District of Columbia

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 10/02/2017 3.06.27 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

State Information

State Information

Plan Year

Start Year 2018

End Year 2019

State DUNS Number

Number 014384031

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name Department of Behavioral Health

Organizational Unit Community Services Administration

Mailing Address 64 New York Avenue NE, 3rd FL.

City Washington, DC

Zip Code 20002

II. Contact Person for the Grantee of the Block Grant

First Name Tanya

Last Name Royster

Agency Name Department of Behavioral Health

Mailing Address Department of Behavioral Health 64 New York Avenue, N.E. 3rd Floor

City Washington

Zip Code 20002

Telephone (202) 673-2200

Fax (202) 673-3433

Email Address tanya.royster@dc.gov

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name Denise

Last Name Dunbar

Telephone 202-673-7126

Fax 202-645-8426

Email Address denise.dunbar@dc.gov

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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 provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers 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.

The authorized official signing for the applicant organization certifies that the applicant organization 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 for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Tanya A. Royster

Signature of CEO or Designee[1]: _____

Title: Director

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

CHIEF EXECUTIVE OFFICER FUNDING AGREEMENT

Certifications and Assurances

Letter Designating Signatory Authority

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
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Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
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Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
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I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Tanya A. Royster

Signature of CEO or Designee: 

Title: Director

Date Signed: 08/30/2017

mm/dd/yyyy

*If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

GOVERNMENT OF THE DISTRICT OF COLUMBIA

ADMINISTRATIVE ISSUANCE SYSTEM

Mayor's Order 2015-146
May 27, 2015

SUBJECT: Delegation of Authority to the Director, Acting Director, or Interim Director, the Department of Behavioral Health, or his or her Designee to Sign Documents Related to the Substance Abuse Prevention and Treatment (SAPT) Block Grant and to sign funding agreements with the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration for grants to be administered by the Department of Behavioral Health

ORIGINATING AGENCY: Office of the Mayor

By virtue of the authority vested in me as Mayor of the District of Columbia by sections 422(6) and (11) of the District of Columbia Home Rule Act, approved December 24, 1973, 87 Stat. 790, Pub. L. 93-198, D.C. Official Code § 1-204.22(6) and (11) (2014 Repl.), it is hereby **ORDERED** that:

1. **FIRST DELEGATION OF AUTHORITY:** The Mayor hereby delegates to the Director, Acting Director, or Interim Director of the Department of Behavioral Health, or his or her designee, authority to sign funding agreements and certifications, provide assurances of compliance to the Secretary of the U.S. Department of Health and Human Services, and to perform similar acts relevant to the administration of the Substance Abuse Prevention and Treatment (SAPT) Block Grant until such time as this delegation of authority is rescinded.

2. **SECOND DELEGATION OF AUTHORITY:** The Mayor hereby delegates to the Director, Acting Director, or Interim Director of the Department of Behavioral Health, or his or her designee, authority to sign funding agreements with the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration for grants to be administered by the Department of Behavioral Health.

3. **RESCISSION:** Mayor's Order 2013-228, dated December 5, 2013, is hereby rescinded.

4. **EFFECTIVE DATE:** This Order shall become effective immediately.

MURIEL E. BOWSER
MAYOR

ATTEST:
LAUREN C. VAUGHAN
SECRETARY OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA

ADMINISTRATIVE ISSUANCE SYSTEM

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MURIEL E. BOWSER
MAYOR

ATTEST:
LAUREN C. VAUGHAN
SECRETARY OF THE DISTRICT OF COLUMBIA

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

Footnotes:

Not Applicable

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Overview of State Behavioral Health Prevention, Early Identification, Treatment, and Recovery Support Systems

A major accomplishment for the District of Columbia Department of Behavioral Health (DBH) during FY 2017 was the development and implementation of an organizational realignment process. The newly realigned behavioral health system will be officially launched in fiscal year 2018 on October 1, 2017. The guiding principles include: 1) ***Openness***- an open and transparent system that listens, engages, understands, and responds appropriately to staff and community concerns; 2) ***Consumer and Client Focused***- provide opportunities for consumer and client participation and engage them as partners; 3) ***Accountability***- staff meet commitments that creates a culture of success, mutual accountability and respect; 4) ***Empowerment***- encourage staff to actively participate in creating a common organizational culture; and 5) ***Communication***- maintain an environment that encourages participation, and shares information in various ways including individual, group, and mass media platforms.

Behavioral Health Authority

The Behavioral Health Authority plans and develops: 1) mental health and substance use disorder services; 2) ensures timely access; 3) monitors the service system; 4) supports service providers by operating the DBH Fee for Service (FFS) system; 5) provides grant or contract funding for services not covered through the FFS system; 6) regulates the providers within the District's public behavioral health system; and 7) identifies the appropriate mix of programs, services, and supports necessary to meet the behavioral health needs of District residents. The Authority components are described below.

- ***Office of the Director***- leads management and oversight of the public behavioral health system; directs the design, development, communication, and delivery of behavioral health services and supports; and identifies approaches to enhance access to services that support recovery and resilience. The Office of the Director includes the Chief of Staff who oversees risk management and compliance with Language Access requirements and the Americans with Disability Act.

- ***Office of the Ombudsman***- identifies and helps consumers and clients resolve problems, complaints and grievances through existing processes; educates on available services and helps to maximize outreach; refers individuals when appropriate to other District agencies for assistance; and comments on behalf of residents on District behavioral health policy, regulations and legislation.

- ***Legal Services***- provides legal advice to the Director on all aspects of DBH operations and activities; drafts, researches and/or reviews legislation, regulations, and policies that affect the DBH mission and programs; and formulates strategic advice on DBH program development, compliance and oversight activities.

- ***Legislative and Public Affairs***- develops, leads and coordinates the agency's public education, internal and external communications, and public engagement and outreach initiatives; manages legislative initiatives and acts as the liaison to the Executive Office of the Mayor and the District Council; facilitates responses to constituent complaints and service requests; and provides information and support for special projects.

Accountability Administration

The Accountability Administration oversees provider certification; mental health community residence facility licensure; program integrity; quality improvement; incident management; major investigations; claims audits; and compliance monitoring. It issues the annual Provider Scorecard. The Accountability Administration includes a new division called Program Integrity that strengthens provider oversight and overall system performance review. The Administration

components are described below.

- ***Office of Accountability-*** leads the Accountability Administration by providing oversight and management of DBH certification, licensure, incident management, and program integrity activities.

- ***Investigations Division-*** conducts major investigations of complaints and certain unusual incidents and develops the final investigative report submitted to the agency Director, General Counsel, and other appropriate parties that includes recommendations for remedial action.

- ***Licensure Division-*** reviews and processes applications for licensure for Mental Health Community Residence Facilities (MHCRF) for approval; monitors MHCRF compliance with agency regulations and policies; and generates and enforces statements of deficiencies and corrective action plans when necessary.

- ***Certification Division-*** reviews and processes applications for certification and recertification for behavioral health providers for approval, monitors provider compliance with certification regulations and policies, and generates and enforces statements of deficiencies and corrective action plans when necessary.

- ***Program Integrity Division-*** provides oversight of certified providers through audits and reviews to ensure they meet service delivery and documentation standards for mental health and substance use disorder services.

Administrative Operations Administration

Led by the Chief Operating Officer, the Administrative Operations provides highly functioning administrative activities to support the vision and mission of DBH. The Administration is responsible for the business functions including budget and financial management; human resource management; property and space management; records management; and general administrative support. The Administration components are described below.

- ***Office of the Chief Operating Officer-*** provides leadership, management, and vision necessary to ensure proper operational controls; administrative and reporting procedures; and people systems are in place to effectively manage day-to-day operations; and to guarantee financial strength and operating efficiency of DBH.

- ***Claims and Billing Division-*** manages the services revenue cycle for Saint Elizabeths, the Comprehensive Psychiatric Emergency Program (CPEP), and DBH operated adult and child/youth outpatient clinics; processes claims for the certified community based behavioral health providers; and responsible for billing and claim adjudications including local payments, claim accounts receivable, customer service for provider claims, claim reporting, and eligibility file management.

- ***Fiscal Services Division-*** coordinates, in conjunction with the Director and senior management, financial plans to fulfill ongoing program requirements; leads operational and capital budget preparation, execution, and administration; coordinates budget loading and tracking activities; provides guidance on strategic financial planning and fiscal soundness of spending plans; develops options to achieve budget objectives; conduct fiscal monitoring for compliance, audits, risk assessments, fiscal orientations, site visits and closeout reports for all sub grants; and monitors spending for Human Care Agreements and Contracts.

- ***Records Management Division-*** manages the medical records program and maintains official medical records for DBH consumers and clients; oversees the development, implementation, maintenance, and adherence to DBH policies and procedures covering the privacy of and access to patient health information; in compliance with federal and state laws and the provider's information privacy practices.

- ***Human Resources Division-*** develops and administers human resource services including management advisory services; human resources policy development; position classification/ position management; staffing and recruitment; employee and labor relations; performance management; benefits administration;, records management; human resources information systems and human rights; and equal employment.

- ***Revenue Management Division-*** plans, implements and manages finance and revenue generating sources for DBH directly provided services and Saint Elizabeths Hospital.

Clinical Services Administration

Led by the Chief Clinical Officer, the Clinical Services Administration supervises the operation of all clinical programs and sets standards for the provision of clinical care throughout the public behavioral health system. It includes all DBH directly provided assessment, referral, and clinical services; forensic services; the comprehensive emergency psychiatric program; and the disaster behavioral health program. The Administration oversees involuntary commitment at community hospitals, and coordinates services that assist individuals transitioning from psychiatric hospitals and nursing homes to community based behavioral health services. The Administration components are described below.

- ***Office of the Chief Clinical Officer-*** supervises and sets standards for the provision of clinical care throughout the agency and public behavioral health system for children, youth, and adults; oversees community hospitals that treat consumers on an involuntary basis; serves as the petitioner in guardianship cases; and oversees the agency's disaster response for the District.

- ***Behavioral Health Services Division-*** directs and manages mental health services at two (2) DBH-operated locations, currently 35 K Street Northeast and 821 Howard Road Southeast.
  - ***Adult Services Branch-*** provides clinical assessment and treatment for persons who are 18 years of age and older who present with urgent same-day mental health concerns, and evaluations for persons in crisis that do not arise to the level of needing an emergency room visit are also provided.

  - ***Children's Services Branch-*** provides urgent same-day service and clinical assessment and treatment for children up to 7 years old who present with challenging social, emotional and disruptive behaviors that cause impairment in functioning at home, school, daycare and the community.

  - ***Pharmacy Branch-*** provides psychiatric medications for residents enrolled in the public behavioral health system who are uninsured and unable to pay for medications.

- ***Comprehensive Psychiatric Emergency Program Division (CPEP)-*** provides emergency mental health services to adults 18 years of age and older, including immediate and extended observation care to individuals who present in crisis, as well as services in the community; and participates in the District's cold weather alert response.

  - ***Psychiatric Emergency Services Branch-*** provides immediate access to multi-disciplinary emergency psychiatric services 24/7; assesses and stabilizes psychiatric crises of patients who present voluntarily or involuntarily who live or visit the District, and formulates appropriate next level of care in the community or at other treatment facilities.

  - ***Mobile Crisis/Homeless Services Outreach Branch-*** Mobile Crisis provides crisis intervention and stabilization services to residents and visitors who are experiencing psychiatric crises in the community or at home. Services include linkage to DBH, psychoeducation, treatment compliance support, and grief and loss services to individuals after a traumatic event. Homeless Outreach connects homeless individuals and families with behavioral health services and assists in the District's encampment protocol.

- ***Access HelpLine Division-*** enrolls consumers into services, authorizes appropriate units and duration of services based on clinical review of medical necessity criteria and capacity limits; ensures District residents receive crisis services, as well as provides telephonic suicide prevention and other counseling as appropriate.

- ***Forensics Division-*** provides and oversees continuum of behavioral health and others services for justice-involved individuals from pre-arrest to post-incarceration to ensure their successful return to the community.

- ***Assessment and Referral Center Division-*** assesses and refers adults seeking treatment for substance use disorders to appropriate services including detoxification, inpatient, medication assisted treatment or outpatient substance use disorder treatment programs, or recovery support services. The Mobile Assessment and Referral Center, a mobile outreach vehicle, visits communities throughout the District to conduct assessment, referral, and HEP-C and HIV testing.

Community Services Administration

The Community Services Administration develops, implements and monitors a comprehensive array of prevention, early intervention and community-based behavioral health services and supports for adults, children, youth, and their families that are culturally and linguistically competent and supports resiliency and recovery. This Administration includes services and supports in the former Adult Services, Children/Youth Services, Substance Use Disorder Prevention Services, and Treatment and Recovery Services. The Administration components are described below.

- ***Office of Community Services-*** leads oversight and management of the agency's integrated community-based, prevention, early intervention and specialty behavioral health programs.

- ***Prevention and Early Intervention Division-*** develops and delivers prevention and early intervention services, education, support, and outreach activities to help inform and identify children, youth and their families who may be at risk or affected by some level of mental health and/or substance use disorder. This division applies a public health and community-based approach to delivering evidence-based substance abuse prevention and mental health promotion programs. It includes the Early Childhood Branch, School Mental Health Branch, and a Substance Use Disorder Prevention Branch.

    - ***Early Childhood Branch-*** provides school-based and center-based early childhood mental health supports and child and family-centered consultation to staff and families to build their capacity to promote social and emotional development, respond to mental health issues and prevent escalation of challenging behaviors, and increase referrals for additional services.

    - ***School Mental Health Branch-*** provides school-based, primary prevention services to students and school staff and consultation to schools, principals, teachers and classrooms on early intervention and treatment to students and parents.

    - ***Substance Use Disorder Prevention Branch-*** ensures comprehensive prevention systems by developing policies, programs, and services to prevent the onset of illegal drug use, prescription drug misuse and abuse, alcohol misuse and abuse, underage alcohol and tobacco use.

- ***Specialty Care Division-*** develops, implements and ensures sustainability of specialized and evidence-based behavioral health programs for adults, adolescents, transition-aged youth, children and their families, and new grant funded initiatives that impact the well-being of individuals and communities. This division includes the Community-Based Services Branch and a New Initiatives Branch.

- ***Community-Based Services Branch-*** oversees development, implementation and monitoring of community-based mental health and substance use disorders services including evidenced-based and promising practices, to address the needs of adults, children, youth and their families.

- ***New Initiatives Branch-*** provides overall technical direction and administration of a broad range of grant-funded projects and other new initiatives, tracks and monitors their progress and outcomes, and makes recommendations on their integration into the agency and full-scale implementation.

- ***Linkage and Assessment Division-*** provides community-based mental health and substance use disorder screening, assessments, and referrals for adults, children, youth and families, ensuring they have easy access to a full continuum of quality behavioral health services and supports. It includes the Assessment Center Branch, the Co-Located Program Branch, and the Psychiatric Residential Treatment Facility Branch.

  - ***Assessment Center Branch-*** provides the Superior Court of the District of Columbia with court-ordered, high-quality, comprehensive, culturally competent mental health consultation, and psychological and psychiatric evaluations for children and related adults with involvement in child welfare, juvenile justice and family court.

  - ***Co-Located Programs Branch-*** oversees the co-location of DBH clinicians at various District government agency and community-based sites who conduct behavioral health screenings, assessments and consultations, and make referrals to the behavioral health provider network.

  - ***Psychiatric Residential Treatment Facility Branch-*** provides centralized coordination and monitoring of placement, continued stay, and post-discharge of children and youth in psychiatric residential treatment facilities (PRTF), and oversees the coordination of the PRTF medical necessity review process.

- ***Housing Development Division-*** develops housing options and administers associated policies and procedures governing eligibility, access to housing, and issuance of vouchers for eligible individuals enrolled with DBH; monitors providers' compliance with contracts and provides technical assistance to providers on the development of corrective action plans; develops and monitors any Memorandum of Understanding or grant agreements related to housing development and funding of housing vouchers.

- ***Residential Support Services and Care Continuity Division-*** manages the housing program to support consumers based on housing needs and required level of support; provides referrals to landlords; assures properties are inspected and approved; monitors service provision according to individualized clinical treatment plans; assures coordination and resolves problems among landlords, tenants, and providers, and conducts regular reviews to transition ready individuals to more independent housing of their choice.

Consumer and Family Affairs Administration

The Consumer and Family Affairs Administration promotes and protects the rights of individuals with behavioral health disorders; encourages and facilitates consumer and client and family leadership of treatment and recovery plans, and ensures consumer and client voice in the development of the behavioral health system. The Administration also promotes consumer and client leadership, manages the peer certification training, and provides expertise on the consumer and client perspective. This Administration is made up of the following teams: Peer Support, Consumer Engagement, Consumer Rights, Quality Improvement and Saint Elizabeths Hospital.

Systems Transformation Administration

The Systems Transformation Administration conducts research, analysis, planning and evaluation leading to defined individual, service and system outcomes; works to improve efficiency and collaboration among internal and external partners; develops and implements learning opportunities to advance system change, and greater effectiveness of the service delivery system.

The Systems Transformation Administration uses information systems and data to develop a transformational strategic plan as well as programmatic regulations, policies, and procedures to support the DBH mission. The Administration includes functions of the former Provider Relations, Information Technology and Applied Research and Evaluation, and the Office of Strategic Planning, Policy and Evaluation. The Administration components are described below.

- ***Office of System Transformation-*** leads the development and implementation of programmatic, organizational, and system change management process, and manages the grant process.

- ***Information Systems Innovation and Data Analytics Division (ISIDA)-*** provides and maintains high-quality hardware and software applications that support the provision and monitoring of consumer and client services. It also produces and analyzes data for decision-making. This division is made up of the Data and Performance Management Branch, Information Systems Support Branch, and Technology Infrastructure Branch.

    - ***Data and Performance Management Branch-*** meets the agency's data reporting and analysis needs by working with staff to identify what information is needed, creates reports and dashboards that presents and makes the information accessible, and helps staff understand what the information means and how it can be used to improve performance.

    - ***Information Systems Support Branch-*** ensures continuity of operations and continual improvement of existing practice management, billing software applications, electronic health record applications and other systems, and provides business analysis support for new systems.

    - ***Technology Infrastructure Branch-*** manages the agency's technical support systems, including server maintenance; maintains asset inventory, and provides multi-functional device support and management.

- ***Strategic Management and Policy Division-*** develops programmatic regulations, policies and procedures to support the agency's mission and manages the Performance Plan and Performance Accountability Report.

- ***Network Development Division-*** monitors and provides technical assistance to individual providers and the provider network on emerging clinical, care coordination, administrative and organizational issues to ensure and enhance the provision of services. Supports the development of new providers interested in certification.

- ***Training Institute Division-*** enhances the knowledge and competencies of the DBH provider network and internal and external customers through performance-based and data-driven learning environments.

Saint Elizabeths Hospital

Saint Elizabeths Hospital provides inpatient psychiatric, medical, and psycho-social person-centered treatment to adults to support their recovery and return to the community. The Hospital's goal is to maintain an active treatment program that fosters individual recovery and independence as much as possible. The Hospital is licensed by the District's Department of Health and meets all the conditions of participation promulgated by the federal Centers for Medicare and Medicaid Services. The Saint Elizabeths Hospital components are described below.

- ***Office of the Chief Executive-*** provides overall executive management and leadership for all services and departments of Saint Elizabeths.

- ***Office of the Director of Medical Affairs-*** provides the clinical, operational, strategic, and cultural leadership necessary to deliver care that is high- value (in terms of cost, quality and patient experience) to support their recovery and reintegration into the community.

- ***Chief Clinical Officer-*** provides clinical leadership and interdisciplinary treatment teams; ensures the provision of social work services; treatment programs; rehabilitation services; utilization review; and volunteer services.

- ***Nursing Services-*** provides active treatment and comprehensive, high-quality 24 hour nursing care through a recovery-based therapeutic program; establishes the training curriculum for all levels of hospital staff and ensures compliance with training programs for clinical and clinical support staff to maintain the health and safety of patients and staff.

- ***Office of the Chief of Staff-*** primarily responsible for the organization, ongoing management and oversight of key Hospital administrative functions; regularly interacts and coordinates with medical staff and executive leadership; and serves as liaison with external partners including the Department of Corrections, DC Superior Court, and the District of Columbia Hospital Association.

- ***Quality and Data Management-*** provides quality improvement utilizing performance improvement techniques; uses data and research to guide clinical practices; provides oversight of reporting functions; and manages the reporting functions from the electronic medical record.

- ***Office of the Chief Operating Officer-*** provides the operational, strategic, and cultural leadership necessary to plan, direct and manage major administrative functions. This ensures the provision of high quality services while also meeting the needs of individuals in care and external stakeholders. The Chief Operating Officer regularly interacts and coordinates with finance, information systems, human resources, performance improvement, and risk management.

- ***Engineering and Maintenance-*** provides maintenance and repairs to ensure a functional, safe, and secure facility to maximize the benefits of the therapeutic environment.

- ***Fiscal and Support Services-*** provides for the formulation, execution, and management of the Hospital's budget, billing and revenue operations; approves and finances all requests for procurements; and oversees the overall financial integrity of the Hospital to ensure the appropriate collection, allocation, utilization and control of resources.

- ***Housekeeping-*** maintains a clean and sanitized environment to enhance the therapeutic environment and level of clinical performance.

- ***Materials Management-*** receives and delivers materials, supplies, and postal and laundry services; maintains an inventory of goods, replenishes stock, and performs electronic receiving for all goods and services.

- ***Nutritional Services-*** provides optimum nutrition and food services, medical nutrition therapy and nutrition education services in a safe and sanitary environment.

- ***Security and Safety-*** provides a safe and secure facility for patients, visitors, and staff to support a therapeutic environment.

- ***Transportation and Grounds-*** manages the resources, administrative functions, contracts, and personnel; provides transportation and maintenance services including solid and medical waste disposal, and snow and ice removal.

Public Behavioral Health System Currently Organized at State Local Levels- Child System

The Child System is described in great detail under Criterion 3- Children's Services. An abbreviated summary is provided here. The child/youth services include: 1) Mental Health Rehabilitation Services; 2) Early Childhood Interventions (Early Childhood Mental Health Consultation-Healthy Futures, D.C. Social Emotional and Early Development Project, Parent Infant Early Childhood Enhancement Program, Primary

Project, Physicians' Practice Group, Child Urgent Same Day Services, and Co-Located Programs); 3) School Mental Health Program- Primary and Secondary Prevention Programs; 4) Youth Suicide Prevention and School Climate Survey Amendment Act of 2016 (Law 21-120); 5) Children and Adolescent Mobile Psychiatric Services; 6) Psychiatric Residential Treatment Facilities; 7) Functional Assessment Scales; and 8) Evidence-Based Practices.

The transition age youth initiatives include: 1) Transformation Transfer Initiative; 2) Now Is The Time-Healthy Transitions; 3) It's Time to Let Help In; 4) FY 2017 First Episode Psychosis Transition Age Youth Pilot Project; 5) Trauma, Intellectual Developmental Disabilities/Mental Illness; 6) Proposed Projects (services, training, resources); and 7) Transition Age Youth Housing Initiative.

Prevention-There are four (4) D.C. Prevention Centers that each combine two (2) District wards. They were developed to strengthen community capacity, address needed community and system changes, reduce substance use risk factors, and achieve target outcomes for District children and youth. The Centers promote healthy children, youth, and families as well as a drug-free city.

The prevention activities also include the SUD social marketing campaigns that are presented from the perspective of youth and related adults. They include: 1) "*The Blunt Truth*" (addresses marijuana use); 2) *There's a Reason"* (addresses underage drinking); and 3) *"K2 Zombie"* (addresses fake weed and other synthetic drug use among youth).

Evidenced Based and Evidence Informed Curriculum- The DBH School Mental Health Program (SMHP) implements primary and secondary prevention programs that include evidenced-based or evidence informed programs. These activities include: Violence Prevention; 2) Sexual Abuse Prevention; 3) Suicide Prevention; 4) Anger Management; 5) Ask 4 Help-K-5; 6) Parenting Program; and 7) Substance Abuse Prevention.

Early Identification- The early childhood interventions were previously referenced. An additional early identification project is the DC Mental Health Access Project (DC MAP). It supports the integration of health and mental health by providing pediatricians with immediate access to mental health and/or psychiatric consultation as children/youth are identified as potentially needing behavioral health services.

Treatment- DBH currently offers nine (9) evidence-based practices as part of the treatment process that include: 1) Child Parent Psychotherapy for Family Violence; Trauma Systems Therapy; 3) Parent Child Interaction Therapy; 4) Trauma Focused Cognitive Behavioral Therapy; 5) Multi-Systemic Therapy; 6) Multi-Systemic Therapy for Youth with Problem Sexual Behavior; 7) Adolescent Community Reinforcement Approach (SUD); 8) Transition to Independence Process (an evidenced supported model); and 9) Cognitive Behavioral Therapy for Psychosis (CBTp).

The substance use disorder treatment services include a variety of strategies for adolescents and adults: 1) assessment (comprehensive, ongoing, brief), 2) drug screening; clinical care coordination; 4) case management; 5) case management HIV; 6) crisis intervention; 7) counseling (individual, family, group, psycho-educational, and psycho- educational HIV); 8) medication management; 9) recovery support; 10) residential room and board; 11) recovery support evaluation; 12) recovery support management; 13) recovery mentoring and coaching; 14) life skills support; 15) spiritual support; 16) education services; 17) transportation services; 21) recovery social activities; and 22) environmental stability.

Recovery Support Services- In the District of Columbia non-clinical services are provided to an individual by a certified Recovery Support Services (RSS) provider to assist him or her in achieving or sustaining recovery from a SUD. There are eight (8) billable recovery support services: 1) Recovery Support

Evaluation; 2) Recovery Support Management; 3) Recovery Coaching (Recovery Mentoring and Coaching); 4) Recovery Support Service (Life Skills Support Services); 5) Spiritual Support Services; 6) Education Support Services; 7) Recovery Social Activities; and 8) Environmental Stability.

