-to-face with the consumer every 90 days and shall include significant changes in the consumer's status, engagement, participation in recovery planning, and preferences for services; and the ISP shall be revised accordingly to include a consumer-directed wellness plan that addresses crisis self-management strategies and implements advance directives, as desired by the consumer. For those consumers who express a choice to discontinue case management services because of their dissatisfaction with care, the provider must review the ISP to consider reasonable solutions to address the consumer's concerns.
4. The Board shall have policies and procedures in effect to ensure that, during normal business hours, case management services shall be available to respond in person, electronically, or by telephone to preadmission screening evaluators of consumers with open cases at the Board to provide relevant clinical information in order to help facilitate appropriate dispositions related to the civil involuntary admissions process established in Chapter 8 of Title 37.2 of the *Code of Virginia*.

### **E. Mental Health and Substance Abuse Case Management Services Performance Goals**

1. For an individual who has been discharged from a state hospital, a private psychiatric hospital, or a psychiatric unit in a public or private hospital or released from a commitment hearing and has been referred to the Board and determined by the Board to be appropriate for case management services, a preliminary assessment shall be initiated at first contact and completed, preferably within 14 but in no case more than 30 calendar days of referral, and an individualized services plan (ISP) shall be initiated within 24 hours of the consumer's admission to a program area for case management services and updated when required by the Department's licensing regulations. A copy of an advance directive, a wellness recovery action plan, or a similar expression of a consumer's treatment preferences, if available, shall be included in the clinical record.
2. For consumers for whom case management services will be discontinued due to failure to keep scheduled appointments, outreach attempts, including home visits, telephone calls, letters, and contacts with others as appropriate, to reengage the consumer shall be documented. The Board shall have a procedure in place to routinely review the rate of and reasons for refused or discontinued case management services and shall take appropriate actions when possible to reduce that rate and address those reasons.

## **II. Data Quality Performance Expectations and Goals**

### **A. Data Quality Performance Expectations**

1. The Board shall submit complete Community Consumer Submission (CCS) consumer, type of care, and services file extracts to the Department in accordance with the schedule in Exhibit E of this contract, a submission for each month by the end of the following month.

### **B. Data Quality Performance Goals**

1. If the Board experiences a fatal error rate of more than five percent of its CCS consumer records in more than one monthly submission, the Board shall develop and implement a data quality improvement plan to achieve the goal of no more than five percent of its CCS consumer records containing fatal errors within a timeframe negotiated with the Department.
2. The Board shall ensure that all required CCS data is collected and entered into its information system when a case is opened or a consumer is admitted to a program area, updated at least annually when a consumer remains in service that long, and updated

## FY 2009 Community Services Performance Contract

when a consumer is discharged from a program area or his case is closed. The Board shall identify situations where data is missing or incomplete and implement a data quality improvement plan to increase the completeness, accuracy, and quality of CCS data that it collects and reports.

### III. Continuous Quality Improvement Process Affirmations

Pursuant to Section 7: Accountability in the Community Services Performance Contract Central Office, State Facility, and Community Services Board Partnership Agreement, the Board provides the following affirmations of its compliance with the listed Emergency Services, Case Management, and Data Quality Performance Expectations and Goals. If a particular affirmation cannot be initiated by the Executive Director, the Board shall attach an explanation to this exhibit with a plan for complying with the expectation or goal, including specific actions and target dates. The Department will review this plan and negotiate any changes with the Board, whereupon, the plan will become part of this exhibit.

#### Expectation or Goal

#### Affirmation

- I.A.1. For consumers currently receiving services, the Board has a protocol in effect 24 hours per day, seven days per week (a) for service providers to alert emergency services staff about consumers deemed to be at risk of needing an emergency intervention, (b) for service providers to provide essential clinical information, which should include advance directives, wellness recovery action plans, or safety and support plans to the extent they are available, that would assist in facilitating the disposition of the emergency intervention, and (c) for emergency services staff to inform the case manager of the disposition of the emergency intervention. The Board will provide a copy this protocol to the Department upon request.

\_\_\_\_\_ Initials of the Executive Director

During its inspections, the Department's Licensing Office will examine this protocol to verify this affirmation as it reviews the Board's policies and procedures.

- I.A.2. For individuals hospitalized through the civil involuntary admission process in a state hospital, a private psychiatric hospital, or a psychiatric unit in a public or private hospital for whom the Board will provide services upon the consumer's discharge, the Board has in place a protocol to engage those individuals in appropriate Board services and supports upon their return to the community. The Board will provide this protocol to the Department upon request.

\_\_\_\_\_ Initials of the Executive Director

During its inspections, the Department's Licensing Office will examine this protocol to verify this affirmation as it reviews the Board's policies and procedures.

- I.B.1. Every preadmission screening evaluator hired after July 1, 2008 meets the educational qualifications endorsed in October, 2007 by the Department and the Virginia Association of Community Services Boards.

\_\_\_\_\_ Initials of the Executive Director

During its inspections, the Department's Licensing Office will verify this affirmation as it reviews personnel records.

## FY 2009 Community Services Performance Contract

- I.B.2. Every preadmission screening evaluator employed by the Board has completed the certification program approved by the Department before performing preadmission screenings.

\_\_\_\_\_ Initials of the Executive Director

During its inspections, the Department's Licensing Office will verify this affirmation as it reviews personnel or training records or documentation.

- I.B.4. In preparing preadmission screening reports, preadmission screening evaluators consider available relevant clinical information, including a review of clinical records, wellness recovery action plans, advance directives, and information or recommendations provided by other current service providers or appropriate significant persons (e.g., family members or partners). Reports reference the relevant clinical information used by the preadmission screening evaluator.

\_\_\_\_\_ Initials of the Executive Director

During its inspections, the Department's Licensing Office will verify this affirmation as it reviews consumer services records, including records selected from a sample identified by the Board for consumers who received preadmission screening evaluations.

- I.B.5. If the emergency services intervention occurs in a hospital or clinic setting, the Board's preadmission screening evaluator informs the charge nurse or requesting medical doctor of the disposition, including leaving a written clinical note describing the assessment and recommended disposition or a copy of the preadmission screening form containing this information, and this action is documented in the consumer's service record at the Board with a progress note or with a notation on the preadmission screening form that is included in the consumer's service record.

\_\_\_\_\_ Initials of the Executive Director

During its inspections, the Department's Licensing Office will verify this affirmation as it reviews consumer services records, including records selected from a sample identified by the Board for consumers who received preadmission screening evaluations, for a progress note or a copy of the preadmission screening form.

- I.D.1. Case managers employed or contracted by the Board meet the knowledge, skills, and abilities qualifications in the Case Management Licensing Regulations.

\_\_\_\_\_ Initials of the Executive Director

During its inspections, the Department's Licensing Office will verify this affirmation as it reviews personnel records.

- I.D.2. Consumers of case management services are offered a choice of case managers to the extent possible, and this is documented by a procedure to address requests for changing a case manager. The Board will provide a copy this procedure to the Department upon request.

\_\_\_\_\_ Initials of the Executive Director

During its inspections, the Department's Licensing Office will verify this affirmation as it reviews consumer services records and by examining the procedure.

## FY 2009 Community Services Performance Contract

- I.D.3. Reviews of the ISP, including necessary assessment updates, are conducted face-to-face with the consumer every 90 days and include significant changes in the consumer's status, engagement, participation in recovery planning, and preferences for services; and the individualized services plan (ISP) shall be revised accordingly to include a consumer-directed wellness plan that addresses crisis self-management strategies and implements advance directives, as desired by the consumer. For those consumers who express a choice to discontinue case management services because of their dissatisfaction with care, the provider reviews the ISP to consider reasonable solutions to address the consumer's concerns.

\_\_\_\_\_ Initials of the Executive Director

During its inspections, the Department's Licensing Office will verify this affirmation as it reviews consumer services records, including records from a sample identified by the Board for consumers who discontinued case management services.

- I.D.4. The Board has policies and procedures in effect so that, during normal business hours, case management services are available to respond in person, electronically, or by telephone to preadmission screening evaluators of consumers with open cases at the Board to provide relevant clinical information in order to help facilitate appropriate dispositions related to the civil involuntary admissions process established in Chapter 8 of Title 37.2 of the *Code of Virginia*.

\_\_\_\_\_ Initials of the Executive Director

During its inspections, the Department's Licensing Office will verify this affirmation as it examines the Board's policies and procedures.

- I.E.1. a. For an individual who has been discharged from a state hospital, a private psychiatric hospital, or a psychiatric unit in a public or private hospital or released from a commitment hearing and has been referred to the Board and determined by the Board to be appropriate for case management services, an individualized services plan (ISP) is initiated within 24 hours of the consumer's admission to a program area for case management services and updated when required by the Department's licensing regulations.
- b. A copy of an advance directive, a wellness recovery action plan, or a similar expression of a consumer's treatment preferences, if available, is included in the consumer's clinical record.

\_\_\_\_\_ Initials of the Executive Director

During its inspections, the Department's Licensing Office will verify these affirmations as it reviews consumer service records.

- I.E.2. For consumers for whom case management services will be discontinued due to failure to keep scheduled appointments, outreach attempts, including home visits, telephone calls, letters, and contacts with others as appropriate, to reengage the consumer are documented. The Board has a procedure in place to routinely review the rate of and reasons for refused or discontinued case management services and shall take appropriate actions when possible to reduce that rate and address those reasons. The Board will provide a copy of this procedure to the Department upon request.

## FY 2009 Community Services Performance Contract

\_\_\_\_\_ Initials of the Executive Director

During its inspections, the Department's Licensing Office will examine this procedure to verify this affirmation.

### IV. Continuous Quality Improvement Process Measures

The Board agrees to monitor and collect data and report on the following measures or to use data from the Department or other sources to monitor its accomplishment of the performance expectations and goals in this exhibit.

#### Expectation or Goal

#### Measure

I.A.2. The Board agrees to monitor and report quarterly to the Department on the percentage of individuals hospitalized through the civil involuntary admission process in a state hospital, a private psychiatric hospital, or a psychiatric unit in a public or private hospital and discharged to the Board who keep scheduled face-to-face (non-emergency) service visits within seven days after discharge from the hospital or unit. The Department agrees to monitor this measure through comparing AVATAR data on consumers discharged from state hospitals to the Board with CCS data about their admission to the mental health program area and dates of service after discharge from the hospital or unit.

I.B.3. The Board agrees to conduct periodic surveys for one month in each quarter to gather the following information about the attendance of its preadmission screening evaluators at commitment hearings in person or via two-way electronic video and audio or telephonic communication systems (tracked and reported separately) and to report the results to the Department quarterly:

- a. the number of commitment hearings attended in the Board's service area,
- b. the number of commitment hearings attended outside of the Board's service area for Board consumers, and
- c. the number of commitment hearings attended outside of the Board's service area on behalf of other Boards.

The Board and the Department also will use information provided by the Office of the Executive Secretary of the Supreme Court about the total numbers of commitment hearings held each month by courts in the Board's service area to monitor this goal.

I.C.1. The Board agrees to conduct a two week test of its emergency services each quarter to monitor the availability of emergency services 24 hours per day and seven days per week and the access of consumers with emergency needs to a prescreening evaluator within 15 minutes of their initial calls. The test will consist of calls made to its emergency services at various times of the day and night during the work week and on weekends, distributed so that calls are balanced between regular business hours and after-hours periods. The Board agrees to maintain documentation of these tests, including information about circumstances in which this goal is not met, locally for three years and to report a summary and analysis of the results semi-annually to the Department.

I.C.2. The Board agrees to collect, as part of its two week tests of its emergency services each quarter, the time within which the preadmission screening evaluator is available from the initial contact for consumers identified with emergency needs and to monitor achievement of the goal that the evaluator be available within one hour of initial contact if the Board is an urban board or within two hours if the Board is a rural board. The Board agrees to maintain documentation of these tests, including information about circumstances in which this goal

## **FY 2009 Community Services Performance Contract**

is not met, locally for three years and to report a summary and analysis of the information semi-annually to the Department as part of its report on the preceding measure.

- I.E.1. The Board agrees to monitor and report semi-annually to the Department on the percentage of consumers who have been discharged from a state hospital, a private psychiatric hospital, or a psychiatric unit in a public or private hospital or released from a commitment hearing and referred to the Board and determined by the Board to be appropriate for case management services for whom a preliminary assessment is initiated at first contact and completed, preferably within 14 but in no case more than 30 calendar days of referral.
- I.E.2. The Board agrees to conduct a survey for one month in each quarter or to regularly track data to report the rate of refused or discontinued case management services (number of consumers refusing or discontinuing the service divided by the total number of consumers receiving case management services during the reporting period) and reasons for refused or discontinued case management services and to identify the actions taken to reduce that rate and address those reasons. The Board agrees to maintain documentation of this information locally for three years and to report a summary and analysis of the information semi-annually to the Department.
- II.A.1. The Board agrees to submit 100 percent of its monthly CCS consumer, type of care, and services file extracts submitted to the Department in accordance with the schedule in Exhibit E of this contract, a submission for each month by the end of the month following the month for which the extracts are due. The Department will monitor this measure quarterly and negotiate an Exhibit D with the Board if it fails to meet this goal for more than two months in a quarter.
- II.B.1. The Board agrees to monitor the total number of consumer records rejected due to fatal errors divided by the total consumer records in the Board's monthly CCS consumer extract file. If the Board experiences a fatal error rate of more than five percent of its CCS consumer records in more than one monthly submission, the Board agrees to develop and implement a data quality improvement plan to achieve the goal of no more than five percent of its CCS consumer records containing fatal errors within a timeframe negotiated with the Department.
- II.B.2. a. The Board agrees to monitor the total number of consumers without service records submitted showing receipt of any substance abuse service within the prior 90 days divided by the total number of consumers with a TypeOfCare record showing a substance abuse discharge those 90 days. If more than 10 percent of its consumers have not received any substance abuse service within the prior 90 days and have not been discharged from the substance abuse program area, the Board agrees to develop and implement a data quality improvement plan to reduce that percentage.
- II.B.2. b. The Board agrees to monitor the total number of consumers with a TypeOfCare record showing a discharge (with a TypeOfCare Through Date in the record) from the mental health or substance abuse program area during the previous quarter without an appropriate completed discharge status divided by the total number of consumers with a TypeOfCare record showing a discharge from the mental health or substance abuse program area during the previous quarter. If more than 10 percent of its consumers are discharged during a quarter without an appropriate completed discharge status, the Board agrees to develop and implement a data quality improvement plan to reduce this percentage.

**FY 2009 Community Services Performance Contract**

**Exhibit B: Continuous Quality Improvement Process**

**Signature:** In witness thereof, the Board provides the affirmations initialed by the Executive Director in section III. of this Exhibit and agrees to monitor and collect data and report on the measures in section IV of this Exhibit or to use data from the Department or other sources to monitor the accomplishment of the performance expectations and goals in this Exhibit, as denoted by the signature of the Board's Executive Director.

\_\_\_\_\_ By: \_\_\_\_\_

\_\_\_\_\_ Name: \_\_\_\_\_  
Board Title: Executive Director

Date: \_\_\_\_\_

**FY 2009 Community Services Performance Contract**

**Exhibit C: Statewide Consumer Outcome and Board Performance Measures**

<b>Measure</b>	<b>Access for Pregnant Women</b>	<b>Continuity of Care</b>
<b>Program Area</b>	Substance Abuse Services Only	Mental Health Services Only
<b>Source of Requirement</b>	SAPT Block Grant	CQI Performance Measure <sup>1</sup>
<b>Type of Measure</b>	Aggregate	Individual
<b>Data Needed For Measure</b>	Number of Pregnant Women Requesting Service	Face-to-Face Status
	Number of Pregnant Women Receiving Services Within 48 Hours	Date of First Face-to-Face Outpatient Visit
<b>Reporting Frequency</b>	Annually	Quarterly
<b>Reporting Mechanism</b>	Performance Contract Reports	Ad Hoc Report

Other Board Provider Performance and Consumer Outcome measures will be collected through the current CCS, which CSBs submit to provide TEDS data and to satisfy federal Mental Health and SAPT Block Grant requirements. These measures include changes in employment status and type of residence, number of arrests, and type and frequency of alcohol or other drug use.

<sup>1</sup> Percentage of discharges from state psychiatric hospitals that were followed by at least one scheduled face-to-face (non-emergency) outpatient visit within 7 days.

The Board also agrees to participate in the conduct of the following surveys:

1. Annual Consumer Survey of MH and SA Outpatient Consumers,
2. Annual Youth Services Survey for Families (i.e., Child MH survey), and
3. MR Family Survey (done at the time of the consumer's annual planning meeting).

As part of its continuous quality improvement process and in accordance with Section 5, *Advancing the Vision*, of the Partnership Agreement and recommendations in the *Services System Transformation Initiative Data/Outcomes Measures Workgroup Report* (September 1, 2006), the Board shall develop and implement a plan by June 30, 2009 to assess and increase its recovery orientation over time, initially for adults with serious mental illnesses. This plan shall include use of a standardized instrument selected from a menu of instruments identified by the Department and the Virginia Association of Community Services Board in the *Report*, such as the ROSI, to assess the Board's recovery orientation periodically. In developing and implementing this plan, the Board shall involve consumers, for instance by training and hiring consumers to administer the Recovery Oriented Systems Indicators (ROSI) or other standardized instrument and to compile and analyze the results. Once it selects and implements an instrument, the Board shall share the results of its use with the Department.

**FY 2009 Community Services Performance Contract**

**Exhibit D: Individual Board Performance Measures**

**Signatures:** In witness thereof, the Department and the Board have caused this performance contract amendment to be executed by the following duly authorized officials.

**Virginia Department of Mental Health,  
Mental Retardation and Substance  
Abuse Services**

\_\_\_\_\_  
\_\_\_\_\_  
**Board**

By: \_\_\_\_\_

Name: James S. Reinhard, M.D.  
Title: Commissioner

Date: \_\_\_\_\_

By: \_\_\_\_\_

Name: \_\_\_\_\_  
Title: Chairman of the Board

Date: \_\_\_\_\_

By: \_\_\_\_\_

Name: \_\_\_\_\_  
Title: Executive Director

Date: \_\_\_\_\_

## FY 2009 Community Services Performance Contract

### Exhibit E: Performance Contract Process and Contract Revision Instructions

**05-02-08:** The Department distributes the FY 2009 Performance Contract to Boards electronically on **May 2**.

**05-09-08:** The Department distributes the FY 2009 Letters of Notification to Boards on **May 9**, with enclosures that show tentative allocations of state and federal block grant funds. Another enclosure may list performance measures that have been negotiated with a Board to be included in Exhibit D of the contract. The Office of Information Technology Services (OITS) completes distribution of the FY 2009 Community Services Performance Contract package software (CARS-ACCESS) to CSBs by **May 9**. Department staff completes training Boards on the software by **May 23**.

**06-20-08:** Exhibit A and other parts of the FY 2009 Community Services Performance Contract, submitted electronically in CARS-ACCESS, are due in the OITS *in time to be received by June 20*. Tables 1 and 2 of the Performance Contract Supplement (also in CARS-ACCESS) must be submitted with the contract. *While a paper copy of the complete contract is not submitted*, paper copies of the following completed pages with signatures where required are due in the Office of Community Contracting (OCC) by **June 20**: the signature page of the contract body; the Board's current organization chart (page 3 of Exhibit H), Exhibit B, Exhibit D, if applicable, Exhibit F (two pages), page 1 of Exhibit G, Exhibit K (if applicable), and the signature page of the Partnership Agreement (page 10). Page 2 of Exhibit G must be submitted as soon as possible and no later than **September 30**.

Contracts must conform to Letter of Notification allocations of state and federal funds, or amounts subsequently revised by or negotiated with the OCC and confirmed in writing, and must contain actual appropriated amounts of local matching funds. If the Board cannot include the minimum 10 percent local matching funds in the contract, it must submit a written request for a waiver of the matching funds requirement, pursuant to § 37.2-509 of the *Code of Virginia* and State Board Policy 4010, to the OCC with its contract. This requirement also applies to mid-year and end of the fiscal year performance contract reports, submitted after the ends of the 2<sup>nd</sup> and 4<sup>th</sup> quarters, and contract revisions, if either report or the contract revision reflects less than the minimum 10 percent local matching funds.

**06-30-08:** Program Accountants in the Department's Office of Grants Management (OGM) prepare Electronic Data Interchange (EDI) transfers for the *first two semi-monthly payments* (both July payments) of state and federal funds for all Boards and send the requests to the Department of Accounts, starting with the transmission on **June 30**.

**07-14-08:** Program Accountants receive authorizations to prepare EDI transfers for *payments 3 through 6* (both August and September) of state and federal funds for Boards whose contracts were received and determined to be complete by July 14 and, after OCC Administrators authorize their release, prepare and send the transfers to the Department of Accounts, starting with the transmission on **August 1**. Payments will not be released without complete contracts, as defined in item 1 of Exhibit I. For a Board whose contract is received after July 14, EDI transfers for these four semi-monthly payments will be processed within two weeks of receipt of the contract, if the contract is complete.

**07-22-08:** Department staff complete reviews by **July 22** of FY 2009 contracts received by June 20 that are complete and acceptable. Contracts received after June 20 will be processed in the order in which they are received.

1. The **Office of Grants Management** (OGM) analyzes the revenue information in the contract for conformity to Letter of Notification allocations and makes corrections and changes on the financial forms in Exhibit A of the contract.

## FY 2009 Community Services Performance Contract

2. The **Offices of Mental Health, Child and Family, Mental Retardation, and Substance Abuse Services** review and approve new service proposals and consider program issues related to existing services, based on Exhibit A.
3. The **Office of Community Contracting (OCC)** assesses contract completeness, examines maintenance of local matching funds, analyzes existing service levels for numbers of consumers served, integrates new service information, makes corrections and changes on the service forms in Exhibit A, negotiates changes in Exhibit A, and finalizes the contract for signature by the Commissioner. The OCC Administrator notifies the Board when its contract is not complete or has not been approved and advises the Board to revise and resubmit its contract.
4. The **Office of Information Technology Services (OITS)** receives CARS-ACCESS and Community Consumer Submission (CCS) submissions from the Boards, maintains the community database, and processes signed contracts into that database as they are received from the OCC.

**07-31-08:** Boards submit their final FY 2008 CCS consumer, type of care, and service extract files for June to the OITS in time to be received by **July 31**. Boards submit their final FY 2008 quarterly System Transformation Initiative (STI) reports in time to be received in the OCC by **July 31**.

**08-22-08:** The OITS distributes the FY 2008 end of the fiscal year performance contract report software (CARS-ACCESS) by **August 22**.

**08-27-08:** Boards submit their complete CCS reports for total (annual) FY 2008 CCS service unit data to the OITS in time to be received by **August 27**. This later date for final FY 2008 CCS service unit data, as opposed to July 31, 2008, allows for the inclusion of all units of services delivered in FY 2008, which might not be in local information systems in July. Since all services provided by Boards directly and contractually should be in their local information systems, service unit information in final CCS FY 2008 submissions should match service unit information in FY 2008 CARS performance contract reports. Any corrections of service information needed as a result of Departmental review of the August 27 submissions must be completed by **October 1**.

**09-15-08:** Program Accountants receive authorization to prepare EDI transfers for *payments 7 and 8* (October) and, after OCC Administrators authorize their release, prepare and send the transfers to the Department of Accounts, for transmission starting on **September 30** for payment 7 for Boards with signed contracts and that submitted their final FY 2008 CCS consumer, type of care, and service extract files and their final FY 2008 quarterly STI reports by July 31. Payments 7 and 8 will not be released without a contract signed by the Commissioner and receipt of those CCS extract files and final STI reports.

After the Commissioner signs it, the OCC sends a copy of the approved contract Exhibit A to the Board, with the signature page containing only the Commissioner's signature. The Board must review this contract, which reflects all of the changes negotiated by Department staff (see 7-22-08); complete the signature page, which documents its acceptance of these changes; and return the completed signature page to the OCC.

**10-01-08:** Boards send complete FY 2008 end of the fiscal year performance contract reports that include Uniform Cost Report information electronically in CARS-ACCESS to the OITS *in time to be received by October 1*. *Reports must be accompanied by the Executive Director's certification that the software error check was performed, the report contains no errors identified by the error checking software, and the data submitted in the reports is accurate.*

Boards must insure that substance abuse prevention units of service data in their CARS-ACCESS end of the fiscal year reports are identical to the units of service data that they submitted through the KIT Prevention System.

## FY 2009 Community Services Performance Contract

OITS staff places the reports in a temporary data base for OCC and OGM staff to access them and print paper copies of the reports. OCC Administrators review services sections of reports for correctness, completeness, consistency, and acceptability; resolve discrepancies with Boards; communicate necessary changes to Boards; and make the changes on the paper copies of the reports. Program Accountants review the financial portions of reports for arithmetic accuracy, completeness, consistency, and conformity with state funding actions; resolve discrepancies with Boards; communicate necessary changes to Boards; and make the changes on the paper copies of reports.

Once OCC and OGM staffs complete their reviews and corrections of a Board's reports, the OCC administrator notifies the Board to submit new reports, reflecting only those approved changes, to OITS. Upon receipt, the process described above is repeated to ensure that the new reports contain only those changes identified by OGM and OCC staff. If the reviews document this, OCC and OGM staffs approve the reports. OITS staff then processes final report data into the Department's community database.

Late report submission, if an extension of the October 1 due date has not been obtained through the process in Exhibit I of this contract, or submitting a report without correcting errors identified by the CARS-ACCESS error checking program will result in a letter from the Commissioner to the Board Chairman and local government officials. See Exhibit I for additional information.

Boards submit their first CCS consumer, type of care, and service extract files for the first two months of FY 2009 to the OITS in time to be received by **October 1**.

Boards submit their annual local inpatient purchase of services surveys for FY 2008 to the OCC in time to be received by **October 1**.

**10-13-08:** Program Accountants receive authorization to prepare EDI transfers for *payments 9 and 10* (November), and, after OCC Administrators authorize their release, prepare and send these transfers to the Department of Accounts, beginning with the transmission on **October 31** for Boards whose complete FY 2008 end of the fiscal year performance contract reports were received by October 1. Payments will not be released without (1) complete reports, as defined in item 2.a. of Exhibit I of this contract, (2) complete CCS submissions (see 07-31-08 and 08-27-08) for FY 2008 and for the first two months of FY 2009, and (3) the completed signature page received from the Board (see 9-15-08).

**10-31-08:** If necessary, Boards submit new FY 2008 end of the fiscal year performance contract reports not later than **October 31** that correct errors or inaccuracies. The Department will not accept CARS-ACCESS report revisions after October 31. Boards submit CCS FY 2009 monthly consumer, type of care, and service extract files for September to the OITS in time to be received by **October 31**.

Boards submit their System Transformation Initiative (STI) Quarterly Status Reports for the first quarter of FY 2009 to the OCC in time to be received by October 31.

**11-13-08:** Program Accountants receive authorization to prepare EDI transfers for *payments 11 and 12* (December), and, after OCC Administrators authorize their release, prepare and send these transfers to the Department of Accounts, beginning with the transmission on **November 28** for Boards that submitted their FY 2009 first quarter STI reports by October 31.

**11-28-08:** Boards submit their CCS FY 2009 monthly consumer, type of care, and service extract files for October to the OITS in time to be received by **November 28**.

**12-01-08:** Boards that are not local government departments or included in local government audits send one copy of the audit report for the preceding fiscal year on all board-operated programs to the Department's Office of Budget and Financial Reporting. *While the Code requires reports within 90 calendar days after the end of the fiscal year, the*

## FY 2009 Community Services Performance Contract

*Auditor of Public Accounts will not penalize late submissions up to December 1.* A management letter and plan of correction for deficiencies must be sent with this report.

Boards submit a copy of C.P.A. audit reports for all contract programs for their last full fiscal year, ending on June 30, to the Office of Budget and Financial Reporting by **December 1**. For programs with different fiscal years, reports are due five months after the end of the year. Management letters and plans of correction for deficiencies must be included with these reports.

Audit reports for Boards that are local government departments or are included in local government audits are submitted to the Auditor of Public Accounts by the local government. Under a separate cover, the Board must forward a plan of correction for any audit deficiencies that are related to or affect the Board to the Office of Budget and Financial Reporting by **December 1**.

If the Board receives an audit identifying material deficiencies or containing a disclaimer or prepares the plan of correction referenced in the preceding paragraph, the Board and the Department shall negotiate an Exhibit D that addresses the deficiencies or disclaimer and includes a proposed plan with specific timeframes to address them, and this Exhibit D and the proposed plan shall become part of this contract.

**12-15-08:** Program Accountants receive authorization to prepare EDI transfers for *payment 13* (first January), and, after OCC Administrators authorize their release, prepare and send these transfers to the Department of Accounts, beginning with the transmission on **January 2** for Boards whose FY 2008 end of the fiscal year performance contract reports have been **verified** as accurate and internally consistent, per items 2.b. through d. of Exhibit I, whose CCS submissions for FY 2008 are complete, and whose CCS monthly extracts for September and October have been received. Payments will not be released without verified reports, complete CCS submissions for FY 2008, and CCS submissions for September and October.

**12-31-08:** Boards submit their CCS FY 2009 monthly consumer, type of care, and service extract files for November to the OITS in time to be received by **December 31**.

**01-02-09:** The Department distributes the exposure draft of the FY 2010 performance contract for a 60-day public comment period pursuant to § 37.2-508 of the *Code of Virginia*.

Program Accountants receive authorization to prepare EDI transfers for *payments 14 through 16* (second January, February), and, after OCC Administrators authorize their release, prepare and send these transfers to the Department of Accounts, beginning with the transmission on **January 16** for Boards that submitted their FY 2008 C.P.A. audit, or plan of correction if the Board is a local government department or is included in a local government audit submitted to the Auditor of Public Accounts by the local government (see 12-01-08), to the Department's Office of Budget and Financial Reporting by December 1. Payments will not be released without receipt of the audit report or plan of correction.

**01-09-09:** The OITS distributes FY 2009 mid-year performance contract report software by **January 9**.

**01-30-09:** Boards submit their System Transformation Initiative (STI) Quarterly Status Reports for the second quarter of FY 2009 to the OCC in time to be received by January 30. Boards submit their CCS FY 2009 monthly consumer, type of care, and service extract files for December to the OITS in time to be received by **January 30**.

**02-16-09:** Boards send complete mid-year performance contract reports to the OITS electronically in CARS-ACCESS *within 45 calendar days after the end of the second quarter, in time to be received by February 16*. OITS staff places the reports on a shared drive for OCC and OGM staff to access them. The offices review and act on the reports using the

## FY 2009 Community Services Performance Contract

process described at 10-01-08. When reports are acceptable, OITS staff processes the data into the Department's community data base.

Program Accountants receive authorization to prepare EDI transfers for *payment 17* (first March), and, after OCC Administrators authorize their release, prepare and send these transfers to the Department of Accounts, beginning with the transmission on **February 27** for Boards that submitted their FY 2009 second quarter STI reports by January 30.

- 02-27-09:** Program Accountants receive authorization to prepare EDI transfers for *payments 18 and 19* (2<sup>nd</sup> March, 1<sup>st</sup> April) and, after OCC Administrators authorize their release, prepare and send these transfers to the Department of Accounts, starting with the transmission on **March 13** for Boards whose complete FY 2009 mid-year performance contract reports were received by February 16 and whose monthly CCS consumer, type of care, and service extract files for November and December were received by the end of the month following the month of the extract. Payments will not be released without complete reports, as defined in item 2.a. of Exhibit I, and without these monthly CCS submissions. Boards submit their CCS FY 2009 monthly consumer, type of care, and service extract files for January to the OITS in time to be received by **February 27**.
- 03-31-09:** Boards submit their CCS FY 2009 monthly consumer, type of care, and service extract files for February to the OITS in time to be received by **March 31**.
- 04-03-09:** Program Accountants receive authorization to prepare EDI transfers for *payments 20 through 22* (2<sup>nd</sup> April, May) and, after OCC Administrators authorize their release, prepare and send these transfers to the Department of Accounts, starting with the transmission on **April 17** for Boards whose FY 2009 mid-year performance contract reports have been **verified** as accurate and internally consistent, per items 2.b. through d. of Exhibit I and whose monthly CCS consumer, type of care, and service extract files for January and February were received by the end of the month following the month of the extract. Payments will not be released without verified reports and without these monthly CCS submissions.
- 04-17-09:** The Department distributes final revised FY 2009 Letters of Notification to Boards by **April 17**, with enclosures reflecting any changes in allocations of state and federal block grant funds since the original Letters of Notification (issued May 9, 2008) for Boards to use in preparing their final FY 2009 contract revisions.
- 04-30-09:** Boards submit their System Transformation Initiative (STI) Quarterly Status Reports for the third quarter of FY 2009 to the OCC in time to be received by April 30. Boards submit their CCS FY 2009 monthly consumer, type of care, and service extract files for March to the OITS in time to be received by **April 30**.
- 05-01-09:** The Department distributes the FY 2010 Community Services Performance Contract and Letters of Notification to Boards on **May 1**, with enclosures that show the tentative allocations of state and federal funds. The OITS completes distribution of the FY 2010 Community Services Performance Contract package software (CARS-ACCESS) to CSBs by **May 8**.

The final revised FY 2009 Performance Contract Exhibit A, prepared in accordance with instructions in this Exhibit, is due in the OITS by **May 1**. Final contract revisions must conform to final revised Letter of Notification allocations, or amounts subsequently revised by or negotiated with the Department and confirmed in writing, and must contain actual amounts of local matching funds. Revised contracts are reviewed and acted on using the process at **7-22-08**. If the Board cannot include the minimum 10 percent local matching funds in its revised contract, it must submit a written request for a waiver of the matching funds requirement, pursuant to § 37.2-509 of the *Code of Virginia* and State Board Policy 4010, to the OCC with its revised contract.

## FY 2009 Community Services Performance Contract

- 05-15-09:** Program Accountants receive authorization to prepare EDI transfers for *payment 23* (first June), and, after OCC Administrators authorize their release, prepare and send these transfers to the Department of Accounts, beginning with the transmission on **May 29** for Boards that submitted their FY 2009 third quarter STI reports by April 30.
- 05-29-09:** Boards submit their CCS FY 2009 monthly consumer, type of care, and service extract files for April to the OITS in time to be received by **May 29**.
- 06-01-09:** Program Accountants receive authorization to prepare EDI transfers for *payment 24* and, after OCC Administrators authorize their release, prepare and send these transfers to the Department of Accounts for transmission on **June 15**, after the Department has made any final adjustments in the Board's state and federal funds allocations, for Boards whose monthly CCS consumer, type of care, and service extract files for March and April were received by the end of the month following the month of the extract. Payments will not be released without these monthly CCS submissions.
- 06-19-09:** The FY 2010 Community Services Performance Contract, submitted electronically in CARS-ACCESS, is due in the OITS and the paper copies of the applicable parts of the contract are due in the OCC by **June 19**.
- 06-30-09:** Boards submit their CCS FY 2009 monthly consumer, type of care, and service extract files for May to the OITS by **June 30**.
- 07-17-09:** The OITS distributes FY 2009 end of the fiscal year performance contract report software to Boards.
- 07-31-09:** Boards submit their final CCS FY 2009 consumer, type of care, and service extract files for June to the OITS in time to be received by **July 31**.
- 08-31-09:** Boards submit their System Transformation Initiative (STI) Quarterly Status Reports for the fourth quarter of FY 2009 to the OCC in time to be received by August 31.
- Boards submit their complete Community Consumer Submission (CCS) reports for total (annual) FY 2009 service units to the OITS in time to be received by **August 31**. This later date for final FY 2009 CCS service unit data, as opposed to July 31, 2009, allows for the inclusion of all units of services delivered in FY 2009, which might not be in local information systems in July. Since all services provided by Boards directly and contractually should be in their local information systems, service unit information in final CCS FY 2009 submissions should match service unit information in FY 2009 CARS performance contract reports. Any corrections of service information needed as a result of Departmental review of the August 31 submissions must be completed by October 1.
- 10-01-09:** Boards send complete FY 2009 end of the fiscal year performance contract reports electronically in CARS-ACCESS to the OITS *in time to be received by* **October 1**. Boards submit their annual local inpatient purchase of services surveys for FY 2009 to the OCC in time to be received by **October 1**.

## FY 2009 Community Services Performance Contract

### Exhibit E: Performance Contract Process and Contract Revision Instructions

The Board may revise Exhibit A of its signed performance contract *only in the following circumstances*:

1. a new, previously unavailable category or subcategory of core services is implemented;
2. an existing category or subcategory of core services is totally eliminated;
3. a new program offering an existing category or subcategory of core services is implemented;
4. a program offering an existing category or subcategory of core services is eliminated;
5. new earmarked state general or federal funds are received to expand an existing service or establish a new one;
6. state general or federal block grant funds are moved between program (MH, MR, SA) areas (an exceptional situation);
7. allocations of state general, federal, or local funds change; or
8. a major error is discovered in the original contract.

*Contract revisions should not be made to reflect minor deviations from the contract level in numbers of consumers to be served within existing programs and services.*

To avoid frequent submissions of revisions, these circumstances should be consolidated and reflected in revisions that are periodically sent to the Department. A final revision must be submitted before the end of the term of this contract, as specified in this Exhibit, so that any discrepancies in state general or federal fund disbursements can be resolved and any other changes can be reflected in the final revision.

Revisions of Exhibit A must be submitted using the CARS-ACCESS software and the same procedures used for the original performance contract.

**FY 2009 Community Services Performance Contract**

**Exhibit F: Federal Compliances**

Certification Regarding Salary: Federal Mental Health and Substance Abuse Prevention and Treatment Block Grants

**Check One**

- \_\_\_\_\_ 1. The Board has no employees being paid totally with Federal Mental Health Block Grant funds or Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funds at a direct salary (not including fringe benefits and operating costs) in excess of \$191,300 per year.
  
- \_\_\_\_\_ 2. The following employees are being paid totally with Federal Mental Health or SAPT Block Grant funds at a direct salary (not including fringe benefits and operating costs) in excess of \$191,300 per year.

	<b>Name</b>	<b>Title</b>
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

**Assurances Regarding Equal Treatment for Faith-Based Organizations**

The Board assures that it is and will continue to be in full compliance with the applicable provisions of 45 CFR Part 54, Charitable Choice Regulations, and 45 CFR Part 87, Equal Treatment for Faith-Based Organizations Regulations, in its receipt and use of federal Mental Health Services and Substance Abuse Prevention and Treatment Block Grants and federal funds for Projects for Assistance in Transitions from Homelessness programs. Both sets of regulations prohibit discrimination against religious organizations, provide for the ability of religious organizations to maintain their religious character, and prohibit religious organizations from using federal funds to finance inherently religious activities.

## FY 2009 Community Services Performance Contract

### Exhibit F: Federal Compliances

#### Assurances Regarding Restrictions on the Use of Federal Block Grant Funds

The Board assures that it is and will continue to be in full compliance with the applicable provisions of the federal Mental Health Services Block Grant (CFDA 93.958) and the federal Substance Abuse Prevention and Treatment Block Grant (CFDA 93.959), including those contained in the General Requirements Document and the following requirements. Under no circumstances shall Federal Mental Health Services and Substance Abuse Prevention and Treatment Block Grant funds be used to:

1. provide mental health or substance abuse inpatient services<sup>1</sup>;
2. make cash payments to intended or actual recipients of services;
3. purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
4. satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;
5. provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs;
6. provide financial assistance to any entity other than a public or nonprofit private entity; or
7. provide treatment services in penal or correctional institutions of the state.

[Source: 45 CFR § 96.135]

---

Signature of Executive Director

---

Date

- <sup>1</sup> However, the Board may expend SAPT Block Grant funds for inpatient hospital substance abuse services only when all of the following conditions are met:
- a. the individual cannot be effectively treated in a community-based, non-hospital residential program;
  - b. the daily rate of payment provided to the hospital for providing services does not exceed the comparable daily rate provided by a community-based, non-hospital residential program;
  - c. a physician determines that the following conditions have been met: (1) the physician certifies that the person's primary diagnosis is substance abuse, (2) the person cannot be treated safely in a community-based, non-hospital residential program, (3) the service can reasonably be expected to improve the person's condition or level of functioning, and (4) the hospital-based substance abuse program follows national standards of substance abuse professional practice; and
  - d. the service is provided only to the extent that it is medically necessary (e.g., only for those days that the person cannot be safely treated in a community-based residential program).

[Source: 45 CFR § 96.135]

**FY 2009 Community Services Performance Contract**

**Exhibit G: Local Government Approval of the Community Services Performance Contract – Page 1**

1. Name of the Board: \_\_\_\_\_

2. City or County designated as the Board's Fiscal Agent: \_\_\_\_\_

3. Name of the Fiscal Agent's City Manager or County Administrator or Executive:

Name: \_\_\_\_\_ Title: \_\_\_\_\_

4. Name of the Fiscal Agent's County or City Treasurer or Director of Finance:

Name: \_\_\_\_\_ Title: \_\_\_\_\_

5. Name of the Fiscal Agent official to whom checks should be electronically transmitted:

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Note:** Subsection A.18 of § 37.2-504 of the *Code of Virginia* authorizes an operating community services board to receive state and federal funds directly from the Department and act as its own fiscal agent when authorized to do so by the governing body of each city or county that established it.



**FY 2009 Community Services Performance Contract**

**Exhibit H: Board Membership**

<b>Table 1: Board Membership Characteristics</b>			
Name of Board			
Total Appointments:	Vacancies:	* Filled Appointments:	
<b>Number of Consumers and Family Members</b> (Ref. § 37.2-100 for Definitions)			
Number of Consumers or Former Consumers		Number of Family Members of Consumers or Former Consumers	
§ 37.2-501 and § 37.2-602 of the <i>Code of Virginia</i> require appointments to the Board to be broadly representative of the community. One-third of the appointments to the Board shall be identified consumers or former consumers or family members of consumers or former consumers, at least one of whom shall be a consumer receiving services.			

Use Table 1 in the Performance Contract Supplement (CARS/ACCESS) to complete this table.

FY 2009 Community Services Performance Contract

Exhibit H: Board Membership

Board Membership List					
Name: (List Officers After Names)	Address: (With zip code)	Phone Number	Start Date of Term	End Date of Term	Term No. (1st, 2 <sup>nd</sup> , 3 <sup>rd</sup> )

*Use Board of Directors Membership List in the CARS/ACCESS software to complete this table.*

*AP-6*

62.

05-06-2008

**FY 2009 Community Services Performance Contract**

**Exhibit H: Board Organization Chart**

Attach the Board's organization chart here.

## **Exhibit I: Administrative Performance Standards**

### **Standards**

The Board shall meet these administrative performance standards in submitting its performance contract, contract revisions, mid-year and end of fiscal year performance contract reports, and monthly Community Consumer Submission (CCS) extracts to the Department.

1. The performance contract and any revisions submitted by the Board shall be:
  - a. complete, that is all required information is displayed in the correct places and all required Exhibits and Forms, including applicable signature pages, are included;
  - b. consistent with Letter of Notification allocations or figures subsequently revised by or negotiated with the Department;
  - c. prepared in accordance with instructions in the Department-provided CARS-ACCESS software and any subsequent instructional memoranda; and
  - d. received by the due dates listed in Exhibit E of this contract.

If these performance contract standards are not met, the Department may delay future semi-monthly payments until satisfactory performance is achieved.

2. The current contract term mid-year and the previous contract term end of fiscal year performance contract reports submitted by the Board shall be:
  - a. complete, that is all required information is displayed in the correct places, all required data are included in the electronic CARS-ACCESS application reports, and any required paper forms that gather information not included in CARS-ACCESS are submitted;
  - b. consistent with the state general and federal block grant funds allocations in the most recent Letter of Notification or figures subsequently revised by or negotiated with the Department;
  - c. prepared in accordance with instructions;
  - d. (i) internally consistent and arithmetically accurate: all related expenses, revenues, and service, cost, and consumer data are consistent, congruent, and correct within a report, and (ii) submitted only after errors identified by the CARS-ACCESS error checking programs are corrected; and
  - e. received by the due dates listed in Exhibit E of this contract, unless, pursuant to the process on the next page, an extension of the due date for the end of the fiscal year report has been obtained from the Department.

If these standards are not met for mid-year reports, the Department may delay future semi-monthly payments until satisfactory performance is achieved. If the Board does not meet these standards for its end of the fiscal year reports, the Department may delay future semi-monthly payments until satisfactory performance is achieved, and the Commissioner may contact the Board and local government officials about failure to comply with both aspects of standard 2.d or to satisfy standard 2.e.

3. Monthly consumer, type of care, and service extract files must be submitted by the end of the month following the month of the extract in accordance with the CCS Extract and Design Specifications (including the current Business Rules). If the Board fails to meet the extract submission requirements in Exhibit E of this contract, the Department may delay future semi-monthly payments until satisfactory performance is achieved.
4. Substance abuse prevention units of service data in the Board's CARS-ACCESS end of fiscal year report must be identical to the service unit data that the Board submitted to the Department through the KIT Prevention System.

## **Exhibit I: Administrative Performance Standards**

### **Process for Obtaining an Extension of the End of the Fiscal Year Report Due Date**

Extensions will be granted only in very exceptional situations, for example, unanticipated staff, hardware, or software problems such as an ITS failure, a key staff person's illness or accident, or an emergency that makes it impossible to meet the due date.

1. It is the responsibility of the Board to seek, negotiate, obtain, and confirm the Department's approval of an extension of the due date within the time frames specified below.
2. As soon as the Board becomes aware that its end of the fiscal year report cannot be submitted in time to be received in the Department by 5:00 p.m. on the first business day of October in the current contract term, its executive director must inform the Office of Community Contracting Director or its Community Contracting Administrator that it is requesting an extension of this due date. This request should be submitted as soon as possible and it must be in writing, describe completely the reason(s) and need for the extension, and state the date on which the Department will receive the report.
3. The written request for an extension must be received in the Office of Community Contracting no later than 5:00 p.m. on the fourth business day before the date in the second step. A facsimile transmission of the request to the number used by the Office of Community Contracting (804-371-0092), received by that time and date, is acceptable if receipt of the transmission is confirmed with a return facsimile memo from the Office no later than 5:00 p.m. on the third business day before the date in the second step. Telephone extension requests are not acceptable and will not be processed.
4. The Office of Community Contracting will act on all requests for due date extensions that are received in accordance with this process and will notify the requesting Boards by facsimile transmission of the status of their requests by 5:00 p.m. on the second business day before the date in the second step.
5. If an extension of the end of the fiscal year report due date is granted, this will not result in automatic continuation of semi-monthly payments. All of the requirements for these payments, contained in Exhibit E, must be satisfied for semi-monthly payments to continue.

## Exhibit J: Regional Program Operating Principles

A definition of regional programs and descriptions of regional program models are included in the Core Services Taxonomy for reference purposes and as examples for how regional programs might function. Regional programs are funded by the Department or the Board and operated explicitly to provide services to individuals who are consumers of the Boards participating in the programs. Regional programs may be managed by the participating Boards or by one Board, have a single or multiple service sites, and provide one or more types of service. Regional programs also may include self-contained, single purpose programs (e.g., providing one type of core service, usually residential) operated by one Board for the benefit of other Boards or programs contracted by one Board that serve consumers from other Boards.

Regional programs 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 consumers from admission to state facilities. Each consumer receiving services provided through a regional program must be identified as being served by a particular Board. That Board will be responsible for contracting for and reporting on the consumers that it serves and the services that it provides; and each consumer will access services through and have his or her individualized services plan managed by that particular Board. Boards are the single points of entry into publicly funded mental health, mental retardation, and substance abuse services, the local points of accountability for the 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, mental retardation, or substance abuse services.

These regional program operating principles provide guidance for Boards to implement and manage identified regional programs and to account for services provided by these programs. These 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), contain complete and accurate information about consumers, services, revenues, and expenses. These principles and the Regional Program Procedures in Appendix D of the General Requirements Document apply to all regional programs in which the Board participates.