Juvenile Justice Initiatives

- ***Juvenile Behavioral Diversion Program (JBDP)-*** Operated within the D.C. Superior Court Juvenile Division this program is intended for children and youth who are often served within multiple systems who are at risk of re-offending without linkage to mental health services and other important supports.

- ***Juvenile Adjudicatory Competency Program (JACP)-*** A partnership with Court Social Services to provide the District of Columbia Family Court with comprehensive, culturally sensitive and clinically appropriate competency evaluations to assist in the determination of a juvenile's capability to stand trial.

- ***Alternatives to Court Experience (ACE)-*** This program is operated by the District Department of Human Services. Juvenile prosecutors at the Office of the Attorney General (OAG) divert appropriate youth from the justice system to ACE, where program specialists comprehensively assess each child's needs for services and supports.

Behavioral Health Service Partners

The child and youth behavioral health service partners include but are not limited to:
1) Office of the State Superintendent of Education, 2) D.C. Public Schools, 3) D.C. Public Charter Schools, 4) Child and Family Services Agency, 5) Department of Youth Rehabilitation Services, 6) Department on Disability Services, 7) Department of Human Services, 8) D.C. Superior Court Juvenile Division, 9) Court Social Services, and many others.

- **Diverse Racial and Ethnic Initiatives**

  - ***My Brother's Keeper Initiative (MBK-DC)***- On January 16, 2017 Mayor Muriel Bowser launched the District of Columbia My Brother's Keeper initiative to provide programming targeting boys and young men of color in four (4) key areas: 1) education,
    2) justice, 3) health, and 5) job opportunities. Seeking to develop coalitions with public and private sector leaders, My Brother's Keeper DC is part of President Obama's MBK Community Challenge to implement evidence-based strategies that create equal opportunities for boys and young men of color. To represent and implement the values of the program, Mayor Bowser also designated Martin Luther King, Jr. Commissioners as My Brother's Keeper Ambassadors.

Mayor Bowser stated that "*from establishing the Ron Brown College Preparatory High School, to creating more opportunities for summer jobs through the expansion of the Marion Barry Summer Youth Employment Program, we have seen tremendous progress in reaching our boys and young men of color.*" She noted that "*we are doubling down on strategies that are making a difference in the lives of boys and young men of color, and through this initiative my Administration will continue to press forward in closing the gaps that still remain for far too many young men in our city."*

The Bowser Administration plans to bridge the opportunity gap in the following ways:

1. **Justice** - Elevate efforts to foster healthy and inclusive relationships between District youth and law enforcement officers.

2. **Education** - Renew urgency surrounding education reform and making the needed investments to prepare the next generation of Washingtonians for today's economy.

3. **Health** - Shape positive health identities by targeting all life circumstances and acknowledging that mental health is a fundamental element of well-being for positive development.

4. **Job Opportunities** - Invest in initiatives that connect the city's youth to jobs and opportunities to develop skills needed in the workplace

My Brother's Keeper DC will target three (3) types of partnerships: 1) **Fund**- leadership will contact private institutions, venture capital firms, and family philanthropists to provide capital; 2) **Grow**- Academic institutions and non-profits will provide technical assistance, data processing, and impact evaluation; and 3) **Support**- Community leaders, advisory board members, and other key partners will offer resources that allows initial successes to advance over time.

- **Services for Lesbian, Gay, Bi-sexual, Transgender, Questioning (LGBTQ) Youth and Young Adults**

  - ***Wanda Alston Foundation (WAF*)-** Advocates for increased resources for youth while providing programs including: housing, life skills training, linkages to other social services, and capacity building assistance for other community allies.

  - ***Supporting and Mentoring Youth Advocates and Leaders (SMYAL)-*** Some of the services include: 1) case management (development of personal action plan, weekly check-in meetings, and crisis navigation); 2) supportive services (medical care, mental health services, and self-care support); 3) skill development (education, job readiness, and life skills such as cooking, budgeting, etc.); 4) social support (community outings and access to LGBTQ youth networking); and 4) after-care (open line of post-program communication between the youth and their case manager for up to 12 months).

  - ***Transgender Health Empowerment, Inc. (T.H.E.)-*** Works to enhance the quality of life of the diverse transgender population by advocating for and supporting a continuum of health and social services. In fulfilling their mission, T.H.E. is the home of the Tyra Hunter Drop-In Center for transgender, gay, lesbian and bisexual youth, providing showers, laundry, clothing and food to the homeless. T.H.E. also operates transitional housing for gay, lesbian, bisexual and transgender youth.

  - ***Different Avenues*-** Provides services to youth and young adults who are homeless or living in unstable housing. Many of the clients are transgender, gay, lesbian or bisexual. It also assists youth who are parents and their families. The services include a drop-in center, HIV/AIDS prevention education, sexual health education, access to drug prevention and mental health services, peer-based leadership training and legal referrals.

- **Public Behavioral Health System Currently Organized at State Local Levels- Adult System**

  The Adult System is described in great detail under Criterion 1- Comprehensive Community-Based Mental Health Service Systems. An abbreviated summary is provided here. In its dual role as the State Mental Health Authority and the Single State Agency (SUD), DBH provides services and contracts with community providers for mental health rehabilitation services and supports and substance use disorder services and supports.

  The adult clinical services include: 1) DBH directs and manages mental health services at two (2) locations (35 K Street Northeast and 821 Howard Road Southeast); 2) the Adult Services Branch provides clinical assessment and treatment; 3) the Pharmacy Branch provides psychiatric medications for residents enrolled in the public behavioral health system who are uninsured and unable to pay for medications; 4) the Comprehensive Psychiatric Emergency Program Division provides emergency mental health services; 5) the Psychiatric Emergency Services Branch provides immediate access to multi-disciplinary emergency psychiatric services 24/7; 6) the Mobile Crisis/Homeless Outreach Branch responds to individuals in the community in psychiatric crisis and provides homeless outreach service visits; 7) the Access Help Line enrolls consumers into services and ensures District residents receive crisis services, as well as provides telephonic suicide prevention and other counseling as appropriate; 8) the Forensics Division provides and oversees behavioral health and other services for justice-involved individuals from pre-arrest to post-incarceration to ensure their successful return to the community; 9) the Assessment and Referral Center Division assess and refer adults seeking treatment for SUD to appropriate services and the Mobile Assessment and Referral Center visits communities throughout the District to conduct assessment, referral, and HEP-C and HIV testing; 10) the Consumer and Family Affairs Administration promotes the involvement of consumers, including family members and young adults, across the behavioral health system including a Peer Operated Drop-In Center and D.C. Certified Peer Academy; 11) the adult evidence-based programs include Assertive Community Treatment and the Supported Employment Program (partners include Department of Human Services, Rehabilitation Services Administration, and Department on Disability Services).

- **Prevention Activities**

  - ***National Capital Region Compact to Combat Opioid Addiction*-** The Mayor of the District of Columbia and the Governors of Maryland and Virginia have pledged to work collaboratively to help stop the damaging effects of opioid addiction on the lives of those addicted, their families, law enforcement, health care providers, and the broader community.

  - ***Prevention Centers*-** The DBH funds four (4) D.C. Prevention Centers (DCPCs) that are designed to strengthen the community's capacity to reduce substance use and prevent risk factors. The services include community education, community leadership, and community change.

- ***Combating Opioid Misuse within the HEP-C/HIV Population***- DBH substance use disorder staff attended this training event in September 2016. The presentations addressed the challenges in screening, treating and managing patient populations co-infected with Hepatitis-C, HIV, mental illness and opioid misuse.

- ***Prevention Symposium***- This activity was implemented in October 2016. The participants included DBH substance use disorder staff, prevention center staff, and other participants. The goal is to continue to build prevention related activities to address workforce, data, and expertise in the field issues.

- ***D.C. Epidemiological Outcomes Workgroup (DC EOW)***- The DC EOW goals will be sustained through local and Strategic Prevention Framework Partnership for Success funds. The emphasis on risk and protective factors increases an understanding that substance use and other aspects of behavioral health share many of the same risk and protective factors. Common risk factors predict diverse behavior problems including substance use, anxiety and depression, delinquency, violence, school dropout, and teen pregnancy.

  The DC EOW was expanded in FY 2016 in an effort to have a more robust group of stakeholders. Membership is made up of representatives from the following agencies: 1) Department of Health; 2) Department of Behavioral Health; 3) Child and Family Services Agency; 4) D.C. Metropolitan Police Department; 5) Criminal Justice Coordinating Council; 6) Alcohol Beverage Regulatory Agency; 7) Department of Consumer and Regulatory Affairs; 8) Children's National Health System; 9) D.C. Pretrial Services Agency; 10) Department of Transportation; 11) D.C. Hospital Association; 12) The Children's Trust; 13) Legacy Foundation: 14) DBH D.C. Prevention Center representative; and 15) Research Triangle Institute.

- **Recovery Coaching Training**

  - A 36-hour Recovery Coaching Training curriculum was developed in FY 2016 by the DBH substance use disorder staff. The proposed certification program began in FY 2017. The training prepares persons in recovery, recovery program staff, leaders of recovery provider organizations, peer specialists, and recovery coach candidates to implement recovery coaching skills and strategies within an array of recovery support services.

- **Adults, Young Adults and Youth Substance Use Campaigns**

  - ***The Blunt Truth (addresses marijuana use)***- While health effects associated with marijuana use can be equally applicable to adults, the *Blunt Truth* adult focus centers on the laws governing marijuana consumption in the District of Columbia. Materials point out the "cans" and "can nots," so that individuals can make informed decisions and stay within the realm of the law.

  - ***"Adult Synthetics" (addresses synthetic drug use among adults)***- The Adult Synthetics campaign clarifies that the purchase, sell, and use of synthetic drugs are illegal in the

District of Columbia. The campaign addressed designer drugs such as "Molly" and other drugs found to be popular among adults. The associated laws were made available through brochures, palm cards, and a website in order to inform as many adults as possible.

- ***"Opioid Awareness Campaign" (addresses opioid use among adults, young adults and youth)***- DBH is developing this campaign to raise awareness about the risks associated with opioid use and to direct individuals to help. Phase 1 targets adults, specifically older African American male heroin users age 40-69. Phase 2 targets youth and young adults to shed light on how the misuse of prescribed opioids can lead to addiction, be a gateway to more potent variations of opioids, or result in death.

- **Mayor's Office of Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Affairs**

  This is a permanent, cabinet-level office within the Office of Community Affairs in the Executive Office of the Mayor, established by statute in 2006 to address important concerns of the District's LGBTQ) residents. The District has one of the highest concentrations of LGBTQ residents in the country with an estimated 7 to 10% of the population being LGBTQ. The Office of LGBTQ Affairs works collaboratively with an Advisory Committee, appointed by the Mayor, to define issues of concern to the LGBTQ community and find innovative ways of utilizing government resources to help address these issues. This includes: 1) services are available for grant funding and business opportunities from the District Department of Small and Local Business Development; 2) community resources with links and publications including a directory of LGBTQ community organizations; 3) LGBTQ education and training; and 4) improving the treatment of LGBTQ residents by providing technical assistance.

- **Report on the Health of the Lesbian, Gay, Bisexual and Transgender (LGBT) Community in the District of Columbia 2011-2013**

  Some of the highlights from this District Department of Health report include:
  - 12.3% of high school youth identified as either lesbian, gay or bisexual;
  - LGBT adults were more likely than their non-LGBT counterparts to report 15-30 days of mental health not being good, which includes stress, depression and problems with emotions;
  - Non-LGBT adults were more likely than their LGBT counterparts to have a disability that required the use of special equipment;
  - 4.5% of adults who identified as non-LGBT reported that they have had sexual intercourse with someone of the same sex;
  - Non-LGBT adults were more likely than their LGBT counterparts to be physically inactive and obese;
  - LGBT adults were more likely than their non-LGBT counterparts to be binge drinkers and reporting that they have used either cocaine or heroin;
  - LGBT adults were more likely than their non-LGBT counterparts to be tested for HIV;

- LGBT adults were more likely than their non-LGBT counterparts to have engaged in high risk behaviors such as unprotected anal sex, therefore increasing their risk for HIV infection;
- LGBT adults were more likely than non LGBT adults to be treated for a STD within the past 12 months, use street/party drugs in the past 12 months and had sex with a partner other than a primary partner within the past 12 months; and
- LGBT adults were more likely than their non-LGBT counterparts to be diagnosed with asthma and depressive disorder.

- **Health Homes Initiative**

  The District Health Homes (HH) initiative is a joint effort by DBH and the Department of Health Care Finance. HH1 was launched in January 2016. HH2/ ***MyHealth GPS*** was launched in July 2017. The HH services include: 1) comprehensive care management; 2) care coordination; 3) health promotion; 4) comprehensive transitional care/follow-up; 5) patient and family support; and 6) referral to community and social support services.

- **Community Residential Facilities (CRFs)**

  The CRFs activities and residence include: 1) Mental Health Community Residence Facilities licensure; 2) Supportive Residence; 3) Supportive Rehabilitation Residence; Intensive Rehabilitative Residence; and 4) Transitional Residence.

- **Crisis Stabilization Beds**

  Provides a short-term, safe supportive living environment for consumers who do not require inpatient treatment for stabilization. DBH contracts with two (2) community providers for 15 crisis beds, 8 at Jordan House and 7 at Crossing Place.

- **Housing Programs**

  The housing programs include: 1) Home First Housing Subsidy Program; 2) Supported Independent Living Program; 3) D.C. Local Rent Supplement Program; and 4) Federal Voucher Programs.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state?s behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state?s unique data system (including community-level data), as well as SAMHSA?s data sets including, but not limited to, the **National Survey on Drug Use and Health** (NSDUH), the **Treatment Episode Data Set** (TEDS), the **National Facilities Surveys on Drug Abuse and Mental Health Services**, the annual **State and National Behavioral Health Barometers**, and the **Uniform Reporting System** (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorderprevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the **National Survey of Substance Abuse Treatment Services** (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the **Behavioral Health Barometers**. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the **Healthy People Initiative**[1] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[1] **http://www.healthypeople.gov/2020/default.aspx**

Footnotes:

An Evaluation of the Opioid Treatment System and Recommendations for Enhancements

Developed for the

District of Columbia Department of Behavioral Health

DC-104

October 2015

Prepared under the

Substance Abuse and Mental Health Services Administration
State Technical Assistance Project

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CONTENTS

I. Introduction

A. Purpose of the Technical Assistance

In March 2015, the Substance Abuse and Mental Health Services Administration (SAMHSA) assigned the State Technical Assistance Project a request for technical assistance (TA) from the District of Columbia. This report describes the TA delivered under the State TA Project in accordance with the request. Specifically, the State TA Project provided TA to evaluate the current opioid treatment system and guide the development of a work plan to modernize the system.

JBS International, Inc., is the State TA Project contractor and is a health and human services consulting firm based in North Bethesda, Maryland. JBS International contracted with Carolyn Baird and Cynthia Banfield-Weir to deliver the TA.

B. Consultants' Background

Carolyn Baird is a doctorally prepared nurse who is credentialed as a certified addictions registered nurse-advanced practice (CARN-AP) and a certified co-occurring disorders professional diplomate (CCDPD). She was a subject matter expert on the team that developed the certified co-occurring disorders provider credential for the state of Pennsylvania now administered by the International Certification and Reciprocity Consortium (IC&RC). She also participated as a subject matter expert in the development and revision of the content of the Medical Education and Support Services to Opioid Treatment Programs (MESSOTP) training and is a regular presenter of that training. At that time she also served as a subject matter expert for a planned Treatment Improvement Protocol (TIP)on methadone for nurses (not published).

Cynthia Banfield-Weir is a licensed independent clinical social worker and a board certified diplomate. She has 25 years of administrative and clinical supervision experience in community-based methadone programs in Massachusetts. She has been a surveyor for the Commission on Accreditation of Rehabilitation Facilities (CARF) for 18 years. She is an independent consultant specializing in licensing, accreditation, best practices, and training and has participated in writing best practices trainings for CSAT through DB Consulting Group. She has presented nationally on topics such as treatment planning, evidence-based practice performance improvement, and Medical Education and Support Services to Opioid Treatment Programs (MESSOTP).

II. Technical Assistance Summary

A. Methodology

This TA was developed so that one or more consultants would come to the District of Columbia to review the current status of the Medication Assisted Treatment (MAT) program for opioid use disorders, develop recommendations for implementation of Chapter 63 (Certification Standards for Substance Use Disorder Treatment and Recovery Providers) regulations, and assist in both expanding treatment capacity and integrating care throughout levels of treatment in specialized populations.

The consultants participated in one conference call with the Department of Behavioral Health (DBH) staff members for clarification of the identified needs and to develop a list of resources the consultants would review in preparation for the onsite visit. They reviewed the Chapter 63 Certification Readiness Review Tool, Chapter 63 draft document, Provider Readiness Findings and Business Readiness Plans for four providers, and Key Changes for Chapter 63.

The consultants visited the District of Columbia for 5 days to meet with key members of the DBH merger staff. They also visited the three MAT programs that are certified and have Human Care Agreements (HCAs) and one that is DBH certified but does not have an HCA. The consultants met with staff at each location to identify strengths, weakness, opportunities, and threats in their respective programs.

The consultants developed an initial assessment and recommendations and attended a debriefing with the DBH team.

B. Observations

The merger of the Department of Mental Health and the Department of Substance Abuse, to create DBH, and the rewrite of Chapter 63 have put the District of Columbia in a unique position to shape its delivery system. Concurrently, the Medicaid expansion has resulted in the development of some innovative projects such as the iCAMS (Integrated Care Applications Management System) electronic medical record (EMR). The EMR under development has the capacity to achieve the District's long-term goal of integrating care across the treatment continuum. The EMR system will allow all providers of one patient to communicate patient information in real time, assist in billing, and schedule the patient across treatment providers. A Medicaid Healthcare Common Procedure Coding System code has given the District the opportunity to develop billing codes that encourage opportunities for DBH to use and be reimbursed for clinical care coordination.

The influx of new staff in the merged department has brought new skills and ideas to enrich this initiative. The DBH team is motivated to assist providers in making the adjustment to Chapter 63. Some of the implementation at the department level is in place. Already, three integrated screening sites in the District of Columbia conduct on-demand screening and triage for any level of care. The strength of this system is that it offers one step for patients in accessing care. The screening team identifies which service is most appropriate and makes active referrals to these programs. In addition, transportation is offered to assist patients in getting to providers after referral. Ideas for the expansion of services include services for adolescents, specialized services for women, an overdose prevention project, and increased availability of a variety of MAT programs across all levels of care.

District of Columbia MAT providers have integrated counseling and case management within their programs. The ratio of patients to counselors is approximately 50:1. The providers are universally highly motivated to provide quality services. In some facilities, innovative approaches are being offered to deal with complex issues. All the facilities provide specialty groups. Programs are committed to quality services and ensuring the safety of their patients. Programs have already responded to DBH feedback about reducing the amount of time taken to admit patients in MAT services after initial screening. Some of the programs have been socially

and politically active in increasing treatment access for patients, in encouraging other clinics to improve their practice, and in improving the public's perception of MAT programs. Three of the programs in the District of Columbia have achieved 3-year CARF accreditation. The consultants were impressed with the innovation and creativity demonstrated at some programs. For example, The District of Columbia area has an active heroin task force that includes many different disciplines whose mission is to use a team approach to address the heroin problems in the District.

DBH and the providers are facing a number of challenges. For example, the MAT culture has been in place for a long time, which has made it difficult to introduce alternative treatment approaches. Also, some programs operate in isolation addressing only one aspect of the patient's presentation with minimum collaboration between organizations. This approach can make ensuring that all providers are working toward a common goal with patients difficult to achieve. In addition, there is great confusion in the programs about the operationalization of the new Chapter 63 regulations. Program staff feel overwhelmed and frustrated with parts of the new regulations and noted that DBH's implementation process has not provided them with enough specific guidance to operationalize services at the program level. The result is program staff becoming reacting negatively to the regulations rather than reaching out to the DBH credentialing staff for additional support and clarification. During the consultants' site visits, some staff expressed questions that were troubling to them but had never contacted DBH for guidance.

It does not appear that DBH has conducted consistent audits of the providers on a regular basis using the standards laid out by the previous regulations. Without the audit process, the providers have no feedback with which to evaluate their practice. Also, there are some areas in the DBH system that are not sufficiently integrated. For example, the department that credentials the programs does not do the audits that inform credentialing of an organization's compliance with regulatory requirements. In addition, staff in the credentialing department depend on the audit department to keep them informed of sentinel events in programs. Without integration and close collaboration, the credentialing department cannot use its process of corrective action plans to shape provider performance.

The current Chapter 63-suggested ratio of a 1:150 staff-to-patient ratio for case management caseloads is not realistic for providing quality services. Counseling and case management are blended. Although regulations permit supervisors to supervise up to 10 staff with up to 300 patients, most of the programs report a much lower staffing ratio. The supervisors already sign off on all their counseling staff treatment plans and assessments and oversee patient care. The clinical care coordinator position mandated in the new Chapter 63 regulations has a 1:75 staff-to-patient ratio, which presents a problem for the programs. Each supervisor oversees the cases assigned to his/her supervisees. Any coordination of care or case management is provided by each clinician.

The new construction of the clinical care coordinator position cannot be adapted to the treatment system. The programs would have to have each supervisor assigned to 75 cases, which would require programs with 700 patients to have 9.3 clinical care coordinators. The regulations permit only the doctor or supervisory level staff to act in this role. Complicating the effort to understand the position is the inclusion of the medical director as a potential clinical care coordinator. Doctors represent a significant cost to the clinic, and although they have responsibility for all patients they do not directly supervise staff and sign off on treatment plans. Programs cannot afford to have a doctor do case coordination with 75 patients. Programs cannot hire more than one clinical care coordinator; the providers do not know how to conform to this regulatory change.

If the case manager caseload is set at 50 patients instead of 150 according to Chapter 63, the supervisor would not be overseeing an excessive number of patients. Most of the providers had significantly fewer than 10 counselors assigned to each supervisor. The caseloads are around 50–60 per clinician in all the sites. Given the way clinics operate, the natural person to be the clinical care coordinator is the supervisor. If each supervisor supervises 5 staff with a case load of 50, the supervisor is responsible for a total of 250 patients. Within that framework it is conceivable that each supervisor would have about 75 patients who meet the criteria of needing clinical case coordination. The clinical case coordinator as defined by Chapter 63 is

primarily one of oversight, ensuring that each patient who reaches a critical acuity receives this service. The clinical care coordinator under the current definition should do the initial assessment and diagnostic visit.

DBH staff state that there are not enough qualified individuals for potential hires. They are in need of certified staff to provide the services in accordance with evidence-based practices and Chapter 63. It was noted that staff at the clinics were identified as CAC l and CAC ll, which are credentials for certified addiction counselors administered by the Department of Health. Some programs have advertised for new staff but have been unable to afford hiring them at the requested or expected salary level.

Integration between levels of care is an area that needs attention. Some of the programs did not have efficient treatment networks. For example, one of the sites had the patients seek out their own prenatal care. The women resisted going to an obstetrician–gynecologist, however, because many of them did not feel MAT patients were welcome.

DBH reported a problem with intake admissions being delayed. The screening team found that there was a significant delay in patients being admitted into a MAT program. In some cases, patients had to wait for 2 weeks. DBH sent a letter to the providers informing them that this problem needed attention. Since that time the providers have improved their admission procedures and significantly reduced admission waiting time. However, it might be prudent to make some changes in the process to prevent future difficulty.

Finally, DBH staff believe they do not have the system capacity to serve their adolescent clients. They are concerned that adolescents who need services do not access them.

C. Recommendations

The DBH team must define the expectations for the clinical care coordinator position in terms of behaviors. A clear, detailed definition should be developed and written, along with a frequently asked questions (FAQ) sheet. Once this is done, providers should review the definition and give feedback regarding their understanding of how to structure the position. Once everyone understands the description and functions of the position, the DBH team should conduct an audit of patient charts to determine if the position is being used as intended.

DBH should develop an audit tool that is reflective of the complete Chapter 63 regulations. This document should add specific duties to job descriptions. If DBH wants the clinical care coordinator to work with only acute cases, a system for calculating which patients qualify for clinical care coordination based on patient acuity should be developed.

DBH has options for alleviating the issue of a restricted workforce pool. For example, the department may want to consider a training program that would prepare staff in qualifying for additional credentials. Also, DBH may choose to expand its clinician requirements to open up the pool of certification bodies. The Addiction Nursing Certification Board administers the CARN and the CARN-Advanced Practice certifications. Using substance abuse professionals from all disciplines would broaden the pool of potential employees. The District of Columbia Addiction Professional Consortium is a member board of IC&RC, which provides certification for addiction professionals. IC&RC currently offers the Certified Alcohol and Other Drugs of Addiction Counselor, the Certified Advanced Alcohol and Other Drugs of Addiction Counselor, and the Certified Prevention Specialist. IC&RC has additional credentials, such as Certified Co-occurring Disorders Professional and Certified Co-occurring Disorders Professional Diplomate that would be appropriate in this integrated system.

Other credentialing bodies and other credentials also provide staff with the appropriate level of training. Psychologists have the American Psychological Association Certificate of Proficiency in the Treatment of Alcohol and other Psychoactive Substance Use Disorders. Nursing has the Addiction Nursing Certification Board. The District of Columbia Addictions Professional Consortium is another option and offers credentials for both levels of addiction counseling as well as the Prevention Specialist Credential. Although the consortium does not offer the co-occurring disorders professional credentials (CCDP and CCPDP), it is an IC&RC member board and may make it possible for IC&RC to provide these credentials in the District of

Columbia. DBH is urged to advocate with legislative bodies to aquire deemed status for these certifications and those of other disciplines.