### Regional Program Operating Principles

1. Individual Board Reporting: The CCS, a secure and HIPAA-compliant individual consumer data reporting system, is the basis for all statewide individual consumer and service data and information. Therefore, every individual served in any manner must be included in some Board's information system, so that necessary consumer and service information can be extracted by Boards and provided to the Department using the CCS. If a Board does not collect information about all of its consumers 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 Board participating in a regional program shall admit consumers 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 Board shall maintain and report revenue, expense, cost, consumer, and service information associated with the regional program for each consumer that it serves through that program.
  - b. If one Board operates a regional program on behalf of other Boards in a region, it shall admit all consumers for services provided by the regional program, maintain CCS data about these consumers in its information system, and maintain and report revenue, expense, cost, consumer, and service information associated with those consumers, or, if the participating Boards elect, each referring Board may report on its consumers.
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 Board or to one Board 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 general and federal funds to Boards for community services and through which Boards report on the use of those and other funds. All regional programs shall be included in the performance contract and reflected in the CARS and CCS.

- a. If the Department disburses regional program funds to each participating Board, each participating Board shall follow existing performance contract and report requirements and procedures for that portion of the regional program funded by that Board.
  - b. If the Department disburses regional program funds to a Board that operates a regional program on behalf of the other Boards in a region, the operating Board 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 Board that has agreed to serve as the fiscal agent (fiscal agent Board) for the regional program, disbursements will be based on, accomplished through, and documented by appropriate procedures, developed and implemented by the region, that are consistent with the Regional Program Procedures in Appendix D of the General Requirements Document.
  - d. When funds are disbursed to a fiscal agent Board, each participating Board shall identify, track, and report regional program funds that it receives and spends as funds for that regional program. Each participating Board, including the fiscal agent Board, shall reflect in its CARS reports and CCS 3 extracts only its share of the regional program, in terms of consumers served, services provided, revenues received, expenses made, and costs of the services. Any monitoring and reporting of and accountability for the fiscal agent Board's handling of state or federal funds for a regional program shall be accomplished through the performance contract and reports. Alternately, if the participating Boards elect, each Board may perform these functions for its share of the regional program.
  - e. When funds are disbursed to a fiscal agent Board that pays a contract agency to deliver regional program services, the fiscal agent Board and participating Boards may elect to establish an arrangement that is consistent with the Regional Program Procedures in Appendix D of the General Requirements Document in which the fiscal agent Board reports all of the revenues and expenditures in the fiscal pages of Exhibit A while the participating Boards and the fiscal agent Board report information about consumers served, units of services, and expenses for those units only for their consumers 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 Boards elect, the fiscal agent Board may admit the consumers of other participating Boards and, for purposes of this regional program, treat those consumers as its own for documentation and reporting purposes.
3. Financial Reporting: All revenues, expenses, and costs for a regional program shall be reported to the Department only once; they may be reported by individual Boards, the Board that serves as the fiscal agent, or both, depending on how the regional program is designed and operates. For example, the fiscal agent Board might report the revenues and expenses for a regional program provided by a contract agency, and a Board that refers its consumers to that regional program may report the service and cost information related to its consumers.
  4. Consumer Reporting: Each consumer who is served through a regional program shall be reported to the Department only once for a particular service. However, a consumer receiving services from more than one Board should be reported by each Board that provides a service to that consumer. For example, if a consumer receives outpatient mental health services from one Board and residential crisis stabilization services from a second Board operating that

program on behalf of a region, the consumer would be admitted to each Board and each Board would report information about the consumer and the service it provided to the consumer.

5. **Service Reporting:** Each service provided by a regional program shall be reported only once, either by the Board providing or contracting for the service or the Board that referred its consumer to the regional program operated or contracted by another Board or by the region.
6. **Contracted Regional Programs:** When a Board that is the case management Board for a consumer refers a consumer to a regional program that is operated by a contract agency and paid for by the regional program's fiscal agent Board, the case management Board shall report the service and cost information, but not the revenue 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 Boards elect, the fiscal agent Board could admit the consumer for this service and report the consumer, service, cost, revenue, and expense information itself; in this situation, the case management Board would report nothing about this service.
7. **Transfers of Resources Among Boards:** Boards 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 the CARS) shall be used wherever possible, rather than developing new reporting systems, to avoid unnecessary or duplicative data collection and entry. For example, the special project function in the CCS could be used to report additional data elements that are not in the CCS for special projects, instead of establishing new, stand-alone reporting mechanisms. Any new service or program shall be implemented as simply as possible regarding reporting requirements.
9. **Regional Administrative and Management Expenses:** Boards 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 cause additional administrative and management expenses for regional programs. Boards 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 Board participating in a regional program supplements the allocation of state or federal funds received by the Board operating that program through transferring resources to the operating Board, the participating Board 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 Board will avoid displaying an unrealistically low service cost in its reports for the regional program and double counting consumers served by and service units delivered in the regional program, since the operating Board already reports this information.
11. **Balances:** Unexpended balances of current or previous fiscal year regional program funds should not be retained by the participating Boards to which the regional fiscal agent Board 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 Boards to ensure maximum utilization of these funds. Each region should establish procedures for monitoring expenditures of regional program funds and redistributing those unexpended balances that are consistent with the Regional Program Procedures in Appendix D of the General Requirements Document 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 a regional program, the distribution of state allocations for the regional program among participating Boards, and the financial participation of each Board whose consumers receive services from the regional program, should be resolved at the regional level

among the Boards participating in the program, with the Department providing information or assistance upon request.

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

14. Minimum Matching Funds Requirements: If a Board that operates or serves as the fiscal agent for a regional program cannot satisfy the statutory minimum 10 percent local matching funds requirement due to the state funds that it receives for that regional program, the Department, in accordance with provisions in this contract, State Board Policy 4010, and § 37.2-509 of the *Code of Virginia*, shall grant an automatic waiver of that matching funds requirement.

## **Exhibit K: Joint Agreements**

If the Board enters into a joint agreement pursuant to § 37.2-512 or § 37.2-615 of the *Code of Virginia*, the Board shall describe the agreement in this exhibit and attach a copy of the joint agreement to this Exhibit.

<b>Table of Contents</b>		
<b>I.</b>	<b>Purpose</b>	<b>2</b>
<b>II.</b>	<b>Joint Department and Board Requirements</b>	
	<b>A.</b> General Requirements	2
	<b>B.</b> Continuity of Care Procedures	2
	<b>C.</b> Discharge Planning Protocols	2
	<b>D.</b> Procedures for Continuity of Care Between CSBs and State Hospitals (2/3/1997)	2
	<b>E.</b> Discharge Assistance Project Procedures	3
<b>III.</b>	<b>Board Requirements</b>	
	<b>A. State Requirements</b>	
	1. General State Requirements	3
	2. Continuity of Care	3
	3. Preadmission Screening	3
	4. Discharge Planning	3
	5. Protection of Consumers	3
	6. Financial Management Requirements, Policies, and Procedures	4
	7. Procurement Requirements, Policies, and Procedures	7
	8. Reimbursement Requirements, Policies, and Procedures	8
	9. Human Resource Management Requirements, Policies, and Procedures	8
	10. Information Technology Capabilities and Requirements	10
	11. Licensing	11
	12. Quality of Care	11
	13. Planning	11
	14. Interagency Relationships	12
	15. Providing Information	12
	16. Forensic Services	12
	17. Access to Services for Individuals who are Deaf	13
	18. Subcontracting	14
	<b>B. Federal Requirements</b>	
	1. General Federal Compliance Requirements	14
	2. Disaster Response and Emergency Preparedness Requirements	15
	3. Federal Certification Regarding Lobbying for the MH and the SAPT Block Grants	15
	<b>C. State and Federal Requirements</b>	
	1. Employment Anti-Discrimination	16
	2. Service Anti-Discrimination	16
<b>IV.</b>	<b>Department Requirements</b>	
	<b>A. State Requirements</b>	
	1. Human Rights	17
	2. Licensing	17
	3. Policies and Procedures	17
	4. Reviews	17
	5. Planning	17
	6. Information Technology	17
	7. Providing Information	18
	8. Licensing Review Protocol for CARF-Accredited Services	18
<b>Appendices</b>		
	<b>A.</b> Continuity of Care Procedures	22
	<b>B.</b> Discharge Assistance Project Procedures	32
	<b>C.</b> Substance Abuse Treatment and Prevention Block Grant Requirements	37
	<b>D.</b> Regional Program Procedures	43

**1. Purpose**

## Community Services Performance Contract General Requirements Document

- A. Title 37.2 of the *Code of Virginia* establishes the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (the Department) to ensure delivery of publicly funded services and supports to individuals with mental illnesses, intellectual disabilities (previously identified as mental retardation), or substance use disorders and authorizes the Department to fund community mental health, mental retardation, and substance abuse services.
- B. Sections 37.2-500 through 37.2-511 of the *Code of Virginia* require cities and counties to establish community services boards for the purpose of providing local public mental health, mental retardation, and substance abuse services; § 37.2-600 through § 37.2-614 authorize certain cities or counties to establish behavioral health authorities that plan and provide those same local public services. In this Document, community services boards, local government departments with policy-advisory community services boards, and behavioral health authorities will be referred to as Boards or CSBs.
- C. This General Requirements Document (Document) includes or incorporates by reference ongoing statutory, regulatory, policy, and other requirements that are not expected to change frequently. This Document is incorporated into and made a part of the current Community Services Performance Contract by reference. Any substantive change in this Document, except changes in statutory, regulatory, policy, or other requirements or in other documents incorporated by reference in it, which changes are made in accordance with processes or procedures associated with those statutes, regulations, policies, or other requirements or documents, shall be made in accordance with applicable provisions of the Partnership Agreement and shall be considered to be a performance contract amendment that requires a new contract signature page, signed by both parties.

## II. Joint Department and Board Requirements

- A. **General Requirements:** Boards and the Department shall comply with all applicable federal and state laws, regulations, policies, and procedures. If any laws, regulations, policies, or procedures that become effective after the issuance of this Document change requirements in it, they shall replace the applicable provisions in this Document and shall be binding upon Boards and the Department, but the Department and Boards retain the right to exercise any remedies available to them by law or applicable provisions in the community services performance contract.
- B. **Continuity of Care Procedures:** In fulfilling their respective statutory responsibilities for preadmission screening and discharge planning, Boards and the Department shall comply with State Board Policies 1035 and 1036 and with the Continuity of Care Procedures, which are contained in Appendix A of this Document.
- C. **Discharge Planning Protocols:** Boards and the Department shall comply with the most recent version of the *Discharge Planning Protocols*, which are issued by the Department and are incorporated into and made a part of this Document by reference. Boards shall provide discharge planning pursuant to § 37.2-505 or § 37.2-606 of the *Code of Virginia* and in accordance with State Board Policies 1035 and 1036, the Continuity of Care Procedures, which are contained in Appendix A of this Document, and the most recent version of the *Discharge Planning Protocols*.
- D. **Procedures for Continuity of Care Between Boards and State Hospitals:** Boards and the Department shall comply with the *Procedures for Continuity of Care Between Community Services Boards and State Psychiatric Facilities* that were issued on February 3, 1997, and are incorporated into and made a part of this Document by reference.

## Community Services Performance Contract General Requirements Document

- E. Discharge Assistance Project Procedures:** Boards, if they participate in any Discharge Assistance Project (DAP) funded by the Department, and the Department shall adhere to provisions of the DAP Procedures in Appendix B of this Document.

### III. Board Requirements

#### A. State Requirements

- 1. General State Requirements:** Boards shall comply with applicable state statutes and regulations, State Mental Health, Mental Retardation and Substance Abuse Services Board regulations and policies, and Department procedures including:
  - a. Community Services Boards, § 37.2-500 through § 37.2-512 or Behavioral Health Authorities, § 37.2-600 through § 37.2-615 of the *Code of Virginia*;
  - b. State and Local Government Conflict of Interests Act, § 2.2-3100 through § 2.2-3127 of the *Code of Virginia*;
  - c. Virginia Freedom of Information Act, § 2.2-3700 through § 2.2-3714 of the *Code of Virginia*, including its notice of meeting and public meeting provisions;
  - d. Government Data Collection and Dissemination Practices Act, § 2.2-3800 through § 2.2-3809 of the *Code of Virginia*;
  - e. Virginia Public Procurement Act, § 2.2-4300 through § 2.2-4377 of the *Code of Virginia*;
  - f. Early Intervention Services System, § 2.2-5300 through § 2.2-5308 of the *Code of Virginia*, if a Board receives early intervention (Part C) state funds;
  - g. Chapter 8 (Admissions and Dispositions) and other applicable provisions of Title 37.2 and other titles of the *Code of Virginia*; and
  - h. Applicable provisions of the current Appropriation Act.
- 2. Continuity of Care:** Section 37.2-500 or 37.2-601 of the *Code of Virginia* requires each Board to function as the single point of entry into publicly funded mental health, mental retardation, and substance abuse services. The Board fulfills this function for any person who is located in the Board's service area and needs mental health, mental retardation, or substance abuse services.
- 3. Preadmission Screening:** Boards shall provide preadmission screening services pursuant to § 37.2-505 or § 37.2-606, § 37.2-805, § 37.2-809 through § 37.2-813, and § 37.2-814 and § 16.1-335 et seq. of the *Code of Virginia* and in accordance with the Continuity of Care Procedures for any person who is located in a Board's service area.
- 4. Discharge Planning:** Boards shall provide discharge planning pursuant to § 37.2-505 or § 37.2-606 of the *Code of Virginia* and in accordance with the Continuity of Care Procedures and the most recent version of the *Discharge Planning Protocols*.
- 5. Protection of Consumers**
  - a. Human Rights:** Boards shall comply with the current *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services* (the Human Rights Regulations) adopted by the State Mental Health, Mental Retardation and Substance Abuse Services Board. In the event of a conflict between any of the provisions of this Document and provisions in the Human Rights Regulations, the applicable provisions of the Human Rights Regulations shall apply. Boards shall cooperate with any Department investigation of allegations or complaints of human rights violations, including providing any information needed for the investigation as required under state law and as permitted under 45 CFR § 164.512 (d) in as expeditious a manner as possible.

## Community Services Performance Contract General Requirements Document

- b. Consumer Disputes:** The filing of a complaint or the use of the informal dispute resolution mechanism in the Human Rights Regulations by a consumer or his family member or authorized representative shall not adversely affect the quantity, quality, or timeliness of services provided to that consumer unless an action that produces such an effect is based on clinical or safety considerations and is documented in the consumer's individualized services plan (ISP).
- c. Consumer Dispute Resolution Mechanism:** Boards shall develop their own procedures for satisfying requirements in § 37.2-504 or § 37.2-605 of the *Code of Virginia* for a local consumer dispute resolution mechanism.

### 6. Financial Management Requirements, Policies, and Procedures

- a. Generally Accepted Accounting Principles:** If it is an operating board, a behavioral health authority, or an administrative policy board that is not a city or county department or agency or is not required to adhere to local government financial management requirements, policies, and procedures, the Board's financial management and accounting system must operate and produce financial statements and reports in accordance with Generally Accepted Accounting Principles. It must include necessary personnel and financial records and a fixed assets system. It must provide for the practice of fund accounting and adhere to cost accounting guidelines issued by the Department.

If it is an administrative policy board that is a city or county department or agency or is required to adhere to local government financial management requirements, policies, and procedures or it is a local government department with a policy-advisory board, the Board shall comply with local government financial management requirements, policies, and procedures. If the Department receives any complaints about the Board's financial management operations, the Department will forward these complaints to the local government and any other appropriate authorities. In response to those complaints, the Department may conduct a review of that Board's financial management activities.

- b. Accounting:** Boards shall account for all service and administrative expenses accurately and submit timely reports to the Department to document these expenses. Boards shall comply with the Uniform Cost Report Manual issued by the Department, pursuant to § 37.2-508 or § 37.2-608 of the *Code of Virginia*, when submitting reports to the Department in accordance with requirements contained in the Community Services Performance Contract.
- c. Annual Independent Audit:** If it is an operating board, a behavioral health authority, or an administrative policy board that is not a city or county department or agency or is not required to adhere to local government financial management requirements, policies, and procedures, the Board shall obtain an independent annual audit conducted by certified public accountants. Audited financial statements shall be prepared in accordance with generally accepted accounting principles (GAAP). The appropriate GAAP basis financial reporting model is the Enterprise Fund in accordance with the requirements of Governmental Accounting Standards Board (GASB) Statement Number 34, *Basic Financial Statements- and Management's Discussion and Analysis- for State and Local Governments*. GASB 34 replaces the previous financial reporting model *Health Care Organizations Guide*, produced by the American Institute of Certified Public Accountants. Copies of the audit and the accompanying management letter must be provided to the Office of Budget and Financial Reporting in the Department and to each local government that established the Board. Boards shall, to the extent practicable, obtain unqualified audit opinions. Deficiencies and exceptions noted in an audit or

## Community Services Performance Contract General Requirements Document

management letter must be resolved or corrected within a reasonable period of time, mutually agreed upon by the Board and the Department.

If it is an administrative policy board that is a city or county department or agency or is required to adhere to local government financial management requirements, policies, and procedures or it is a local government department with a policy-advisory board, the Board shall be included in the annual audit of its local government. Copies of the applicable portions of the accompanying management letter must be provided to the Office of Budget and Financial Reporting in the Department. Deficiencies and exceptions noted in a management letter must be resolved or corrected within a reasonable period of time, mutually agreed upon by the Board, its local government(s), and the Department.

If an administrative policy board that is a city or county department or agency or is required to adhere to local government financial management requirements, policies, and procedures or a local government department with a policy-advisory board obtains a separate independent annual audit conducted by certified public accountants, audited financial statements shall be prepared in accordance with generally accepted accounting principles. The appropriate GAAP basis financial reporting model is the Enterprise Fund in accordance with the requirements of Governmental Accounting Standards Board (GASB) Statement Number 34, *Basic Financial Statements- and Management's Discussion and Analysis- for State and Local Governments*. GASB 34 replaces the previous financial reporting model *Health Care Organizations Guide*, produced by the American Institute of Certified Public Accountants. The local government will determine the appropriate fund classification in consultation with its certified public accountant. Copies of the audit and the accompanying management letter must be provided to the Office of Budget and Financial Reporting and to each local government that established the Board. Boards shall, to the extent practicable, obtain unqualified audit opinions. Deficiencies and exceptions noted in an audit or management letter must be resolved or corrected within a reasonable period of time, mutually agreed upon by the Board and the Department.

- d. Federal Audit Requirements:** When the Department subgrants federal grants to a Board, all federal government audit requirements must be satisfied.
- e. Subcontractor Audits:** Every Board shall obtain, review, and take any necessary actions on audits, which are required by the Financial Management Standards for Community Services Manual issued by the Department, of any subcontractors that provide services that are procured under the Virginia Public Procurement Act and included in a Board's performance contract. The Board shall provide copies of these audits to the Office of Budget and Financial Reporting in the Department.
- f. Bonding:** If it is an operating board, a behavioral health authority, or an administrative policy board that is not a city or county department or agency or is not required to adhere to local government financial management requirements, policies, and procedures, Board employees with financial responsibilities shall be bonded in accordance with local financial management policies.
- g. Fiscal Policies and Procedures:** If it is an operating board, a behavioral health authority, or an administrative policy board that is not a city or county department or agency or is not required to adhere to local government financial management requirements, policies, and procedures, a Board's written fiscal policies and procedures shall conform to applicable State Board policies and Departmental policies and procedures, contained in the Financial Management Standards for Community Services Manual issued by the Department.

## Community Services Performance Contract General Requirements Document

- h. Financial Management Manual:** If it is an operating board, a behavioral health authority, or an administrative policy board that is not a city or county department or agency or is not required to adhere to local government financial management requirements, policies, and procedures, a Board shall be in material compliance with the requirements in the current Financial Management Standards for Community Services Manual issued by the Department.
- i. Local Government Approval:** Boards shall submit their performance contracts to the local governments in their service areas for review and approval, pursuant to § 37.2-508 or § 37.2-608 of the *Code of Virginia*, which requires approval of the contracts by September 30. Boards shall submit their contracts to the local governing bodies of the cities and counties that established them in accordance with the schedules determined by those governing bodies or at least 15 days before meetings at which the governing bodies are scheduled to consider approval of their contracts. Unless prohibited from doing so by its local government(s), a Board may submit its contract to the Department before it is approved by its local government(s).
- j. Department Review:** If a Board is an operating board, a behavioral health authority, or an administrative policy board that is not a city or county department or agency or is not required to adhere to local government financial management requirements, policies, and procedures, the Department may conduct a review of the Board's financial management activities at any time. While it does not conduct routine reviews of the Board's financial management activities, the Department may conduct a review in response to significant deficiencies, irregularities, or problems identified in the Board's independent annual audit or management letter or in response to complaints or information that it receives. Boards shall submit formal plans of correction to the Office of Budget and Financial Reporting in the Department within 45 days of receipt of official reports of reviews. Minor compliance issues must be corrected within 45 days of submitting a plan. Action to correct major compliance issues must be initiated within 45 days and completed within 180 days of submitting a plan, unless the Department grants an extension.

If it is an administrative policy board that is a city or county department or agency or is required to adhere to local government financial management requirements, policies, and procedures or it is a local government department with a policy-advisory board, the Department may conduct a review of a Board's financial management activities at any time in order to fulfill its responsibilities for federal sub-recipient (Board) monitoring requirements under the Single Audit Act (OMB Circular A-133). While it does not conduct routine reviews of the Board's financial management activities, the Department may conduct a review in response to significant deficiencies, irregularities, or problems identified in the Board's audit or management letter or in response to complaints or information that it receives. Such reviews shall be limited to sub-recipient monitoring responsibilities in Subpart D.400 of the Single Audit Act associated with receipt of federal funds by the Board. Boards shall submit formal plans of correction to the Office of Budget and Financial Reporting in the Department within 45 days of receipt of official reports of reviews. Minor compliance issues must be corrected within 45 days of submitting a plan. Action to correct major compliance issues must be initiated within 45 days and completed within 180 days of submitting a plan, unless the Department grants an extension.

- k. Balances of Unspent Funds:** In calculating amounts of unspent state funds, the Department shall prorate balances of unexpended unrestricted funds after the close of the fiscal year among unrestricted state funds, local matching funds, and fee revenues, based on the relative proportions of those revenues received by the

## Community Services Performance Contract General Requirements Document

Board. This normally will produce identified balances of unrestricted state funds, local matching funds, and fee revenues, rather than just balances of unrestricted state funds. Restricted state funds, such as Programs of Assertive Community Treatment (PACT) and Discharge Assistance Projects (DAP), shall be accounted for separately, given their restricted status, and the Department shall identify balances of unexpended restricted state funds separately.

### 7. Procurement Requirements, Policies, and Procedures

- a. Procurement Policies and Procedures:** If it is an operating board, a behavioral health authority, or an administrative policy board that is not a city or county department or agency or is not required to adhere to local government procurement requirements, policies, and procedures, a Board shall have written procurement policies and procedures in effect that address internal procurement responsibilities, small purchases and dollar thresholds, ethics, and disposal of surplus property. Written procurement policies and procedures relating to vendors shall be in effect that address how to sell to the Board, procurement, default, and protests and appeals. All written policies and procedures must conform to the Virginia Public Procurement Act and the current Community Services Procurement Manual issued by the Department.

If it is an administrative policy board that is a city or county department or agency or is required to adhere to local government procurement requirements, policies, and procedures or it is a local government department with a policy-advisory board, a Board shall comply with its local government's procurement requirements, policies, and procedures, which must conform to the Virginia Public Procurement Act. If the Department receives any complaints about the Board's procurement operations, the Department will forward these complaints to the local government and any other appropriate authorities. In response to those complaints, the Department may conduct a review of that Board's procurement activities.

- b. Procurement Manual:** If it is an operating board, a behavioral health authority, or an administrative policy board that is not a city or county department or agency or is not required to adhere to local government procurement requirements, policies, and procedures, a Board shall be in material compliance with the requirements contained in the current Community Services Procurement Manual issued by the Department.
- c. Department Review:** If a Board is an operating board, a behavioral health authority, or an administrative policy board that is not a city or county department or agency or is not required to adhere to local government procurement requirements, policies, and procedures, the Department may conduct a review of the Board's procurement activities at any time. While it does not conduct routine reviews of the Board's procurement activities, the Department may conduct a review in response to significant deficiencies, irregularities, or problems identified in the Board's independent annual audit or management letter or in response to complaints or information that it receives. The review will include a sampling of Board subcontracts. Boards shall submit formal plans of correction to the Office of Administrative Services in the Department within 45 days of receipt of official reports of reviews. Minor compliance issues must be corrected within 45 days of submitting a plan. Action to correct major compliance issues must be initiated within 45 days and completed within 180 days of submitting a plan, unless the Department grants an extension.