With the help of DBH leadership, the clinics should be encouraged to sign memorandums of agreement with referral sources that are known to work well with this patient population. Providers should be encouraged to reach out to their referral sources to ensure that patients get the best care possible. In one clinic, for example, patients were returning from residential programs without any discharge paperwork or other information to inform the clinic what kind of services they had received. Sometimes the clinic did not know whether the patients had been given methadone on the return date, as no arrangements had been made with the program.

Facilities must establish procedures to ensure that clinical information is communicated between providers. DBH could provide training on continuity of care and interacting with other services. This training could also help organizations develop an interagency transition/discharge document and give examples of policies and procedures that support best practice in this area. These activities will assist DBH in moving beyond the SAMHSA definition of Level 1 integration of the treatment system (see Appendix).

To prevent future problems occurring with the intake admission process while acknowledging the importance of physician time in intake scheduling, the three MAT providers could arrange their schedules so that at least one clinic was staffed with a doctor each day of the week. If necessary a patient could be admitted to the clinic that had the physician available. In the event that the patient needed an alternative site, a transfer could be arranged so the patient could dose in his or her intended home clinic the next day.

Alternatively, each clinic could be assigned a day to do emergency intakes. That particular clinic would receive all the referrals that day from the intake screening unit. The clinics may need to set aside time for emergency admissions.

Some of the issues DBH faces can be addressed by initiating a monthly provider meeting. The primary function of this meeting is to keep provider leadership fully informed about what is expected and include this group in planning any changes. To move providers to integrate care, this meeting could be a forum for solving problems among agencies (e.g., the issue of patients arriving with no discharge plan could be addressed).

Another topic for a monthly meeting is how DBH can assist providers in achieving adequate communication among all parts of a person's treatment. Admission and discharge practices could be discussed so that the providers know whether they are meeting the admission-within-24-hours benchmark. New best practices in the field can be shared with all attendees, and DBH can regularly reinforce its standards and goals. Further, providers should have the opportunity to bring their problems with integration of patient care to this group for problem solving. Providers who are developing a new service or have innovative programming should be invited to share this with their peers. Meeting minutes should be completed and shared with all providers. The provider meeting could also include an educational function so that all members are informed about all levels of care. Additional information about MAT may help curb some of the stigma experienced by MAT patients in other levels of care.

In 2011 the District of Columbia lost all its specialized women's services due to an administrative change in service delivery; however, the newly formed DBH is working toward making available more services for women. There are some newly certified residential programs for women and children. In addition, DBH is working on a memorandum of understanding with the Child and Family Services Agency that would allow for more streamlined treatment for women leaving incarceration.

It is recommended that DBH increase the system capacity to serve adolescent clients by developing a mobile therapy program that can provide mobile screening and counseling. Adolescents can have difficulty accessing transportation, and treatment may be best offered in the schools. A model for such a program is Holy Family Institute in Pittsburgh, Pennsylvania. A description of their service model is available on the Institute's website: http://www.hfi-pgh.org/.

DBH may want to develop a Student Assistance Program (SAP) in conjunction with the Department of Education to increase the number of adolescents who come into treatment. A peer-to-peer program could be

established as part of the SAP, and a peer-to-peer pilot may be helpful to determine if such a program would engage more adolescents in treatment. The SAP in Pennsylvania, for example, supports and assists school staff in helping students overcome barriers to learning; drug and alcohol problems are often identified. The SAP has set up peer-to-peer support, and peers also offer intervention and education in the schools. This would be a good way for DBH to use the newly trained prevention specialists on its staff. Additionally, pairing adolescent screening with needle exchange may lead to more people in this age group following up and receiving services.

DBH should encourage all providers and related agencies to take advantage of the many free resources for professional trainings by obtaining and disseminating information, maintaining a database of training opportunities, and arranging trainings.

It is recommended that the iCAMS electronic medical record be used to hold patients accountable for their own care. As in most areas, MAT patients in the District of Columbia tend to cycle through the programs. This can result in patients being unable to move beyond their current level of drug dependence because each treatment episode is considered alone without the input from previous service providers. One of the programs visited by the consultants demonstrated a state-of-the-art policy for retention of these often nonadherent patients. This program required the patient to come to a group daily rather than pursue an administrative discharge for program nonadherence. Program staff discovered that this approach reduced the dropout and administrative discharge rates. In addition, ongoing evaluation of utilization rates, access delays, open assessments, and current census rates are a few of the types of information that can be gathered through iCAMS and monitored by DBH.

It is important for quality improvement that ongoing evaluation and reevaluation be conducted at the program level.

D. Outcomes

Short Term:

S1 immediate—The DBH team will have a regular monthly meeting to discuss progress on its mission and strategic plan. This meeting will develop minutes that are distributed to all members of the team. The team could use this body as a working group by assigning various members specific projects from month to month that could be reported out to the greater team.

S2 immediate—DBH has a definition of the clinical care coordinator that clarifies what the position actually is expected to do and specifically how this is to be operationalized at the clinic level. A written description and an FAQ sheet will be developed and given to the providers.

S3 immediate—DBH uses the American Society of Addiction Medicine's National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use as the resource for guiding evidence-based practice in the opioid treatment programs.

S4 immediate—The DBH team has written long-term goals for services in the District of Columbia.

S5 immediate—The strategic goals for 2015 have been reviewed and brought into concurrence with the principles and philosophy of the DBH team.

S6 3 months—The DBH team has evaluated the current level of treatment services in comparison to where the team would like them to be.

S7 3 months—The DBH team has informed the providers of the direction that the department intends to take.

S8 3 months—DBH has a document/checklist that includes all elements of the Chapter 63 regulations and has shared it with the providers.

S9 3 months—A schedule for regular provider audits is in place and has been communicated to providers.

S10 3 months—As a first step, providers should conduct an audit of their own programs and submit their findings and corrective action plan to DBH. The consultants urge the DBH team to emphasize to the providers that this is a change process. Providers may fail and will need to solve problems to reach the objectives set by the District of Columbia. Members of the DBH team should clarify that they are looking for effort in the providers' attempts to meet the standards as a first step. It is not expected that all providers will be able to meet the standards the first time around.

S11 3 months—DBH will bring together the leadership of all the programs the department oversees for a monthly provider meeting. The attendees should be individuals who can effect change in their agencies. This meeting would be chaired by the administrator at DBH. The first step is to define for the meeting what the overall strategic plan of DBH is. Also, the DBH goals for the current year should be spelled out clearly in writing and delivered to providers. A major initiative is the integration of care.

S12 3 months—DBH will own the locus of authority and understand that leadership comes from its office. DBH is the leader of the treatment community.

S13 3 months—DBH will identify the variety of substance abuse credentials available across all practice disciplines and explore the potential for expanding the workforce pool through the expansion of qualified credentials.

S14 3 months—DBH will complete current efforts to establish an agreement with Family Court for treatment and housing programs for women.

S15 3 months—DBH will complete a roster of referral sources knowledgeable about substance use disorders and integrate it into the iCAMS electronic medical record for ease of use by all providers.

Medium Term:

Medium (M)1—DBH staff should conduct the next audit. Staff are reminded that they should use the audit process as a method for shaping the treatment in their community. The regulatory team may want to review their goals and strategic plan with an outside entity to ensure that these features are communicated clearly. This activity should also include a review of the DBH credentialing audit tool.

M2 6 months—DBH has explored options for agencies with HCAs to provide suboxone services to patients. This exploration includes clarifying for providers what the requirements for such a program are.

M3 6 months—DBH has learned what the requirements for Vivitrol are, reviewed this information, and considered it not only from the standpoint of the barriers providers would face but also from the advantages of offering alternative MAT medications.

M4 1 year—The provider meetings and the DBH audit process will raise treatment integration to SAMHSA's Level 2 (coordinated). The SAMHSA-defined level of care describes a treatment system that, although not located in the same building, communicates about shared patient care.

M5 1 year—The regulatory body uses the audit process to ensure that MAT is not an exclusionary criterion for any level of care.

M6 1 year—DBH has contacted DB Consulting Group about scheduling the MESSOTP training currently sponsored by SAMHSA and being given around the country. This training updates all substance use disorder providers in state-of-the-art evidence-based MAT treatment.

M7 1 year —DBH has all providers taking advantage of training opportunities to increase knowledge and skills. The Providers' Clinical Support System for Opioid Therapies (or PCSS-O) and the Providers' Clinical Support System for Medication Assisted Treatment (or PCSS-MAT) are good sources for free webinars.

Long term:

(L)1 5 years—DBH uses the audit for certification of providers to reinforce the District of Columbia's long-term goal of achieving at least Level 5 integration (see Appendix). This is a very long-term goal and should be developed by shaping communication with the provider network using small steps.

L2 5–10 years—DBH actively works toward the integration of substance abuse and mental health services. This might require providers of the two disciplines co-locating together and combining service requirements.

L3 1–3 years—In conjunction with the courts, DBH has streamlined the services that are required of patients to eliminate the need for ex-offenders to become "professional patients" because of the number of daily requirements that can be given as a result of their being served by multiple agencies.

L4 ongoing—DBH actively advocates for legislative relief of the requirement in MAT that only a doctor can do admissions. Alternative professionals such as advanced practice registered nurses and physician assistants could complete this function with medical oversight.

L5 ongoing—DBH is committed to providing ongoing guidance to its providers so as to encourage best practices for MAT patients.

APPENDIX

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet ill-defined team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

Table 2A. Six Levels of Collaboration/Integration (Key Differentiators)

COORDINATED		CO-LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Key Differentiator: Clinical Delivery					
▸▸ Screening and assessment done according to separate practice models ▸▸ Separate treatment plans ▸▸ Evidenced-based practices (EBP) implemented separately	▸▸ Screening based on separate practices; information may be shared through formal requests or Health Information Exchanges ▸▸ Separate treatment plans shared based on established relationships between specific providers ▸▸ Separate responsibility for care/EBPs	▸▸ May agree on a specific screening or other criteria for more effective in-house referral ▸▸ Separate service plans with some shared information that informs them ▸▸ Some shared knowledge of each other's EBPs, especially for high utilizers	▸▸ Agree on specific screening, based on ability to respond to results ▸▸ Collaborative treatment planning for specific patients ▸▸ Some EBPs and some training shared, focused on interest or specific population needs	▸▸ Consistent set of agreed upon screenings across disciplines, which guide treatment interventions ▸▸ Collaborative treatment planning for all shared patients ▸▸ EBPs shared across system with some joint monitoring of health conditions for some patients	▸▸ Population-based medical and behavioral health screening is standard practice with results available to all and response protocols in place ▸▸ One treatment plan for all patients ▸▸ EBPs are team selected, trained and implemented across disciplines as standard practice
Key Differentiator: Patient Experience					
▸▸ Patient physical and behavioral health needs are treated as separate issues ▸▸ Patient must negotiate separate practices and sites on their own with varying degrees of success	▸▸ Patient health needs are treated separately, but records are shared, promoting better provider knowledge ▸▸ Patients may be referred, but a variety of barriers prevent many patients from accessing care	▸▸ Patient health needs are treated separately at the same location ▸▸ Close proximity allows referrals to be more successful and easier for patients, although who gets referred may vary by provider	▸▸ Patient needs are treated separately at the same site, collaboration might include warm hand-offs to other treatment providers ▸▸ Patients are internally referred with better follow-up, but collaboration may still be experienced as separate services	▸▸ Patient needs are treated as a team for shared patients (for those who screen positive on screening measures) and separately for others ▸▸ Care is responsive to identified patient needs by of a team of providers as needed, which feels like a one-stop shop	▸▸ All patient health needs are treated for all patients by a team, who function effectively together ▸▸ Patients experience a seamless response to all healthcare needs as they present, in a unified practice

Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

Table 2B. Six Levels of Collaboration/Integration (Key Differentiators, continued)

COORDINATED		CO-LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Key Differentiator: Practice/Organization					
▸▸ No coordination or management of collaborative efforts ▸▸ Little provider buy-in to integration or even collaboration, up to individual providers to initiate as time and practice limits allow	▸▸ Some practice leadership in more systematic information sharing ▸▸ Some provider buy-into collaboration and value placed on having needed information	▸▸ Organization leaders supportive but often co-location is viewed as a project or program ▸▸ Provider buy-in to making referrals work and appreciation of onsite availability	▸▸ Organization leaders support integration through mutual problem-solving of some system barriers ▸▸ More buy-in to concept of integration but not consistent across providers, not all providers using opportunities for integration or components	▸▸ Organization leaders support integration, if funding allows and efforts placed in solving as many system issues as possible, without changing fundamentally how disciplines are practiced ▸▸ Nearly all providers engaged in integrated model. Buy-in may not include change in practice strategy for individual providers	▸▸ Organization leaders strongly support integration as practice model with expected change in service delivery, and resources provided for development ▸▸ Integrated care and all components embraced by all providers and active involvement in practice change
Key Differentiator: Business Model					
▸▸ Separate funding ▸▸ No sharing of resources ▸▸ Separate billing practices	▸▸ Separate funding ▸▸ May share resources for single projects ▸▸ Separate billing practices	▸▸ Separate funding ▸▸ May share facility expenses ▸▸ Separate billing practices	▸▸ Separate funding, but may share grants ▸▸ May share office expenses, staffing costs, or infrastructure ▸▸ Separate billing due to system barriers	▸▸ Blended funding based on contracts, grants or agreements ▸▸ Variety of ways to structure the sharing of all expenses ▸▸ Billing function combined or agreed upon process	▸▸ Integrated funding, based on multiple sources of revenue ▸▸ Resources shared and allocated across whole practice ▸▸ Billing maximized for integrated model and single billing structure

Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

Table 3. Advantages and Weaknesses at Each Level of Collaboration/Integration

COORDINATED		CO-LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Advantages					
▸▸ Each practice can make timely and autonomous decisions about care ▸▸ Readily understood as a practice model by patients and providers	▸▸ Maintains each practice's basic operating structure, so change is not a disruptive factor ▸▸ Provides some coordination and information-sharing that is helpful to both patients and providers	▸▸ Colocation allows for more direct interaction and communication among professionals to impact patient care ▸▸ Referrals more successful due to proximity ▸▸ Opportunity to develop closer professional relationships	▸▸ Removal of some system barriers, like separate records, allows closer collaboration to occur ▸▸ Both behavioral health and medical providers can become more well-informed about what each can provide ▸▸ Patients are viewed as shared which facilitates more complete treatment plans	▸▸ High level of collaboration leads to more responsive patient care, increasing engagement and adherence to treatment plans ▸▸ Provider flexibility increases as system issues and barriers are resolved ▸▸ Both provider and patient satisfaction may increase	▸▸ Opportunity to truly treat whole person ▸▸ All or almost all system barriers resolved, allowing providers to practice as high functioning team ▸▸ All patient needs addressed as they occur ▸▸ Shared knowledge base of providers increases and allows each professional to respond more broadly and adequately to any issue
Weaknesses					
▸▸ Services may overlap, be duplicated or even work against each other ▸▸ Important aspects of care may not be addressed or take a long time to be diagnosed	▸▸ Sharing of information may not be systematic enough to effect overall patient care ▸▸ No guarantee that information will change plan or strategy of each provider ▸▸ Referrals may fail due to barriers, leading to patient and provider frustration	▸▸ Proximity may not lead to greater collaboration, limiting value ▸▸ Effort is required to develop relationships ▸▸ Limited flexibility, if traditional roles are maintained	▸▸ System issues may limit collaboration ▸▸ Potential for tension and conflicting agendas among providers as practice boundaries loosen	▸▸ Practice changes may create lack of fit for some established providers ▸▸ Time is needed to collaborate at this high level and may affect practice productivity or cadence of care	▸▸ Sustainability issues may stress the practice ▸▸ Few models at this level with enough experience to support value ▸▸ Outcome expectations not yet established

Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

Substance Abuse and Mental Health Services Administration

SAMHSA

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District of Columbia

Opioid STR Needs Assessment

Grant # 1 H79 TI080229-01

July 31, 2017

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Brief Overview: The District & The National Opioid Epidemic

The District of Columbia is an urban environment located on 61 square miles of land with an estimated 681,170 residents (2016). The city is divided into four heterogeneous quadrants and 8 Wards, of unequal size and population. As of 2016, the District was 47.7% African American Alone, 45.6% White Alone, 10.9% Hispanic or Latino (of any race), and 4.1% Asian Alone—with a significant geographic disparity. The median household income for 2011-2015 was $70,848 but 17.3% of the population was living in poverty.[i] Moreover, because of the District's proximity to Maryland and Virginia, individuals flow freely between the three jurisdictions, particularly persons who inject drugs. This overview informs the nature of the opioid problem as well as the DC Department of Behavioral Health's (DBH) planned response.

On a national scale, the opioid epidemic is unprecedented. For 2015, SAMHSA's National Survey on Drug Use and Health reports 871,000 past-year users of heroin[ii] and 3.8 million misusers of pain relievers.[iii] In the District, the same survey reports 3,000 heroin users (there are no state-level estimates of non-medical use of pain relievers).[iv] Among high school students, YRBS shows that 4.6% of students report past-year heroin use and 13.5% report past-year non-medical use of prescription pain medications. While the District has had a long-standing population of heroin users, which has remained largely constant over the decades, these youth statistics are troubling (and are the impetus for youth-focused prevention in the District). Moreover, the District's Office of the Chief Medical Examiner (OCME) reports that opioid overdose deaths nearly tripled between 2013 and 2016, from 83 to 216.

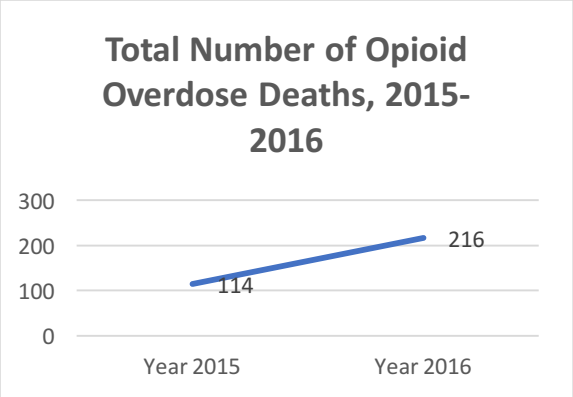
National data also show that the District's treatment system is feeling the consequences of increased opioid abuse. According to TEDS, the number of treatment admissions for heroin in the District increased from 1,187 in 2013 to 1,517 in 2015 (28%). TEDS also reports that admissions for non-heroin opiates more than doubled between 2013 and 2015, from 47 to 112. While much smaller in absolute terms, this is still a disconcerting trend. This report examines the District's opioid situation in more detail in an effort to assess needs using District-level data.

Opioid-Involved Overdoses: Fatal & Non-Fatal

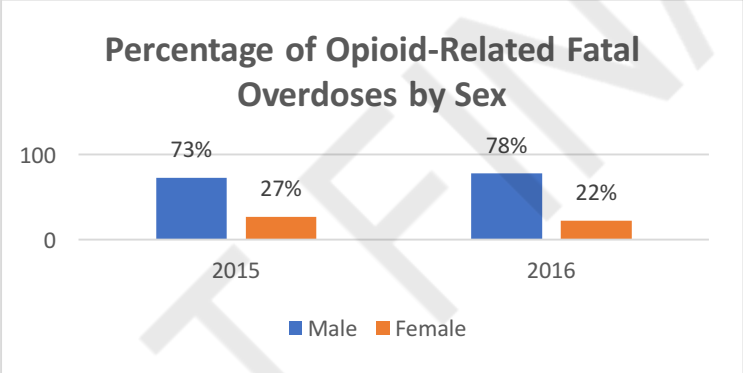
Fatal Overdoses

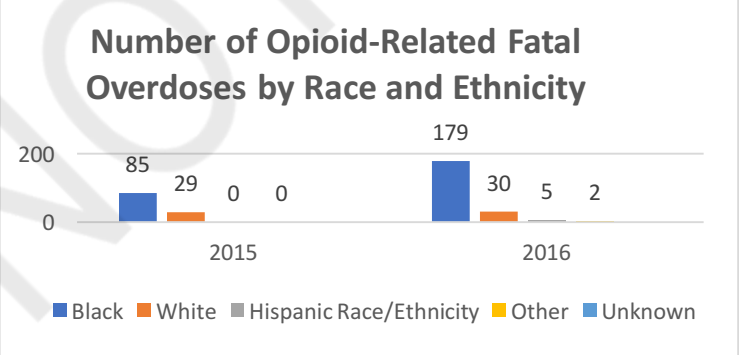
According to the DC Office of the Chief Medical Examiner (OCME) there were 114 opioid-related fatal overdoses in 2015 and 216 such deaths in 2016, an 89% increase.[v] In fact, there were only 83 fatal overdoses in 2013, indicating a 160% increase over three years. Based on U.S. Census estimates, these figures translate to 31.71 fatal overdoses per 100,000 for 2016.[vi]

As of this writing, DBH was able to obtain data only for January and February of 2017, in which OCME recorded 24 opioid related deaths. However, given the small sample size, we will not extrapolate those numbers into a declining rate for 2017.

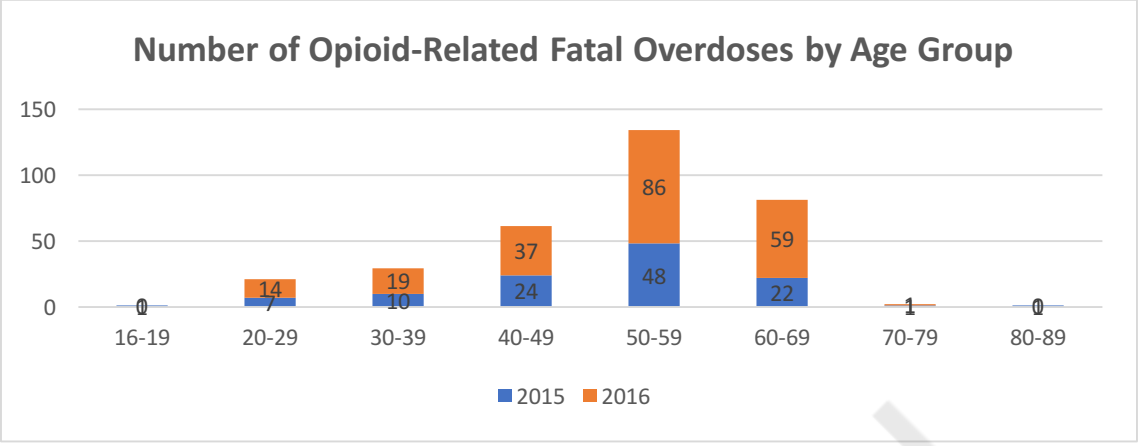


As indicated in DBH's STR proposal, fatal overdoses have been concentrated among older, African American males. Men constituted 73% of the 114 fatal opioid overdoses in 2015 and 78% of such overdoses in 2016. African Americans accounted for 75% of fatal opioid overdoses in 2015 and 83% of those fatalities in 2016.

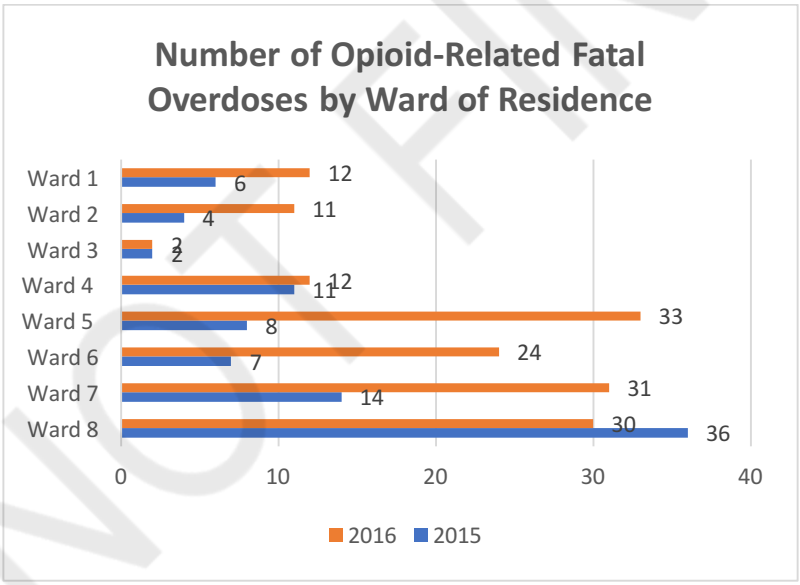




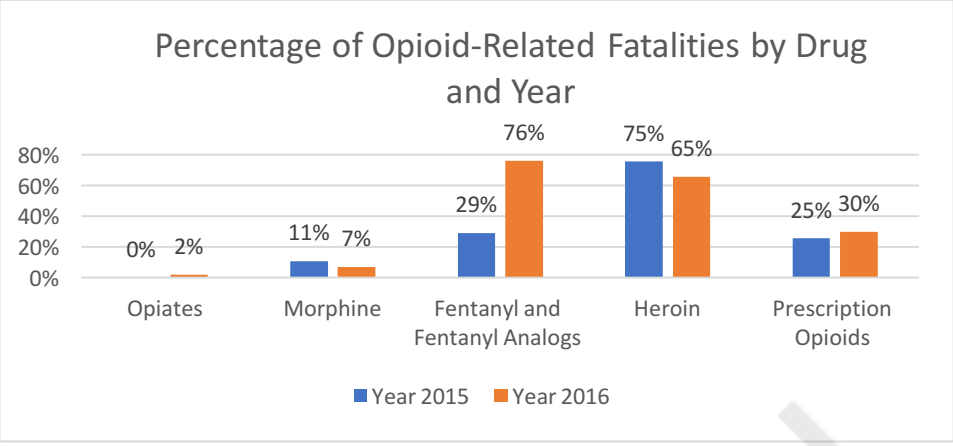
In 2016, individuals between the ages of 50 and 69 accounted for 67% of the fatal opioid overdoes (40% in the 50-59 age group; 27% in the 60-69 age group), demonstrating that the District's fatal overdoses are skewing towards older residents. In contrast, the 30-39 age group accounted for 8% and the 20-29 age group accounted for only 6%.



Data from OCME also reveal important geographical variation in fatal opioid overdoses, indicating that Wards 5, 7, and 8 collectively account accounted for 44% (n=95) of the fatal opioid overdoses in 2016. Notably Ward 6 saw a significant increase in fatalities from 2015 to 2016 (almost equaling the rate in Wards 5, 7 & 8), while Ward 8 experienced a small reduction over the same period. Fatality data indicate that Wards 5, 7, 8 and 6 are at the greatest risk.



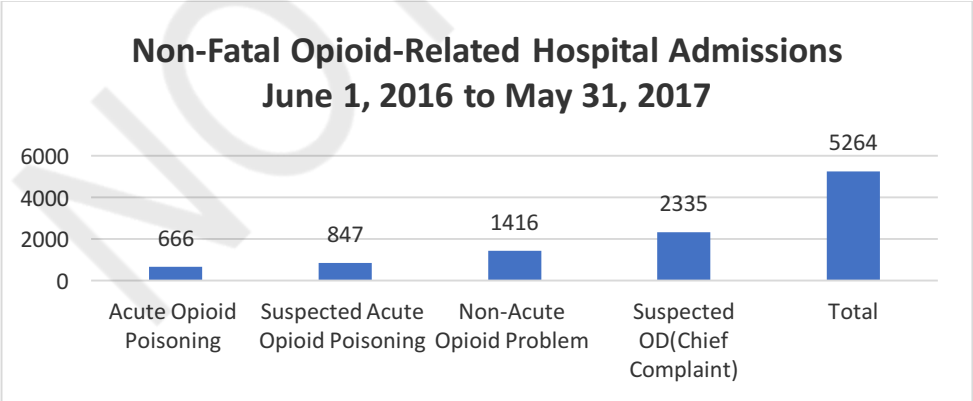
Importantly, the specific drugs detected among fatal overdose victims changed between 2015 and 2016. Heroin was present in 75% of the fatal overdoses in 2015 but only 65% of fatal overdoses in 2016. In contrast, the presence of fentanyl and its analogs increased dramatically over the same period, from 30% in 2015 to 76% in 2016. And prescription opiates were involved with a larger absolute number of overdoses in 2016 than 2015, but accounted for roughly similar (albeit growing) percentage in both years (25% in 2015; 30% in 2016). These data indicate that fentanyl constitutes the single largest fatal overdose threat, followed closely by heroin. However, these findings also indicate that most individuals who overdose are using many kinds of opiates, as more than one drug is usually present in each case.



OCME data also show that methadone was present in the largest share of fatalities involving a prescription opioid—in 2015 (n=9) and 2016 (n=20)—indicating that methadone may be utilized as a drug of abuse or, alternatively, that individuals enrolled in methadone MAT may be overdosing on other opioids while still taking their prescribed methadone. Buprenorphine was also present in four fatal overdoses in 2015 and seven fatal overdoses in 2016. The implications of these findings are discussed in more detail in under Opioid Service Gaps.

Non-Fatal Overdoses

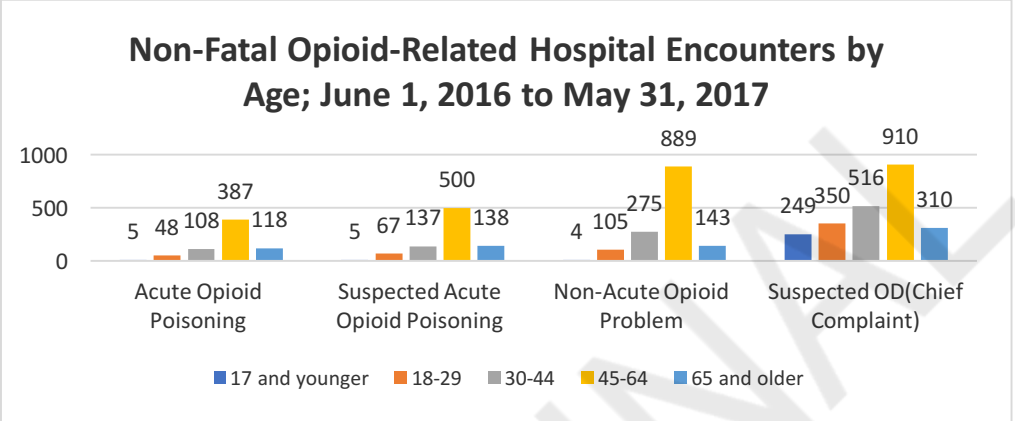
In addition to data on fatal overdoses, the District also collects data on non-lethal opioid-related admissions at eight primary hospitals in the city.[1] In the 12-month period between June 1, 2016 and May 31, 2017, there were 666 incidents of acute opioid poisoning, 847 incidents of suspected acute opioid poisoning, 1,416 incidents of a non-acute opioid problem, and 2,335 incidents of a suspected overdose-related complaint.[2]

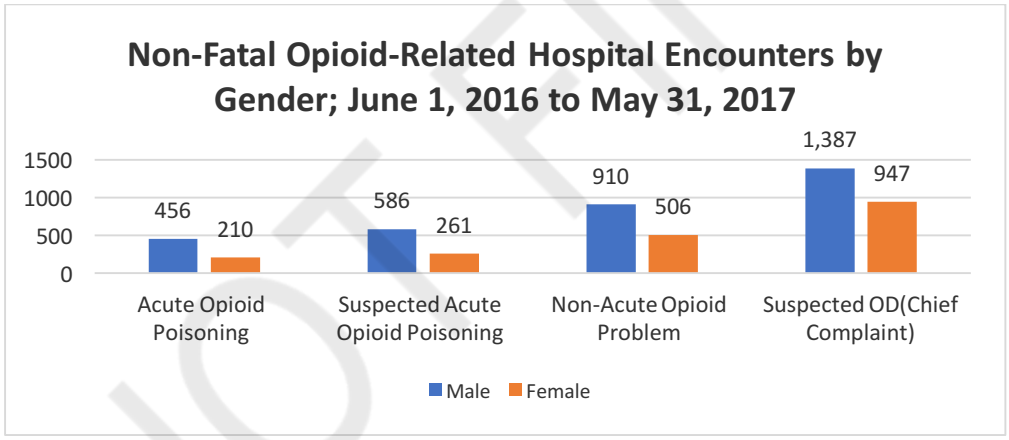


[1] Howard University Hospital does not record data at the same level of detail as others. All of Howard's 413 potential opioid-related incidents are therefore recorded only as "suspected overdose related complaint."

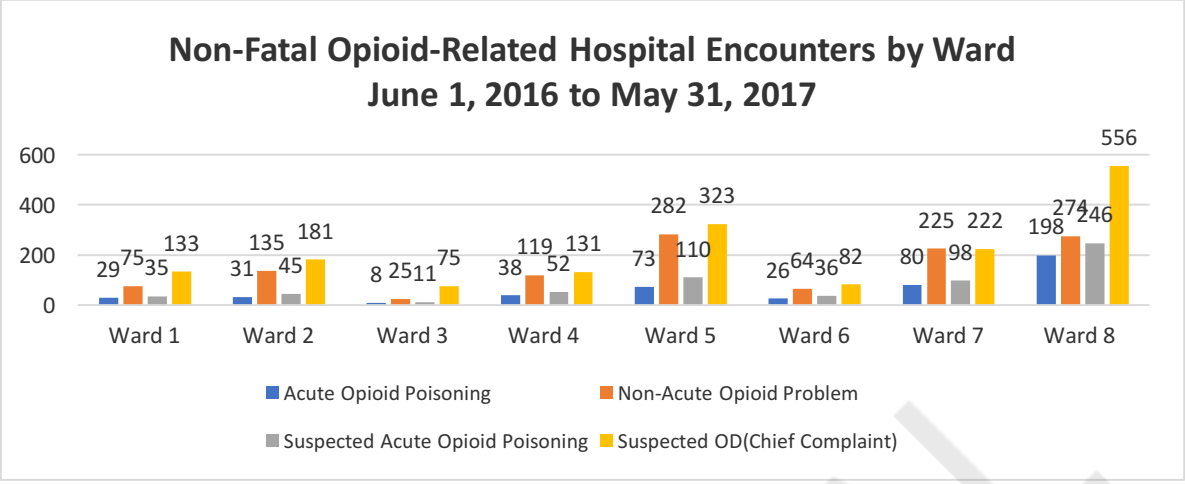
[2] "Acute opioid poisoning" indicates that opioid poisoning was the discharge diagnosis code; "suspected acute poisoning" is a non-poisoning opioid discharge diagnosis code and overdose/unresponsiveness/poisoning as the chief complaint; "Non-acute opioid problem" is a non-poisoning opioid discharge diagnosis code without overdose/unresponsiveness/poisoning in the chief complaint; and "suspected overdose-related complaint" is overdose/unresponsiveness/poisoning in the chief complaint but no explicit opioid diagnosis.

Non-fatal overdoses appear to adhere largely to the demographic trends observed for fatal overdoses. Non-fatal overdoses are significantly more common in the 45-64 age group, with individuals in that range accounting for 58% of the acute overdoses and 59% of the suspected acute poisonings. Similarly, males accounted for 68% of confirmed acute opioid poisoning incidents and 69% of suspected acute poisonings. Hospital data do not currently allow for accurate reporting on race/ethnicity.

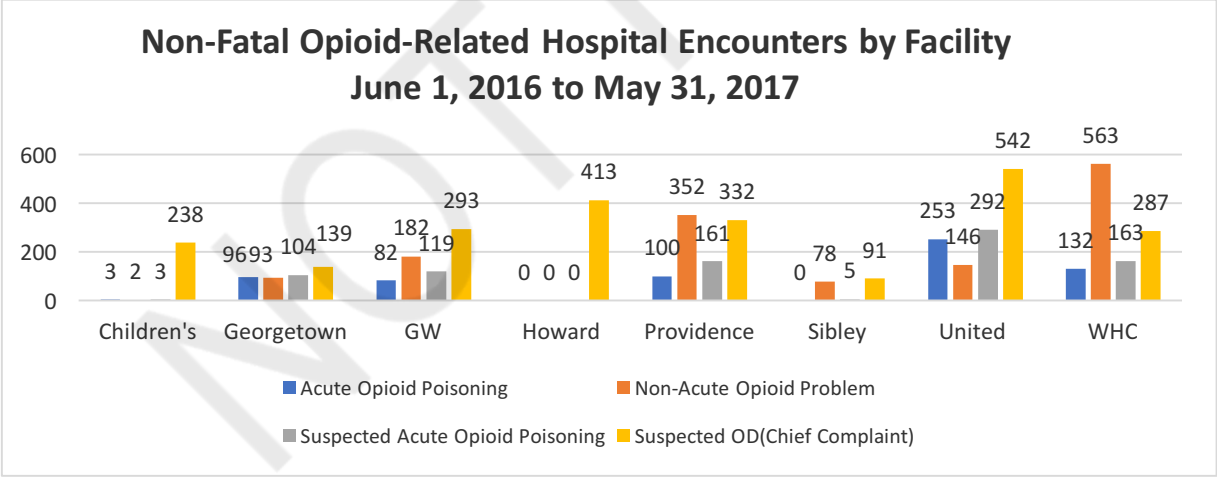




Geographically, non-fatal overdoses were broadly similar to fatal overdoses—concentrated in Wards 5, 7, and 8. Together, those 3 wards accounted for 53% of acute opioid poisonings and 54% of suspected acute opioid poisonings (only slightly larger than their collective share of fatal overdoses). Notably, however, Ward 8 had significantly more non-fatal overdoses than any other ward, despite having roughly similar numbers of fatal overdoses to Wards 5 and 7.



Finally, these data allow us to view non-fatal overdose data by specific hospital, and therefore by geography. Unfortunately, data from Howard University Hospital do not allow for comparisons of acute and suspected acute poisonings. Looking at data for the other seven hospitals, United Medical Center (Ward 8) accounts for 38% of acute opioid poisoning incidents, followed by Washington Hospital Center (Ward 5) with 20%, Providence (Ward 5) with 15%, Georgetown (Ward 2) with 14%, George Washington (Ward 2) with 12%. Children's Hospital (Ward 5) and Sibley Memorial (Ward 3) appear to see very few confirmed opioid overdoses, though this may be a function of different data reporting schemas.



These data reflect the geographic concertation of the fatal overdoses—in that hospitals in Ward 8 and Ward 5 see the largest share of opioid-related incidents. Examining the broadest definition of overdose to include Howard University Hospital, the trends continue largely similarly—but with Howard seeing the second-largest number of incidents (after United). These data are valuable to for targeting additional resources under STR. See Opioid Service Gaps.

Prescription Drug Monitoring Program (PDMP) Data

The District's PDMP sits within the DC Department of Health (DOH) under the Health Regulation and Licensing Administration, Pharmaceutical Control Division. After passing legislation to create the PDMP in 2014, program registration began July 1, 2016—with database information access beginning in October 2016.

The DC PDMP collects data on Schedule II-V drugs. Presently, the District's PDMP allows for individual-level PDMP reporting for prescribers, pharmacists, law enforcement, licensing boards, and others (e.g., the state Medicaid office). However, because the PDMP is still relatively new, as of this writing, the District does not have the ability to conduct aggregate analytics for research and planning purposes, including those that would reveal opioid and/or benzodiazepine prescriptions per 100 persons. As a result, the District cannot currently use PDMP data to locate areas that are at the highest risk for overprescribing, misuse, or diversion.

DOH is currently acquiring these analytic capabilities (with the help of a CDC grant discussed below) and will work with DBH, the Heroin Task Force, and other relevant stakeholders to effectively utilize these analytic capabilities to assess the scope of opioid and benzodiazepine prescriptions and craft targeted prevention and treatment approaches, as warranted. Notably, a small amount of data is available from the OCME on the presence of prescription drugs in fatal overdoses. For all fatal opioid overdoses in 2016, methadone was present in 9% of cases, oxycodone was present in 6%, codeine in 5%, and buprenorphine in 3%. All other drugs for which OCME tests were present in less than 3% of cases.

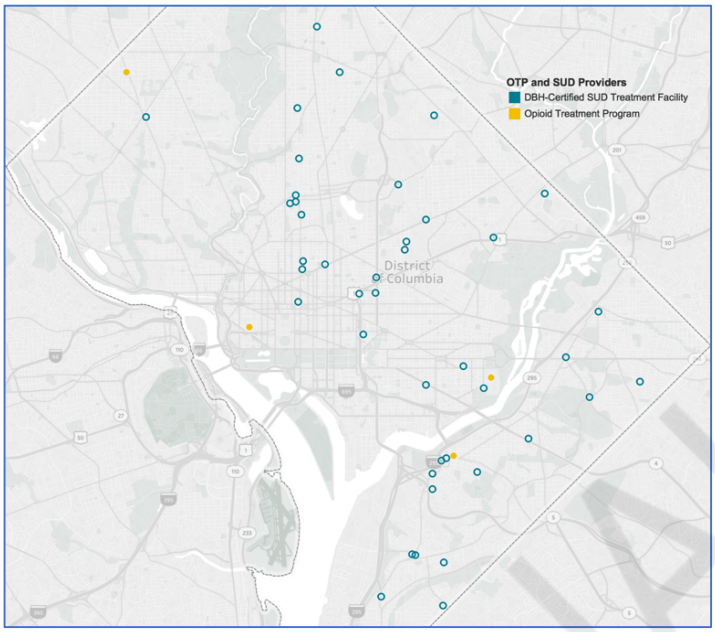
PDMP Policy/Legislation

Under District law, dispensers are required to report all reportable-dispensations; however, neither prescribers nor dispensers are required to query the system prior to writing a prescription for or issuing a controlled substance.

Medication Assisted Treatment, Program Capacity & Demographics

The District's SUD treatment system is partially bifurcated. DBH certifies "providers" but does not have jurisdiction over private physicians or physician groups. DBH's treatment system has 30 certified substance abuse treatment providers, of which 16 have contracts (Human Care Agreements, HCAs) to provide treatment services on DBH's behalf. The 30 certified providers operate 48 facilities throughout the city. The District has four (4) DBH-certified Opioid Treatment Programs (OTPs), three of which have HCAs. In addition, the District has 77 Office-Based Opioid Treatment (OBOT) providers; however, OBOTs are not under DBH jurisdiction and are not counted as "providers" above. OBOTs are discussed in more detail below.

Non-Office-Based SUD Treatment Providers: OTPs & Non-OTPs



In FY 2016, the DBH system conducted 6,008 unique client assessments[3], of which 2,460 (41%) identified heroin as the primary drug of abuse, while another 116 (2%) identified other opiates and synthetics as the primary drug of abuse.[4] Taken together, individuals whose primary SUD problem was either heroin or other opiates constituted 43% (n=2,576) of all assessments conducted in the DBH SUD treatment system. Demographically, these individuals are similar to those suffering fatal and non-fatal overdoses.

For FY2016, 52% of these individuals were between the ages of 50 and 69.[5] Individuals using opioids were 70% male (n=1,716) and 89% African American (n=2,293). In addition, 16% reported a housing status of "homeless", another 27% reported "dependent living", and 56% were living independently. These housing status data serve to further highlight the challenges faced by the District's opioid users as well as by the public SUD system serving them.[6]

District Opioid Treatment Programs (OTPs)

The four DBH-certified methadone OTPs are located in Wards 2, 3, 6, and 8. They have a cumulative capacity of 2,015 (of which 1,825 slots are for public-pay clients). DBH has contracts with Good Hope Institute, United Planning Organization (UPO), and Partners in Drug Rehabilitation Counseling (PIDARC) to provide publicly funded methadone MAT. All OTPs provide psychosocial interventions either in-house or on a contract basis, per the terms of their certification and as required by District law.

[3] This report uses client assessments because DBH's system renders this the most accessible dataset. Not all of the 6,008 unique clients who received assessments enrolled in treatment. So, this constitutes a slight over count of the treatment admissions but provides a rich dataset for analysis and offers a proxy measure for new enrollments.
[4] There were also five cases where the primary drug of choice was non-prescription methadone.
[5] Another 28% (n=734) were 80+ years old. This seems to be a data error and has been excluded from analyses.
[6] Ward of residence data was not immediately available at the time of this publication.

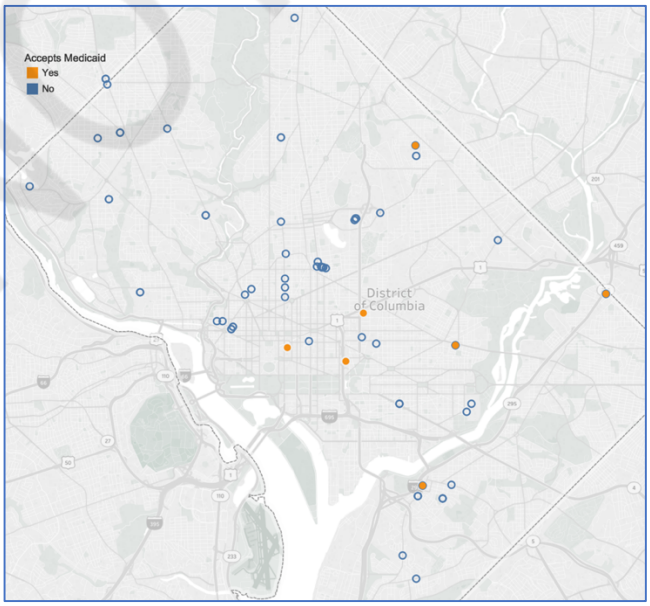
- **Good Hope Institute- Ward 8**; 1320 Good Hope Road SE, Washington, DC 20020 **(Capacity: 700)**
  - **FY2016 public enrollment[7]: 720**
- **UPO- Ward 6**: 1900 Massachusetts Ave, SE Washington, DC 20003 **(Capacity: 400)**
  - **FY2016 enrollment: 488**
- **PIDARC- Ward 2** 2112 F St. NW, #102 Washington, DC 20037 **(Capacity: 725)**
  - **FY2016 enrollment: 841**
- **Aquilla- Ward 3 & Ward 6** 5100 Wisconsin Ave NW, Suite 307, Washington, DC 20016; 721 D Street SE, Suite 2, Washington, DC 20003 **(Capacity: 190)**
  - **FY2016 enrollment: Unavailable to DBH (all clients are non-public payers)**

Enrollment at the three OTPs accepting public pay clients increased 62% from FY2015 to FY2016, from 1,264 clients to 2,049 clients. These increases were driven by a significant expansion at Good Hope (from 430 to 720) and PIDARC (from 306 to 841). Enrollment at UPO actually declined over the same period (from 528 to 488). Enrollment at the three contracted OTPs was 60% male in FY2016. Though data were not available at the time of this writing, they are consistent with the demographics found throughout this report

District Office-Based Opioid Treatment (OBOTs)

According to SAMHSA and DC DOH, there are 77 office-based opioid treatment (OBOT) locations in the District, spread across all 8 Wards (See map). Seven of the OBOT practitioners are also certified by DC Department of Health Care Finance (DHCF) to provide office-based MAT through Medicaid. As indicated on the map, the Medicaid-certified OBOTs are located in Wards 2, 5, 6, 7, and 8. There are currently no OBOTs accepting Medicaid clients in Wards 1, 3, or 4.

Office-Based Opioid Treatment Locations (Medicaid vs. Private Pay)



[7] DBH does not have access to information on private-pay clients.

According to the SAMHSA website (as of July 11, 2017), there are 14 DATA-certified physicians who may treat up to 30 patients each and no DATA-certified physicians who may see up to 100 patients each—down from the 16 and 3 that SAMHSA reported for 2016 and down still further from the 19 and 5 that SAMHSA records for 2015.[vii] However, these data are inconsistent with the SAMHSA data displayed graphically above, indicating that there are 77 authorized buprenorphine prescribers in the District, at least some of whom DBH believes are certified at the 100-patient level. Moreover, DBH is aware that at least one physician (Dr. Edwin Chapman) has been approved to treat up to the new limit of 275 patients. Because these practitioners are not subject to DBH regulation, DBH does not currently have data on whether they are prescribing up to their capacity. For updates to the needs assessment, DBH may be able to obtain data on clients served under Medicaid from DHCF but currently has no mechanism for tracking private-pay clients.

Moreover, as part of an FY2017 effort to enhance buprenorphine-based MAT, DOH has awarded funds to one provider to conduct capacity building and support a needs assessment and targeted delivery of training, capacity building activities, and technical support to clinicians (physicians, NPs, PAs, clinical pharmacists) to apply for or already waived to prescribe buprenorphine-based treatment. DBH will work to ensure that STR funds support but do not supplant these efforts. And future needs assessments will include updates on this DOH-funded expansion. DOH aims to increase the number of active prescribing physicians by 300%. DBH will work closely with DOH to improve the coordination of an OBOT expansion.

Federally Qualified Health Centers (FQHCs) and Look-A-Likes

There are seven Federally Qualified Health Centers (FQHCs) with 35 locations throughout the city. They are:

- Community of Hope (Ward 1, Ward 5, and Ward 8)
- Elaine Ellis Center of Health (Ward 7)
- Family and Medical Counseling Services (Ward 8)
- La Clinica Del Pueblo (Ward 1)
- Mary's Center for Maternal & Child Care Inc. (Wards 1, 4, & 5)- does opioid treatment but not DBH SUD certified
- Unity Health Care Inc. (Wards 1, 2, 3, 5, 6, 7 & 8)
- Whitman Walk Clinic (Wards 2 & 8)- does opioid treatment but not DBH SUD certified

There is also one FQHC Look-A-Like, Bread for the City, with two additional locations in Wards 6 and 8. Of these FQHCs, only two—Mary's Center and Whitman Walker Clinic—are currently providing opioid treatment services. Data on the number of opioid clients served at these FQHCs is not available to DBH at the time of this writing because FQHCs are only subject to DBH if they are also certified SUD treatment providers. DBH may be able to obtain data on Medicaid-funded treatment at FQHCs to enhance future planning efforts. In addition, as part of an

FY2017 effort to enhance buprenorphine-based MAT, DOH has awarded sole source awards to four FQHCs to support the development of their capacity to provide opioid RSS inclusive of but not limited to: behavioral counseling, vocational rehabilitation, assessment of other socio-economic needs, housing, mental health, addressing general health issues with special emphasis on sexually transmitted infections, case coordination, and case management services. This project is still in its infancy, so DOH does not have any data yet. DBH will work with DOH to support this effort. These sites may not be fully accounted for the RSS section below.

Detoxification & Hospitals

There are 10 hospitals in the District, in Wards 1, 2, 3, 5, & 8. The eight primary hospitals are:

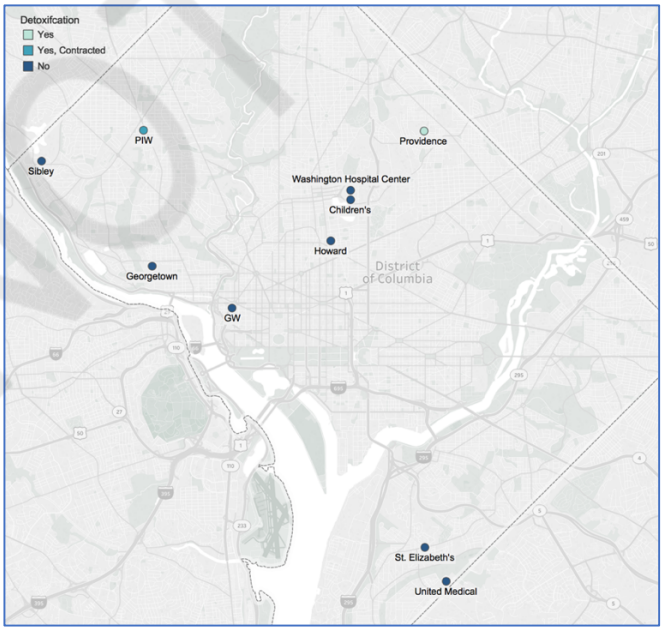
- Children's National Medical Center (Ward 5)
- Georgetown Univ. Hospital (Ward 2)
- George Washington Univ. Hospital (Ward 2)
- Howard University Hospital (Ward 1)
- Providence Hospital (Ward 5)
- Sibley Memorial Hospital (Ward 3)
- United Medical Center (Ward 8)
- Wash. Hospital Center (Ward 5)

In addition, there are two psychiatric hospitals:

- Psychiatric Institute of Washington (PIW) (Ward 3)
- St. Elizabeth's Hospital (Ward 8 and operated by DBH

Only Providence and PIW offer detoxification services, and DBH contracts only with PIW.