## Community Services Performance Contract General Requirements Document

### 8. Reimbursement Requirements, Policies, and Procedures

- a. **Reimbursement System:** Each Board's reimbursement system shall comply with § 37.2-504, § 37.2-511, § 37.2-605, § 37.2-612, and § 20-61 of the *Code of Virginia*. Its operation must be described in organizational charts identifying all staff members, flow charts, and specific job descriptions for all personnel involved in the reimbursement system.
- b. **Policies and Procedures:** Written fee collection policies and procedures shall be adequate to maximize revenues from consumers and responsible third party payors.
- c. **Schedule of Charges:** A schedule of charges shall exist for all services that are included in the Performance Contract, shall be related reasonably to the cost of the services, and shall be applicable to all recipients of the services.
- d. **Ability to Pay:** A method, approved by a Board's board of directors, that complies with applicable state and federal regulations shall be used to evaluate the ability of each consumer to pay fees for the services he or she receives.
- e. **Reimbursement Manual:** Boards shall be in material compliance with the requirements in the current Community Services Reimbursement Manual issued by the Department.
- f. **Department Review:** While it does not conduct routine reviews of the Board's reimbursement activities, the Department may conduct a review at any time in response to significant deficiencies, irregularities, or problems identified in the Board's independent annual audit or management letter or in response to complaints or information that it receives. Boards shall submit formal plans of correction to the Office of Cost Accounting and Reimbursement in the Department within 45 days of receipt of official reports of reviews. Minor compliance issues must be corrected within 45 days of submitting a plan. Action to correct major compliance issues must be initiated within 45 days and completed within 180 days of submitting a plan, unless the Department grants an extension.
- g. **Medicaid and Medicare Regulations:** Boards 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.

### 9. Human Resource Management Requirements, Policies, and Procedures

- a. **Statutory Requirements:** If it is an operating board, a behavioral health authority, or an administrative policy board that is not a city or county department or agency or is not required to adhere to local government human resource management requirements, policies, and procedures, a Board shall operate a human resource management program that complies with state and federal statutes, regulations, and policies. When its executive director position becomes vacant, a Board shall provide to the Office of Community Contracting in the Department a current position description and salary range and the advertisement for the position for review, pursuant to § 37.2-504 or § 37.2-605 of the *Code of Virginia*. This review does not include Department approval of the selection or employment of a particular candidate for the position. In accordance with § 37.2-504 or § 37.2-605 of the *Code of Virginia*, if it is an operating board or a behavioral health authority, a Board shall employ its executive director under an annually renewable contract that contains performance objectives and evaluation criteria. A Board shall provide a copy of this employment contract to the Department upon request.

## Community Services Performance Contract General Requirements Document

If it is an administrative policy board that is a city or county department or agency or is required to adhere to local government human resource management requirements, policies, and procedures or it is a local government department with a policy-advisory board, a Board shall be part of a human resource management program that complies with state and federal statutes, regulations, and policies. When its executive director position becomes vacant, a Board shall provide to the Office of Community Contracting in the Department a current position description and the advertisement for the position for review, pursuant to § 37.2-504 of the *Code of Virginia*. This review does not include Department approval of the selection or employment of a particular candidate for the position.

- b. Policies and Procedures:** If it is an operating board, a behavioral health authority, or an administrative policy board that is not a city or county department or agency or is not required to adhere to local government human resource management requirements, policies, and procedures, a Board's written human resource management policies and procedures must include a classification plan and uniform employee pay plan and must address benefits, progressive discipline (standards of conduct), professional conduct, employee ethics, compliance with the state Human Rights Regulations and the Board's local human rights policies and procedures, conflicts of interest, employee performance evaluation, equal employment opportunity, employee grievances, hours of work, leave, outside employment, recruitment and selection, transfer and promotion, termination and layoff, travel, initial employee orientation, examinations, employee to executive director and board of directors contact protocol, and on-the-job expenses.

If it is an administrative policy board that is a city or county department or agency or is required to adhere to local government human resource management requirements, policies, and procedures or it is a local government department with a policy-advisory board, a Board shall adhere to its local government's human resource management policies and procedures.

- c. Job Descriptions:** If it is an operating board, a behavioral health authority, or an administrative policy board that is not a city or county department or agency or is not required to adhere to local government human resource management requirements, policies, and procedures, a Board must have written, up-to-date job descriptions for all positions. Job descriptions must include identified essential functions, explicit responsibilities, and qualification statements, expressed in terms of knowledges, skills, and abilities as well as business necessity and bona fide occupational qualifications or requirements.
- d. Grievance Procedure:** If it is an operating board, a behavioral health authority, or an administrative policy board that is not a city or county department or agency or is not required to adhere to local government human resource management requirements, policies, and procedures, a Board's grievance procedure must satisfy § 15.2-1506 or § 15.2-1507 of the *Code of Virginia*.
- e. Uniform Pay Plan:** If it is an operating board, a behavioral health authority, or an administrative policy board that is not a city or county department or agency or is not required to adhere to local government human resource management requirements, policies, and procedures, a Board must adopt a uniform pay plan in accordance with § 15.2-1506 of the *Code* and the Equal Pay Act of 1963.
- f. Department Review:** If it is an operating board, a behavioral health authority, or an administrative policy board that is not a city or county department or agency or is not required to adhere to local government human resource management requirements, policies, and procedures, employee complaints regarding a Board's human resource management practices will be referred back to the Board for

## Community Services Performance Contract General Requirements Document

appropriate local remedies. The Department may conduct a human resource management review to ascertain a Board's compliance with performance contract requirements and assurances, based on complaints or other information received about a Board's human resource management practices. If a review is done and deficiencies are identified, a Board shall submit a formal plan of correction to the Office of Human Resource Management and Development in the Department within 45 days of receipt of an official report of a review. Minor compliance issues must be corrected within 45 days of submitting the plan. Action to correct major compliance issues must be initiated within 45 days and completed within 180 days of submitting the plan, unless the Department grants an extension.

If it is an administrative policy board that is a city or county department or agency or is required to adhere to local government human resource management requirements, policies, and procedures or it is a local government department with a policy-advisory board, employee complaints regarding a Board's human resource management practices will be referred back to the local government for appropriate local remedies. In response to complaints that it receives, the Department may conduct a review of the local government's human resource management practices at any time.

- 10. Information Technology Capabilities and Requirements:** Boards shall meet the following requirements.
  - a. Hardware and Software Procurement:** Any hardware and software purchased by a Board with state or federal funds shall be capable of addressing requirements established by the Department, including communications, compatibility, and network protocols and the reporting requirements in the Performance Contract. Such procurements may be subject to review and approval by the Office of Information Technology Services in the Department.
  - b. Operating Systems:** Boards shall use or have access to operating systems that are compatible with or are able to communicate with the Department's network. A Board's computer network or system must be capable of supporting and running the Department's CARS-ACCESS software and the current version of the Community Consumer Submission (CCS) extract software and should be capable of processing and reporting standardized aggregate and individual consumer, service, outcome, and financial information based on documents and requirements listed in the Performance Contract.
  - c. Electronic Communication:** Boards shall ensure that their information systems communicate with those used by the Department and that this communication conforms to the security requirements of the Health Insurance Portability and Accountability Act of 1996. This communication shall provide file and data exchange capabilities for automated routines and access to legally mandated systems via the TCP/IP networking protocol.
  - d. Data Access:** Boards shall develop and implement or access automated systems that allow for output of fiscal, service, and consumer data, taking into consideration the need for appropriate security and confidentiality. Output shall be in a format prescribed by the Department. In addition to regular reports, such data may be used to prepare ad hoc reports on consumers and services and to update Department files using this information. Boards shall ensure that their information systems meet all applicable state and federal confidentiality, privacy, and security requirements, particularly concerning the distribution of identifying information, diagnosis, service history, and service use and that their information systems are compliant with the Health Insurance Portability and Accountability Act of 1996.

## Community Services Performance Contract General Requirements Document

**11. Licensing:** Boards shall comply with the current licensing regulations adopted by the State Board. Boards shall establish systems to ensure ongoing compliance with applicable licensing regulations. Results of licensing reviews, including scheduled reviews, unannounced visits, and complaint investigations, shall be provided to all members of a Board in a timely manner.

### 12. Quality of Care

#### a. Individualized Services Plan (ISP)

- 1) **Assessment:** Each consumer shall receive an assessment appropriate to his or her needs that a) includes, where appropriate, consideration of co-occurring mental illness, intellectual disabilities, or substance use disorder, b) is consistent with the Department's licensing regulations, and c) is performed by an individual with appropriate clinical training. The assessment and the development of the ISP shall be completed within time periods specified in the applicable Medicaid or Departmental licensing regulations. After the initial assessment, the consumer shall be referred to a qualified service provider for treatment appropriate to his or her condition or needs.
- 2) **Service Planning:** Boards shall develop and implement a written ISP for each consumer who is admitted that is appropriate to his or her needs and the scope of the services required and reflects current acceptable professional practice. This ISP shall include an assessment of level of functioning, treatment goals, and all services and supports needed, whether delivered by a Board, its subcontractors, or other providers.
- 3) **Plan Implementation:** The implementation of the ISP shall be documented and the ISP shall be reviewed within the time periods specified in applicable Medicaid or Departmental licensing regulations, or for unlicensed services, except motivational treatment, consumer monitoring, assessment and evaluation, early intervention, or consumer-run services as defined in the current Core Services Taxonomy and in which an ISP is not required, at least every six months or more often as indicated by the consumer's level of functioning. Discharge planning and discharge from services shall be consistent with the ISP or the program's criteria for discharge.

### 13. Planning

- a. **General Planning:** Boards shall participate in collaborative local and regional service and management information systems planning with state facilities, other Boards, 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*, Boards shall provide input into long-range planning activities that are conducted by the Department, including the Comprehensive State Plan required by § 37.2-315 of the *Code of Virginia*. Boards shall report unduplicated community waiting list information to the Department when required for the Comprehensive State Plan update. Boards shall work with local prevention planning bodies composed of representatives of multiple systems and groups to develop community-based prevention plans based on assessed needs and resources and submit annual Community Prevention Plan reports to the Department.
- b. **Participation in State Facility Planning Activities:** Boards shall participate in collaborative planning activities with the Department to the greatest extent possible regarding the future role and structure of the state facilities that it operates.

# Community Services Performance Contract General Requirements Document

## 14. Interagency Relationships

- a. Pursuant to the case management requirements of § 37.2-500 or § 37.2-601 of the *Code of Virginia*, Boards shall, to the extent practicable, develop and maintain linkages with other community and state agencies and facilities that are needed to assure that their consumers are able to access the treatment, training, rehabilitative, and habilitative mental health, mental retardation, and substance abuse services and supports identified in their individualized services plans. Boards shall comply with the provisions of § 37.2-504 or § 37.2-605 of the *Code of Virginia* regarding interagency agreements.
- b. Boards also shall develop and maintain, in conjunction with the courts having jurisdiction in the cities and counties served by the Boards, cooperative linkages that are needed to carry out the provisions of § 37.2-805 through § 37.2-821 and related sections of the *Code* pertaining to the involuntary admission process.
- c. Boards 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*) and Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq. and § 2.2-5300 through § 2.2-5308 of the *Code of Virginia*) that relate to services that they provide. Pursuant to § 2.2-5305 and § 2.2-5306 of the *Code of Virginia*, a Board shall provide information to the Local Interagency Coordinating Council of which it is a member that is necessary to satisfy state and federal requirements about Part C services that it provides directly to Part C-eligible individuals. Nothing in this Document shall be construed as requiring Boards to provide services related to these acts in the absence of sufficient funds and interagency agreements.

- 15. Providing Information:** Boards shall provide any information requested by the Department that is related to performance of or compliance with the Performance Contract in a timely manner, considering the type, amount, and availability of the information requested. The provision of information shall comply with applicable laws and regulations governing the confidentiality, privacy, and security of information regarding individuals receiving services from Boards.

## 16. Forensic Services

- a. Upon receipt of a court order pursuant to § 19.2-169.2 of the *Code of Virginia*, a Board shall provide or arrange for the provision of services to restore the individual to competency to stand trial. These services shall be provided in the local or regional jail, juvenile detention center (when a juvenile is being tried as an adult), or other location in the community where the individual is currently located. These services shall include treatment and restoration services, emergency services, assessment services, the provision of medications and medication management services, and other services that may be needed by the individual in order to restore him to competency and to prevent his admission to a state hospital for these services.
- b. Upon written notification from a state facility that an individual hospitalized for treatment for restoration to competency pursuant to § 19.2-169.2 of the *Code of Virginia* has been restored to competency and is being discharged back to the community, a Board shall to the greatest extent possible provide or arrange for the provision of services in the local or regional jail, juvenile detention center (when a juvenile is being tried as an adult), or other location in the community where the individual is located to that individual to ensure the maintenance of his psychiatric stability and competency to stand trial. Services shall include

## Community Services Performance Contract General Requirements Document

treatment and restoration services, emergency services, assessment services, the provision of medications and medication management services, and other services which may be needed by the individual in order prevent his readmission to a state hospital for these services.

- c. Upon receipt of a court order pursuant to § 16.1-356 of the *Code of Virginia*, a Board shall perform a juvenile competency evaluation. Upon receipt of a court order pursuant to § 16.1-357, a Board shall provide services to restore a juvenile to competency to stand trial through the Department's statewide contract.
  - d. Upon receipt of a court order, a Board shall provide or arrange for the provision of forensic evaluations required by local courts in the community, in accordance with State Board Policy 1041.
  - e. Forensic evaluations and treatment shall be performed on an outpatient basis unless the results of an outpatient evaluation indicate that hospitalization is necessary. A Board shall consult with local courts in placement decisions for hospitalization of forensic consumers based upon evaluation of the individual's clinical condition, need for a secure environment, and other relevant factors. A Board's staff shall conduct an assessment of risk to provide information to the Commissioner for the determination of whether a forensic consumer in need of hospitalization requires placement in a civil facility or a secure facility. A Board's staff will contact and collaborate with the Forensic Coordinator of the state hospital that serves the Board in making this determination. A Board's assessment shall include those items required prior to admission to a state hospital, per the Continuity of Care Procedures in Appendix A of this Document.
  - f. Each Board shall designate a Forensic Admissions Coordinator, a Forensic Evaluation Coordinator, and an NGRI Coordinator to collaborate with the local courts, the forensic staff of state facilities, and the Department. Each Board shall notify the Department's Director of Forensic Services of the name, title, and contact information of these designees and shall inform the Director of any changes in these designations. Each Board shall ensure that designated staff complete the forensic training necessary to maintain forensic certification.
  - g. Boards shall provide discharge planning for persons found not guilty by reason of insanity. Pursuant to § 19.2-182.2 through § 19.2 -182.7, and § 19.2-182.11 of the *Code of Virginia*, a Board shall provide discharge planning, collaborate with the state facility staff in preparing conditional release plans, implement the court's conditional release orders, and submit written reports to the court on the person's progress and adjustment in the community no less frequently than every six months for acquittees who have been conditionally released to a locality served by the Board. A Board should provide to the Department's Director of Forensic Services written monthly reports on the person's progress and adjustment in the community for their first 12 continuous months in the community for acquittees who have been conditionally released to a locality served by the Board and copies of court orders regarding acquittees on conditional release.
  - h. If a forensic consumer does not meet the criteria for admission to a state hospital, his psychiatric needs should be addressed in the local jail, prison, detention center, or other correctional facility in collaboration with local treatment providers.
- 17. Access to Services for Individuals who are Deaf, Hard of Hearing, Late Deafened, or Deafblind:** The Board should identify and develop a working relationship with the Regional Deaf Services Program and the Regional Deaf Services Coordinator that serve the Board's service area and collaborate with them on the provision of appropriate, linguistically and culturally competent services,

## Community Services Performance Contract General Requirements Document

consultation, and referral for individuals who are deaf, hard of hearing, late deafened, or deafblind.

**18. Subcontracting:** A subcontract means a written agreement between a Board and another party under which the other party performs any of the Board's obligations. Subcontracts, unless the context or situation supports a different interpretation or meaning, also may include agreements, memoranda of understanding, purchase orders, contracts, or other similar documents for the purchase of services or goods by a Board from another organization or agency or a person on behalf of an individual consumer. A subcontract does not include employment of staff by a Board through contractual means.

**a. Subcontracts:** The written subcontract must, as applicable and at a minimum, state the activities to be performed, the time schedule and duration, the policies and requirements that are applicable to the subcontractor, the maximum amount of money for which a Board may become obligated, and the manner in which the subcontractor will be compensated, including payment time frames. Subcontracts shall not contain provisions that require a subcontractor to make payments or contributions to a Board as a condition of doing business with the Board. A Board shall not include, assess, or otherwise allocate its own administrative expenses in its contracts with subcontractors.

**b. Subcontractor Compliance:** A Board shall require that its subcontractors comply with the requirements of all applicable federal and state statutes, regulations, and policies that affect or are applicable to the services included in its Performance Contract. A Board shall require that any agency, organization, or individual with which it intends to subcontract services that are included in its Performance Contract is fully qualified and possesses and maintains current all necessary licenses or certifications from the Department and other applicable regulatory entities before it enters into the subcontract and places consumers in the subcontracted service. A Board shall require all subcontractors that provide services to consumers and are licensed by the Department to maintain compliance with the Human Rights Regulations adopted by the State Board. A Board shall, to the greatest extent practicable, require all other subcontractors that provide services purchased by that Board for consumers and are not licensed by the Department to develop and implement policies and procedures that comply with the Board's human rights policies and procedures or to allow the Board to handle allegations of human rights violations on behalf of the Board's consumers who are receiving services from such subcontractors. When a Board funds providers such as family members, neighbors, consumers, or other individuals to serve consumers, the Board may comply with these requirements on behalf of those providers, if both parties agree.

**c. Subcontractor Dispute Resolution:** Boards shall include contract dispute resolution procedures in their contracts with subcontractors.

**d. Quality Improvement Activities:** Boards shall, to the extent practicable, incorporate specific language in their subcontracts regarding their quality improvement activities. Each vendor that subcontracts with a Board should have its own quality improvement system in place or should participate in the Board's quality improvement program.

### B. Federal Requirements

**1. General Federal Compliance Requirements:** Boards shall comply with all applicable federal statutes, regulations, policies, and other requirements; including applicable provisions of the federal Mental Health Services Block Grant (CFDA

## Community Services Performance Contract General Requirements Document

93.958) and the federal Substance Abuse Prevention and Treatment Block Grant (CFDA 93.959) Requirements contained in Appendix C of this Document, and:

- a. the Federal Immigration Reform and Control Act of 1986;
- b. applicable provisions of Public Law 105-17, Part C of the Individuals with Disabilities Education Act, if a Board receives federal early intervention (Part C) funds; and
- c. Confidentiality of Alcohol and Substance Abuse Records, 42 C.F.R. Part 2.

Non-federal entities, including Boards, expending \$500,000 or more in a year in federal awards shall have a single or program-specific audit conducted for that year in accordance with Office of Management and Budget Circular A-133.

Boards shall prohibit the following acts by themselves, their employees, and agents performing services for them:

- a. the unlawful or unauthorized manufacture, distribution, dispensation, possession, or use of alcohol or other drugs; and
- b. any impairment or incapacitation from the use of alcohol or other drugs (except the use of drugs for legitimate medical purposes).

### 2. Disaster Response and Emergency Service Preparedness Requirements:

Boards agree to comply with section 416 of Public Law 93-288 and § 44-146.13 through § 44-146.28 of the *Code of Virginia* regarding disaster response and emergency service preparedness. Section 416 of P.L. 93-288 authorizes the State Office of Emergency Services to require the Department to comply with the *Commonwealth of Virginia Emergency Operations Plan, Volume 2, Emergency Support Function No. 8: Health and Medical Services, Section 4: Emergency Mental Health Services*. Section 4 requires Boards to comply with Department directives coordinating disaster planning, preparedness, and response to emergencies and to develop procedures for responding to major disasters. These procedures must address:

- a. conducting preparedness training activities;
- b. designating staff to provide counseling;
- c. coordinating with state facilities and local health departments or other responsible local agencies, departments, or units in preparing Board all hazards disaster plans;
- d. providing crisis counseling and support to local agencies, including volunteer agencies;
- e. negotiating disaster response agreements with local governments and state facilities; and
- f. identifying community resources.

### 3. Federal Certification Regarding Lobbying for the Mental Health and Substance Abuse Prevention and Treatment Block Grants: Boards certify, to the best of their knowledge and belief, that:

- a. No federal appropriated funds have been paid or will be paid, by or on behalf of the Board, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement.

## Community Services Performance Contract General Requirements Document

- b. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the Board shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
- c. The Board shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 or more than \$100,000 for each failure.

### C. State and Federal Requirements

- 1. **Employment Anti-Discrimination:** Boards certify that they will conform to the applicable provisions of Title VII of the Civil Rights Act of 1964 as amended, the Equal Pay Act of 1963, Sections 503 and 504 of the Rehabilitation Act of 1973, the Vietnam Era Veterans Readjustment Act of 1974, the Age Discrimination in Employment Act of 1967, the Americans With Disabilities Act of 1990, the Virginians With Disabilities Act, the Virginia Fair Employment Contracting Act, the Civil Rights Act of 1991, regulations issued by Federal Granting Agencies, and other applicable statutes and regulations, including § 2.2-4310 of the *Code of Virginia*. Boards agree as follows.
  - a. Boards will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability, or other basis prohibited by state law relating to discrimination in employment, except where there is a bona fide occupational qualification reasonably necessary to the normal operation of the Board. Boards agree to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.
  - b. Boards, in all solicitations or advertisements for employees placed by or on behalf of themselves, will state that they are equal opportunity employers.
  - c. Notices, advertisements, and solicitations placed in accordance with federal law, rule, or regulation shall be deemed sufficient for the purpose of meeting these requirements.
- 2. **Service Delivery Anti-Discrimination:** Boards certify that they will conform to the applicable provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans With Disabilities Act of 1990, the Virginians With Disabilities Act, the Civil Rights Act of 1991, regulations issued by the U.S. Department of Health and Human Services pursuant thereto, other applicable statutes and regulations, and paragraphs a and b below.
  - a. Services operated or funded by Boards have been and will continue to be operated in such a manner that no person will be excluded from participation in, denied the benefits of, or otherwise subjected to discrimination under such services on the grounds of race, religion, color, national origin, age, gender, or disability.

## Community Services Performance Contract General Requirements Document

- b. Boards and their direct and contractual services will include these assurances in their services policies and practices and will post suitable notices of these assurances at each of their facilities in areas accessible to consumers.
- c. Boards will periodically review their operating procedures and practices to insure continued conformance with applicable statutes, regulations, and orders related to non-discrimination in service delivery.