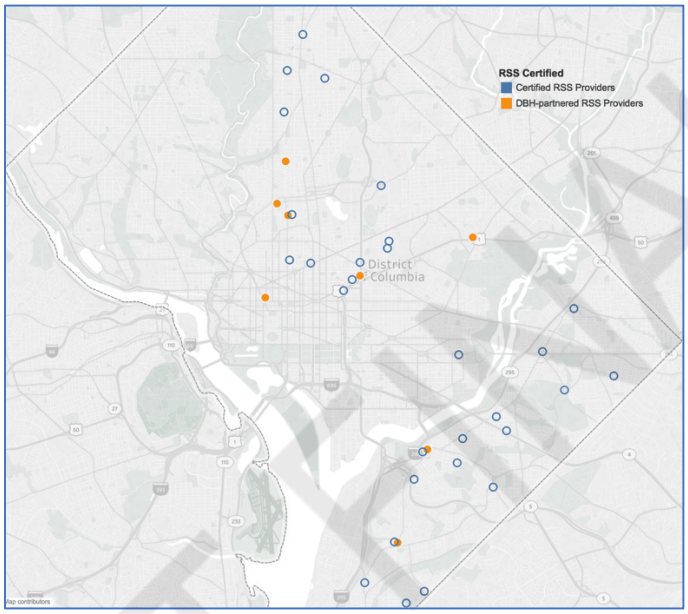
District Hospitals (Including Psychiatric Facilities)



Recovery Support Services System and Initiatives

Through DBH, the District certifies 14 recovery support service (RSS) providers with a total of 37 facilities. Of the certified RSS providers, eight currently provide District-funded RSS. In addition, all but one of the certified RSS providers are also DBH-certified SUD treatment providers. There are certified RSS providers in every ward except Ward 3. See the map below. DOH is also working to enhance the RSS capabilities of four selected FQHCs.

RSS Providers, Certified Only & DBH-Partnered



DBH-certified RSS providers may provide any of the following eight (8) services: Recovery Support Evaluation, Recovery Support Management, Recovery Coaching, Life Skills Support Services, Education Support Services, Recovery Social Activities, Transportation (Public), and (in certain cases) Environmental Stability. There is currently no opioid specific training or component to DBH's RSS certification system or to the specific recovery services described above. Furthermore, demographic and utilization data opioid RSS clients are not available at the time of this writing.

Recovery Coaches & Peer Specialists

DBH has two local recovery-related positions: Recovery Coaches and Peer Specialists.[8]

Within DBH, any individual can become a Recovery Coach (regardless of lived experience) by taking DBH's Recovery Coach training. The first Recovery Coach Training was held in April 2017 with 19 attendees, of which 11 were non-DBH staff. Each Recovery Coach must complete 40 hours of training to receive a Certificate of Completion. As of this writing, future Recovery

[8] Both designations are locally certified but not nationally certified.

Coach trainings will be announced by DBH's Office of Consumer and Family Administration. Currently, DBH does not have a national certification program for Recovery Coaching.

In addition, DBH has a Peer Specialist Certification Program housed in the Office of Consumer and Family Administration. To be eligible for the certification, an individual must be (a) a self-disclosed current or previous consumer of behavioral health services within the DBH network living in recovery with mental illness and/or substance use disorder (or a family member), (b) able to demonstrate personal recovery, and (c) show an ability to help others with their recovery. The six-week certification program requires the completion of classroom work, an 80-hour unpaid field practicum with a District community-based behavioral health provider, and a score of at least 85% on the certification exam. Once certified, peer specialists may: (1) Assist in the development of strengths-based personal goals, (2) Help a peer monitor individual progress and advocate for effective services (3) Model effective coping techniques and self-help strategies, (3) Act as a mentor or facilitator to help resolve issues, (4) Educate on how to navigate the behavioral health system, and (5) Build Community supports. The Peer Specialist program began in 2002.

Re-Integration for Persons Released from Incarceration

DBH recently signed an MOU with the DC Department of Corrections (DOC) through the Residential Substance Abuse Treatment (RSAT) program that will allow individuals to be assessed 10 days prior to release from incarceration. Based on their need, those clients can be referred directly from DOC to receive substance abuse and mental health services. This arrangement also allows DOC to use DBH's electronic health records system. Future iterations of the needs assessment will provide additional information on this new partnership and document a number of efforts under the Mayor's Office of Returning Citizen Affairs.

Naloxone-Related Efforts

Naloxone is administered in the community and through DC Fire and EMS Department (FEMS). Currently, the District's community naloxone distribution system is handled primarily by DOH. DOH has also worked with DHCF to ensure open prescription for naloxone (removing prior authorization) under both fee-for-service Medicaid and all three of the District's Medicaid Managed Care Organizations (MCOs). DBH's prevention branch is beginning to work much more closely with DOH, given the importance of naloxone in avoiding fatal opioid overdoses.

Community-Level Naloxone Efforts

DOH developed a Community Naloxone Pilot Program to train staff and community members to administer naloxone. Under the program, DOH provides naloxone training and kits to Helping Individual Persons Succeed (HIPs) and Family and Medical Counseling Services, which is also a DBH-certified SUD treatment provider and an FQHC. In addition, naloxone is disseminated through 12 needle exchange sites, located in every ward in the District except Ward 2.

DOH uses the peer educator model at HIPS and Family Medical to provide additional outreach in the community. 30 trained peers can administer naloxone, help disseminate important information (data-based messages on spikes in overdoses etc.), and link clients to support services.

Initially, DOH resupplied each site with naloxone kits on-demand; however, after encountering supply issues, DOH modified the system. First, DOH kept an "emergency" supply of to meet short term needs. Eventually DOH developed a standing monthly order to alleviate these concerns, now allocating 50-75 kits for each site per-month, based on observed trends. Over 1,000 kits were distributed since September 2016, and DOH has purchased an addition 2,500 for future distribution, focusing on Wards 5,7, and 8—which have been identified as the areas of greatest need (both in this report and previously by DOH).

DOH recently trained 140 community partners and volunteers between September 2016 and May 2017. Naloxone trainings are currently conducted monthly and the primary participants have been members of the pilot sites. However, trainings have also included staff from: The Metropolitan Police Department, the DC Public Court System, pharmacies, hospitals, and the DC Department of Corrections. DOH has also conducted targeted outreach to FQHCs and the DC Primary Care Association and is now seeking to directly target emergency room providers, the DC Department of Corrections, the DC Public Library, and the DC Department of Parks and Recreation for additional trainings. DOH has committed to financing the trainings locally for 3 years but is also seeking grant options.

FEMS Naloxone Efforts

DC Fire and EMS Department (FEMS) also administers naloxone and collects data on those administrations. Broadly, rates of administration have increased significantly since January of 2015. Peak monthly administration topped out at 314 in June of 2016. However, the mean annual administrations have also been steadily rising, with an average of 145 monthly administrations in 2015, 247 in 2016, and 236 in the first 4 months of 2017 (note that winter months historically have fewer administrations). In addition, demographically, individuals who receive naloxone from FEMS are broadly similar to individuals who suffer opioid-related overdoses (fatal or non-fatal) and to individuals assessed by DBH's public SUD treatment system. Individuals receiving naloxone were 90% African American, 74% male, and 52% ages 51-70 (with another 16% ages 41-50).

Non-Naloxone Prevention Systems & Initiatives

DBH's Substance Use Disorder Services (SUDS) Prevention branch shepherds much of SUD prevention efforts in the District (though, as noted, the naloxone-related prevention is under DOH). Taken together, DBH's efforts seek to prevent or delay the onset of alcohol, tobacco, and other drug use among District residents—with a particular focus on youth.

DBH has four DC Prevention Centers, which serve as prevention hubs throughout the District. As an extension of DBH, they are strategically placed to provide coverage for two wards each. Parent companies receive sub-grants from DBH with support from SABG funding. Each Center has a minimum of one director, one community mobilizer, and one PFS coordinator. The location and service area of each center is as follows:

- **Wards 1 & 2**: 1419 Columbia Road, NW, Washington, DC 20009 (Ward 1)
- **Wards 3 & 4**: 5335 Wisconsin Avenue, NW, Suite 440, Washington, DC 20015 (Ward 3)
- **Wards 5 & 6**: 1022 Maryland Avenue, NE, Washington, DC 20002 (Ward 6)
- **Wards 7 & 8**: 3939 Benning Road, NE, Washington, DC 20019 (Ward 7)

Over the past several years, the SUDS Prevention branch has been increasing its focus on opioid misuse. In 2017, DBH partnered with a pharmaceutical company and the Community Anti-Drug Coalitions of America (CADCA) to disseminate 100,000 medication deactivation pouches throughout the District. The pouches provide a safe and responsible method for disposing of unused prescription medication in the home, by combining tap water and 10-15 pills. This reduces unintended use by youth and also produced environmental benefits. Pouches were provided via pharmacies (Walgreens, CVS, and Harris Teeter) and community based partners.

In addition, using discretionary funding through SAMHSA's SPF Partnership for Success grant, the District is developing an opioid awareness campaign for youth to share messages around the risks associated with prescription medication misuse. This data-driven campaign will be launched in areas within DC where misuse of prescription medication has been more prevalent and is a direct result of data discussed earlier in this report. As an enhancement to the opioid awareness campaign, SAMHSA's STR funding will be used to create prevention messaging for adults who have historically been heroin users, focusing on: the risks associated with heroin use, additives to heroin, and the administration of naloxone. This campaign will be aimed at filling the information gap regarding the risks associated with heroin and other opioid misuse, especially given the recent data indicating the fatalities associated with fentanyl and its analogs. The campaign will improve public safety and reduce overdoses (fatal and non-fatal). Messaging around the District's Good Samaritan law (see below) will be included in the campaign.

DOH-Led Prevention Activities

DOH is pursuing many opioid-related prevention activities. This section details those for which DBH currently has information. However, DBH will update this section as new information on DOH's ongoing efforts becomes available through further improved collaboration under STR.

Needle Exchange

Since 2007, DOH has pursued a successful needle exchange program—removing 803,596 needles from the street in 2016 alone, and resulting in a 95% decline in the number of newly diagnosed HIV infections attributable to injection drug use from 2007 to 2016 (from 149 cases to 7 cases). A 2015 study indicates that the District has an estimated 12,000 active injection drug users.[viii] Data from District needle exchange programs also provide another source of data

on District heroin use, indicating that heroin remains the leading injection drug in the District. DOH leverages needle exchange programs for their access to opioid users and the significant trust developed by their staff.

CDC Prescription Drug Overdose Data Driven Prevention Initiative (DDPI)
DC DOH received a three-year planning and data-focused DDPI grant from CDC, which provides the District with additional resources to combat prescription drug abuse, diversion, and death related to opioids. This grant includes a needs assessment, stakeholder engagement and identification (and stakeholder meeting), enhancement of the PDMP analytic ability (discussed above), and a focus on the ability to work with broader stakeholders. DBH will partner with DOH to leverage STR and DDPI together and avoid duplication.

Opioid-Related Policy & Legislation

The District has pursued a host of opioid-related policy and legislative changes to combat the epidemic, most of which are discussed in their relevant sections above. This section will also be updated in future iterations of the needs assessment to reflect the full range of policy changes.

MAT Billing Policies and Related Efforts
For OTPs, DBH has issued clarifying guidance regarding Medicaid-funded MAT provided through DBH-contracted OTPs, further explaining required billing codes and procedures. Although MAT administration at OTPs can be billed directly to Medicaid (DHCF), DBH requires therapeutic guidance in each instance, which must be documented to DBH (and billed, as appropriate). DBH also requires a record of dose administration in the DBH system. And DBH clarified the District's requirement of per-encounter billing (vs. service roll up).

Notably, for OBOTs and FQHCs, DOH has issued awards this fiscal year (discussed in the appropriate sections of this report), which have the combined short-term goals of (1) securing a training and capacity building provider to support primary care providers to integrate buprenorphine-based treatment for opioid use disorders (2) supporting FQHCs to provide or increase provision of buprenorphine-based MAT and care coordination, (3) enabling FQHCs to obtain the Medicaid enhanced rate for behavioral health services, and (4) increasing the number of providers who are prescribing buprenorphine-based treatment by 300%.

Finally, in June 2016, DHCF issued policy in response to identified barriers to OBOT buprenorphine treatment, stating that (1) buprenorphine shall only be dispensed with prior authorization from DHCF (or the clients MCO); (2) prior authorization shall last 12 months; (3) a pharmacist may dispense a 7-day supply while authorization is pending; (4) practitioners must document the ability to provide linkages to counseling; however, strict adherence to regular counseling shall not be a requirement maintaining a patient in treatment or obtaining refills; (5) providers may exceed the standard 24mg/day if clinically justified (but that justification must be included with the prior authorization request); (6) practitioners shall conduct urine tests at least bi-monthly as a quality measure to assess other opiate use but not as a prerequisite for

treatment; (7) there shall be no lifetime limit on buprenorphine, naltrexone, or methadone under Medicaid (FFS or MCO).

Task Forces and Councils

The District has undertaken several efforts to convene the stakeholders to address the opioid crisis. At the regional level, in 2016, Mayor Muriel Bowser joined the governors of Maryland and Virginia in signing the *National Capital Region Compact to Combat Opioid Addiction*. The Compact pledges that DC, Maryland, and Virginia will work collaboratively to stop the damaging effects of the opioid epidemic and convened a regional opioid summit in May 2017.

In addition, the District has two notable intra-governmental efforts. The interagency *Heroin and Opioid Task Force* was established in 2014 to strategize solutions to reduce morbidity and mortality associated with District opioid use. On a monthly basis, the Task Force convenes stakeholders from District agencies and regional/federal partners to share data and develop strategies to curtail the heroin epidemic.[9] Data from stakeholders is presented at Task Force meetings and used to enhance syndromic surveillance, analysis, and policy development. DOH supports this task force. In addition, the United States Attorney's Office for the District of Columbia heads a *Heroin/Opioid Working Group* which aims to curtail the opioid crisis through grass-root initiatives (rather than the policy work of the Task Force). Working with local police, community-based organizations, and outreach teams from District Government agencies, the Working Group implements initiatives that directly target heroin/opioid users and those close to them (e.g., family members). Activities have included direct outreach and engagement and bringing resources directly to locations affected by use (e.g., parks). Staff and resources from the Attorney General's support this effort.

Good Samaritan Law & PDMP

In 2012, the District passed DC BILL 19-754, "Good Samaritan Overdose Prevention Amendment Act of 2012." The bill provides legal protections for individuals who were victims of overdoses and/or individuals who seek medical assistance for individuals who are victims of overdoses. Finally, District PDMP laws are discussed under the PDMP section above, and naloxone-related policies and legislation are discussed under Naloxone-Related Efforts.

Estimated Current Treatment Need

Calculating treatment need is difficult. Fortunately, a recent study provides an estimate of 2012 treatment need for the District (and the 50 States) using NSDUH and other SAMHSA data sources.[ix] The authors report a rate of past year opioid abuse or dependence of 6.7% (with a 95% confidence interval of 3.6% to 12.3% per 1000 resident population 12 years of age or greater) for 2012. **Applying that rate to the current District population age 12 and older yields**

[9] Participants include: DBH, DOH (Center for Policy Planning and Evaluation & Pharmaceutical Control Division), DHCF, FEMS, OCME, DC Department of Forensic Sciences (DFS), Metropolitan Police Department (MPD), DC Office of the Attorney General (OAG), the Washington Regional Threat Assessment Center/Fusion Team (WRTAC), the US Drug Enforcement Administration, and the Federal Bureau of Investigation.

a treatment need point estimate of 3,919 (with a 95% confidence interval ranging from 2,106 to 7,194). These findings are noteworthy given the 2,049 clients enrolled in methadone MAT in FY2016.

The same study also reports findings on opioid treatment capacity. It finds that the District's potential buprenorphine treatment capacity rate of 5.8 per 1,000 residents age 12 and older (95% C.I. is 5.6 to 6.0) exceeds the average rate for the nation of 4.1 per 1,000 (95% C.I is 4.1-4.1); likewise, they estimate that OTPs in the District are at 100% capacity compared with the 82.3% average for the rest of the nation. In fact, the District is one of only 13 states where the study reports that all OTPs are operating at full capacity. These findings suggest that the District's MAT system may be better equipped to manage its opioid epidemic, on average, as compared to other states. However, it also indicates that the District may lack the capacity to serve additional clients at current OTPs.

The District was not able to employ the Calculating for an Adequate System Tool (CAST) for this report but plans to utilize it in the future.

Opioid Service Gaps & Lessons Learned

Findings from overdose data (fatal and non-fatal) as well as data from DBH's public treatment system demonstrate that:

- The observable opioid-using population in the District is disproportionately older (roughly, age 40-65), African-American, and male.
- The observable opioid-using population is concentrated in Wards 5, 7, and 8 (and may be rising in Ward 6).
- A significant share (16%) of OUD clients receiving assessments through DBH's public SUD treatment were homeless, indicating that OUD is a significant problem in the District's homeless community.
- Opioid-related fatalities have risen significantly, driven in large-part by fentanyl and its analogs
- District hospitals (and FEMS) encounter a large number of opioid users (demographically consistent with the description above) and represent an area for improved collaboration to facilitate MAT enrollment.
    - Wards 6 and 8 lack hospitals yet have significant levels of individuals with OUD.
- Leading indicators such as youth use of prescription opioids in the YRBS and the doubling of TEDS admissions for prescription opioid abuse indicate a need to get out in front of a potential "new wave" of users.
- Less data is available on prescription opioid users outside of the publicly-funded treatment system and FEMS/overdose data, which makes it difficult to assess the extent of the problem in certain segments of the District population.

These data will be useful for targeting a myriad of STR efforts, including (but not limited to): prevention campaigns, treatment capacity (slots) expansion, improved access (including "warm

handoffs" to treatment from other points in the system), and treatment quality improvement (including care coordination). More detailed findings are discussed below.

OTP Methadone Clinics

- There are no OTPs in Ward 5 or Ward 7, despite the high concentration of need in these wards. DBH will further explore the implications of this finding.[10]
- All three OTPs that accept publicly funded clients appear to have operated at capacity (2,015) in FY2016. This indicates that OTPs may have limited capacity to expand without significant changes to staffing, structure etc. But it also indicates that the OTPs may be doing a good job responding to the increased need (relative to previous years).

OBOTs & FQHCs

- DOH is currently leading efforts to expand the capacity of OBOTs and work with FQHCs. However, relatively little information is available to DBH as of this writing. DBH will work through the Heroin Task Force to coordinate STR efforts across all relevant agencies.
- DBH will also seek to work with DOH to establish a baseline capacity for existing OBOTs and FQHCs against which to measure progress as well as furthering the expansion (and working to expand Medicaid-funded services).
- FQHCs represent an area ripe for MAT expansion and service coordination in the District.
- Though OBOTs and FQHCs are outside DBH jurisdiction, they are crucial to ensuring a high-quality MAT network. The strategic plan will outline DBH's STR-funded efforts in this regard.

RSS

- Data are not currently available to assess the extent to which DBH's RSS system is able to facilitate access to MAT and support individuals in recovery from OUD. This is a priority area.
- DBH and DOH will enhance collaboration around recovery-oriented efforts spearheaded by DOH through FQHCs.
- Peer-based efforts are crucial. DBH and DOH will work collaboratively to streamline peer-based outreach and RSS efforts and enhance existing peer services at DBH to better serve (and target) individuals with OUDs.

Areas for Further Exploration

- The data presented herein do not permit data-based assessments of the potential service gaps regarding: transportation and other access issues, community connections, integration with physical health, family treatment, or recovery supports (including employment/education assistance). Though DBH can provide anecdotal assessments of these needs, future iterations of this needs assessment will focus on these issues in

[10] The District's geographic size is a factor. At minimum, this highlights the importance of transportation and access.

more detail. In particular, DBH will seek to better assess the ability of OBOTs and OTPs to provide comprehensive, coordinated care—which DBH believes is an area of concern.

In addition, this needs assessment reveals both the early successes of the District's intra-governmental cooperation (e.g., the Heroin Task Force) and areas for increased cooperation and infrastructure improvement. Those areas include (not exhaustive):

- Developing and utilizing analytic capabilities for the District's PDMP, including intra-governmental sharing of aggregate date (in progress and also supported by DDPI)
    - After consultation with DOH, the District may also want to explore laws/policy that mandate PDMP utilization
- Further developing the collaboration between DBH and DOH's naloxone programs and other prevention efforts
- Further developing collaboration between DBH and DOH to better monitor, oversee, assess, and expand OBOTs using buprenorphine-based MAT

The Heroin Task Force appears to be the ideal forum for much of this enhanced coordination.

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[i] U.S. Census Bureau. District of Columbia Quick Facts. https://www.census.gov/quickfacts/DC Accessed July 28, 2017.

[ii] Muhur, P et al. (2013). Associations of nonmedical pain reliever use and initiation of heroin use in the United States. Rockville, MD: SAMHSA. http://archive.samhsa.gov/data/2k13/DataReview/DR006/nonmedical-pain-reliever-use-2013.pdf Accessed May 13, 2016.

[iii] SAMHSA. Key substance use and mental health indicators in the United States: Results for the 2015 NSDUH. https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.pdf

[iv] SAMHSA. NSDUH 2014-15 State Estimates, (https://www.samhsa.gov/data/sites/default/files/NSDUHsaeStateTabs2015B/NSDUHsaeSpecificStates2015.htm#tab27); and NSDUH 2012-13 (http://pdas.samhsa.gov/saes/state)

[v] DC Office of the Chief Medical Examiner. April 2017. Opioid Related Fatal Overdoses January 1, 2014 to February 28, 2017.

[vi] U.S. Census Bureau. District of Columbia Quick Facts Tables. https://www.census.gov/quickfacts/fact/table/DC/PST045216

[vii] SAMHSA. Number of Data-Certified Physicians. https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/certified-physicians?field_bup_us_state_code_value=DC Accessed July 28, 2017.

[viii] Ruiz, M. (2016). Using capture-recapture methods to estimate the population of people who inject drugs in Washington, DC. *AIDS Behav.* 20(2): 363-8.

[ix] Jones, C. M., et al. (2015) National and state treatment need and capacity for opioid agonist medication-assisted treatment. *American Journal of Public Health*. 105(8): e55-63.

Step 2: Identify the Unmet Service Needs and Critical Gaps within the Current System

- **Early Childhood and Children**

  The Department of Behavioral Health (DBH) Continuum of Care is an important component of the early childhood and children services. DBH has a variety of services for young children that include: 1) Healthy Futures- provides mental health consultation services in Child Development Centers (CDCs); 2) Primary Project- provides early identification of student's level of social-emotional adjustment in the classroom and at CDCs; and 3) School Mental Health Program- provides prevention, early intervention and treatment services to young children and children in the District of Columbia schools. Young children can receive services at all levels of the continuum.

  Most Important Early Childhood Unmet Service Needs or Critical Gaps

  One of the unmet needs or critical gaps is that few individuals working with the early childhood population have received specific training in early childhood development. One of the initiatives for the D.C. Social Emotional and Early Development Project (D.C. SEED) is to provide Early Childhood trainings to a wide range of audiences (e.g., child development staff, Access Help Line staff, and clinicians) to help increase knowledge regarding children birth to age 6. The developmental progress of the children will be measured by changes in knowledge. This issue is described in the Planning Tables under Priority Area 1.

  Another unmet need or critical gap is related to sufficient numbers of evidence-based treatment services for young children with mental health concerns. While DBH, specifically the Parent Infant Early Childhood Enhancement Program and the School Mental Health Program, have been providing mental health services for young children for years; there are not enough services in District of Columbia for young children.

  One of the goals of D.C. SEED is to support the expansion and strengthening of mental health services for children birth to age 6 who have been diagnosed with a serious emotional disturbance or are at risk for one. D.C. SEED will train providers on three (3) evidence-based programs which will increase the capacity for young children and families to receive services. Progress will be measured through monitoring the number of children receiving services as well as looking at improvements based on their functioning (pre/post assessments). This issue is described in the Planning Tables under Priority Area 2.

- **Transition Age Youth and Young Adults**

  The Department of Behavioral Health (DBH) offers a range of programs and services for children and adults but limited programs to address the needs of Transition Age Youth (TAYs) and young adults (YAs). There needs to be a seamless provision of mental health services and recovery supports for TAY as they enter adulthood, particularly those who are at high risk and multi-system involved.

  - ***Most Important Unmet Transition Age Youth and Young Adults Service Needs or Critical Gaps***

The current provider network is somewhat fragmented causing a silo system of care that complicates access for individuals transitioning from adolescence to adulthood. The delivery of mental health services has been divided into two (2) systems: one serving children and one serving adults, with different eligibility requirements, health care providers, and funding streams.

When a young person "ages out" by surpassing the DBH age-defined eligibility limit of 22, the services are discontinued and they are referred to the adult mental health system. This lack of continuity of care is not only disruptive, a youth must adjust to a new culture of care, with new case managers, therapists, and treatments. Also, the services in general may not be age-appropriate or consistent with the kind of care or treatment plan customized for the youth up until this point.

Studies have found that this interruption in services, coupled with the abrupt discontinuation of regular contacts with peers in the child health system, may cause young people to adjust poorly to the new services or reject them altogether. DBH has found that this fragmented approach has led to an abandonment of mental health treatment by many TAY who start-out in the child mental health system and upon aging leave the system entirely.

DBH and its providers need to develop more training opportunities that focus on the needs of TAY and YAs. This issue is described in the Planning Tables under Priority Area 3.

Another service need or critical gap is related to substance use disorder (SUD) treatment for TAY and YAs. The system was set up to provide SUD services to youth ages 12-20, however, the 21 and above population was integrated with the adult SUD population. Findings show that the young adult population was not ready to be integrated with the adults, which caused their needs to be unmet. In response to the increasing need to expand SUD treatment and recovery services to transition age youth (TAY), DBH implemented the expansion of the Adolescent Community Reinforcement Approach (A-CRA) services to now cover TAY ages 21-24. The expansion increases the infrastructure and service capacity for the SUD treatment programs. This issue is described in the Planning Tables under Priority Area 4.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's **NBHQF**. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at **http://www.samhsa.gov/data/quality-metrics/block-grant-measures**. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).
3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-

identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

The District of Columbia Department of Behavioral Health (DBH) during FY 2017 was the development and implementation of an organizational realignment process. The newly realigned behavioral health system will be officially launched in fiscal year 2018. In addition to becoming a data driven agency, DBH has adopted a focus of continuous quality improvement. The Department recognizes that it must create a structured process for identifying gaps, analyzing and improving service delivery. The quality improvement and data collection are located within two Administration, Systems Transformation Administration and Accountability Administration.

Systems Transformation Administration
The Systems Transformation Administration conducts research, analysis, planning and evaluation leading to defined individual, service and system outcomes; works to improve efficiency and collaboration among internal and external partners; develops and implements learning opportunities to advance system change, and greater effectiveness of the service delivery system.
The Systems Transformation Administration uses information systems and data analysis to develop a transformational strategic plan as well as programmatic regulations, policies, and procedures to support the DBH mission. The Administration includes Information Systems Innovation and Data Analytics Division (ISIDA), which provides and maintains high-quality hardware and software applications that support the provision and monitoring of consumer and client services. It also produces and analyzes data for decision- making. Additionally, Data and Performance Management Branch meets the agency's data reporting and analysis needs by working with staff to identify what information is needed, creates reports and dashboards that presents and makes the information accessible, and helps staff understand what the information means and how it can be used to improve performance.

Accountability Administration
The Accountability Administration oversees provider certification; mental health community residence facility licensure; program integrity; quality improvement; incident management; major investigations; claims audits; and compliance monitoring. It issues the annual Provider Scorecard. The Accountability Administration includes a new division called Program Integrity that strengthens provider oversight and overall system performance review. Furthermore, provides oversight of certified providers through audits and reviews to ensure they meet service delivery and documentation standards for mental health and substance use disorder services.

The Department has the current capability to generate extensive custom data reports using SSRS (a SQL Server statistics program fully incorporated into our electronic health record DATA), which allows information to be extracted at the client, program, and provider level. This capability has already been used in past years to inform strategic planning, monitoring activities and quality improvement planning. SSRS is sufficient for the majority of our SUD data needs. There are more sophisticated reports which are beyond the capacity of SSRS to complete and these reports are purchased from FEI (the developer of the DATA System).

The District Automated Treatment and Accounting (DATA) system is the current electronic health record for SUD reporting. Additionally, the newly implemented SQL data warehouse, which allows for the collections of SUD and Mental Health data, as well as Medicaid and other claims based data, which allow for DBH to track client, level data between both system.

The DBH is currently able to collect and report on client level data. DBH used the SUD TEDS and NOMS format.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: : Provide training for Department of Behavioral Health (DBH) providers certified to deliver substance use disorder (SUD) treatment for transition age young adults (21-24).

Priority Type: SAT, MHS

Population(s):

Goal of the priority area:

Provide training to licensed clinicians and supervisor identified by SUD providers to receive Adolescent Community Reinforcement Approach (A-CRA) for transition age young adults (21-24). A-CRA SUD treatment program.

Objective:

Increase the number of transition age young adults that providers serve in the A-CRA SUD treatment program.

Strategies to attain the objective:

The strategies are: 1) Identify providers that will offer A1CRA training to external clinicians. @) Identify providers that will offer A-CRA training to A-CRA training to internal clinicians. 3) Provide A-CRA training.

Priority #: 2

Priority Area: : Provide training for Department of Behavioral Health (DBH) providers so they are better equipped to work with transition age youth (TAY) and young adults (YAs) age 16- 25. Training will include both evidenced-based practices (EBPs) and cultural understanding of the population

Priority Type: SAT, MHS

Population(s): SMI, SED

Goal of the priority area:

Offer evidenced based and cultural competence training to District providers and community entities so that they have the appropriate tools and skills to serve the changing needs of the TAY and YAs population.

Objective:

Improve mental health and SUD services offered to the TAY and YAs to include EBPs and Cultural understanding so that interventions and treatment are specific to the needs and culture of this population.

Strategies to attain the objective:

The EBP strategies include: 1) identify and prioritize the needs and skill deficits of the Districts TAY and YAs: 2) Identify specific EBP's to address the needs of TAY and YAs: 3) Identify providers to training in EBP's and offer services; and train services providers. 4) Monitor services delivery and evaluate impact The cultural competence strategies which include: 1) Identify cultural training competence programs for professionals and the community that include TAY and YAs voice and influence: 2) train providers and the community on cultural competence needs of TAY and YAs, and 3) monitor cultural competence and evaluate performance.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of transition age young adults served by the A-CRA SUD treatment providers.

Baseline Measurement: Base line data will not be available until FY2018.

First-year target/outcome measurement: There is no traget number established. The outcome is based on the number of transition age young adults that providers serve in the A-CRA SUD treatment program.

Second-year target/outcome measurement: There is no traget number established. The outcome is based on the number of transition

age young adults that providers serve in the A-CRA SUD treatment program.

Data Source:

Program and provider data.

Description of Data:

The number of transition age young adults that providers serve in the A-CRA SUD treatment program.

Data issues/caveats that affect outcome measures::

none currently known.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$4,877,515		$0	$3,000,000	$30,800,209	$569,200	$373,050
a. Pregnant Women and Women with Dependent Children**	$348,394		$0	$0	$3,200,000	$0	$0
b. All Other	$4,529,121		$0	$3,000,000	$27,600,209	$569,200	$373,050
2. Primary Prevention	$1,393,575		$0	$4,032,000	$2,399,926	$0	$0
3. Tuberculosis Services	$0		$0	$0	$773,475	$0	$0
4. Early Intervention Services for HIV	$348,394		$0	$0	$344,214	$0	$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention							
9. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	$348,394		$0	$0	$18,628,020	$0	$0
11. SABG Total (Row 1, 2, 3, 4 and 10)	**$6,967,878**	**$0**	**$0**	**$7,032,000**	**$52,945,844**	**$569,200**	**$373,050**

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
Pregnant Women	32	25
Women with Dependent Children	618	463
Individuals with a co-occurring M/SUD	1653	1459
Persons who inject drugs	900	787
Persons experiencing homelessness	992	797

Please provide an explanation for any data cells for which the stats does not have a data source.

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Expenditure Category	FFY 2018 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment	$4,877,514
2 . Primary Substance Abuse Prevention	$1,393,576
3 . Tuberculosis Services	
4 . Early Intervention Services for HIV*	$348,394
5 . Administration (SSA Level Only)	$348,394
6. Total	**$6,967,878**

* For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Strategy	IOM Target	FY 2018
		SA Block Grant Award
Information Dissemination	Universal	$278,530
	Selective	
	Indicated	
	Unspecified	
	Total	**$278,530**
Education	Universal	$153,550
	Selective	$187,673
	Indicated	
	Unspecified	
	Total	**$341,223**
Alternatives	Universal	
	Selective	
	Indicated	$65,542
	Unspecified	
	Total	**$65,542**
Problem Identification and Referral	Universal	
	Selective	$68,245
	Indicated	$68,245
	Unspecified	
	Total	**$136,490**

Community-Based Process	Universal	$449,098
	Selective	
	Indicated	
	Unspecified	
	Total	**$449,098**
Environmental	Universal	
	Selective	
	Indicated	$62,693
	Unspecified	
	Total	**$62,693**
Section 1926 Tobacco	Universal	
	Selective	$60,000
	Indicated	
	Unspecified	
	Total	**$60,000**
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
Total Prevention Expenditures		**$1,393,576**
Total SABG Award*		**$6,967,878**
Planned Primary Prevention Percentage		**20.00 %**

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	FY 2018 SA Block Grant Award
Universal Direct	$363,756
Universal Indirect	$580,114
Selective	$315,918
Indicated	$133,787
Column Total	**$1,393,575**
Total SABG Award*	**$6,967,878**
Planned Primary Prevention Percentage	**20.00 %**

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Targeted Substances	
Alcohol	☑
Tobacco	☑
Marijuana	☑
Prescription Drugs	☑
Cocaine	☐
Heroin	☑
Inhalants	☐
Methamphetamine	☐
Synthetic Drugs (i.e. Bath salts, Spice, K2)	☑
Targeted Populations	
Students in College	☑
Military Families	☐
LGBT	☑
American Indians/Alaska Natives	☐
African American	☑
Hispanic	☑
Homeless	☑
Native Hawaiian/Other Pacific Islanders	☐
Asian	☐
Rural	☐
Underserved Racial and Ethnic Minorities	☐

Footnotes:

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems	$150,000	$118,393		
2. Infrastructure Support	$53,540			
3. Partnerships, community outreach, and needs assessment	$200,000			
4. Planning Council Activities (MHBG required, SABG optional)	$5,000			
5. Quality Assurance and Improvement	$25,000	$565,052		
6. Research and Evaluation	$25,000			
7. Training and Education	$50,000	$97,733		
8. Total	**$508,540**	**$781,178**	**$0**	**$0**

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[25] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[26] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[27]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[28] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[29] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[30]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[31] SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[32] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[33] Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[34] and ACOs[35] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[36] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[37]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[38] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[39] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

experience health insurance coverage eligibility changes due to shifts in income and employment.[40] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[41] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[42] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states? Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[43] SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[44] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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[41] TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

[42] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, http://annapoliscoalition.org/?portfolio=publications; Creating jobs by addressing primary care workforce needs, http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html

[43] About the National Quality Strategy, http://www.ahrq.gov/workingforquality/about.htm; National Behavioral Health Quality Framework, Draft, August 2013, http://samhsa.gov/data/NBHQF

[44] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, http://www.cms.gov/cciio/resources/letters/index.html; Affordable Care Act, Indian Health Service, http://www.ihs.gov/ACA/

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

The District of Columbia has taken several measure to ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

D.C. Healthy Communities Collaborative (DCHCC) Community Health Needs Assessment: The DCHCC includes: 1) a coalition of four (4) hospitals: Children's National Health System, Howard University Hospital, Providence Health System, and Sibley Memorial Hospital); 2) four (4) federally qualified health centers (Bread for the City, Community of Hope, Mary's Center, and Unity Health Care); and 3) two (2) associations (D.C. Hospital Association and D.C. Primary Care Association).

The DCHCC authored the 2016 Community Health Needs Assessment Report to serve as an evidence-based, community-driven foundation for community health improvement efforts. Four (4) priority community needs emerged: 1) mental health (prevention and treatment of psychological, emotional, and relational issues that lead to higher quality of life); 2) place-based care/bringing care to the community (care options that are convenient and culturally sensitive); 3) care coordination (deliberate organization of patient care activities and information sharing protocols among all of the participants concerned with a patient's care to achieve safer and more effective care); and 4) health literacy (ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions).

Federally Qualified Health Centers (FQHCs): More commonly known as Community Health Centers (CHCs) are community-based and patient-directed primary care centers. They serve those who have limited access to health care and include low income individuals, the uninsured and underinsured, immigrants, those who are homeless, and those who live in public housing. During FY 2017, the FQHCs below provided services in the District of Columbia.

Community of Hope- Creates opportunities for low-income families in the District including those experiencing homelessness to achieve good health, a stable home, family-sustaining income, and hope. There are three (3) locations in the District.
Elaine Ellis Center of Health – Provides comprehensive primary care and social services to residents in the District.
Family and Medical Counseling Services – Employs community-based, culturally competent approaches to provide comprehensive services that promote the emotional competent approaches to provide comprehensive services that promotes emotional and physical health of families and individuals, regardless of income or socioeconomic status in an effort to maximize quality of life.

La Clinica Del Pueblo- Serves the Latino and immigrant populations of Washington DC metropolitan area. The goal is to provide culturally appropriate health services, focusing on those most in need.

Mary's Center for Maternal and Child Care, Inc.- Provides health care, family literacy and social services to individuals whose needs often go unmet by the public and private systems. It uses a holistic, multipronged approach to help each participant access individualized services that set them on the path toward good health, stable families, and economic independence. Mary's Center is a DBH Mental Health Rehabilitation Services (MHRS) core services agency and has three (3) District health locations.
Unity Health Care Inc.- Promotes healthier communities through compassion and comprehensive health and human services, regardless of ability to pay. Unity Health Care has 10 clinics sites, 11 homeless sites, three school-based health centers and two other specialty sites.

Whitman Walker Clinic- The mission is to provide high quality, culturally competent community health center services to District's diverse urban community, including individuals who face barriers to accessing care, and with a special expertise in Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) and HIV care. There are two (2) centers in the District.

Bread for the City- This FQHC look-a-like provides District residents with comprehensive services, including food, clothing, medical care, and legal and social services. There are two (2) centers in the District.

Integration of Behavioral Health and Primary Care
Health Homes/MY DC Health Home: On January 2016 DC Department of Health Care Finance (DHCF) and the Department of Behavioral Health (DBH) implemented a Health Home State Plan benefit which targets individuals with severe and persistent mental illness, and aim to: (1) improve the integration of physical and behavioral health care; (2) lower rates of hospital emergency department use; (3) reduce avoidable hospital admissions and re-admissions; (4) reduce healthcare costs; (5) improve the experience of care, quality of life and consumer satisfaction; and (6) improve health outcomes. Medicaid providers that deliver Health Home services are DBH certified Core Services Agencies and Assertive Community Treatment (ACT) providers that meet specific standards as part of DBH's Health Home certification process. Health Home providers serve as the central point for coordinating patient-centered and population-focused care, and will be responsible for integrating behavioral and primary care for eligible individuals. Health Home providers utilize a team-based approach, built on evidence-based care management guidelines. Providers also collaborate with DC Medicaid Managed Care Organizations (MCOs), Dual-Eligible Special Needs Plans (D-SNPs), primary care providers (PCPs) and hospitals for the exchange of data critical to ensuring that the right people receive services, at the right time.

Health Homes 2/MYHealth GPS: The District of Columbia's (District) Department of Health Care Finance (DHCF) is launching a care coordination benefit for Medicaid beneficiaries with multiple chronic conditions, called My Health GPS. As part of the District's My Health GPS program, interdisciplinary teams embedded in the primary care setting will serve as the central point for integrating and coordinating the full array of eligible beneficiaries' primary, acute, behavioral health, and long-term services and supports to improve health outcomes and reduce avoidable and preventable hospital admissions and ER visits. Unlike DHCF's initial Medicaid Health Home benefit (My DC Health Home) where individuals must have a severe mental illness to receive services, the My Health GPS program will deliver care coordination services to beneficiaries with multiple chronic conditions, enrolled in either Fee-For-Service or Managed Care. The District's My Health GPS program began in July 2017.

DC Mental Health Access in Pediatrics (DC MAP): In an effort to promote integration of behavioral health and primary care, DBH developed the Quality Improvement Mental Health Learning Collaborative and the DC Mental Health Access in Pediatrics (DC-MAP) program. There are two primary initiatives: 1) annual, universal mental health screening through the pediatric primary care provider and 2) DC Mental Health Access in Pediatrics (DC MAP), a children's mental health consultation program for pediatricians and primary care physician practices. Through the DC-MAP, DBH works with pediatricians to identify problems early and conduct an annual mental health screening within a primary care visit. This initiative promotes the integration of behavioral health and primary care for children and recognizes mental wellness as part of a good health. To support the program, DHCF issued a new billing code for mental health screening during an annual well child visit. This unique code also allows collection of data on the number of screens completed and the number of positive screens across the District Participating practices serve children in all wards and cover approximately 80 percent of the children enrolled in Medicaid. Practices also have access to on-call child psychiatrist, psychologist, social worker and a care coordinator for behavioral health consultation regarding diagnosis or medication management.

The Assessment and Referral Center (ARC), under the Clinical Services Administration is the primary entry-point for adults (21 years and older), seeking publicly funded treatment for SUD and referrals for other services. The ARC is a walk-in and appointment-based facility which conducts treatment assessments, TB, HIV/HEP-C Testing services, HIV pre and post counseling, linkage and referral to treatment. ARC clinicians conduct Substance Use Disorder (SUD) Assessments and referral to SUD Treatment. In

addition, DBH utilizes a Mobile Assessment and Referral Center (MARC) for same day services where they are able to provide the same services as the ARC (conduct TB, HIV/HEP-C testing services, TB and HIV pre and post counseling and referral to treatment such as the TB clinic. Nurse conduct primary health assessment and referral to services as needed.

Seriously Emotionally Disturbed (SED) Youth with Aggressive Behavior in community and inpatient care settings: In FY 17, DBH received technical assistance from the National Association of State Mental Health Program Directors to address an increase in acts of physical aggression among youth with SED in inpatient settings.. The consultant report reviewed findings from the literature on local and national efforts to prevent and manage physical aggression in youth, included information on effective screening, evidenced-based approaches to intervention/treatment, outcomes, and limitations. The consultant conducted initial planning calls with representatives of the two impacted acute inpatient care hospitals, followed by an on-site visits, presentations of materials, discussed options, and provided guidance to meet the District's needs. Follow-up consultation will be provided remotely as needed to help ensure successful the implementation of recommendations.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

Approximately 70% of SUD clients have also received mental health services within the same year. This data has facilitated the need to fully integrate the two systems and address client's needs for co-occurring care. DBH has made significant progress in building the necessary infrastructure and a coordinated, integrated system of care for substance abuse treatment and recovery services, since the merger of the two (2) agencies in FY 2014. The District continues to develop access to care for individuals needing co-occurring treatment.

The award of the State Youth Treatment (SYT) grant from SAMHSA has enabled the District to enhance co-occurring treatment within the adolescent treatment network, the Adolescent–Community Reinforcement habilitation Approach (A-CRA) was selected as the evidence-based practice to implement the SYT services. The A-CRA model incorporates primary care into the treatment modality as well as the various other family and community supports. The Adolescent Community Reinforcement Approach (A-CRA) is a behavioral intervention that seeks to replace environmental contingencies that have supported alcohol or drug use. This outpatient program uses pro-social activities and behaviors that support recovery and has guidelines for three types of sessions: adolescents alone, parents/caregivers alone, and
adolescents and parents/caregivers together. There are 17 different A-CRA procedures that address, for example, problem-solving skills to cope with day-to-day stressors, communication skills, and active participation in pro-social activities with the goal of improving life satisfaction and eliminating alcohol and substance use problems. Role-playing/behavioral rehearsal is a critical component of the skills training used in A-CRA, particularly for the acquisition of better communication and relapse prevention skills. Homework between sessions consists of practicing skills learned during sessions and participating in prosocial leisure activities. The addition of this EBP supports This initiative has built capacity building within both the adolescent and adult SUD treatment provider networks. as well as the workforce in the adolescent system. In FY 2017 continuing into FY 2018 DBH is expanding these services to the transitional aged youth (TAY) in the Adult Substance Abuse Rehabilitation Services (ASARS) programs, which is Medicaid reimbursable.

Additionally, in July 2017, the D.C. Department of Health Care Finance (DHCF), the single state agency for Medicaid, launched My Health GPS. DHCF a per member per month payment to approved primary care
providers who deliver comprehensive care management services to District Medicaid beneficiaries with three or more qualifying chronic conditions. Primary care providers through incentivized payments will be held accountable for providing and coordinating patient's care with others as defined in the individualized care plan. Services rendered are geared toward: 1) improving the integration of physical and behavioral health care; and 2) reducing health care costs by the reduction of Medicaid beneficiaries' use of emergency department non-emergency visits; and 3) the reducing preventable hospital admissions and re-admissions. The primary care provider is also expected to improve the quality of care and quality of services delivered and improve health outcomes.

In January 2016, the Department of Behavioral Health in conjunction with DHCF implemented Health Homes 1. Mental Health providers received a per member per month reimbursement for doing the same task as described above. The differences between the two (2) programs are as follows:

Eligibility for Health Homes 1 is determined by an individual having a serious mental illness only.

A mental health provider is responsible for providing mental health services and coordinating care with the primary provider as well as family members and stakeholders as defined in the individualized care plan.

There is no incentive payment at this point for Health Home 1 providers.

The Medicaid beneficiary can choose the Health Home that best meets his or her needs.

At present, a work group comprised of the Department of Behavioral Health and the D.C. Department of Health Care Finance (DHCF), the single state agency for Medicaid, are currently utilizing the Centers for Medicare and Medicaid Services (CMS) requirements to analyze parity compliance.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? (●) Yes ( ) No

and Medicaid? (●) Yes ( ) No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

The DBH Accountability Administration oversees provider certification; mental health community residence facility licensure; program integrity; quality improvement; incident management; major investigations; claims audits; and compliance monitoring. It issues the annual Provider Scorecard. The Accountability Administration includes a new division called Program Integrity that strengthens provider oversight and overall system performance review. The Administration components are described below.

• Office of Accountability- leads the Accountability Administration by providing oversight and management of DBH certification, licensure, incident management, and program integrity activities.

• Investigations Division- conducts major investigations of complaints and certain unusual incidents and develops the final investigative report submitted to the agency Director, General Counsel, and other appropriate parties that includes recommendations for remedial action.

• Licensure Division- reviews and processes applications for licensure for Mental Health Community Residence Facilities (MHCRF) for approval; monitors MHCRF compliance with agency regulations and policies; and generates and enforces statements of deficiencies and corrective action plans when necessary.

• Certification Division- reviews and processes applications for certification and recertification for behavioral health providers for approval, monitors provider compliance with certification regulations and policies, and generates and enforces statements of deficiencies and corrective action plans when necessary.

• Program Integrity Division- provides oversight of certified providers through audits and reviews to ensure they meet service delivery and documentation standards for mental health and substance use disorder services.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? (●) Yes ( ) No

6. Do the behavioral health providers screen and refer for:

a) Prevention and wellness education (●) Yes ( ) No

b) Health risks such as

i) heart disease (●) Yes ( ) No

ii) hypertension (●) Yes ( ) No

viii) high cholesterol (●) Yes ( ) No

ix) diabetes (●) Yes ( ) No

c) Recovery supports (●) Yes ( ) No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? (●) Yes ( ) No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? (●) Yes ( ) No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

A work group comprised of the Department of Behavioral Health and the D.C. Department of Health Care Finance (DHCF), the single state agency for Medicaid, are currently utilizing the Centers for Medicare and Medicaid Services requirements to analyze parity compliance. A report will be issued in the fall of 2018.

10. Does the state have any activities related to this section that you would like to highlight?

There are no activities that the Department of Behavioral Health would like to highlight at this time.

Please indicate areas of technical assistance needed related to this section

Determining and implementing incentivized/alternative payment methodologies.

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[45], **Healthy People, 2020**[46], **National Stakeholder Strategy for Achieving Health Equity**[47], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[48].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[49]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[50]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[51]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[45] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[46] **http://www.healthypeople.gov/2020/default.aspx**

[47] **http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf**

[48] **http://www.thinkculturalhealth.hhs.gov**

[49] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[50] **http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208**

[51] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please respond to the following items:

1.	Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?		
	a) Race	◉ Yes	○ No
	b) Ethnicity	◉ Yes	○ No
	c) Gender	◉ Yes	○ No
	d) Sexual orientation	◉ Yes	○ No
	e) Gender identity	◉ Yes	○ No
	f) Age	◉ Yes	○ No
2.	Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?	○ Yes	◉ No
3.	Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?	○ Yes	◉ No
4.	Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?	◉ Yes	○ No
5.	If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) standard?	◉ Yes	○ No
6.	Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care?	○ Yes	◉ No

7. Does the state have any activities related to this section that you would like to highlight?

The Department of Behavioral Health does not have anything to highlight at this time.

Please indicate areas of technical assistance needed related to this section

No, not at this time.

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ? Cost, (V = Q ? C)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[52], The New Freedom Commission on Mental Health[53], the IOM[54], and the NQF[55]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[56] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[57] are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[58] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

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[52] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[53] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[54] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[55] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[56] **http://psychiatryonline.org/**

[57] **http://store.samhsa.gov**

[58] **http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ○ Yes ○ No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☐ Leadership support, including investment of human and financial resources.
- **b)** ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☐ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☐ Provider involvement in planning value-based purchasing.
- **e)** ☐ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☐ Quality measures focus on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds,the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction? ○ Yes ○ No

2. Are there any concretely planned initiatives in our state specific to self-direction? ○ Yes ○ No

If yes, describe the currently planned initiatives. In particular, please answer the following questions:

a) How is this initiative financed:

b) What are the eligibility criteria?

c) How are budgets set, and what is the scope of the budget?

d) What role, if any, do peers with lived experience of the mental health system play in the initiative?

e) What, if any, research and evaluation activities are connected to the initiative?

f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

7. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard? (●) Yes ( ) No

Does the state have any activites related to this section that you would like to highlight?

The District SABG Block Grant program integrity activities include: 1) adherence to requirements set forth in the District's City-Wide Grants Manual and Source Book, 2) Department of Behavioral Health (DBH) policiesy; and 3) DBH funded programs and sub-grantee award process including DBH fiscal and program monitoring. Mayor's Office of Partnerships and Grant Services (OPGS): This Office serves as the District government's grants clearinghouse in order to effectively administer mandatory policies and procedures that govern the solicitation of competitive grant funds among District agency grant seekers and their prospective grantees and/or sub-grantees. The City-Wide Grants Manual and Source Book establishes best practices policies and procedures for the application for, acceptance of, and disbursement of private, federal and local grant funds. The Sourcebook also provides an overview of the minimum requirements for the programmatic and financial operation of grants and sub-grants awarded by the District and any of its covered agencies.