### IV. Department Requirements

#### A. State Requirements

1. **Human Rights:** The Department shall operate the statewide human rights system described in the current Human Rights Regulations, monitor compliance with the human rights requirements in those regulations, and conduct reviews and investigations referenced in the Regulations. The Department's human rights staff shall be available on a daily basis, including weekends and holidays, to receive reports of allegations of violations of a consumer's human rights.
2. **Licensing:** The Department shall license programs and services that meet the requirements of the current Licensing Regulations and conduct licensing reviews in accordance with the provisions of those regulations. The Department shall respond in a timely manner to issues raised by a Board regarding its efforts to coordinate and monitor services provided by independent providers licensed by the Department.
3. **Policies and Procedures:** The Department shall revise, update, and provide to Boards copies of the uniform cost report, financial management, procurement, and reimbursement manuals cited in sections III.A.6, 7, and 8 of this Document. The Department shall provide or otherwise make available to Boards copies of relevant regulations and policies adopted by the State Mental Health, Mental Retardation and Substance Abuse Services Board.
4. **Reviews:** The Department shall review and take appropriate action on audits submitted by a Board in accordance with the provisions of this Document. The Department may conduct procurement, financial management, reimbursement, and human resource management reviews of a Board's operations, in accordance with provisions in section III of this Document.
5. **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*.
6. **Information Technology:** The Department shall operate and provide technical assistance and support, to the extent practicable, to Boards about the CARS-ACCESS information system and the Community Consumer Submission (CCS) software referenced in the Performance Contract and comply with State Board Policies 1030 and 1037. The Department shall operate the FIMS and the KIT Prevention System referenced in the Performance Contract. The Department shall develop and implement communication, compatibility, and network protocols in accordance with the provisions in section III of this Document. 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 in accordance with the Performance Contract and this Document. The Department shall ensure that any software application that it issues to Boards for reporting purposes associated with the Performance Contract has been field tested by a reasonable number of Boards to assure compatibility and functionality with the major IT systems used by Boards, is

## Community Services Performance Contract General Requirements Document

operational, and is provided to Boards sufficiently in advance of reporting deadlines to allow Boards to install and run the software application.

7. **Providing Information:** The Department shall provide any information requested by Boards that is related to performance of or compliance with the Performance Contract in a timely manner, considering the type, amount, and availability of the information requested.
8. **Licensing Review Protocol for CARF-Accredited Board Outpatient and Day Support Services:** The Department and Boards with directly operated programs that are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) have agreed to the following provisions, pursuant to the Partnership Agreement and in accordance with applicable requirements of the *Code of Virginia* and associated regulations.
  - a. The Department's Office of Licensing shall accept CARF surveys as a review of regulation compliance for those licensing regulations or standards that are the same for outpatient and day support services at Boards that have triennial licenses for these services. These regulations or standards are identified in the crosswalk between the licensing regulations and CARF standards that follows this section (IV.A.8).
  - b. The Office of Licensing shall accept the CARF review of compliance for the administrative, human resource, record management, and physical plant licensing regulations that also are covered by CARF regulations for outpatient and day support services.
  - c. Boards that are accredited by the CARF shall provide the results of CARF surveys to the Office of Licensing. These results shall be public documents.
  - d. The Office of Licensing shall conduct annual unannounced focused reviews as required by the *Code of Virginia* on specific areas of risk and on areas not covered by CARF standards, which may include emergency services in outpatient services, case management services licensed under the outpatient license, medication administration, review of incidents, or areas cited for deficiencies as a result of complaints or in previous surveys.
  - e. The Office of Licensing shall continue to access the same documents, records, staff, and consumers that it needs to access to conduct inspections and complaint investigations.
  - f. When practicable, the Office of Licensing shall issue triennial licenses to coincide with CARF accreditations.
  - g. New services implemented by a Board shall not be subject to these provisions until they achieve triennial licensing status.
  - h. The Office of Licensing shall conduct complaint investigations. Boards shall continue to report serious injuries to or deaths of consumers and allegations of abuse or neglect to the Department. The Offices of Licensing and Human Rights shall review these reports to ensure that reporting continues as required by applicable provisions of the *Code of Virginia* and associated human rights and licensing regulations.
  - i. Should multiple or serious violations be identified as a result of an investigation or inspection or the Department reduces a license in one of these services, full inspections by the Office of Licensing of all licensing regulations shall resume.

## Community Services Performance Contract General Requirements Document

<b>Crosswalk Between Licensing Regulations and 2008 CARF Standards</b>		
<b>No.</b>	<b>Department Licensing Standard</b>	<b>2008 CARF Standard</b>
	<b>Ch. 105, Part I. General Provisions</b>	
	<b>Ch. 105, Part II. Licensing Process</b>	
	<b>Ch. 105, Part III. Administrative Services</b>	
140	License Availability	
150	Compliance with Laws, Regulations, and Policies	Sec. 1, E.1-2
160	Reviews by Department; Request for Information	Sec. 1, E.1
170	Corrective Action Plan	
180	Notification of Changes	
190	Operating Authority, Governing Body, and Organizational Structure	Sec. 1, A.1, A.2, A.6, A.8
200	Appointment of Administrator	Sec. 1, A.1
210	Fiscal Accountability	Sec. 1, C.1, F.1-6, F.9-10, M.3
220	Indemnity Coverage	Sec. 1, G.2
230	Written Fee Schedule	Sec. 1, F.8
240	Policy/Funds of Individuals Receiving Services	Sec. 1, F.11
250	Deceptive or False Advertising	Sec. 1, A.4
260	Building Inspection and Classification	Sec. 1, H.1, H.11
270	Building Modifications	
280	Physical Environment	Sec. 1, H.1
290	Food Service Inspections	Sec. 1, H.1
300	Sewer and Water Inspections	Sec. 1, H.1
310	Weapons	Sec. 1, H.19
320	Fire Inspections	Sec. 1, H.11, H.15
330	Beds	Sec. 3, U.4
340	Bedrooms	Sec. 3, U.4
350	Condition of Beds	
360	Privacy	Sec. 3, U.4
370	Ratios of Toilets, Basins, Showers or Baths	
380	Lighting	
390	Confidentiality and Security Personnel Records	Sec. 1, K.7-8
400	Criminal Registry Checks	Sec. 1, I.2
410	Job Description	Sec. 1, I.4-5
420	Qualifications of Employees or Contractors	Sec. 1, I.4-5, I.8-9
430	Employee or Contractor Personnel Records	Sec. 1, I.10, K.8
440	Orientation of New Employees, Contractors, Volunteers, and Students	Sec. 1, H.4, I.4, I.6, I.10-11
450	Employee Training & Development	Sec. 1, H.4, H.16, I.4, I.8, I.11; Sec. 2, A.4
460	Emergency Medical or First Aid Training	Sec. 1, H.4, H.6
470	Notification of Policy Changes	Sec. 1, I.8
480	Employee or Contractor Performance Evaluation	Sec. 1, I.4-6
490	Written Grievance Policy	Sec. 1, I.7
500	Students and Volunteers	Sec. 1, I.6
510	Tuberculosis Screening	Sec. 1, H.9, I.2
520	Risk Management	Sec. 1, G.1-2, H.7-9, H.12
530	Emergency Preparedness and Response Plan	Sec. 1, H.2, H.5, H.13
540	Access to Telephone in Emergencies; Emergency Telephone Numbers	Sec. 1, H.1, H.5-6; Sec. 2, E.5
550	First Aid Kit Accessible	Sec. 1, H.6

## Community Services Performance Contract General Requirements Document

560	Operable Flashlights or Battery Lanterns	Sec. 1, H.5
<b>Ch. 105, Part IV. Services and Supports</b>		
570	Mission Statement	Sec. 1, A.2
580	Service Description Requirements	Sec. 2, A.2
590	Provider Staffing Plan	Sec. 1, I.1, I.8; Sec. 2, A.1, A.12-13
600	Nutrition	Sec. 3, U.4
610	Community Participation	Sec. 2, A.3, A.7
620	Monitoring and Evaluating Service Quality	Sec. 1, N.1-2; Sec. 2, A.13, H.1-5
630	Policies on Screening, Admission, and Referrals	Sec. 2, B.1-5
640	Screening and Referral Services Documentation and Retention	Sec. 2, B.1-5
650	Assessment Policy	Sec. 2, B.7-12
660	Individualized Services Plan (ISP)	Sec. 2, C.1-6, C.8
670	ISP Requirements	Sec. 2, C.1-5
680	Progress Notes or Other Documentation	Sec. 2, C.7
690	Orientation	Sec. 2, B.6
700	Written Policies and Procedures for a Crisis or Clinical Emergency	Sec. 2, A.11
710	Documenting Crisis Intervention and Clinical Emergency Services	Sec. 2, C.7
720	Health Care Policy	Sec. 2, B.9, E.5; Sec. 3, U.5
730	Medical Information	Sec. 2, B.9, E.5
740	Physical Examination	Sec. 2, E.5
750	Emergency Medical Information	Sec. 2, B.9, E.5
760	Medical Equipment	
770	Medication Management	Sec. 2, E.1-11
780	Medication Errors and Drug Reactions	Sec. 1, H.7-8; Sec. 2, E.4-11
790	Medication Administration and Storage or Pharmacy Operation	Sec. 2, E.1-11
800	Policies and Procedures on Behavior Management Techniques	Sec. 2, F.1-15
810	Behavioral Treatment Plan	Sec. 1, K.5-6; Sec. 2, C.1-4
820	Prohibited Actions	Sec. 1, K.1-2, K.6
830	Seclusion, Restraint, and Time Out	Sec. 2, F.1-15
840	Requirements for Seclusion Room	Sec. 2, F.4
850	Transition of Individuals Among Services	Sec. 2, D.1-11
860	Discharge	Sec. 2, D.1-11
<b>Ch. 105, Part V. Records Management</b>		
870	Written Records Management Policy	Sec. 2, G.1-5
880	Documentation Policy	Sec. 2, G.1-5
890	Individual's Service Record	Sec. 2, G.1-5
900	Record Storage and Security	Sec. 1, K.7-8
910	Retention of Individual's Service Records	Sec. 1, K.8
920	Review Process for Records	Sec. 2, H.1-5
<b>Ch. 105, Part VI. Additional Requirements for Selected Services</b>		
930	Registration, Certification, or Accreditation	Opioid Treatment Manual
940	Criteria for Involuntary Termination from Treatment	Opioid Treatment Manual
950	Service Operation Schedule	Opioid Treatment Manual
960	Physical Examinations	Opioid Treatment Manual
970	Counseling Sessions	Opioid Treatment Manual

## Community Services Performance Contract General Requirements Document

980	Drug Screens	Opioid Treatment Manual
990	Take-Home Medication	Opioid Treatment Manual
1000	Preventing Duplication of Medication Services	Opioid Treatment Manual
1010	Guests	Opioid Treatment Manual
1020	Detoxification Prior to Involuntary Discharge	Opioid Treatment Manual
1030	Opioid Agonist Medication Renewal	Opioid Treatment Manual
1040	Emergency Preparedness Plan	Opioid Treatment Manual
1050	Security of Opioid Agonist Medication Supplies	Opioid Treatment Manual
1060	Cooperative Agreements with Community Agencies	Sec. 3, J.8
1070	Observation Area	Sec. 3, J.3
1080	Direct-Care Training for Providers of Detox. Services	Sec. 3, J.1, J.4
1090	Minimum No. of Employees or Contractors on Duty	Sec. 3, J.1, J.2, J.4, J.6
1100	Documentation	Sec. 3, J.5
1110	Admission Assessments	Sec. 3, J.1, J.3, J.5-6
1120	Vital Signs	Sec. 3, J.1, J.5
1130	Light Snacks and Fluids	
1140	Clinical and Security Coordination	
1150	Other Requirements for Correctional Facilities	
1160	Sponsored Residential Home Information	
1170	Sponsored Residential Home Agreements	
1180	Sponsor Qualification and Approval Process	
1190	Sponsored Residential Home Service Policies	
1200	Supervision	
1210	Sponsored Residential Home Service Records	
1220	Regulations Pertaining to Employees	
1230	Maximum Number of Beds in Sponsored Residential Home	
1240	Service Requirements for Providers of Case Management Services	Sec. 3, C.1-6
1250	Qualifications of Case Management Employees or Contractors	Sec. 3, C.2
1260	Admission Criteria	
1270	Physical Environment Requirements of Community Gero-Psychiatric Residential Services	
1280	Monitoring	
1290	Service Requirements for Providers of Gero-Psychiatric Residential Services	
1300	Staffing Requirements for Providers of Gero-Psychiatric Residential Services	
1310	Interdisciplinary Services Planning Team	
1320	Employee or Contract Qualifications and Training	
1330	Medical Director	
1340	Physician Services and Medical Care	
1350	Pharmacy Services for Providers of Gero-Psychiatric Residential Services	
1360	Admission and Discharge Criteria	Sec. 2, A.1-3, B.1-2; Sec. 3, A.35-37
1370	Treatment Team and Staffing Plan	Sec. 3, A.1-30
1380	Contacts	Sec. 3, A.24-27
1390	ICT and PACT Service Daily Operation and Progress Notes	Sec. 3, A.28-33
1400	ICT and PACT Assessment	Sec. 2, B.7-12; Sec. 3, A.14-22
1410	Service Requirements	Sec. 3, A.6-29, A.33

# Community Services Performance Contract General Requirements Document

## Appendix A: Continuity of Care Procedures

**Overarching Responsibility:** Sections 37.2-500 and 37.2-601 of the *Code of Virginia* and State Board Policy 1035 state that community services boards (CSBs) are the single points of entry into publicly funded mental health, mental retardation, and substance abuse services. Related to this principle, it is the responsibility of Boards to assure that consumers receive:

- preadmission screening that confirms the appropriateness of admission to a state hospital or training center (state facilities) and
- discharge planning services, beginning at the time of admission to the state facility, that enable timely discharge from the state facility and appropriate post-discharge, community-based services.

Throughout this Appendix, the term community services board (CSB) is used to refer to an operating CSB, an administrative policy CSB, a local government department with a policy-advisory CSB, or a behavioral health authority, also referred to in the Community Services Performance Contract as Boards. State hospital is defined in § 37.2-100 of the Code of Virginia as a hospital, psychiatric institute, or other institution operated by the Department that provides care and treatment for persons with mental illness. Training center is defined in § 37.2-100 as a facility operated by the Department for the treatment, training, or habilitation of persons with intellectual disabilities.

These procedures must be read and implemented in conjunction with the current *Discharge Planning Protocols*, issued by the Department and incorporated by reference as part of this Document. Applicable provisions in the protocols have replaced most treatment team, discharge, and post-discharge activities that were described in earlier versions of these procedures; however a few remain in the procedures. In the event of a conflict between any Continuity of Care Procedures and the *Discharge Planning Protocols*, provisions in the protocols shall apply.

### I. State Facility Admission Criteria

#### A. State Hospitals

1. An individual must meet the following criteria for admission to a state hospital.
  - a. **Adults:** The individual meets one of the criteria in section A. 1.) and one or more of the other criteria listed in section A and the criterion in section B:

##### **Section A:**

- 1.) the person has a mental illness and there is a substantial likelihood that, as a result of mental illness, the person will, in the near future,
  - a.) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or
  - b.) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs<sup>1</sup>; and

<sup>1</sup> Criteria for involuntary admission for inpatient treatment to a facility pursuant to § 37.2-817.C of the *Code of Virginia*.

- 2.) the person has a condition that requires intensive monitoring of newly prescribed drugs with a high rate of complications or adverse reactions; or
- 3.) the person has a condition that requires intensive monitoring and intervention for toxic effects from therapeutic psychotropic medication and short term community stabilization is not deemed to be appropriate; and

## Community Services Performance Contract General Requirements Document

### **Section B:**

- 4.) all available less restrictive treatment alternatives to involuntary inpatient treatment that would offer an opportunity for the improvement of the person's condition have been investigated and determined to be inappropriate (§37.2-817.C of the *Code of Virginia*).
- b. **Children and Adolescents:** Due to a mental illness, the child or adolescent meets one or more of the criteria in section A and both criteria in section B:

### **Section A:**

- 1.) presents a serious danger to self or others such that severe or irremediable injury is likely to result, as evidenced by recent acts or threats<sup>2</sup>; or
- 2.) is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusional thinking or significant impairment of functioning in hydration, nutrition, self-protection, or self control<sup>2</sup>; or

<sup>2</sup> Criteria for parental or involuntary admission to a state hospital.

- 3.) requires monitoring of newly prescribed drugs with a high rate of complications or adverse reactions or monitoring for toxic effects from therapeutic psychotropic medication; and

### **Section B:**

- 4.) is in need of inpatient treatment for a mental illness and is likely to benefit from the proposed treatment; and
- 5.) all treatment modalities have been reviewed and inpatient treatment at a state hospital is the least restrictive alternative that meets the minor's needs (§ 16.1-338, §16.1-339, and § 16.1-344 of the *Code of Virginia*).

The determination of least restrictive alternative should be a joint decision of the case management CSB and the receiving state hospital, with input from the consumer and family members. The CSB must document specific community alternatives considered or attempted and the specific reasons why state hospital placement is the least restrictive setting for the individual at this time.

2. Admission to state hospitals is not appropriate for:
  - a. individuals who have behaviors that are due to medical disorders, neurological disorders (including head injury), or intellectual disabilities and who do not have a qualifying psychiatric diagnosis or serious emotional disturbance;
  - b. individuals with unstable medical conditions that require detoxification services or other extensive medical services;
  - c. individuals with a diagnosis of dementia, as defined in the Diagnostic and Statistical Manual, unless they also have significant behavioral problems, as determined by qualified state hospital staff;
  - d. individuals with primary diagnoses of adjustment disorder, anti-social personality disorder, or conduct disorder; and
  - e. individuals with a primary diagnosis of substance use disorder unless it is a co-occurring disorder with a qualifying psychiatric diagnosis or serious emotional disturbance.
3. In most cases, individuals with severe or profound levels of intellectual disabilities are not appropriate for admission to a state hospital. However, individuals with a mental illness who are also diagnosed with mild or moderate intellectual disabilities but are exhibiting signs of acute mental illness may be admitted to a state hospital if they meet

## Community Services Performance Contract General Requirements Document

the preceding criteria for admission due to their mental illness and have a primary need for mental health services. Once these psychiatric symptoms subside, the person must be reassessed according to AAIDD criteria and must be discharged to an appropriate setting.

4. Individuals with a mental illness who are also diagnosed with a co-occurring substance use disorder may be admitted to a state hospital if they meet the preceding criteria for admission.
5. For a forensic admission to a state hospital, an individual must meet the criteria for admission to a state hospital.

### B. Training Centers

1. Admission to a training center for a person with an intellectual disability will occur only when all of the following circumstances exist.
  - a. The training center is the least restrictive and most appropriate available placement to meet the individual's treatment and training needs.
  - b. Programs in the community cannot provide the necessary adequate supports and services required by an individual as determined by the CSB, pursuant to § 37.2-505 or § 37.2-606 of the *Code of Virginia*.
  - c. It has been documented in the person's plan of care that the individual and his or her parents or authorized representative have selected ICF/MR services after being offered a choice between ICF/MR and community MR waiver services and that they agree with placement at a training center.
  - d. The training center director approves the admission to the training center, with the decision of the director being in compliance with State Board regulations that establish the procedure and standards for issuance of such approval, pursuant to § 37.2-806 of the *Code of Virginia*.
  - e. Documentation is present that the individual meets the AAIDD definition of an intellectual disability and level 6 or 7 of the ICF/MR Level of Care.
  - f. The individual demonstrates a need for extensive or pervasive supports and training to perform activities of daily living (ICF/MR Level of Care 6 or 7).
  - g. The individual demonstrates one or more of the following conditions:
    - exhibits challenging behaviors (e.g., behavior patterns that may be manifested in self-injurious behavior, aggression toward others, or behaviors that pose public safety risks),
    - does not have a mental health diagnosis without also having an intellectual disability diagnosis, or
    - is medically fragile (e.g., has a chronic medical condition or requires specialized technological health care procedures or ongoing support to prevent adverse physical consequences).
2. After the training center director approves the admission, the CSB shall initiate the judicial certification process, pursuant to § 37.2-806 of the *Code of Virginia*.
3. Admission to a training center is not appropriate for obtaining:
  - a. extensive medical services required to treat an unstable medical condition,
  - b. evaluation and program development services, or
  - c. treatment of medical or behavioral problems that can be addressed in the community system of care.

## Community Services Performance Contract General Requirements Document

### 4. Special Circumstances for Short-Term Admissions

- a. Requests for respite care admissions to training centers must meet the criteria for admission to a training center and the regulations adopted by the State Board. The admission must be based on the need for a temporary placement and will not exceed statutory time limits (21 consecutive days or a maximum of 75 days in a calendar year) set forth in § 37.2-807 of the *Code of Virginia*.
- b. Emergency admissions to training centers must meet the criteria for admission to a training center and must:
  - be based on specific, current circumstances that threaten the individual's health or safety (e.g., unexpected absence or loss of the person's caretaker),
  - require that alternate care arrangements be made immediately to protect the individual, and
  - not exceed statutory time limits (21 consecutive days or a maximum of 75 days in a calendar year) set forth in § 37.2-807 of the *Code of Virginia*.
- c. No person shall be admitted to a training center for a respite admission or an emergency admission unless the CSB responsible for the person's care, normally the case management CSB, has agreed in writing to begin serving the person on the day he or she is discharged from the training center, if that is less than 21 days after his or her admission, or no later than 21 days after his or her admission.

## II. Preadmission Screening Services and Assessments Required Prior to State Facility Admission

### A. CSB Preadmission Screening Requirements

1. CSBs will perform preadmission screening assessments on all individuals for whom admission, or readmission if the person is already in the hospital, to a state hospital is sought. A qualified CSB employee or designee shall conduct a comprehensive face-to-face evaluation of each individual who is being screened for admission to a state hospital. All CSB preadmission screeners for admission to state hospitals shall meet the qualifications for preadmission screeners as required in § 37.2-809 of the *Code of Virginia*. The preadmission screener shall forward a completed DMHMRSAS MH Preadmission Screening Form to the receiving state hospital before the individual's arrival.
2. CSBs should ensure that employees or designees who perform preadmission screenings to a state hospital have expertise in the diagnosis and treatment of mental illnesses and consult, as appropriate, with professionals who have expertise in working with and evaluating persons with intellectual disabilities or substance use disorders or children and adolescents with serious emotional disturbance.
3. CSBs should ensure that employees or designees who perform preadmission screenings for admission to a training center have expertise in the diagnosis and treatment of persons with intellectual disabilities and consult, as appropriate, with professionals who have expertise in working with and evaluating individuals with mental illnesses or substance use disorders.
4. Results of the CSB's comprehensive face-to-face evaluation of each individual who is being screened for admission to a state facility should be forwarded to the receiving state facility for its review before the person's arrival at the facility. This evaluation should include the CSB assessments listed in the following section.
5. When an individual who has not been screened for admission by a CSB arrives at a state facility, he should be screened in accordance with procedures negotiated by the

## Community Services Performance Contract General Requirements Document

state facility and the CSBs that it serves. State facility staff will not perform preadmission screening assessments.

6. Preadmission screening CSBs must notify the state hospital immediately in cases in which the CSB preadmission screener did not recommend admission but the individual has been judicially admitted to the state hospital.
7. The case management CSB or its designee shall conduct preadmission screening assessments for the readmission of any of its consumers in a state hospital.

**B. Assessments Required Prior to Admission to a State Hospital:** Section 37.2-815 of the *Code of Virginia* requires an examination, which consists of items 1 and 2 below and is conducted by an examiner, of the person who is the subject of a civil commitment hearing. The same *Code* section permits CSB staff, with certain limitations, to perform these examinations. The same items are required for a voluntary admission, but they do not have to be performed by an examiner referenced in § 37.2-815.

1. If there is reason to suspect the presence of a substance use disorder and available information is not adequate to make a determination of its existence, a substance use disorder screening, including completion of:
  - a. a comprehensive drug screen including blood alcohol concentration (BAC), with the consumer's consent, and
  - b. the Substance Abuse Subtle Screening Inventory (SASSI) or Simple Screening Instrument (SSI) for adults or the adolescent version of SASSI for adolescents age 12 and older. The SASSI will not be required for youth under age 12.
2. A clinical assessment that includes:
  - a. a face-to-face interview or one conducted via two-way electronic video and audio communication system, including arrangements for translation or interpreter services for individuals when necessary;
  - b. clinical assessment information, as available, including documentation of:
    - a mental status examination, including the presence of a mental illness and a differential diagnosis of an intellectual disability,
    - determination of current use of psychotropic and other medications, including dosing requirements,
    - a medical and psychiatric history,
    - a substance use, dependence, or abuse determination, and
    - a determination of the likelihood that, as a result of mental illness, the person will, in the near future, suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs;
  - c. a risk assessment that includes an evaluation of the likelihood that, as a result of mental illness, the person will, in the near future, cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any;
  - d. an assessment of the person's capacity to consent to treatment, including his ability to:
    - maintain and communicate choice,
    - understand relevant information, and
    - comprehend the situation and its consequences;

## **Community Services Performance Contract General Requirements Document**

- e. a review of the temporary detention facility's records for the person, including the treating physician's evaluation, any collateral information, reports of any laboratory or toxicology tests conducted, and all admission forms and nurses' notes ;
  - f. a discussion of treatment preferences expressed by the person or contained in a document provided by the person in support of recovery;
  - g. an assessment of alternatives to involuntary inpatient treatment; and
  - h. recommendations for the placement, care, and treatment of the person.
3. To the extent practicable, A medical assessment performed by an available medical professional (i.e., an M.D. or a nurse practitioner) at, for example, the CSB or an emergency room. Elements of a medical assessment include a physical examination and a medical screening of:
    - a. known medical diseases or other disabilities;
    - b. previous psychiatric and medical hospitalizations;
    - c. medications;
    - d. current use of alcohol and illicit drugs, using blood alcohol concentrations and the results of the comprehensive drug screen; and
    - e. physical symptoms that may suggest a medical problem.
  4. If there is reason to suspect the presence of an intellectual disability, to the extent practicable, a psychological assessment that reflects the person's current level of functioning based on the current AAIDD criteria should be performed if a recent psychological assessment is not already available to the preadmission screener.
  5. When a state hospital accepts a direct admission, the Medical Officer on Duty should be contacted prior to admission to determine which of these assessments are needed. The state hospital shall communicate the results its decision in writing to the Board within four hours.