Department of Behavioral (DBH) Health Policy 716.6 Screening for Eligibility to Participate in Federal Health Care Programs and to Contract with the District of Columbia Government: The Department will not contract with or employ individuals or entities that are ineligible to participate in federal health care programs or are ineligible to contract with the government of the District of Columbia. Section 4d. Exclusion List contains three (3) lists that provide information on any individual or entity excluded from participation in any federal health care program or from contracting with the District of Columbia. They include: 1) the List of Excluded of Individuals/Entities (LEIE) database maintained by the Department of Health and Human Services (DHHS), Office of Inspector General, (OIG) of individuals or entities excluded by the OIG; 2) the General Services Administration (GSA) Excluded

Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including exclusion actions taken by the OIG; and 3) the District of Columbia Excluded Party List maintained by the District's Debarment and Suspension Panel. The Mental Health Block Grant sub-grantee organizations are screened against these lists. SABGPT- Block Grant DBH and Sub-Grantee Awards: The process begins with the notice of funding availability (NOFA) and request for applications (RFA) announcement, which widely distributed and follows the OPGS and Sourcebook requirements. The proposals are reviewed that will include the DBH Behavioral Health Council input. The review panel recommendations are forwarded to the DBH Director for review and final approval. DBH SABGPT- Block Grant Program and Fiscal Monitoring: The fiscal grant monitors conduct an orientation that addresses issues related to: 1) use of grant funds; 2) administrative requirements; 3) board of directors; 4) audits; 5) reporting requirements; 6) fund disbursement plan; 7) advance invoice submission; 8) expenditure report submission; 9) allowable and unallowable costs; 10) food costs; 11) travel procedures; 12) budget modifications; 13) interest checks; and 14) program close-out. They also collect fiscal information from the sub-grantees, enter the financial information into the DBH financial management system, monitor fiscal activity and reporting, and conduct payment processing. The Mental Health Block Grant Program Manager oversees the programmatic aspects of the DBH programs and sub-grantee awards. This includes: 1) review and approve the sub-grantee progress and other reports; 2) review and approve sub-grantee requests for program and budget modifications prior to implementing the proposed changes; 2) review the Mental Health Block Grant weekly expenditure report; and 3) work with the sub-grantee and fiscal monitors to resolve any issues related to the project.

Please indicate areas of technical assistance needed to this section

No, not at this time.

Footnotes:

Environmental Factors and Plan

8. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[59] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[59] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

2. What specific concerns were raised during the consultation session(s) noted above?

Does the state have any activites related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

9. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- [x] Data on consequences of substance using behaviors
- [x] Substance-using behaviors
- [x] Intervening variables (including risk and protective factors)
- [ ] Others (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- [ ] Children (under age 12)
- [x] Youth (ages 12-17)
- [x] Young adults/college age (ages 18-26)
- [x] Adults (ages 27-54)
- [x] Older adults (age 55 and above)
- [x] Cultural/ethnic minorities
- [x] Sexual/gender minorities
- [ ] Rural communities
- [ ] Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- ☐ Archival indicators (Please list)
- ☑ National survey on Drug Use and Health (NSDUH)
- ☐ Behavioral Risk Factor Surveillance System (BRFSS)
- ☑ Youth Risk Behavioral Surveillance System (YRBS)
- ☐ Monitoring the Future
- ☐ Communities that Care
- ☑ State - developed survey instrument
- ☐ Others (please list)

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? ◉ Yes ○ No

If yes, (please explain)

Needs assessment data is used as a guide in strategically developing prevention efforts that align with SAMHSA's Six (6) Core Strategies. The assessment data provides support for the areas in greatest need and also provides a historical perspective for strategies and approaches that have worked.

If no, (please explain) how SABG funds are allocated:

Does the state have any activities related to this section that you would like to highlight?

No, not at this time.

Please indicate areas of technical assistance needed related to this section

No, not at this time.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? ○ Yes ◉ No

If yes, please describe

While the DC Department of Behavioral Health (DBH) does not have a statewide licensing or certification program, it has supported approximately 25 individuals in becoming Certified Prevention Specialists through the International Certification and Reciprocity Consortium (IC&RC).

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? ◉ Yes ○ No

If yes, please describe mechanism used

The DC Department of Behavioral Health (DBH) has established an email account (suds.prevention@dc.gov) that serves as a repository for training and technical assistance requests. Once the request is received, a member of the Prevention team begins the process or preparing a response based on the expressed need(s). In addition, sub-grantees are able to submit formal requests for training and technical assistance through progress reports submitted on an annual basis. Lastly, during site visits sub-grantees have the opportunity to request training and technical assistance for their staff and/or key community leaders.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? ◉ Yes ○ No

If yes, please describe mechanism used

The DC Department of Behavioral Health (DBH) has developed an assessment tool that is used by sub-grantees to formally assess community readiness in order to implement prevention strategies.

Does the state have any activities related to this section that you would like to highlight?

No, not at this time.

Please indicate areas of technical assistance needed related to this section

No, not at this time.

Narratve Question

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) ○ Yes ○ No ◉ N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** ☐ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
- **b)** ☐ Timelines
- **c)** ☐ Roles and responsibilities
- **d)** ☐ Process indicators
- **e)** ☐ Outcome indicators
- **f)** ☐ Cultural competence component
- **g)** ☐ Sustainability component
- **h)** ☐ Other (please list):
- **i)** ☑ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? ○ Yes ◉ No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? ○ Yes ◉ No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

No.

Does the state have any activities related to this section that you would like to highlight?

No, not at this time.

Please indicate areas of technical assistance needed related to this section.

No, not at this time.

Narratve Question

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☑ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☑ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☑ The SSA funds regional entities to provide prevention services.
- **f)** ☐ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☑ The SSA funds community coalitions to provide prevention services.
- **h)** ☐ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☐ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

The Strategic Prevention Framework State Incentive Grant (SPF SIG) supported development of a new Department of Behavioral Health Prevention website (www.drugfreeyouthdc.com), the "There's a Reason" Underage Drinking Campaign (www.theresareasondc.com) website, and the Synthetic Marijuana Campaign website (www.K2Zombie.DC.com). The Synthetic Marijuana website will be expanded to synthetic drugs and sustained through local funding. Information on synthetic drugs was also included on the Prevention website to provide additional coverage. In FY2018, SABG Prevention Set-Aside resources will continue to expand the DBH Prevention Website operations as needed.

The DBH Community Engagement Branch Manager will serve as lead for information dissemination along with a team of other individuals supported by the SABG. The goal is to disseminate targeted prevention messages and resources to DC youth and adults via the four DC Prevention Centers (DCPCs), website, digital engagement, social media events, and other communication channels. Digital measures are to: 1) increase the reach of synthetic drug, underage marijuana use, and underage drinking prevention messages by 20%, segment by local and acquisition channel; 2) increase the level of primary and target audiences by 1-2% each month; 3) maintain steady engagement with youth influencers (parents/caregivers, other adults); and 4) maintain steady engagement with youth.

DBH prevention staff will collaborate with DC Prevention Centers (DCPC) to:

• Update drug facts each month using the best evidence from SAMHSA, NIDA, NIAAA, and ONDCP;
• Update new information and calendar/event notices from District, Ward, and community leaders;
• Include resource request sections and continue to make available digital versions of DC substance use prevention campaign materials;
• Add contact forms for questions and suggestions from the public who do not frequently use social media or are needing immediate assistance;
• Check social media pages (Facebook and Twitter) on a regular basis and respond to immediate requests;
• Issue proactive posts describing events and activities, new resources, and digital campaign information;
• Use and create hashtags to identify new users and expand prevention messaging; and
• Repost follower and non-follower related prevention messages as appropriate.

Through non-SABG funds, DBH will expand the Synthetic Marijuana/Drug campaign for youth and young adults beyond FY 2017. Local funds supported a new Preventing Underage Marijuana Use Campaign that launched in December 2015 and will continue to be used for community engagement. This initiative was planned and coordinated with the Director of the Department of Health, a co-chair for the Mayor's Initiative 71 Task Force. The public education campaign is a component of the broader comprehensive Initiative 71 work plan. DBH prevention staff and DCPC will continue to disseminate "There's A Reason" Campaign resources this fiscal year. That campaign was adapted from the SAMHSA "Talk. They Hear You" Public Education Campaign and documenting measurable results.
In addition, the Prevention set-aside funding will be used to support the promotion of an Opioid Awareness Campaign that will launch officially in FY2018. The social marketing campaign will consist of two phases (both developed under discretionary funding); the first phase which will focus heroin use prevention for adults and the second phase that will focus on prescription medication misuse prevention for youth.
Digital engagement, campaigns, and DBH prevention branding will be updated on a quarterly basis. Content is based on formative evaluation designed to reach target audiences and segments for targeting. These social marketing campaigns include community engagement components supported by the four DCPCs.
DBH will continue to brand prevention as an integral component in achieving the agency mission. The resources for DCPCs that were created and began being disseminated in FY 2016 such as signage, banners, table top exhibits, and templates for business cards, newsletters, and flyers will continue to be used into FY 2018.
Information dissemination data is collected, analyzed and reported through the online Program Grant monitoring and evaluation system, Data Infrastructure and Reporting System (DIRS). Enhancements were made to DIRS during FY 2016 that will allow for the better collection and reporting of data; specifically for annual SABG reporting. Non-SABG funds will support the evaluation of digital media strategies through a web metric tool.

b) Education:

SABG funded DBH prevention staff and DC Prevention Center staff will continue to support education strategies that are based on DC EOW data findings, emerging community trends, and approaches that have a plausible connection to target outcomes. DBH has invested SABG, SPF SIG, and local funds for ongoing education delivered to DBH prevention staff, DC Prevention Centers, and other sub-recipients. Educational strategies included:
• Sponsoring trainings and technical assistance on the DBH prevention conceptual and operational framework (cultural humility, risk and protective factors Institute of Medicine Classification System, and the Strategic Prevention Framework five step planning process).
• Developing data driven logic models with culturally appropriate evidence-based preventive interventions for use in SPF planning.
• Using District and Ward data and Community Conversation findings to make policy, program, and resource decisions.
• Supporting the development of the prevention workforce through another wave of IC&RC Prevention Specialist trainings and testing for certification.
• Trainings and technical assistance tailored to effective prevention approaches in working with selective and indicated populations.
• Trainings and technical assistance in using the online DIRS system for submitting and monitoring monthly prevention program grant reports.
• Increasing awareness and educating District and Ward stakeholders on priority drug issues (underage drinking, underage marijuana use, synthetic drug use and Initiative 71 laws).

The next two years, SABG funds will support development of a more comprehensive and sustainable education strategy that builds needed workforce skills through structured learning processes. The priority audiences are: 1) DBH prevention staff; 2) DC Prevention Centers that reach and educate more than 35,000 community stakeholders annually; 3) key community leaders who work with the DC Prevention Centers; 4) other DBH substance use prevention sub-recipients; and 5) targeted District agency partners that are addressing risk and protective factors for anxiety and depression, violence, delinquency, and poor school performance.
Focused education strategies are to:
• Continue core trainings and seek prevention certifications that will target a minimum of 30 new individuals who are a part of the District's prevention workforce by September 30, 2019;
• Plan with the DBH Training Institute to offer and sustain core prevention certification trainings online or onsite; and
• Develop a policy, program, and business plan to implement the DC Prevention Leadership Center that supports

education and technical assistance for an expanded prevention workforce.

DBH prevention staff and the DCPCs will continue to support educational events that are based on identified substance use prevention need; in high need communities with low capacity; and with populations that have documented disparities.

c) Alternatives:

Alternative strategies will continue to be supported at the District level through DBH prevention staff and through DCPCs at the Ward level. These activities coincide with the Marion S. Barry Summer Youth Employment Program (SYEP), a locally funded initiative sponsored by the Department of Employment Services that provides District youth ages 14 to 21 with enriching and constructive summer work experiences through subsidized placements in the private and government sectors. In 2015 SYEP expanded the program to include youth ages 22-24 years old.
Particular with the older youth, DBH's Prevention Division has sought and will continue to seek to provide some of the SYEP youth with internships throughout the fall, winter, and spring months. During the fall of 2016, three youth served as interns with one youth continuing to serve for the entire year. The team will continue to look for opportunities to keep these youth engaged in positive alternatives to substance use.
While the emphasis is on earning money and learning skills to succeed in the work world, the program provides an array of opportunities to involve youth in healthy, alternative activities that exclude alcohol and other drugs. Illustrative of that, DBH prevention staff and DCPC staff were recruited by the Executive Office of the Mayor to provide information and hold Community Conversations on synthetic drugs and underage drinking with SYEP youth across the 8 Wards. They sponsored or supported youth health fairs, drug-free events and activities that involved the prevention Mobilzer. DCPCs collaborate with community-based organizations and agencies on alternative activities as part of their community education and community prevention network action plans.
In an effort to be more intentional in planning and supporting alternative activities, DBH prevention has been planning fun engagement events that will center around creating a fun atmosphere for communities within the District that are at the highest risk for substance use and other antis-social activities. To support these efforts, the DBH prevention team will work with District agency partners and DCPCs year round. DBH will be pro-active in planning structured alternative strategies across the 8 Wards with the following partners:
• DBH DOES SYEP program planners
• DC Parks and Recreation and Roving Leaders Program
• After school activities
• DCPC Community Prevention Networks

Alternative activities will focus on increasing awareness of prevention and substance use disorder resources, risks of underage alcohol and marijuana use, ward level data that lead to structured alternates at high risk times (e.g. summer months, holidays, school breaks, after school). This approach will be data-driven, pro-active opposed to reactive requests, provide consistency across Wards, and have potential for evaluation.

d) Problem Identification and Referral:

While the District has documented positive changes in some DC EOW data, the age of first use among middle school youth (cigarettes, alcohol, and marijuana) remains on average age 10. For DC high school youth the average age is 13. There is also a decline in the number of youth being assessed and treated through the four youth substance use disorders treatment programs while behavioral health needs of transitional age youth continue to increase. The most recent DBH Performance Plan includes substance use disorder objectives for prevention, treatment and recovery. The first objective, "Reduce priority risk factors that place District children, youth and families, and communities at risk for substance use and interrelated problems", will help focus DBH efforts toward earlier problem identification and referral to services.

SPF SIG funds allowed DBH and DCPC to assess 500 individuals, community-based organizations, youth and parents/caregivers on challenges related to early risk reduction that results in delayed problem identification. One challenge is that consumers are not aware of how to fully access behavioral health services due to the merger of mental health and substance use disorders.
Other FY 2018 plans included:
• A public education campaign through treatment funds to increase consumer awareness of DBH system services;
• Broader awareness of the 24 hour DBH Access Help Line that provides immediate information and assistance for prevention, treatment and recovery behavioral health services;
• Inclusion of prevention standards in Chapter 63, a first step in accessing Medicaid funds for selective and indicated populations;
• Using Partnership for Success as a mechanism to establish a DBH workgroup on youth behavior health issues across prevention treatment and recovery. The focus is on high need communities and populations with identified disparities. Revising and developing a Risk Reduction strategy/curricula that uses the five step SPF process for indicated and selective adolescent populations.

e) Community-Based Processes:

DBH will continue to allocate SABG prevention set-aside funds for four DC Prevention Centers, dynamic hubs that engage, support and help connect the many community elements needed for promoting healthy drug-free youth. Each Center

serves two Wards each (Wards 1 and 2; Wards 3 and 4; Wards 5 and 6; Wards 7 and 8). Through their grants, DCPC focus on three core functions: 1) community education; 2) community leadership; 3) community changes. These functions provide a consistent strategy but have the flexibility to address the unique characteristics and priorities of the geographic area and populations in their designated Wards. Flexibility in this community prevention system allows partnerships across Ward boundaries to address shared and emergent substance use problems.
The FY 2018 scope of work includes the following requirements:
Administrative Leadership:
• Ensure staffing patterns that include one full-time Project Director/Coordinator and two
Community Mobilizer FTE's that share responsibilities for the three core functions.
• Attend DBH required roundtables, technical assistance and trainings.
• Submit and revise as needed monthly program reports through the online Data
• Infrastructure Reporting System.
• Submit quarterly financial reports and revise as needed.
• Participate in at least one DCPC grant site visit in cooperation with DBH.
• Attend the National Association of State Alcohol and Drug Directors Prevention Research Conference and the SAMHSA Prevention Day. DCPC funds to attend other conferences require written permission from DBH.
• Allocate a maximum of 10% of the grant funds for indirect or overhead costs.
Community Education: This function is designed to provide current, comprehensive and relevant information for a wide range of audiences within the Prevention Center's respective geographic areas.
• Market as a DCPC using DBH provided templates (logo, business cards, letterheads, etc.)
• Provide an "early warning system", track and recommend actions to address new drug trends within the two Wards.
• Disseminate science-based substance abuse prevention education materials within with two Wards.
• Coordinate and support District and National campaigns (e.g. SAMHSA Week, "Talk.
They Hear You.", Synthetic Drug Campaign, and the Underage Marijuana Campaign).
• Use the Community Conversation Guidance document for implementing Community
Conversations and submit findings and recommendations in the monthly program progress report.

Community Leadership: This function is designed to identify, engage, and strengthen the capacity of community prevention partnerships in order to address the areas placing youth at risk for substance use disorders.
• Strengthen and maintain an accessible database of prevention partners involved in the DCPC scope of work.
• Strengthen and maintain an accessible database of prevention strategies that are currently being implemented by prevention partners within the two Wards.
• Identify and support the development of community prevention networks that broaden the reach of DCPC.

Community Changes: This function increases opportunities for pro-active prevention action planning around Ward specific DCEOW data and measurable changes in prevention policy, programs and practices.
• Use the Strategic DC Strategic Prevention Framework (SPF) to mobilize and facilitate data-driven planning with community prevention networks.
• Support community prevention networks in the implementation of the implementation of the SPF logic model and action plan.
• Document community changes by tracking changes in policies, programs, and practices related to implementation of the action plan.

DCPC SABG scope of work and work plan will continue to target three levels of measurable outcomes: 1) priority risk and protective factors; 2) community changes in policies, programs and practices; and 3) distal or behavioral outcomes.
DBH will modify the existing DCPC scopes of work based on DCEOW data and evaluation findings.
Within the community-based process strategy, DCPCs will continue to address the spectrum of prevention interventions: universal, selective and indicated. DIRS program reports collect information on IOM categories and demographics.
DBH has built on the DCPC core services for other discretionary grants such as SPF SIG and now the Strategic Prevention Framework Partnership for Success Grant. Each funding source requires a separate grant and grant scope of work. There are also separate DIRS modules for submitting online program grant reports to better ensure SABG dollars are used to fund primary substance abuse prevention services not funded through other means.

f) Environmental:

SABG funded DBH prevention staff and DCPCs will disseminate underage drinking prevention, underage marijuana prevention, synthetic narcotics prevention and tobacco prevention social marketing materials in FY 2018 to increase understanding of District laws pertaining to youth and adults. The preventing underage marijuana use social marketing campaign will focus on the laws pertaining to passage of Initiative 71 and the behavioral health risks associated with underage use. SABG funded DBH prevention staff will continue to serve on District task forces such as the Criminal Justice Coordinating Council New Psychoactive Substances Workgroup to identify policy and program environmental changes needed to address synthetic drug issues. The DBH Prevention Services Manager will continue to participate on the Heroin Task Force chaired by the Director of the Department of Health and attended by the DBH Director and other executive leadership.
The DCEOW and SAMHSA Barometer data documents the need to continue our focus on underage drinking, underage marijuana use, and synthetic drugs.

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

If yes, please describe

The DC Department of Behavioral Health (DBH) allocates the budget per the terms and conditions of the SABG award (e.g., the set -aside requirement for Primary Prevention). In addition, the Primary Prevention set-aside requirement of SABG funds support a four (4) DC Prevention Centers at approximately $240,000 each ($960,000 total) who serve as prevention hubs within the community and provides coverage for the District's eight (8) wards. Lastly, the Primary Prevention set-aside goes towards supporting five (5) DBH Prevention Services staff.

Does the state have any activities related to this section that you would like to highlight?

No, not at this time.

Please indicate areas of technical assistance needed related to this section.

No, not at this time.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☑ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** ☑ Includes evaluation information from sub-recipients
- **c)** ☑ Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** ☑ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☑ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please list:)
- **g)** ☐ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- **a)** ☑ Numbers served
- **b)** ☐ Implementation fidelity
- **c)** ☐ Participant satisfaction
- **d)** ☑ Number of evidence based programs/practices/policies implemented
- **e)** ☑ Attendance
- **f)** ☑ Demographic information
- **g)** ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy use
- ☐ Binge use

- ☐ Perception of harm
- **c)** ☑ Disapproval of use
- **d)** ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- **e)** ☐ Other (please describe):

Footnotes:

Environmental Factors and Plan

11. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/social)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Are you considering any of the following:

	Targeted services for veterans	(•) Yes ( ) No
	Expansion of services for:	
(1)	Adolescents	(•) Yes ( ) No
(2)	Other Adults	(•) Yes ( ) No
(3)	Medication-Assisted Treatment (MAT)	(•) Yes ( ) No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Either directly or through and arrangement with public or private non-profit entities make pernatal care available to PWWDC receiving services? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Are you considering any of the following:

a) Open assessment and intake scheduling (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare (●) Yes ( ) No

d) Inclusion of recovery support services (●) Yes ( ) No

e) Health navigators to assist clients with community linkages (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, custody issue (●) Yes ( ) No

g) Providing employment assistance (●) Yes ( ) No

h) Providing transportation to and from services (●) Yes ( ) No

i) Educational assistance (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The DBH Accountability Administration oversees provider certification; SUD pregnant women and women with dependent children ; program integrity; quality improvement; incident management; major investigations; claims audits; and compliance monitoring. It issues the annual Provider Scorecard. The Accountability Administration includes a new division called Program Integrity that strengthens provider oversight and overall system performance review.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	(•) Yes ( ) No
b)	14-120 day performance requirement with provision of interim services	(•) Yes ( ) No
c)	Outreach activities	(•) Yes ( ) No
d)	Syringe services programs	(•) Yes ( ) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(•) Yes ( ) No

2. Are you considering any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	(•) Yes ( ) No
b)	Automatic reminder system associated with 14-120 day performance requirement	(•) Yes ( ) No
c)	Use of peer recovery supports to maintain contact and support	(•) Yes ( ) No
d)	Service expansion to specific populations (military families, veterans, adolescents, older adults)	(•) Yes ( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (•) Yes ( ) No

2. Are you considering any of the following:

a)	Business agreement/MOU with primary healthcare providers	(•) Yes ( ) No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	( ) Yes (•) No
c)	Established co-located SUD professionals within FQHCs	( ) Yes (•) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIC in areas that have the greatest need for such services and monitoring the service delivery? (•) Yes ( ) No

2. Are you considering any of the following:

a)	Establishment of EIS-HIV service hubs in rural areas	○ Yes ◉ No
b)	Establishment or expansion of tele-health and social media support services	◉ Yes ○ No
c)	Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS	◉ Yes ○ No

Syringe Service Programs

1.	Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)?	◉ Yes ○ No
2.	Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?	◉ Yes ○ No
3.	Do any of the programs use SABG funds to support elements of a Syringe Services Program?	○ Yes ◉ No

If yes, plese provide a brief description of the elements and the arrangement

No, not at this time.

Criterion 8,9&10

Syringe System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — ○ Yes ◉ No

2. Are you considering any of the following:

- **a)** Workforce development efforts to expand service access — ◉ Yes ○ No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — ◉ Yes ○ No
- **c)** Establish a peer recovery support network to assist in filling the gaps — ◉ Yes ○ No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — ◉ Yes ○ No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — ◉ Yes ○ No
- **f)** Explore expansion of service for:
  - **i)** MAT — ◉ Yes ○ No
  - **ii)** Tele-Health — ◉ Yes ○ No
  - **iii)** Social Media Outreach — ◉ Yes ○ No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? — ◉ Yes ○ No

2. Are you considering any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — ◉ Yes ○ No
- **b)** Establish a program to provide trauma-informed care — ◉ Yes ○ No
- **c)** Identify current and perspective partners to be included in building a system of care, e.g. FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — ◉ Yes ○ No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449) — ◉ Yes ○ No

2. Are you considering any of the following:

- **a)** Notice to Program Beneficiaries — ◉ Yes ○ No
- **b)** Develop an organized referral system to identify alternative providers — ◉ Yes ○ No
- **a)** Develop a system to maintain a list of referrals made by religious organizations — ◉ Yes ○ No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — ◉ Yes ○ No

2. Are you considering any of the following:

- **a)** Review and update of screening and assessment instruments — ◉ Yes ○ No
- **b)** Review of current levels of care to determine changes or additions — ◉ Yes ○ No
- **c)** Identify workforce needs to expand service capabilities — ◉ Yes ○ No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Are you considering any of the following:

a) Training staff and community partners on confidentiality requirements — (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — (●) Yes ( ) No

c) Updating written procedures which regulate and control access to records — (●) Yes ( ) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure — (●) Yes ( ) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — ( ) Yes (●) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

DBH provides SABG funding to 15 providers annually.

3. Are you considering any of the following:

a) Development of a quality improvement plan — (●) Yes ( ) No

b) Establishment of policies and procedures related to independent peer review — ( ) Yes (●) No

c) Develop long-term planning for service revision and expansion to meet the needs of specific populations — (●) Yes ( ) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — (●) Yes ( ) No

If YES, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

Independent Peer Review

DBH works closely with providers to ensure the delivery of quality services to their consumers. As part of this effort, DBH assesses community behavioral health best practices and compliance with DBH policy requirements within our network. The Quality Improvement activities reside within the Accountability Administration, which has instituted a number of internal and external workgroups that informs the continuous quality improvements process.

DBH provides SABG funding to 15 providers annually. To ensure independent peer review requirements are met, DBH has accepted the Commission on the Accreditation of Rehabilitation Facilities (CARF) and or Joint Commission (JCO) certification in lieu of an independent peer review of the funded providers. The state follows Federal regulations for block grant sub-recipients who must have CARF or JCO certification to operate the business. All MAT's must apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion certification and to receive block grant funds.