### **C. CSB Assessments Required Prior to Admission to a Training Center**

1. If there is reason to suspect the presence of a substance use disorder (e.g., current or past substance dependence or addiction) and available information is not adequate to make a determination of its existence, a substance use disorder screening, including completion of:
  - a. a comprehensive drug screen including blood alcohol concentration (BAC), with the consumer's consent, and
  - b. the Substance Abuse Subtle Screening Inventory (SASSI) or Simple Screening Instrument (SSI) for adults or the adolescent version of SASSI for adolescents age 12 and older. The SASSI will not be required for youth under age 12.
2. When indicated, an assessment of the individual's mental status to determine the presence of a co-occurring mental illness. This mental status assessment should include:
  - a. a face-to-face interview, including arrangements for translation or interpreter services for individuals;
  - b. clinical assessment information, as available, including documentation of the following:
    - a mental status examination,
    - current psychotropic and other medications, including dosing requirements,

## Community Services Performance Contract General Requirements Document

- medical and psychiatric history,
  - substance use or abuse,
  - information and recommendations of other current service providers (e.g., treating physicians) and appropriate significant persons (e.g., spouse, parents), and
  - ability to care for self; and
- c. assessment of capacity to consent to treatment, including an evaluation of such processes as the ability to:
- maintain and communicate choice,
  - understand relevant information, and
  - understand the situation and its consequences.
3. A completed application package, which includes the following for a certified admission:
- a. a completed DMHMRSAS Intellectual Disabilities Preadmission Screening form forwarded to the receiving training center before the individual's arrival;
  - b. an ICF/MR Level of Care Assessment;
  - c. an Intellectual Disabilities Social History form;
  - d. a Medical History form and a Current Medical Information form, which contains a statement, signed by a physician within 30 days prior to the date of the admission application, indicating that the individual is free of communicable diseases;
  - e. a psychological evaluation that reflects the person's current level of functioning based on the current AAIDD criteria;
  - f. release of information forms for pertinent consumer information to be transferred between the CSB and the training center;
  - g. a plan for discharge, including tentative date of discharge, appropriate services and supports, and the name of the CSB case manager; and
  - h. an assessment of alternatives to admission and a determination, with appropriate documentation, that training center placement is the least restrictive intervention.
4. For emergency admissions to a training center, information requirements for the admission package are limited, but must include:
- a. a completed DMHMRSAS Intellectual Disabilities Preadmission Screening form;
  - b. an Intellectual Disabilities Social History form;
  - c. a Medical History form and Current Medical Information form, which contains a statement, signed by a physician within 30 days prior to the date of the admission application, as to whether the individual is free of communicable diseases; and
  - d. a psychological evaluation, with level of intellectual disabilities based on the AAIDD criteria, that reflects the person's current level of functioning and ICF/MR level of care; or
  - e. a completed Emergency Care Admission Intake Form with attachments or other emergency admission forms that do not exceed the requirements set forth in the preceding items for emergency admissions but meet training center requirements.

## Community Services Performance Contract General Requirements Document

### D. Disposition of Individuals with Acute or Unstable Medical Conditions

1. Individuals who are experiencing acute or unstable medical conditions will not receive medical clearance for admission to a state hospital or training center. Examples of these conditions include: untreated acute medical conditions requiring surgery or other immediate treatment, acute pneumonia, respiratory distress, acute renal failure or chronic renal failure requiring dialysis, unstable diabetes, symptoms of alcohol or drug toxicity, and erratic consciousness of unknown origin.
2. CSBs should have procedures in place to divert individuals who do not meet state facility admission criteria due to with medical conditions to appropriate medical facilities.

### E. Procedures for Dealing with Inappropriate Judicial Admissions to State Facilities

1. The individual's case management CSB shall immediately formulate and implement a discharge plan, as required by § 37.2-505 or § 37.2-606 of the *Code of Virginia*, if a state hospital determines that an individual who has been judicially admitted to the hospital is inappropriate for admission (e.g., the person does not meet the admission criteria listed in these procedures).
2. CSBs will be notified of the numbers of their admissions that state hospitals have determined do not meet the admission criteria in these procedures. State hospitals will report this information to the Department and the affected CSBs at least quarterly in a format prescribed by the Department. This information will be discussed during the bi-monthly utilization review and utilization management process developed and implemented by CSBs and state hospitals, which is described in the next section. This will include inappropriate jail transfers for evaluation and treatment.

### III. CSB Participation on Interdisciplinary Treatment Teams and Coordination with State Facility in Service Planning

Refer to the current *Discharge Planning Protocols*, issued by the Department and incorporated by reference as part of this Document, for other CSB requirements related to participation in treatment planning while the consumer is in the state hospital or training center (state facility).

- A. Staff of the case management CSBs shall participate in readmission hearings at state hospitals by attending the hearings or participating in teleconferences or video conferences. State hospital staff will not represent CSBs at readmission hearings.
- B. CSBs and state facilities shall develop and implement a bi-monthly utilization review and utilization management process to discuss and address issues related to the CSB's utilization of state facility services. This includes reviewing the status and lengths of stay of the CSB's consumers and developing and implementing actions to address census management issues.

### IV. CSB Discharge Planning Responsibilities

Refer to the current *Discharge Planning Protocols*, issued by the Department and incorporated by reference as part of this Document, for other CSB requirements related to discharge planning responsibilities.

- A. State facilities shall provide or arrange transportation, to the extent practicable, for consumers for discharge-related activities. Transportation includes travel from state facilities to community settings for trial visits and back to state facilities after such visits. The case management CSB shall provide or arrange transportation, to the extent

## Community Services Performance Contract General Requirements Document

practicable, for an individual whose admission to a state facility has been determined to be inappropriate, resulting in the person's discharge in accordance with § 37.2-837, § 37.2-505, § 37.2-606, or § 16.1-346.B of the *Code of Virginia*, and shall provide or arrange transportation for consumers when they are discharged from state facilities.

### V. Discharge Criteria and Resolution of Disagreements about a Consumer's Readiness for Discharge

A. Each state facility and the CSBs that it serves will use the following discharge criteria.

#### 1. State Hospitals

a. **Adults:** An adult will be discharged from a state hospital when hospitalization is no longer clinically appropriate. The interdisciplinary treatment team will use all of the following criteria to determine an individual's readiness for discharge:

- 1.) the individual has a mental illness but there is not a substantial likelihood that, as a result of mental illness, the person will, in the near future,
  - a.) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or
  - b.) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs; and
- 2.) inpatient treatment goals, as documented in the person's individualized treatment plan, have been addressed sufficiently, and
- 3.) the individual is free from serious adverse reactions to or complications from medications and is medically stable.

b. **Children and Adolescents:** A child or an adolescent will be discharged from a state hospital when he or she no longer meets the criteria for inpatient care. The interdisciplinary treatment team will use the following criteria to determine an individual's readiness for discharge:

- 1.) the minor no longer presents a serious danger to self or others, and
- 2.) the minor is able to care for himself in a developmentally appropriate manner; and, in addition,
- 3.) the minor, if he is on psychotropic medication, is free from serious adverse effects or complications from the medications and is medically stable;

OR when any of the following apply:

- 4.) the minor is unlikely to benefit from further acute inpatient psychiatric treatment;
- 5.) the minor has stabilized to the extent that inpatient psychiatric treatment in a state hospital is no longer the least restrictive treatment intervention; or
- 6.) if the minor is a voluntary admission, the legal guardian or the minor, if he is age 14 or older, has withdrawn consent to admission (§ 16.1-338.D of the *Code of Virginia*), unless continued hospitalization is authorized under § 16.1-339, § 16.1-340, or § 16.1-345 of the *Code of Virginia* within 48 hours of the withdrawal of consent to admission.

2. **Training Centers:** An individual will be discharged from a training center when institutional care is no longer clinically appropriate. The interdisciplinary treatment team will use the following clinical criteria to determine an individual's readiness for discharge:

## Community Services Performance Contract General Requirements Document

- a. the individual no longer needs the level of behavioral training or medical treatment provided by the training center;
  - b. the individual's unique psychosocial and medical needs can be met by an appropriate community provider;
  - c. training and treatment goals, as documented in the person's Individual Habilitation Plan (IHP), have been addressed; and
  - d. the individual is free from serious adverse medication reactions and medical complications and is medically stable.
- B. The state facility shall provide assessment information that is equivalent to the information specified in sections II.B. or II.C. (except for items B.3.a. and g. and C.3.a. and h.) of these procedures to the CSB when a consumer is being considered for discharge to the community.
- C. The CSB shall be notified when the state facility interdisciplinary treatment team determines that an individual admitted to a state facility does not meet the admission criteria in these procedures and needs to be discharged in accordance with § 37.2-837 and § 37.2-505 or § 37.2-606 of the *Code of Virginia*.
- D. A disagreement as to whether a consumer is ready for discharge from a state facility is solely a clinically-based disagreement between the state facility treatment team and the CSB that is responsible for the individual's care in the community. A dispute may occur when either:
1. the treatment team determines that the individual is clinically ready for discharge and the CSB disagrees; or
  2. the CSB determines that an individual is clinically ready for discharge and the treatment team disagrees.

### VI. CSB Post-discharge Services

Refer to the current *Discharge Planning Protocols*, issued by the Department and incorporated by reference as part of this Document, for other CSB requirements related to post-discharge services responsibilities.

- A. Individuals discharged from a training center who have missed their first appointment with a CSB case manager or in a day support program shall be contacted by the case management CSB within 14 calendar days.
- B. To reduce readmissions to training centers, CSBs shall, to the extent practicable, establish an MR crisis stabilization/behavior management capability to work with individuals who have been discharged from a training center who are having difficulty adjusting to their new environments.

# Community Services Performance Contract General Requirements Document

## Appendix B: Discharge Assistance Project Procedures

### 1. Purpose

The purpose of the Discharge Assistance Project (DAP) is to obtain and provide community resources to support the successful discharge and placement of state hospital consumers receiving long-term, extended rehabilitation services or other state hospital consumers whose special needs have prevented placement in the community and for whom specialized supports and targeted funding are needed for successful community placement. If a Board receives state general or federal funds from the Department specifically identified for the DAP, the Board shall adhere to these procedures, which are subject to all of the applicable provisions of this Document and the Board's Performance Contract with the Department. In the event of a conflict between any DAP Procedures and any other provisions of this Document or the Performance Contract, those other provisions of this Document or the Contract shall apply.

### 2. Development and Approval of Individualized Services Plans (ISPs): Under the DAP, the Board agrees to develop and implement ISPs to serve identified consumers in the community by providing the services and supports necessary for their successful community placement.

2.1 The Board shall use state general and federal funds provided by the Department and other funds associated with DAP ISPs obtained by the Board, such as Medicaid-fee-for-service payments, Targeted Case Management fees, Rehabilitation (State Plan Option) fees, and MR Waiver fees, other third party and direct consumer fees, and local government funds, solely for the discharge and community support of those consumers for whom the funds were requested and whose ISPs have been submitted to the Department.

2.1.1 Prior to the start of each state fiscal year, the Department will send a Letter of Notification to the Board with an enclosure that shows the tentative allocations of state general and federal funds for the DAP, based on the current ISPs for the consumers currently served by the DAP.

2.1.2 After receipt, the Board shall review its Letter of Notification, current ISPs, DAP utilization reports, feedback from the Department, performance contract reports, and other relevant data. Based on this review, the Board shall develop or revise ISPs for the contract period and submit them to the Department for information purposes.

2.1.3 The total DAP expenses for all of the ISPs submitted pursuant to 2.1.2, less other funds associated with DAP ISPs (described in section 2.1), shall not exceed the amount of state general and federal funds allocated to the Board for the DAP. If the total DAP expenses are less than the Board's total DAP allocation, a representative of the Department's Office of Mental Health Services will contact the Board regarding unallocated DAP funds. If the Board is not able to develop one or more ISPs to utilize these funds for consumers who meet DAP criteria, the Department may reallocate these available DAP funds according to procedures in section 3, and the Board's ongoing total annual DAP allocation shall be reduced accordingly. In the event that a Board's DAP allocation is reduced, the Department shall provide a written notification of the change in DAP funding to the affected Board. This notification shall identify the revised annualized amount allocated to the Board for this project, the effective date of the change, and the individual consumers to be served for the remainder of the state fiscal year.

2.1.4 Upon review of the ISPs submitted pursuant to section 2.1.2, the Department shall provide a written Confirmation of DAP Funding to the Board. The Confirmation of DAP Funding, effective on the first day of the term of this contract, shall identify the total amount allocated to the Board for the DAP, the particular consumers to be served, and the annualized expenses of each consumer's ISP.

## Community Services Performance Contract General Requirements Document

- 2.1.5 Following review of the ISPs pursuant to section 2.1.2, the Board may adjust services and associated expenses at any time during the state fiscal year without approval from the Department, as long as the adjusted DAP expenses of all DAP consumers served by the Board do not exceed the Board's total DAP state general and federal funds allocation and the funding is used for current DAP consumers whose ISPs have been submitted to the Department. The Department may review utilization and financial reports to determine the extent to which such funds transfers are occurring and may subsequently require revisions of ISPs or adjustment to or reallocation of state general and federal funding amounts. Revisions resulting from discharges from the DAP shall follow the reallocation procedures described in section 3 of these procedures.
- 2.1.6 If the Board wishes to serve new consumers in the DAP, it shall submit ISPs to the Department for information purposes. The Board shall include a copy of the *Needs Upon Discharge* form and the *Discharge Plan* with each new ISP submitted. The Board may submit ISPs to serve new consumers at any time, provided that such requests are within the Board's total annual DAP allocation of state general and federal funds and the new consumers meet DAP criteria.
- 2.1.7 Upon review of new ISPs submitted pursuant to sections 2.1.5 or 2.1.6, the Department shall provide a written Confirmation of the DAP Revision to the Board. The Confirmation of the DAP Revision shall identify the amount allocated to the Board for the DAP, the effective date of the revision, the individual consumers to be served for the remainder of the contract term, and the annualized cost of each consumer's ISP.
- 2.2 The Board shall immediately notify the Department's Office of Mental Health Services whenever a current DAP consumer is re-hospitalized at a state hospital, incarcerated, or otherwise no longer requires DAP funding. Funds that become available as a result of such changes in consumer status shall follow the reallocation procedures described in section 3 of these procedures.
3. **Reallocation of DAP Funds**
- 3.1 The Board shall immediately notify the Department's Office of Mental Health Services whenever a current DAP consumer is released from the project, that is, he no longer requires DAP funding. Consumers may be released from the DAP for a number of reasons, including relocation to another state, alternative funding sources, re-hospitalization, incarceration, death, or other situations that would make DAP funding unnecessary.
- 3.1.1 In cases where a current DAP consumer is re-hospitalized at a state hospital or incarcerated, but is likely to return to the community within 90 days, the Board may continue to receive the funds allocated for that consumer during this period. The Board may continue to receive DAP funds for longer than 90 days for such a consumer only with the Department's approval.
- 3.1.2 In cases where a state hospital consumer has been accepted in the DAP but actual discharge from the state facility occurs more than 90 days after the date of acceptance, the procedures in section 3.1.1 shall apply.
- 3.1.3 DAP funds received for current consumers during periods of hospitalization or incarceration, up to 90 days or longer pursuant to sections 3.1.1 and 3.1.2, may be utilized in the following ways.
- 3.1.3.1 The Board may use all or a portion of the funds to maintain housing and provide transitional services for the consumer prior to his discharge. Discharge planning expenses are not allowable.

## **Community Services Performance Contract General Requirements Document**

- 3.1.3.2 The Board may use all or a portion of the funds for non-recurring (one-time) treatment or support expenses for existing DAP consumers that were not budgeted in their ISPs or reimbursed from other sources. These include expenses associated with medications, mental health or substance abuse treatment (excluding inpatient treatment), health and dental care or medically-necessary diagnostic tests, one-time purchases of goods needed for community living, and security deposits on housing arrangements.
      - 3.1.3.3 The Board may submit a request to the Department to use all or a portion of the funds for other (non-DAP) state hospital consumers whose special needs have prevented placement in the community and for whom specialized supports and targeted funding are needed for successful community placement. If the Department approves the request, the Board may use the funds for non-recurring (one-time) purchases to provide discharge assistance for non-DAP consumers in state hospitals. These purchases may include transitional services provided prior to discharge (excluding discharge planning expenses), medications, health and dental care, medically necessary diagnostic tests, goods needed for community living, and security deposits on housing arrangements.
    - 3.1.4 DAP consumers hospitalized at a state hospital or incarcerated for more than 90 days shall be considered released from the project, unless the Board obtained Departmental approval to continue funding beyond 90 days, and DAP state general and federal funds allocated for their ISPs shall be reallocated according to the procedures in section 3.2.
  - 3.2 The Department may reallocate state general and federal funds for the DAP that become available as a result of releases from the DAP in the following ways.
    - 3.2.1 The Department may reallocate the funds to support the discharge of another state hospital consumer who meets DAP criteria. The Board serving the identified consumer shall submit an ISP to the Department for information purposes within 30 days of notification that funds are available.
    - 3.2.2 If the Department does not utilize the funds, the Board serving the consumer who was discharged from the DAP shall have the opportunity to develop a discharge plan for another state hospital consumer who meets DAP criteria or to reallocate funds to existing DAP consumers in need of additional supports, as evidenced by utilization reports. New or revised ISPs shall be submitted to the Department for review within 30 days of notification that funds are available.
    - 3.2.3 If the Board does not identify an appropriate DAP consumer and submit an ISP within 30 days, the state hospital serving that Board's service area may determine whether those state general and federal DAP funds could be used to support the discharge of another consumer in that area who meets DAP criteria. The Board serving such an identified consumer shall submit an ISP to the Department for review within 30 days of notification that funds are available.
  - 3.3 Upon review of ISPs developed using reallocated funds, the Department shall provide a written notification of changes in DAP funding to the Boards affected by the reallocation of funds. This notification shall identify the revised amount of state general and federal DAP funds allocated to each Board, the effective date of the change, and the individual consumers to be served for the remainder of the contract term.
4. **Reporting**
- 4.1 The Board shall provide aggregate semi-annual reports, as part of its performance contract reports, on the number of consumers served, the total expenditures for all DAP

## Community Services Performance Contract General Requirements Document

ISPs, and the total amount of DAP restricted revenues expended. Boards shall not be required to submit more frequent standard reports or reports on individual consumers. The Board also shall identify all DAP consumers that it serves in its CCS 3 extract submissions using the Consumer Designation Code for the DAP.

### 5. Project Management

- 5.1 The Department shall be responsible for the allocation of DAP state general and federal funds and the overall management of the Discharge Assistance Project (DAP).
- 5.2 The Board shall be responsible for managing DAP funds in accordance with the reviewed ISPs and the procedures described in this appendix.
- 5.3 The Department shall allocate state general and federal DAP funds provided to support ISPs on a state fiscal year basis.
- 5.4 Within the Board's overall DAP budget, funds may be expended for any combination of services that assure the needs of participating DAP consumers are met in a community setting. The Board shall update and revise ISPs in response to the changing needs of participating consumers.
- 5.5 Revenues generated from third party and other sources for any DAP participating consumer shall remain in the Board's overall DAP budget to offset the costs of care for those consumers. The Board shall collect and utilize all available revenues from other appropriate sources to pay for DAP ISPs before using state general and federal funds to pay for those ISPs to ensure the most effective use of these state general and federal funds. These other sources include Medicare; Medicaid-fee-for service, Targeted Case Management fees, Rehabilitation (State Plan Option) fees, and MR Waiver payments; other third party payors; auxiliary grants; SSI, SSDI, and direct payments by consumers; payments or contributions of other resources from other agencies, such as social services or health departments; and other state, local, or Department funding sources.
- 5.6 The Department may conduct on-going utilization review of ISPs and analyze utilization and financial information and consumer-related events, such as re-hospitalization, to ensure the continued appropriateness of services and to monitor compliance with ISPs. The utilization review process may result in revisions of ISPs or adjustment to or reallocation of state general and federal funding DAP allocations.

6. **Compensation and Payment:** The Department shall disburse semi-monthly payments of state general and federal funds to the Board that are based on the ISPs reviewed pursuant to section 2.1.2 plus the projected cost of any ISPs subsequently reviewed by the Department.

### 7. Special Conditions

- 7.1 The first priority of the DAP shall be to discharge and support in a community setting state hospital consumers identified in section 1 who are on the Extraordinary Barriers to Discharge List and whose case management Board is an interested and willing participant in the DAP.
- 7.2 The Board's staff, in conjunction with the consumer's state hospital treatment team and the consumer or his authorized representative, shall identify individualized placements in the community in accordance with the *Procedures for Continuity of Care Between Community Services Boards and State Psychiatric Facilities*, *Continuity of Care Procedures*, the *Discharge Planning Protocols*, and the consumer's ISP.
- 7.3 Services may be regionalized when possible and where there is demonstrated cost effectiveness (e.g., long-term assisted living facilities).
- 7.4 Any medications supplied through the Community Resource Pharmacy, including atypical anti-psychotic medications, shall continue, if appropriate, and shall not be funded as part of a consumer's DAP ISP. Other medications that are not available through the

## Community Services Performance Contract General Requirements Document

Community Resource Pharmacy may be purchased with DAP funds and shall be accounted for accordingly.

- 7.5 In the event that a consumer identified as a participant in the Discharge Assistance Project chooses to relocate to another Board, the Department shall reallocate state general and federal DAP funds to that Board to support that consumer's ISP. These funds will be reallocated as a project fund transfer at the approved funding level in that consumer's ISP. Should funds other than state general and federal funds provided through the DAP be required to support the individual in the changed setting, it is the responsibility of the new Board to provide or obtain those funds. If the placement ends, the Department shall reallocate the state general and federal DAP funds to the original Board from which they were transferred.
- 7.6 A particular consumer who is placed outside of the service area of his case management Board may have specific conditions associated with his ISP that do not conform with the provisions in section 7.5. For such a consumer, the Board agrees that, as the consumer's case management Board, it will remain responsible for his out-of-service area placement. If state hospital readmission is required, the consumer will return to the state hospital of origin or the case management Board's primary state hospital.

### Discharge Assistance Procedures: ISP Definitions

**Projected Units/Month:** The number of units of a particular type of service that are required during a month's time.

**Type of Unit:** Units are defined in the current Core Services Taxonomy.

**Unit Cost:** The cost of providing a specific service. For services that are Medicaid reimbursable (Clinic, Rehabilitation [State Plan Option], or Targeted Case Management) enter the reimbursed cost. For other services, enter the Board's current actual unit cost, based on its uniform cost report figures.

**Months Needed:** Number of months during the contract term that the service will be required.

**Annual Cost:** Projected units x unit cost x months needed.

**Local Match:** Additional local match available for services.

**Other State Funds:** As above.

**Medicaid Revenue:** Reimbursement rate paid by the DMAS.

**Other Revenue:** Federal funds, Medicare fees, direct payments by consumers, SSI or other income supplements, other private payments, and any other revenues.

**Net State Project Funds:** The annual cost of each specific service less local match, other state funds, Medicaid revenue, and other revenue. This determines the amount of state general funds required.

**Other Service (specify):** Attach brief descriptive narrative.

In addition to the completed ISP form, please include a brief social history/narrative that describes the following:

- the consumer's readiness and appropriateness for discharge from the state hospital;
- the consumer's length of stay and relevant admissions history;
- the proposed services design, i.e. a narrative elaboration of services listed in the ISP;
- the fiscal circumstances of the consumer, e.g., income, resources, third-party insurers, Medicaid/Medicare eligibility; and
- the projected date of discharge and the state hospital treatment team's agreement to the submitted plan and date of discharge.

**Other (start-up):** Attach detailed budget and brief descriptive narrative.

## Community Services Performance Contract General Requirements Document

### Appendix C: Federal Substance Abuse Prevention and Treatment Block Grant Requirements

#### **Certification Regarding Environmental Tobacco Smoke: Substance Abuse Prevention and Treatment (SAPT) Block Grant and Community Mental Health Services Block Grant**

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; Boards whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing a performance contract, a Board certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services to children as defined by the Act.

A Board agrees that it will require that the language of this certification be included in any subawards that contain provisions for children's services and that all subrecipients shall certify accordingly.

#### **Special Federal Substance Abuse Prevention and Treatment Block Grant (CFDA 93.959) Compliance Requirements**

Treatment services provided with federal Substance Abuse Prevention and Treatment Block Grant (SAPT) funds must satisfy federally mandated requirements. SAPT funds must be treated as the payer of last resort only for providing services to pregnant women and women with dependent children and TB and HIV services [Source: 45 CFR § 96.137]. Relevant requirements of the Substance Abuse Prevention and Treatment Block Grants; Interim Final Rule (45 CFR Part 96) are summarized below. As subgrantees of the Department, the Board and its subcontractors under this performance contract are responsible for compliance with these requirements. Failure to address these requirements may jeopardize all SAPT block grant funds awarded to the Board.

1. **Meet Set-Aside Requirements:** Federal law requires that the state expend its allocation to address established minimum set-asides. In order to address these set-asides, the Department shall designate its awards to the Board in specified categories, which may include:
  - a. primary prevention,
  - b. services to pregnant women and women with dependent children, and
  - c. services for persons at risk of HIV/AIDS.

The Board must utilize these funds for the purposes for which they are indicated in the performance contract and the letter of notification. The Board must provide documentation in its semi-annual (2<sup>nd</sup> quarter) and annual (4<sup>th</sup> quarter) performance contract reports of expenditures of the set-asides to the Office of Substance Abuse Services and the Division of Finance and Administration in the Department to ensure that the state meets its set-aside requirements.

[Sources: 45 CFR § 96.124 and 45 CFR § 96.128]

## Community Services Performance Contract General Requirements Document

2. **Primary Prevention Services:** Federal law requires that funds designated for primary prevention services be directed at individuals not identified to be in need of treatment and that a variety of strategies be utilized, to include the following strategies.
- a. *Information Dissemination:* This strategy provides awareness and knowledge of the nature and extent of alcohol, tobacco, and drug use, abuse, and addiction and their effects on individuals, families, and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two. Examples of activities conducted and methods used for this strategy include:
    - 1) clearinghouse and information resource center(s),
    - 2) resource directories,
    - 3) media campaigns,
    - 4) brochures,
    - 5) radio and TV public service announcements,
    - 6) speaking engagements,
    - 7) health fairs and health promotion, and
    - 8) information lines.
  - b. *Education:* This strategy involves two-way communication and is distinguished from the information dissemination strategy by the fact that interaction between the educator or facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g. of media messages), and systematic judgment abilities. Examples of activities conducted and methods used for this strategy include:
    - 1) classroom and small group sessions (all ages),
    - 2) parenting and family management classes,
    - 3) peer leader and helper programs,
    - 4) education programs for youth groups, and
    - 5) children of substance abusers groups.
  - c. *Alternatives:* This strategy provides for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use. The assumption is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by, alcohol, tobacco, and other drugs and would, therefore, minimize or obviate resort to the latter. Examples of activities conducted and methods used for this strategy include:
    - 1) drug free dances and parties,
    - 2) youth and adult leadership activities,
    - 3) community drop-in centers, and
    - 4) community-service activities.
  - d. *Problem Identification and Referral:* This strategy aims at identification of those who have indulged in illegal or age-inappropriate use of tobacco or alcohol and those persons who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment. Examples of activities conducted and methods used for this strategy include:
    - 1) employee assistance programs,
    - 2) student assistance programs, and
    - 3) driving while under the influence and driving while intoxicated programs.
  - e. *Community-Based Process:* This strategy aims to enhance the ability of the community to provide prevention and treatment services for alcohol, tobacco, and drug abuse disorders more effectively. Activities in this strategy include organizing, planning, enhancing

## Community Services Performance Contract General Requirements Document

efficiency and effectiveness of services implementation, inter-agency collaboration, coalition building, and networking. Examples of activities conducted and methods used for this strategy include:

- 1) community and volunteer training, e.g., neighborhood action training, training of key people in the system, staff and officials training;
  - 2) systemic planning;
  - 3) multi-agency coordination and collaboration;
  - 4) accessing services and funding; and
  - 5) community team-building.
- f. *Environmental*: This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing the incidence and prevalence of the abuse of alcohol, tobacco, and other drugs used in the general population. This strategy is divided into two subcategories to permit distinction between activities that center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives. Examples of activities conducted and methods used for this strategy include:
- 1) promoting the establishment and review of alcohol, tobacco, and drug use policies in schools;
  - 2) technical assistance to communities to maximize local enforcement procedures affecting the availability and distribution of alcohol, tobacco, and other drugs;
  - 3) modifying alcohol and tobacco advertising practices; and
  - 3) product pricing strategies.

[Source: 45 CFR § 96.125]

- 3. Services to Pregnant Women and Women with Dependent Children:** Federal law requires that funds allocated to the Board under this set-aside must support, at a minimum, the following services, either directly or by a written memorandum of understanding:
- a. primary medical care for women, including referral for prenatal care, and child care while such women are receiving this care;
  - b. primary pediatric care, including immunization for their children;
  - c. gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual and physical abuse, and parenting and child care while the women are receiving these services;
  - d. therapeutic interventions for children in custody of women in treatment that may, among other things, address their developmental needs and their issues of sexual and physical abuse and neglect; and
  - e. sufficient case management and transportation to ensure that women and their children have access to services provided by paragraphs 2.a-d.
- In addition to complying with the requirements described above, the Board shall:
- a. treat the family as a unit and, therefore, admit both women and their children into treatment services, if appropriate [Source: 45 CFR § 96.124(e)];
  - b. report to the Department when it has insufficient capacity to provide treatment to the woman and make available interim services, including a referral for prenatal care, within 48 hours of the time the woman initially seeks services [Source: 45 CFR § 96.131]; and
  - c. publicize the availability and priority of treatment for pregnant women [Source: 45 CFR § 96.131].
- 4. Preference in Admission:** The Board must give preference in admission to pregnant women who seek or are referred for and would benefit from SAPT Block Grant-funded

## Community Services Performance Contract General Requirements Document

treatment services. The Board must give admission preference to consumers in the following order:

- a. pregnant injecting drug users,
- b. other pregnant substance abusers,
- c. other injecting drug users, and
- d. all other individuals.

[Source: 45 CFR § 96.128]

5. **Services for persons at risk of HIV/AIDS:** Virginia is no longer considered a designated state under these regulations and is no longer required to spend five percent of the federal SAPT Block Grant on HIV Early Intervention Services (EIS). Further, Virginia is prohibited from spending federal funds on HIV EIS. Consequently, neither the Department nor the Board may spend federal SAPT Block Grant funds for these services. However, if the Board has an HIV rate of 10 percent or more and wishes to continue its HIV EIS during the term of this contract, it may use state general or local funds that are available to it for this purpose. If the Board uses state general funds for HIV EIS, those funds will become restricted for that purpose, and the Board must meet the same requirements as the federal criteria for HIV EIS activities. In any event, the Board should determine if consumers are engaging in high risk behaviors for HIV infection and encourage them to contact their local health departments for HIV testing and preventative supplies.

6. **Interim Services:** Federal law requires that the Board, if it receives any Federal Block Grant funds for operating a program of treatment for substance addiction or abuse, either directly or through arrangements with other public or private non-profit organizations, routinely make available services for persons who have sought admission to a substance abuse treatment program yet, due to lack of capacity in the program, have not been admitted to the program. While awaiting admission to the program, these individuals must be provided, at a minimum, with certain interim services, including counseling and education about HIV and tuberculosis (TB). Interim services means services that are provided until an individual is admitted to a substance abuse treatment program. The purposes of such interim services are to reduce the adverse health effects of substance abuse, promote the health of the individual, and reduce the risk of transmission of disease.

- a. For pregnant women, interim services also include counseling about the effects of alcohol and drug abuse on the fetus and referral for prenatal care. [Source: 45 CFR § 96.121, Definitions]
- b. At a minimum, interim services must include the following:
  - 1) counseling and education about HIV and tuberculosis (TB),
  - 2) the risks of needle sharing, the risks of transmission to sexual partners and infants, and
  - 3) the steps that can be taken to ensure the HIV and TB transmission does not occur and include referral for HIV or TB treatment services, if necessary.

[Source: 45 CFR §§ 96.121 and 96.126]

7. **Services for Individuals with Intravenous Drug Use:** If the Board offers a program that treats individuals for intravenous drug abuse, it must:

- a. provide notice to the Department within seven days when the program reaches 90 percent of capacity;
- b. admit each individual who requests and is in need of treatment for intravenous drug abuse not later than:
  - 1) 14 days after making the request, or
  - 2) 120 days after making the request if the program

## Community Services Performance Contract General Requirements Document

- has no capacity to admit the person on the date of the request, and
  - within 48 hours of the request makes interim services as defined in 45 CFR § 96.126 available until the individual is admitted to the program;
- c. maintain an active waiting list that includes a unique consumer identifier for each injecting drug abuser seeking treatment, including consumers receiving interim services while awaiting admission;
- d. have a mechanism in place that enables the program to:
- 1) maintain contact with individuals awaiting admission, and
  - 2) admit or transfer individuals on the waiting list at the earliest possible time to an appropriate treatment program within a reasonable geographic area;
- e. take individuals awaiting treatment off the waiting list only when one of the following conditions exists:
- 1) such persons cannot be located for admission, or
  - 2) such persons refuse treatment; and
- f. encourage individuals in need of treatment for intravenous drug use to undergo such treatment, using outreach methods that are scientifically sound and that can reasonably be expected to be effective; such outreach methods include:
- 1) selecting, training, and supervising outreach workers;
  - 2) contacting, communicating, and following-up with high risk substance abusers, their associates, and neighborhood residents, within the constraints of federal and state confidentiality requirements, including 42 CFR Part 2;
  - 3) promoting awareness among injecting drug users about the relationship between injecting drug abuse and communicable diseases, such as HIV;
  - 4) recommending steps that can be taken to ensure that HIV transmission does not occur; and
  - 5) encouraging entry into treatment.

[Sources: 45 CFR §§ 96.121 and 96.126]

### 8. Tuberculosis (TB) Services:

- a. Federal law requires that the Board, if it receives any Federal Block Grant funds for operating a program of treatment for substance addiction or abuse, either directly or through arrangements with other public or private non-profit organizations, routinely make available the following tuberculosis services to each individual receiving treatment for substance abuse [45 CFR § 96.121 (Definitions)]:
- 1) counseling individuals with respect to tuberculosis,
  - 2) testing to determine whether the individual has been infected with mycobacteria tuberculosis to identify the appropriate form of treatment for the person, and
  - 3) providing for or referring the individuals infected with mycobacteria tuberculosis for appropriate medical evaluation and treatment.
- b. The Board must follow the protocols established by the Department and the Department of Health and distributed by the Department of Health for screening for, detecting, and providing access to treatment for tuberculosis.
- c. All individuals with active TB shall be reported to the appropriate state official (the Virginia Department of Health, Division of TB Control), as required by state law and in accordance with federal and state confidentiality requirements, including 42 CFR Part 2.
- d. The Board shall:
- 1) establish mechanisms to ensure that individuals receive such services, and
  - 2) refer individuals who are denied admission due to lack of service capacity to other providers of TB services.

[Source: 45 CFR § 96.127]

## Community Services Performance Contract General Requirements Document

### 9. Other Requirements

- a. The Board shall make available continuing education about treatment services and prevention activities to employees in SAPT Block Grant-funded treatment and prevention programs. The Board shall provide support to the greatest extent possible for at least 20 hours annually of prevention-specific training for prevention directors, managers, and staff. If the Board hires a new prevention director or manager, it agrees to support his or her participation in the 12-month prevention director mentorship program as space is available.
- b. The Board shall implement and maintain a system to protect consumer records maintained by SAPT Block Grant-funded services from inappropriate disclosures. This system shall comply with applicable federal and state laws and regulations, including 42 CFR, and provide for employee education about the confidentiality requirements and the fact that disciplinary action may be taken for inappropriate disclosures. [Source: 45 CFR § 96.132]

10. **Faith-Based Service Providers:** In awarding contracts for substance abuse treatment, prevention, or support services, the Board shall consider bids from faith-based organizations on the same competitive basis as bids from other non-profit organizations. Any contract with a faith-based organization shall stipulate compliance with the provisions of 42 CFR Parts 54 and 54a and 45 CFR Parts 96, 260, and 1050. Funding awarded through such contracts shall not be used for inherently religious activities, such as worship, religious instruction, or proselytizing. Such organizations are exempt from the requirements of Title VII of the Civil Rights Act regarding employment discrimination based on religion. However, such organizations are not exempt from other provisions of Title VII or from other statutory or regulatory prohibitions against employment discrimination based on disability or age. These organizations are subject to the same licensing and human rights regulations as other providers of substance abuse services. The Board shall be responsible for assuring that the faith-based organization complies with the provisions described in these sections. The Board shall provide consumers referred to services provided by a faith-based organization with notice of their right to services from an alternative provider. The Board shall notify the Office of Substance Abuse Services in the Department each time such a referral is required.
11. **Prevention Services Addressing Youth Tobacco Use and Underage Drinking:** The Board shall select and implement evidence-based programs and practices that target youth tobacco use and underage drinking, based on rates of youth tobacco and alcohol use and age of first use that exceed or fall below state rates in the Board's service area. The Board shall integrate underage drinking, youth access, and smoking prevention strategies and education into prevention services as appropriate and report this integration through the KIT Prevention System.

[Sources: 42 USC 300x-26 and 45 CFR § 96.130]

12. **Evidence-Based Programs:** The Board shall ensure that a minimum of 50 percent of all prevention programs and strategies entered in the KIT Prevention System and supported wholly or in part by the SAPT Block Grant prevention set-aside are evidence-based or are included in a federal list or registry of evidence-based interventions. If the Board's rate exceeds 50 percent in FY 2007, it shall maintain or increase its FY 2007 percentage of evidence-based programs in FY 2008. The Board shall increase the minimum percentage of evidence-based programs to 75 percent by FY 2010. The Board shall replicate any evidence-based program as directed by that program's guidelines or as adapted in collaboration with that program's developer.

# Community Services Performance Contract General Requirements Document

## Appendix D: Regional Program Procedures

### I. Purpose

The Board may collaborate and act in concert with other Boards or with other Boards and state hospitals or training centers, hereinafter 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 Projects (RDAP), Local Inpatient Purchases of Services (LIPOS), and Regional Restructuring or System Transformation Programs, such as Residential or Ambulatory Crisis Stabilization Programs. These procedures apply to all of those regional programs. In previous contract years, Boards and state facilities entered into memoranda of agreement (MOAs) to structure, implement, monitor, and report on regional programs, such as RDAP or LIPOS. This appendix replaces those MOAs, although Boards, 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, MOAs must be developed if a regional program intends to implement a peer review committee (e.g., a Regional Utilization Review and Consultation Team) established under § 8.01-581.16 whose records and reviews would be privileged under § 8.01-581.16 of the *Code of Virginia*. When the Board 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 of the applicable provisions of this performance contract. In the event of a conflict between any regional program procedures and any other provisions of this contract, the other provisions of this performance contract shall apply.

### II. Regional Management Group

- A. The participating Boards and state facilities shall establish a Regional Management Group. The Executive Director of each participating Board and the Director of each participating state facility shall each serve on or appoint one member of the Regional Management Group. This group shall manage the regional program and coordinate the use of funding provided for the regional program, review the provision of services offered through it, coordinate and monitor the effective utilization of the services and resources provided through the regional program, and perform other duties that they mutually agree to carry out. A Regional Management Group may deal with more than one regional program.
- B. Although not members of the Regional Management Group, designated staff in the Central Office of the Department shall have access to all documents maintained or used by this group, pursuant to the provisions of sections 6.d.2.) and 7.e.2) 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 Regional Management Group may authorize the employment of one or more regional managers to be paid from funds provided for this regional program and to be employed by a participating Board. The Regional Management Group shall specify the job duties and responsibilities for and supervise the regional manager or managers.

### III. Regional Utilization Review and Consultation Team

- A. The Regional Management Group shall establish a Regional Utilization Review and Consultation Team pursuant to § 8.01-581.16 of the *Code of Virginia* to, where applicable:
  1. review the implementation of the individualized services plans (ISPs) 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 consumer and report the results of these reviews to the Regional Management Group;

## Community Services Performance Contract General Requirements Document

2. review the consumers 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 Regional Management Group;
  3. review, at the request of the case management Board, other consumers 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 Board, resolution of individual situations that are preventing a consumer's timely discharge from a state facility or a private provider participating in the regional partnership or a consumer's continued tenure in the community;
  5. identify opportunities for two or more Boards to work together to develop programs or placements that would permit consumers 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 Regional Management Group.
- B. The Regional Utilization Review and Consultation Team shall consist of representatives from participating Boards in the region, participating state facilities, private providers participating in the regional partnership, and others as may be appointed by the Regional Management Group, such as the Regional Manager(s) referenced in section II.C. The positions of the representatives who serve on this team shall be identified in local documentation.
- C. The Regional Utilization Review and Consultation Team 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 individuals who are identified by the team as essential to the review of a consumer's case, including the consumer's treatment team and staff directly involved in the provision of services to the consumer, 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 Regional Utilization and Consultation Team or another group designated by the Regional Management Group shall maintain current information to identify and track consumers served and services provided through the regional program. This information may be maintained in participating Board information systems or in a regional data base. For example, for the RDAP, this information shall include the consumer's name, social security number or other unique identifier, other unique statewide identifier, legal status, case management Board, state hospital of origin, discharge date, state re-hospitalization date (if applicable), and the cost of the individualized services plan (ISP). This team shall maintain automated or paper copies of records for each RDAP-funded ISP. Changes in responsibilities of the case management Board, 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 Regional Utilization and Consultation Team shall conduct utilization reviews of ISPs as frequently as needed to ensure continued appropriateness of services and compliance with approved ISPs and reviews of quarterly utilization and financial reports and consumer-related events such as re-hospitalization, as appropriate. This utilization review process may result in revisions of ISPs or adjustment to or redistribution of RDAP

## Community Services Performance Contract General Requirements Document

funds. This provision does not supersede utilization review and audit processes conducted by the Department pursuant to section 7.e.2.) of the performance contract.

- F. Although not members of the Regional Utilization and Consultation Team, designated staff in the Central Office of the Department shall have access to all documents, including ISPs, maintained or used by this body, pursuant to the provisions of sections 6.d.2.) and 7.e.2.) of the performance contract, and may attend and participate in all meetings as non-voting members and in other activities of this team.

**IV. Operating Procedures for Regional Programs:** These operating procedures establish the parameters for allocating resources for and monitoring continuity of services provided for consumers 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 Boards or to a Board on behalf of the region through their community services performance contracts in accordance with the conditions specified therein.
- B. Each participating Board or a Board on behalf of the region shall receive semi-monthly payments of state general 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 Boards 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 activities of the Regional Management Group and Regional Utilization and Consultation Review Team.
- 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 consumers are met in community settings. ISPs must be updated and submitted, as revisions occur or substitute plans are required, to the Regional Management Group for approval according to procedures approved by the Regional Management Group.
- F. Regional program funds used to support ISPs shall be identified on a fiscal year basis. Amounts may be adjusted by the Regional Management Group 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 Board responsible for implementing a consumer's regional program ISP shall account for and report the revenues and expenses associated with the funded regional program ISP in its initial community services performance contract and final contract revision and in its mid year and end of the fiscal year performance contract reports, submitted through the Community Automated Reporting System (CARS).
- H. The Board responsible for implementing a consumer's regional program ISP shall ensure that the appropriate information about that consumer 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 CCS and applicable CARS reports to the Department.
- I. The participating Boards 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.

## Community Services Performance Contract General Requirements Document

- J. Any medications supplied through the Department's Community Resource Pharmacy shall continue and not be funded as part of an ISP supported through a regional program. Other medications that are not available through the Community Resource Pharmacy may be purchased with regional program funds and accounted for accordingly.
- K. RDAP resources shall be used to discharge and support in community settings, through the regional utilization management of existing or new funds, consumers in state facilities who are on the Extraordinary Barriers to Discharge List, followed by consumers who have been clinically ready for discharge for more than 30 days, followed by consumers who have been ready for discharge for less than 30 days and for whom additional community supports are required. Each consumer discharged from a state facility and placed in the community shall have an identified Board that has agreed to act as the case management Board for and provide services to that consumer. The staff of the case management Board, in conjunction with the consumer, his authorized representative if one has been appointed or designated, and the state facility treatment team, shall determine individualized placements in the community in accordance with the Continuity of Care Procedures, Procedures for Continuity of Care Between Community Services Boards and State Psychiatric Facilities, the current performance contract, and the Discharge Protocols for Community Services Boards and State Mental Health Facilities.
- L. For the RDAP, any one-time balances of unexpended regional program funds realized by each participating Board due to delays in discharge dates, re-hospitalization or incarceration of the consumer, reductions in ISP allocations, or other balances including year-end balances of each participating Board or the region's base allocation may be expended for the following purposes when they are consistent with the legislative intent of paragraphs T, U, V, and W of item 316 in the 2008 Appropriation Act with the prior approval of the Regional Management Group:
  - 1. To be used first by the originating Board or by the region on a one-time basis to promote the discharge of non-RDAP or DAP consumers from state facilities or consumers in private psychiatric hospitals or units participating in the regional partnership who have been difficult to discharge or for one-time needs of previously approved DAP consumers;
  - 2. To be used to reimburse the case management Board's expenses for one-time transitional costs for not guilty by reason of insanity (NGRI) consumers as part of the conditional release process or other consumers in state facilities with documented clinical needs for transitional services; or
  - 3. To be used regionally for developing infrastructure to serve consumers in state facilities or prevent the admission of consumers, who otherwise meet the admission criteria in the Continuity of Care Procedures in Appendix A, to state facilities through one-time activities, such as the development of housing, crisis stabilization, or other regional community placement endeavors or supports.
- M. Unless the Regional Management Group has approved an exception, if the case management Board is not able to complete the initial or re-hospitalized discharge of the identified consumer whose discharge is supported under a RDAP within 30 days of the projected date of discharge, one of the following actions shall be taken within 30 days following the projected date of discharge:
  - 1. That Board shall identify and discharge another consumer within 30 days for whom it is the case management Board and who is on the Extraordinary Barriers List or who has been determined to be clinically ready for discharge; or
  - 2. If the preceding action is not taken within the specified time frame, the allocated funds will revert to the Regional Management Body for discharging a consumer from another

## **Community Services Performance Contract General Requirements Document**

Board with the longest tenure on the Extraordinary Barriers List and for whom RDAP funding is appropriate for addressing the barriers to that consumer's discharge.

- N. For the RDAP, if incarceration in a correctional facility or re-hospitalization in a state hospital will exceed 30 days, the case management Board shall obtain approval from the Regional Management Group to:
1. Return funds, less year to date expenditures, to the Regional Management Group for redistribution;
  2. Develop discharge plans and appropriate services for another consumer meeting the criteria specified in the preceding section for regional review;
  3. Based on a written request to the Regional Management Group, have payments stopped and billing and reimbursement resume upon the consumer's discharge, if that date is within 90 days of the date of re-hospitalization; or
  4. Based on a written request to the Regional Management Group stating that the re-hospitalization will exceed 30 days, but on-going funds will be needed to maintain the consumer's residence for a period not to exceed 90 days, have the necessary funds provided. After the Regional Management Group's review and approval, funds shall be authorized and provided during that period only in the amount required to maintain the consumer's place of residence. Funds shall not be approved for Board-provided direct care services as specified in the consumer's ISP. Any resulting balances shall be allocated in accordance with these operating procedures. The cost of supporting a substitute consumer shall not exceed the original amount requested in the originally approved ISP. Should the cost of services be less than originally requested, unexpended funds will be available to the Regional Management Body for redistribution within the region in accordance with these procedures.
- O. For the RDAP, in the event that a consumer identified as a participant in the RDAP elects to relocate to another Board within the region, project funds shall be redistributed to the new Board to support that consumer's ISP. These funds shall be redistributed as a project fund transfer at the approved funding level for the relocating consumer. The affected Boards shall notify the Regional Management Group and the Department of any changes in case management Board designation for a consumer as soon as they are known or at least monthly.
- P. For the RDAP, certain consumers who are placed outside of the service area of their case management Board may have specific approved conditions associated with their ISPs, Board-to-Board agreements, or regional considerations or conditions under the Discharge Protocols that do not meet the conditions of the preceding paragraph. For those consumers, the out-of-service area placement shall remain the responsibility of the case management Board (Board of origin). If re-hospitalization is required, that consumer shall return to state hospital of origin.
- Q. For the RDAP, if a consumer elects to relocate to a Board outside of the region, project funds shall be redistributed to the new Board to support the consumer's ISP as a project fund transfer at the approved funding level for the relocating consumer. Subsequently, if that RDAP placement ends, for example through the discharge or death of the consumer, the redistributed funds shall be transferred back to the original region.

### **V. General Terms and Conditions**

- A. The Board, the Department, and any other parties participating in the 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 Board and the Department shall comply with or fulfill all provisions or requirements, duties,

## Community Services Performance Contract General Requirements Document

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 Board, the Department, or any other participating parties to make commitments that will bind them beyond the scope of these procedures.
- C. Any alteration, amendment, or modification in these procedures shall be made in accordance with the provisions in the performance contract for amendment or revision.
- D. 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 Board or the Department.

### VI. Privacy of Personal Information

- A. The Board, the Department, and any other parties participating in a regional program agree to maintain all protected health information (PHI) learned about consumers 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), the Virginia Health Records Privacy Act, the *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services*, and each party's own Privacy Policies and Practices. The organization operating the regional program shall provide a notice to consumers 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 consumer's authorization 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 consumers served through the regional program, the parties may disclose the PHI of consumers 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 consumers served in it.
- C. In carrying out their responsibilities in the regional program, the Board, 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 this 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;

## **Community Services Performance Contract General Requirements Document**

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.

**VII. Reporting:** The Board shall provide all required information (e.g., the number of consumers served, the total expenditures for the regional program, and the total amount of regional program restricted revenues expended) to the Department about the regional programs in which it participates, principally through CCS and CARS reports. Boards shall not be required to submit more frequent standard reports or reports on individual consumers, unless such requirements have been established in accordance with sections 6.c.3.) and 7.d.1.) and 4.) of the performance contract. The Board also shall identify all regional program consumers that it serves in its CCS extract submissions using the applicable Consumer Designation Codes.

### **VIII. Project Management**

- A. The Department shall be responsible for the allocation of regional program state general and federal funds and the overall management of the regional program at the state level.
- B. The Regional Management Group 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 Board shall be responsible for managing regional program funds it receives in accordance with these regional program procedures.

## **Community Services Performance Contract General Requirements Document**

- D. Revenues generated from third party and other sources for any regional program shall be used by the region or Board to offset the costs of the regional program. The Board shall collect and utilize all available revenues from other appropriate consumer-specific sources before using state general and federal funds to ensure the most effective use of these state general and federal funds. These other sources include Medicare; Medicaid-fee-for service, Targeted Case Management fees, Rehabilitation (State Plan Option) fees, and MR Waiver payments; other third party payors; auxiliary grants; SSI, SSDI, and direct payments by consumers; 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 consumer-related events, 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.
- IX. Compensation and Payment:** The Department shall disburse semi-monthly payments of state general and federal funds to the Board for the regional program as part of its regular semi-monthly disbursements to the Board.

## FY 2009 Community Services Performance Contract Central Office, State Facility, and Community Services Board Partnership Agreement

### Section 1: Purpose

Collaboration through partnerships is the foundation of Virginia's public system of mental health, mental retardation, and substance abuse services. The Central Office of the Department of Mental Health, Mental Retardation and Substance Abuse Services (the Central Office), 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 these services. CSBs include operating CSBs, administrative policy CSBs, and local government departments with policy-advisory CSBs and behavioral health authorities 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 partnership agreement to implement the vision statement articulated in State Board Policy 1036 and to improve the quality of care provided to consumers 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 consumers and their families and seek similar collaborations or opportunities for partnerships with consumer and family advocacy groups and other stakeholders. We believe that a collaborative strategic planning process helps to identify the needs of consumers and ensures effective resource allocation and operational decisions that contribute to the continuity and effectiveness of care provided across the public mental health, mental retardation, and substance abuse services system. We agree to engage in such a collaborative planning process.

The Central Office, State Facility, and CSB partnership reflects a common purpose derived from:

1. Codified roles defined in Chapters 3, 4, 5, 6, and 7 of Title 37.2 of the *Code of Virginia*, as delineated in the Community Services Performance Contract;
2. Philosophical agreement on the importance of consumer-driven services and supports and other core goals and values contained in this partnership agreement;
3. Operational linkages associated with funding, program planning and assessment, and joint efforts to address challenges to the public system of services; and
4. Quality improvement-focused accountability to consumers and family members, local and state governments, and the public at large, as described in the accountability section of this partnership agreement.

This partnership agreement also establishes a framework for covering other relationships that may exist among the *partners*. Examples of these relationships include Part C of the Individuals with Disabilities Education Act and regional initiatives, such as the Region IV Acute Care Pilot Project, the Discharge Assistance and Diversion program in northern Virginia, reinvestment and restructuring projects, the initiatives to promote integrated services for individuals with co-occurring mental illnesses and substance use disorders, and the system transformation initiative.

This partnership agreement contains sections that address: Roles and Responsibilities; Core Values; Indicators Reflecting Core Values; Advancing the Vision; Critical Success Factors;

## **FY 2009 Community Services Performance Contract Central Office, State Facility, and Community Services Board Partnership Agreement**

Accountability; Consumer and Family Member Involvement and Participation; System Leadership Council; Communication; Quality Improvement; Reviews, Consultation, and Technical Assistance; Revision; Relationship to the Community Services Performance Contract; and Signatures.

### **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, mental retardation, and substance abuse services. These distinct roles promote varying levels of expertise and create opportunities for identifying the most effective mechanisms for planning, delivering, and evaluating services.

#### **Central Office**

1. Ensures through distribution of available funding that a consumer-driven 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 illnesses, intellectual disabilities, or substance use disorders.
2. Promotes at all locations of the public mental health, mental retardation, and substance abuse service delivery system (including the Central Office) quality improvement efforts that focus on consumer 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 involvement and participation of consumers and family members of consumers in policy formulation and services planning, delivery, monitoring, and evaluation.
4. Ensures fiscal accountability that is required in applicable provisions of the *Code of Virginia*, relevant state and federal regulations, and State Mental Health, Mental Retardation and Substance Abuse Services Board policies.
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 *operational 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 consumers 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, mental retardation, and substance abuse services.
9. Problem solves and collaborates with a CSB and State Facility together on a complex or difficult consumer situation when the CSB and State Facility have not been able to resolve the situation successfully at their level.

#### **Community Services Boards**

1. Pursuant to State Board Policy 1035, serve as the single points of entry into the publicly funded system of consumer-driven and community-based services and supports for individuals with mental illnesses, intellectual disabilities, or substance use disorders, including individuals with co-occurring disorders in accordance with State Board Policy 1015.

## **FY 2009 Community Services Performance Contract Central Office, State Facility, and Community Services Board Partnership Agreement**

2. Serve as the local points of accountability for the public mental health, mental retardation, and substance abuse service delivery system.
3. To the fullest extent that resources allow, promote the delivery of community-based services that address the specific needs of individual consumers, particularly those with complex needs, with a focus on service quality, accessibility, integration, and availability and on consumer self-determination, empowerment, and recovery.
4. Support and encourage the involvement and participation of consumers and family members of consumers in policy formulation and services planning, delivery, monitoring, and evaluation.
5. Establish services and linkages that promote seamless and efficient transitions of consumers between state facility and local community services.
6. Promote sharing of program knowledge and skills with *operational partners* to identify models of service delivery that have demonstrated positive consumer outcomes.
7. Problem-solve and collaborate with State Facilities on complex or difficult consumer situations.
8. Encourage and facilitate local interagency collaboration and cooperation to meet the other services and supports needs of consumers.

### **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 of Virginia* and criteria in the Continuity of Care Procedures in the General Requirements Document, including the development of specific capabilities to meet the needs of individuals with co-occurring mental illnesses 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 intellectual disabilities identified by CSBs as needing those services.
3. To the fullest extent that resources allow, provide services that address the specific needs of individual consumers with a focus on service quality, accessibility, and availability and on consumer self-determination, empowerment, and recovery.
4. Support and encourage the involvement and participation of consumers and family members of consumers in policy formulation and services planning, delivery, monitoring, and evaluation.
5. Establish services and linkages that promote seamless and efficient transitions of consumers between state facility and local community services.
6. Promote sharing of program knowledge and skills with *operational partners* to identify models of service delivery that have demonstrated positive consumer outcomes.
7. Problem-solve and collaborate with CSBs on complex or difficult consumer situations.

Recognizing that these unique roles create distinct visions and perceptions of consumer and service needs at each point (statewide, communities, and state facilities) of services planning, management, delivery, and evaluation, the *operational partners* are committed to maintaining effective lines of communication with each other and with other providers involved in the services system through their participation in regional partnerships generally and for addressing particular challenges or concerns. Mechanisms for communication include the System Leadership Council and its subgroups; the System Operations Team; representation on work groups, task forces, and committees; use of websites and electronic communication; consultation activities; and circulation of drafts for soliciting input from other *partners*. When the need for a requirement is identified, the *partners* agree to use a participatory process, similar to the process used by the Central Office to develop Departmental Instructions for State Facilities, to establish the requirement.

## **FY 2009 Community Services Performance Contract Central Office, State Facility, and Community Services Board Partnership Agreement**

These efforts by the *partners* will help to ensure that individuals have access to a public, consumer-driven, community-based, and integrated system of mental health, mental retardation, and substance abuse services that maximizes available resources, adheres to the most effective, evidence-based, best, or promising service delivery practices, utilizes the extensive expertise that is available within the public system of care, and encourages and supports the self-determination, empowerment, and recovery of consumers.

### **Section 3: Core Values**

The Central Office, State Facilities, and CSBs, the *partners* to this agreement, share a common desire for the public system of care to excel in the delivery and seamless continuity of services to consumers 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, consumers, and families. The *partners* embrace common 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.

#### ***Vision Statement***

Our core values are based on our vision, articulated in State Board Policy 1036, for the public mental health, mental retardation, and substance abuse services system. Our vision is of a consumer-driven and community-based system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation 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.

#### ***Core Values***

1. The Central Office, State Facilities, and CSBs are working in partnership; we hold each other accountable for adhering to our core values.
2. As *partners*, we will focus on fostering a culture of responsiveness instead of regulation, finding solutions rather than assigning responsibility, emphasizing flexibility over rigidity, and striving for continuous quality improvement, not just process streamlining.
3. As *partners*, we will make decisions and resolve problems at the level closest to the issue or situation whenever possible.
4. Services should be provided in the least restrictive and most integrated environment possible. Most integrated environment means a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible (28 CFR pt. 35, App. A, page 450, 1998).
5. All services should be designed to be welcoming, accessible, and capable of providing interventions properly matched to the needs of consumers with co-occurring disorders.
6. Community and state facility services are integral components of a seamless public, consumer-driven, and community-based system of care.
7. The goal of all components of our public system of care is that the persons we serve recover, realize their fullest potential, or move to independence from our care.
8. The participation of the consumer and, when one is appointed or designated, the consumer's authorized representative in treatment planning and service evaluation is necessary and valuable and has a positive effect on service quality and outcomes.

## **FY 2009 Community Services Performance Contract Central Office, State Facility, and Community Services Board Partnership Agreement**

9. The consumer's responsibility for and active participation in his or her care and treatment are very important and should be supported and encouraged whenever possible.
10. Consumers have a right to be free from abuse, neglect, or exploitation and to have their basic human rights assured and protected.
11. Choice is a critically important aspect of consumer participation and dignity, and it contributes to consumer satisfaction and desirable outcomes. Consumers should be provided as much as possible with responsible and realistic opportunities to choose.
12. Family awareness and education about a person's disability or illness and services are valuable whenever the individual with the disability supports these activities.
13. Whenever it is clinically appropriate, children and adolescents should receive services provided in a manner that supports maintenance of their home and family environment. Family includes single parents, grandparents, older siblings, aunts or uncles, and other individuals who have accepted the child or adolescent as part of their family.
14. Children and adolescents should be in school and functioning adequately enough that the school can maintain them and provide an education for them.
15. Living independently or in safe and affordable housing in the community with the highest level of independence possible is desired for adult consumers.
16. Gaining employment, maintaining employment, or participating in employment readiness activities improves the quality of life for adults with disabilities.
17. Lack of involvement or a reduced level of involvement with the criminal justice system, including court-ordered criminal justice services, improves the quality of life of all individuals.
18. Pursuant to State Board Policy 1038, the public, consumer-driven, and community-based mental health, mental retardation, and substance abuse services system serves as a safety net for individuals, particularly people who are uninsured or under-insured, who do not have access to other service providers or alternatives.

### **Section 4: Indicators Reflecting Core Values**

Nationwide, service providers, funding sources, and regulators have sought instruments and methods to measure system effectiveness. No one system of evaluation is accepted as the method, as perspectives about the system and desired outcomes vary, depending on the unique role (e.g., as a consumer, family member, payer, provider, advocate, or member of the community) that one has within the system.

Simple, cost-effective measures reflecting a limited number of core values or expectations identified by the Central Office, State Facilities, and CSBs guide the public system of care in Virginia. 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 *operational partners* agree to engage in activities to advance the achievement of the Vision Statement contained in State Board Policy 1036 and stated in section 3 of this agreement. These efforts include the following activities.

1. **Recovery:** The *partners* agree, to the greatest extent possible, to:
  - a. provide more opportunities for consumers to be involved in decision-making,

## FY 2009 Community Services Performance Contract Central Office, State Facility, and Community Services Board Partnership Agreement

- b. increase recovery-oriented peer-provided and consumer-run services,
  - c. educate staff and consumers about recovery, and
  - d. implement recommendations of the System Transformation Initiative Data/Monitoring Work Group, for example, use the ROSI or a similar mechanism to assess the consumer recovery orientation of the CSB, Central Office, or State Facility.
2. **Integrated Services:** The *partners* agree to advance the values and principles in the Charter Agreement signed by the Board and the Central Office and to increase effective screening and assessment of consumers 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.

### Section 6: Critical Success Factors

The *operational partners* agree to engage in activities that will address the seven critical success factors identified in *Envision the Possibilities: An Integrated Strategic Plan for Virginia's Mental Health, Mental Retardation and Substance Abuse Services System*, January 2006. These critical success factors, listed below and described more fully in the *Integrated Strategic Plan*, 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, mental retardation, and substance abuse 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, mental retardation, and substance abuse 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, mental retardation, and substance abuse 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.

## FY 2009 Community Services Performance Contract Central Office, State Facility, and Community Services Board Partnership Agreement

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.

### ***Desirable and Necessary Accountability Areas***

- 1. Mission of the System.** As part of a mutual process, the *partners*, with maximum input from stakeholder groups and consumers, will define a small number of key missions for the public community and state facility services system and a small number of measures for these missions. State Facilities and CSBs will report on these measures at a minimum frequency necessary to determine the level and pattern of performance over several years.
- 2. Central Office Accountability.** In addition to internal governmental accountability, the Central Office agrees to support the mission of the public services system by carrying out its functions in accordance with the vision and values articulated in section 3. Accountability for the Central Office will be defined by the fewest necessary measures of key activities that will be reported at a minimum frequency necessary to determine the level and pattern of performance over several years.
- 3. State Facility Accountability.** In addition to internal governmental accountability, State Facilities agree to support the mission of the public services system by carrying out their functions in accordance with the vision and values articulated in section 3. Accountability for State Facilities will be defined by the fewest necessary measures of key activities that will be reported at a minimum frequency necessary to determine the level and pattern of performance over several years.
- 4. CSB Accountability.** In addition to internal governmental accountability, CSBs agree to support the mission of the public services system by carrying out their functions in accordance with the vision and values articulated in section 3. Accountability for CSBs will be defined by the fewest necessary measures of key activities that will be reported at a minimum frequency necessary to determine the level and pattern of performance over several years.
- 5. Legislative Accountability.** Additional reporting or responses may be required of CSBs, the Central Office, or State Facilities by the General Assembly or in support of a legislative request or study.
- 6. Quality Improvement.** CSBs, State Facilities, and the Central Office will manage internal quality improvement, quality assurance, and corporate compliance systems to monitor activities, detect and address problems, and minimize risk. These activities require no standardized reporting outside of that contained in law, regulation, or policy. The *partners* agree to identify and, wherever possible, implement evidence-based best practices and programs to improve the quality of care that they provide. In the critically important area of service integration for individuals with co-occurring disorders, the *partners* agree to
  - a. engage in periodic organizational self-assessment using identified tools,

**FY 2009 Community Services Performance Contract Central Office,  
State Facility, and Community Services Board Partnership Agreement**

- b. develop a work plan that prioritizes quality improvement opportunities in this area,
  - c. monitor progress in these areas on a regular basis, and
  - d. adjust the work plan as appropriate.
7. **Fiscal.** Funds awarded or transferred by one *partner* to another for a specific identified purpose should have sufficient means of accountability to ensure that expenditures of funds were for the purposes identified. The main indicators for this accountability include an annual CPA audit by an independent auditing firm or an audit by the Auditor of Public Accounts and reports from the recipient of the funds that display the amounts of expenditures and revenues, the purposes for which the expenditures were made and, where necessary, the types and amounts of services provided. The frequency and detail of this reporting shall reflect the minimum necessary.
8. **Compliance with Departmental Regulatory Requirements for Service Delivery.** In general, regulations ensure that entities operate within the scope of acceptable practice. The system of Department licensing, in which a licensed entity demonstrates compliance by policy, procedure, or practice with regulatory requirements for service delivery, is a key accountability mechanism. Where a service is not subject to state licensing, the *partners* may define minimum standards of acceptable practice. Where CSBs obtain nationally recognized accreditation covering services for which the Department requires a license, the Department, to the degree practical and with the fullest possible participation and involvement by the other *partners*, will consider substituting the accreditation in whole or in part for the application of specific licensing standards.
9. **Compliance with Federal and Non-Department Standards and Requirements.** 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 Central Office agrees to identify the minimum documentation needed from the other *partners* to indicate their compliance with applicable Federal and non-Departmental standards and requirements. Where possible, this documentation shall include affirmations by CSBs or State Facilities in lieu of direct documentation. The *partners* shall define jointly the least intrusive and least costly compliance strategies, as necessary.
10. **Compliance with Department-Determined Requirements.** 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 Central Office agrees to define the minimum compliance system necessary to ensure that CSBs and State Facilities perform due diligence in regard to requirements established by the Central Office and that this definition will include only the minimum necessary to meet the intent of the State law or State Board policy for which the requirement is created. Where local government standards are in place, compliance with the local standards shall be acceptable.
11. **Medicaid Requirements.** The Central Office agrees to work proactively with the Department of Medical Assistance Services (DMAS) to create an effective system of accountability that will ensure services paid for by the DMAS meet minimum standards for quality care and for the defined benefit. The Central Office, and CSBs to the fullest extent possible, will endeavor to assist the DMAS in regulatory and compliance simplification in order to focus accountability on the key and most important elements.
12. **Maximizing State and Federal Funding Resources.** The *partners* agree to collect and utilize available revenues from all appropriate sources to pay for services in order to extend the use of state and federal funds as much as possible to serve the greatest number of

## **FY 2009 Community Services Performance Contract Central Office, State Facility, and Community Services Board Partnership Agreement**

individuals in need of services. Sources include Medicaid cost-based, fee-for service, Targeted Case Management, Rehabilitation (State Plan Option), and MR Waiver payments; other third party payers; auxiliary grants; food stamps; SSI, SSDI, and direct consumer payments; payments or contributions of other resources from other agencies, such as local social services or health departments; and other state or local funding sources.

- 13. Information for Decision-Making.** The *partners* agree to work collaboratively to
- a. improve the accuracy, timeliness, and usefulness of data provided to funding sources and stakeholders;
  - b. enhance infrastructure and support for information technology systems and staffing; and
  - c. use this information in their decision-making about resources, services, policies, and procedures and to communicate more effectively with funding sources and stakeholders about the activities of the public services system and its impact on consumers and families.

### **Section 8: Consumer and Family Member Involvement and Participation**

- 1. Consumer and Family Member Involvement and Participation:** 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 participation of consumers and their family members in policy formulation and services planning, delivery, monitoring, and evaluation.
- 2. Consumer and Family Member Involvement in Individual Services Planning and Delivery:** CSBs and State Facilities agree to involve consumers and, with the consent of consumers where applicable, family members, authorized representatives, and significant others in their care, including the maximum feasible 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 consumers. This involves communicating orally and in writing in the primary languages of consumers, 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: System Leadership Council.** The System Leadership Council, established by the *partners* through this agreement, includes representatives of the Central Office, State Facilities, the State Mental Health, Mental Retardation and Substance Abuse Services Board, CSBs, consumers, local governments, the criminal justice system, private providers, and other stakeholders. The Council will meet at least quarterly to, among other responsibilities:

1. identify, discuss, and resolve issues and problems;
2. examine current system functioning and identify ways to improve or enhance the operations of the public mental health, mental retardation, and substance abuse services system; and
3. identify, develop, propose, and monitor the implementation of new service modalities, systemic innovations, and other approaches for improving the accessibility, responsiveness, and cost effectiveness of publicly funded mental health, mental retardation, and substance abuse services.

Some of these responsibilities may be carried out through the System Operations Team (SOT), which includes members of the System Leadership Council and other staff as needed. When requested by the Council, the SOT may serve two functions on an ad hoc basis: coordinating the

**FY 2009 Community Services Performance Contract Central Office,  
State Facility, and Community Services Board Partnership Agreement**

services system's response to programmatic and operational issues and acting as a problem-solving group. The SOT may meet as needed to prioritize, track, and work through various operational issues identified by the Council that confront the services system. When appropriate, the SOT will bring resolutions and policy proposals to the System Leadership Council for its consideration and action.

**Section 10: 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 11: 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, mental retardation, and substance abuse services.

**Section 12: 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 consumers and to enhance the effectiveness and efficiency of their operations.

**Section 13: Revision.** This is a long-term agreement that does not and 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. The *partners* agree that this agreement will be reviewed and renewed at the end of five years from the date of its initial signature, unless they decide jointly to review and renew it sooner. All such reviews and renewals will be 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 14: 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 Community Services Performance Contract.

**Section 15: Signatures.** In witness thereof, the CSB and the Department, acting on behalf of the Central Office and the State Facilities that it operates, have caused this partnership agreement to be executed by the following duly authorized officials.

**Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services**

\_\_\_\_\_

\_\_\_\_\_ **Community Services Board**

By: \_\_\_\_\_

By: \_\_\_\_\_

Name: James S. Reinhard, M.D.  
Title: Commissioner

Name: \_\_\_\_\_  
Title: Executive Director

Date: \_\_\_\_\_

Date: \_\_\_\_\_