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? (●) Yes ( ) No

2. Are you considering any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service (●) Yes ( ) No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ( ) Yes (●) No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opertunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state (●) Yes ( ) No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services (●) Yes ( ) No

c) Preformance-based accountability (●) Yes ( ) No

d) Data collection and reporting requirements (●) Yes ( ) No

2. Are you considering any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs (●) Yes ( ) No

b) Addition of training sessions designed to increase employee understanding of recovery support services (●) Yes ( ) No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services (●) Yes ( ) No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort (●) Yes ( ) No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ( ) Yes (●) No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ( ) Yes (●) No

b) Early Intervention Services Regarding HIV ( ) Yes (●) No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment (●) Yes ( ) No

b) Professional Development ( ) Yes (●) No

c) Coordination of Various Activities and Services ( ) Yes (●) No

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.

https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/Chapter 63 Title 22-A 62 27 DCMR 008905.pdf

Footnotes:

The Assessment and Referral Center (ARC), under the Clinical Services Administration is the primary entry-point for adults (21 years and older), seeking publicly funded treatment for SUD and referrals for other services. The ARC is a walk-in and appointment-based facility which conducts treatment assessments, TB, HIV/HEP-C Testing services, HIV pre and post counseling, linkage and referral to treatment. ARC clinicians conduct Substance Use Disorder (SUD) Assessments and referral to SUD Treatment. In addition, DBH utilizes a Mobile Assessment and Referral Center
(MARC) for same day services where they are able to provide the same services as the ARC (conduct TB, HIV/HEP-C testing services, TB and HIV pre and post counseling and referral to treatment such as the TB clinic. Nurse conduct primary health assessment and referral to services as needed.

In FY 2016, the DBH system conducted 6,008 unique client assessments, of which 2,460 (41%) identified heroin as the primary drug of abuse, while another 116 (2%) identified other opiates and synthetics as the primary drug of abuse. Taken together, individuals whose primary SUD problem was either heroin or other opiates constituted 43% (n=2,576) of all assessments conducted in the DBH SUD treatment system.

For FY2016, 52% of these individuals were between the ages of 50 and 69.5 Individuals using opioids were 70% male (n=1,716) and 89% African American (n=2,293). In addition, 16% reported a housing status of "homeless", another 27% reported "dependent living", and 56% were living independently. These housing status data serve to further highlight the challenges faced by the District's opioid users as well as by the public SUD system serving them.

Medication Assisted Treatment, Program Capacity & Demographics

The District's SUD treatment system is partially bifurcated. DBH certifies "providers" but does not have jurisdiction over private physicians or physician groups. DBH's treatment system has 30 certified substance abuse treatment providers, of which 16 have contracts (Human Care Agreements, HCAs) to provide treatment services on DBH's behalf. The 30 certified providers operate 48 facilities throughout the city. The District currently has four (4) DBH-certified Opioid
Treatment Programs (OTPs), three of which have Human Care Agreements with the department.

Opioid Treatment Programs (OTPs)

The four DBH-certified methadone OTPs are located in Wards 2, 3, 6, and 8. They have a cumulative capacity of 2,015 (of which 1,825 slots are for public-pay clients). DBH has contracts with Good Hope Institute, United Planning Organization (UPO), and Partners in Drug Rehabilitation Counseling (PIDARC) to provide publicly funded methadone MAT. All OTPs provide psychosocial interventions either in-house or on a contract basis, per the terms of their certification and as required by District law. Additionally, the District has 77 Office-Based Opioid Treatment (OBOT) providers; however, OBOTs are not certified by DBH and therefore are not counted as "providers" above.

Good Hope Institute- Ward 8; 1320 Good Hope Road SE, Washington, DC 20020 (Capacity: 700)
• FY2016 public enrollment7: 720
UPO- Ward 6: 1900 Massachusetts Ave, SE Washington, DC 20003 (Capacity: 400)
• FY2016 enrollment: 488
PIDARC- Ward 2 2112 F St. NW, #102 Washington, DC 20037 (Capacity: 725)
• FY2016 enrollment: 841
Aquilla- Ward 3 & Ward 6 5100 Wisconsin Ave NW, Suite 307, Washington, DC 20016;
721 D Street SE, Suite 2, Washington, DC 20003 (Capacity: 190)
• FY2016 enrollment: Unavailable to DBH (all clients are non-public payers)

Enrollment at the three OTPs accepting public pay clients increased 62% from FY2015 to FY16, from 1,264 clients to 2,049 clients. These increases were driven by a significant expansion at Good Hope (from 430 to 720) and PIDARC (from 306 to 841). Enrollment at UPO actually declined over the same period (from 528 to 488). Enrollment at the three contracted OTPs was 60% male in FY2016.

Office-Based Opioid Treatment (OBOTs)

According to SAMHSA and DC DOH, there are 77 office-based opioid treatment (OBOT) locations in the District, spread across all 8 Wards (See map). Seven of the OBOT practitioners are also certified by DC Department of Health Care Finance (DHCF) to provide office-based MAT through Medicaid. As indicated on the map, the Medicaid-certified OBOTs are located in Wards 2, 5, 6, 7, and 8. There are currently no OBOTs accepting Medicaid clients in Wards 1, 3, or 4.

Detoxification & Hospitals

There are 10 hospitals in the District, in Wards 1, 2, 3, 5, & 8. The eight primary hospitals are:
• Children's National Medical Center (Ward 5) • Georgetown Univ. Hospital (Ward 2)
• George Washington Univ. Hospital (Ward 2) • Howard University Hospital (Ward 1)
• Providence Hospital (Ward 5) • Sibley Memorial Hospital (Ward 3)
• United Medical Center (Ward 8) • Wash. Hospital Center (Ward 5)

In addition, there are two psychiatric hospitals:
• Psychiatric Institute of Washington (PIW) (Ward 3) • St. Elizabeth's Hospital (Ward 8 and operated by DBH
Only Providence and PIW offers detoxification services, however DBH contracts only with PIW and Providence recently announced that they will be closing their detoxification unit. This will result in a gap in detox services for District Residents.

Focusing on the growing number of opioid overdoses, in 2015 DOH created the Heroin Overdose Taskforce. Each month, key stakeholders within the DC government convene to share information regarding current public health and law enforcement efforts related to heroin and other opioids. The stakeholders include members from DOH, as well as the Department of Behavioral Health (DBH), Office of the Chief Medical Examiner (OCME), Office of the Attorney General (OAG), Department of Forensic Sciences (DFS), Fire and EMS Department (FEMS) and the Metropolitan Police Department (MPD). The Heroin Task Force is, hosted monthly by DOH and focuses on collecting and reporting on epidemiological data and information to address issues; identify processes, systems, interventions and collaborations that will support a system-wide approach to addressing opioid use and misuse.

Charitable Choice

In October of 2002, the District implemented the Drug Treatment Choice Program (DTCP) pursuant to the District of Columbia Choice in Drug Treatment Act of 2000 (D.C. Law 13-146; D.C. Official Code § 7-3001 et seq.); which allowed the consumer the right to choose the treatment provider that would meet the consumers individual needs.

Referrals

DBH finalized new certification standards for all substance use disorder (SUD) treatment and recovery providers in September 2015.
These new standards are designed to:
1) Increase the standard of care and enhance person-centered treatment given by providers
2) Enforce the utilization of ASAM criteria standards with required treatment services by qualified practitioners
3) Support implementation of reimbursable Medicaid services for eligible individuals
4) Align the certification standards with other DBH programs to effectively link and refer clients to the proper level of treatment adhering to;
a. Chapter 63 - ASARS
b. Electronic Health Record (DATA/WITS)
c. DBH assessment and placement criteria based on the American Society of Addiction Medicine (ASAM), and Treatment and Assessment Protocol assessment tool (TAP)
And
d. Person-Centered Model of care
The Districts identified workforce has increased overtime, however with the new Chapter 63 regulatory standards reinforcing the need for qualified practitioners the SUD Provider network is experience several challenges. The Department of Behavioral Health (DBH) oversees a network of over 30 certified mental health providers and over 60 certified substance use disorder treatment service providers. DBH conducts numerous trainings for ancillary partners such as police and attorneys through the DBH Training Institute. The District and DBH currently have a shortage of licensed mental health and substance use disorder clinicians. With a rapidly growing consumer-bases and city-wide population growth, the District has a relatively low number of licensed clinicians to serve the clients in treatment and recovery.

The recent change in the District regulation call for Clinical Care Coordination, a licensed or certified Qualified Practitioner who has the overall responsibility for the development and implementation of the client's treatment plan, is responsible for identification, coordination, and monitoring of non-SUD-treatment clinical services, and is identified in the client's treatment plan. In the Districts efforts to address the whole person from a person centered lens are supported by this enhanced requirement for client's continuity of care needs for both M/SUD services across of the Behavioral Health Network.

DBH has developed a no wrong door system of care to ensure that client needs are met and access and referral to treatment is seamless. The Person-centered Cultural diversity strategic framework sets future strategic priorities and directions for in policy and service delivery processes. These polices and services are: integrate cultural and linguistic diversity into planning; monitoring and evaluation n build organizational capacity to work within culturally diverse communities, and provide culturally and linguistically responsive services and programs in behavioral health services. A very important part of this framework is planning for the future of DBH. The training institute has been an intricate part of the implementation of the Person-centered training, 2014 development and planning and will continue to provide booster and follow-up training for internal and external Provider Network staff.

The District has two formal agreements to improve referral process, thus ensuring individuals are assessed and placed in the appropriate the treatment modality of care based on individual need. Specifically the District is in the process of implementing an electronic system to enhance medical necessity, access and authorization processes for SUD treatment. This effort includes updating the current E.H.R. system, to include a new Recovery module.

Patient Records

DBH currently maintains consumer health records within an electronic health records (EHR) system, which contains all PHI information for consumers who access the network of providers. DBH requires that all behavioral health records be maintained in a manner that complies with applicable state and Federal (42 CFR Part 2) HIPPA regulations, accreditation standards, professional practice standards, and legal standards. Furthermore, the department provides ongoing training for staff and community partners regarding client confidentiality and requirements, training on responding to requests asking for acknowledgement of the presence of client. On an ongoing basis the Office of the General Council and the Transformation Systems Administration update Departmental regulations, policies and procedures which regulate and control access to records, under current Federal HIPAA laws and policies. Specifically, the Records Management Division, manages the medical records program and maintains official medical records for DBH all consumers and clients; oversees the development,

implementation, maintenance of, and adherence to DBH policies and procedures covering the privacy of, and access to, patient health information in compliance with federal and state laws and the provider's information privacy practices. While, the Network Development and Community based Services provide ongoing site technical assistance, workgroups, small committees, workshops and WebEx demonstrations.

Syringe Service Programs

Utilizing the Human Care Agreement process (State level contracting vehicle the District ensures that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes (42 U.S.C.§ 300x-31(a)(1)F). The Department's SUD network refers client to DOH's HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)needle exchange program in the District as a collaborative effort to develop the continuum of care model to support treatment and recovery. DOH/HAHSTA's policies and procedures have been developed for use by approved needle exchange programs (NEX) as guidelines for People Who Inject Drugs (PWID). Development and implementation of these policies and procedures provides direction to organizations engaged in hypodermic needle and syringe exchange in the District, and supports compliance with regulations governing the operation of such programs.

Naloxone-Related Efforts
Naloxone is administered in the community and through DC Fire and EMS Department (FEMS). Currently, the District's community naloxone distribution system is handled primarily by DOH. DOH has also worked with DHCF to ensure open prescription for naloxone (removing prior authorization) under both fee-for-service Medicaid and all three of the District's Medicaid Managed Care Organizations (MCOs). DBH's prevention branch is beginning to work much more closely with DOH, given the importance of naloxone in avoiding fatal opioid overdoses.

Community-Level Naloxone Efforts
DOH also developed a Community Naloxone Pilot Program to train staff and community members to administer naloxone. Under the program, DOH provides naloxone training and kits to Helping
Individual Persons Succeed (HIPs) and Family and Medical Counseling Services, which is also a
DBH-certified SUD treatment provider and an FQHC. In addition, naloxone is disseminated through 12 needle exchange sites, located in every ward in the District except Ward 2.

DC Fire and EMS Department (FEMS) also administers naloxone and collects data on those administrations. Broadly, rates of administration have increased significantly since January of 2015. Peak monthly administration topped out at 314 in June of 2016. However, the mean annual administrations have also been steadily rising, with an average of 145 monthly administrations in 2015, 247 in 2016, and 236 in the first 4 months of 2017 (note that winter months historically have fewer administrations). In addition, demographically, individuals who receive naloxone from FEMS are broadly similar to individuals who suffer opioid-related overdoses (fatal or non-fatal) and to individuals assessed by DBH's public SUD treatment system. Individuals receiving naloxone were 90% African American, 74% male, and 52% ages 51-70 (with another 16% ages 41-50).

Group Homes

Under the sub-grant, Oxford House is required to provide and maintain self-run, self-supported housing for recovering substance users. The target population is individuals recovering from alcoholism and/or drug addiction who can benefit from long term supportive housing in a in an alcohol/drug free environment to maintain sobriety. Priority will be given to individuals who would be homeless and those in early stages of recovery.

DBH awarded $398,700.63 (This is the FY 16-17 budget) 279,090.63 (This is FY 17 alone) to Oxford House from our SAMSHA block grant to fund outreach workers to establish homes through-out the District. This meets our federal block grant requirement to provide for and encourage the development of groups homes for recovering substance abusers, under 42 U.S.C. 300x-25. DBH does not certify or regulate Oxford House which is a model of abstinence (sober) living homes. Currently, DBH does not require a formal MOU to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing.

Professional Development

Through the Training Institute Division and the collaborative efforts from each administration, District wide trainings are offered on an on-going basis. The administrations collaborate to discuss information regarding formularies of evidence based practices, recommend trainings, provide technical assistance/guidance, and construct policy according to best practices for substance abuse standards.

The Department requires the use of EBP's to support the delivery of substance use disorder prevention and treatment services. DBH has implemented training opportunities to support the development, improvement and sustainability of methods related to evidence-based practices. Under ASARS, Chapter 63 regulations all Substance Abuse treatment and recovery programs are required to be certified through DBH's Certification Division under the Accountability Administration, including private, non-contracted substance abuse treatment and recovery programs. EBP's, governed by Chapter 63, are required by the Department in accordance with the regulations. Implementation of EBP's are reinforced through both education opportunities for providers, as well as the service review process implemented by the Accountability Administration. All EBP's qualifying of Medicaid funding are required to be registered or approved by SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP).
Performance based accountability is tracked under the purview of the Clinical Services Administration. Regulatory standards need to be met as reporting requirements for DBH certification standards. The Systems Transformation Administration is responsible for ensuring there is an

EHR in place to collect the data and report TEDS/NOMS. While, DBH's Training Institute Division provides a comprehensive list of trainings in accordance with recommendations and needs to address new/emerging trends.

The Department has developed and implemented additional trainings and workshops designed to increase employee understanding of recovery support services. The Department contracted with a vendor to develop a curriculum for which providers, staff and M/SUD peers could participate. Trainings have been and will continue to be established to address state office staff across departments and divisions. The goal is to increase staff knowledge of develop innovative programs and initiatives to support the delivery of quality services. Trainings implemented to date supports integration efforts, between internal, co-located and external staff under M/SUD.

For example, in FY 18, a "dashboard," (a daily data report which summarizes key critical agency data points), will be accessible daily for Department staff, particularly management to review. Specifically, the dashboard will allow management to make data-driven decisions and related recommendations for improvements such as trainings, based on the Departments overall performance. This information will further enhance the department's ability to ensure quality services are provided DC Residents eligible for DBH services.

Environmental Factors and Plan

12. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017? ○ Yes ◉ No

Does the state have any activities related to this section that you would like to highlight?

The Department of Behavioral Health (DBH) has adopted a quality management process; Continuous Quality Improvement (CQI) to address the need for improving the quality behavioral health services District-wide. The Department has developed and continues to revamp, a process for developing a structured approach for identifying gaps; analyzing and improving service delivery, through the use of a quality electronic health record (E.H.R.) system. The Department adopted the DATA-WITs system, an open source practice management system, to enable the agency to capture date efficiently and effectively.

Several internal and external workgroups provide data-driven reports that inform the continuous quality improvement process (CQI). The departments CQI process also promotes and encourages a Total Quality Management (TQM) environment. The TQM philosophy supports the development of strategies and techniques, which assist in the exploration of how the department can and will continue restructuring an integrative behavioral system, city-wide. These efforts will further inform how the department will continue promoting growth and sustainability, build partnerships and meaningful collaborations with community agencies. Application of data driven decisions will further enable the agency to thrive in a changing healthcare environment and provide personal job satisfaction for internal and external staff by allowing for their input, creativity and efficiency in the work that they do.

Primarily Quality Improvement (QI) activities reside within the DBH Accountability Administration (AA), Program Integrity Division, which includes both the Accountability Branch and the Community Services Review Branch, and the Systems Transformation Administration, responsible for managing data systems under the auspices of the Information Systems Innovation and Data Analytics Division (ISIDIA). The work of ISDIA, includes providing and maintaining high-quality hardware and software applications that support the provision and monitoring of consumer and client services. In terms of capturing data for the substance use services, the department has implemented the use of DATA-WITS, data and practice management system, which supports ISIDIA in in the development and production of data to inform the decision-making process.

The DBH Accountability Branch is responsible for performing continuous reviews of provider service delivery in multiple ways. It performs a yearly claims audit that is used to assess whether services are being delivered according to regulation and policy promulgated by DBH. While this is largely a compliance review, the data collected is also important for CQI activities. For instance, audits often determine that a given agency or agencies are not performing timely assessments or treatment planning. DBH issues Corrective Action Plans based on audit results that direct providers to address these issues.

In addition, staffs within the accountability office are responsible for producing the Department's annual Provider Scorecard. The DBH Provider Scorecard highlights behavioral health providers that perform well through adherence to agency, District and federal standards, while also highlighting opportunities for provider and system improvement. It makes accessible valuable information for consumers of community behavioral health services in the District as they seek out helpful sources to make informed choices about where to get community mental health care that best meets their needs. More broadly, the document serves as a lens of scrutiny and transparency available to the general public and for the residents of the District of Columbia.

DBH works closely with providers to ensure the delivery of quality services to their consumers. As part of that effort, DBH assesses community behavioral health best practices and compliance with DBH policy requirements within our system. These data sources allow DBH to compile the Provider Scorecard. In compiling the Scorecard, DBH utilizes programmatic expertise and data collection and analysis techniques to create and present a useful process performance document, that includes the Overall Score and 'star rating' afforded to providers. DBH publishes provider scores each year on its website.

The Program Integrity Division also houses the Community Services Review unit. The CSR unit performs community service reviews (sometimes called quality service reviews) on participants in the District public behavioral health system. The CSR is a process of guided interviews based on a published protocol that collects information on all the services provided to a randomly chosen consumer participant. The aggregate data collected by these interviews are used to inform technical assistance to particular providers and the system as a whole. The protocol is used for: (1) appraising the current status of persons receiving services (e.g., adults with serious and persistent mental illness) in key life areas and (2) determining the adequacy of performance of key practices for these same persons. The protocol examines short-term results for adults with mental illness and any home providers

and the contribution made by local providers and the service system in producing those results. Case-based review findings are used in stimulating and supporting efforts to improve services for consumer and clients who are residents of the District of Columbia.

Program Integrity also holds quarterly Quality Council meetings that include all providers as participants. This allows for providers to communicate concerns about quality issues affecting the system, as well as for DBH to inform providers of issues of which they should be aware.

Please indicate areas of technical assistance needed related to this section.

No, not at this time.

Footnotes:

Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

Trauma [60] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[61] paper.

60 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

61 *Ibid*

Please respond to the following items

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues? (●) Yes ( ) No

2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers? (●) Yes ( ) No

3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care? (●) Yes ( ) No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight.

As part of the screening and assessment process with DBH, whether through the agency's primary assessment site the DBH-Assessment and Referral Center (ARC), the contracted court system assessment center, contracted detox service providers, Department of Corrections (DOC) assessment office, the HIV-EIS contracted provider under the auspices of a local Federally Qualified Healthcare Center (FQHC), there is a thorough biopsychosocial assessment conducted on each individual entering our system. This process consists of a GAIN SS for adults, which supports the identification of the severity of need for further substance use or mental health challenge assessment. If the need for a more comprehensive assessment is identified, consumers are then assessed using the Treatment Assessment Protocol (TAP), which is a combination of the American Society of Addictions Medicine Patient Placement Criteria (ASAM-PPC) and the GAIN-I. The TAP includes several trauma assessment questions, which directly correlates to the identified problems and subsequent goals on the individual treatment plan. All individuals receiving

District funded substance use treatment services are assessed using the TAP, either at the ARC, or at one of the two designated detox entry sites into the treatment system. At present, District Providers implement the use of Trauma Recovery and Empowerment model, Cognitive Behavioral Therapy (CBT) and Cognitive Behavioral Interventions (CBI). Additionally, DBH is reviewing the state regulations for adult substance use services, under Chapter 63 regulations, to include explicit policies to n support the use of specific EBP's including those addressing trauma concerns.
All District funded substance use providers are governed by the agency's Title 22A, Chapter 63 Certification Standard, which speaks to the need for providers to coordinate individualized care for the population seeking services, to ensure consumers are connected to services based on individualized needs identified in their treatment plans. Specific policies incorporate the requirement to ensure individuals are placed in the appropriate level of care (modality), and that treatment interventions and techniques which address trauma are included in the individualized treatment plans.
DBH provides the provider network with training, which includes Integrated Dual Diagnosis Treatment, Patient-Centered Training and other treatment related trainings to support trauma-informed care. The Departments partnership with the Child and Family Services Agency created an opportunity for providers to be trained in Trauma Systems Therapy.
The Department has partnered with Child and Family Services (CFSA) the District's child welfare agency to provide trauma informed care training to the adolescent substance abuse providers. The DC CFSA is in their last year of a five year federal grant, which was designed to establish and strengthen trauma-informed care as the foundation of serving children and youth in the District's child welfare system. In collaboration with other youth serving community agencies, CFSA chose the Trauma Systems Therapy (TST) Model. The TST model focuses on addressing trauma in two ways (1) a traumatized child or youth who cannot regulate his/her emotional state and (2) a social environment/system of care that cannot help contain this regulation. TST focuses on the child and on his/her relationships and surroundings.

National data shows that identified adverse childhood experiences (ACE) have had a negative impact, on youth and adults, with approximately 70 percent of the population having documented ACE experiences. The Department's Office of Prevention is focusing the DC Epidemiological Outcomes Workgroup on collecting and analyzing ACE data to identify early childhood risk and protective factors that can be used to target early preventive interventions. DCEOW representatives include a cross-cutting team of District leaders from: the Alcoholic Beverage Regulation Administration, Child and Family Services Administration, Department of Youth Rehabilitation Services, Metropolitan Police Department, Office of the State Superintendent of Education, Department of Health, and the Children and Youth Investment Trust Corporation. This work will set the stage for a renewed look at the risk and protective factor model especially in urban areas and culturally diverse populations. As the developers of the Social Immunization Approach to Public Health and Substance Abuse stated in an editorial published in the Journal of the National Medical Association: Overall data on illicit drug use hides the fact that residents of some communities are at greater risk than those living elsewhere. For example, we know there is substantially higher prevalence of illicit drug use among inner-city residents than among those who reside in suburban or rural areas. It is essential that these high-risk communities be specifically identified so that the available drug control resources can be provided to them on a priority basis. The editorial also supported an analysis of epidemiological and census data the zip code level in order to clearly identify affected areas. While ACE is generally considered a tool to assess individual adult trauma, DBH is focusing prevention efforts on universal, selective and indicated strategies that prevent and reduce the effects of trauma in stressful and high risk community environments.

Please indicate areas of technical assistance needed related to this section.

No, not at this time.

Footnotes:

Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[62]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[63]

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[62] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. **OJJDP Model Programs Guide**

[63] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services? (●) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? (●) Yes ( ) No

3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system? (●) Yes ( ) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

The Department of Behavioral Health (DBH) enrolls individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansion. Through the establishment of DBH, we have focused public awareness and policy attention on the implementation of behavioral health by further investigating each client's insurance posture and engaging and enrolling people into Medicaid with substance use and/or mental health disorders who are in the justice system. We know that treatment is effective and recovery is possible, even with criminal justice involvement. Therefore, we have devised a system that best supports Medicaid participation, healthy individuals and a strong community, which includes extensive partnership with the criminal justice community. The criminal justice community benefits from DBH which integrates treatment and mental health services for District of Columbia residents, as well as residents within the criminal justice system, with both mental health and substance use disorders. DBH provides integrated care that provides SUD treatment and supports for individuals with mental health care for the dually diagnosed. A significant number of the criminal justice population has both mental health and substance use disorders at the same time. In the past treatment and supports were delivered separately, which required people seeking help for both illnesses to navigate two separate agencies, this was particularly onerous for individuals with criminal justice involvement. Therefore, with integrated treatment, any combination of needs is addressed properly. Our integrated system effectively serves individuals

involved in the criminal justice system with co-occurring disorders whether they are seeking help for substance use disorders or mental health conditions.
DBH certifies of 86 providers that treat approximately 35,000 residents for one or the other disorder, with a number of providers being dual diagnose capable. DBH ensures that pre-trial providers are competent to assess for both mental health and substance use disorders at the same time so we can design the proper treatment. DBH implements a process that sustains clinical services and maintains an infrastructure within the mental health and substance abuse systems to support integrated pre-trial service delivery. Services provided prior to adjudication and/or sentencing for individuals with mental health and/ or substance use disorders include the following:
The GAIN Short Screener (GAIN SS): The Short Screener essentially provides a screening to determine level of substance abuse severity and MH severity. A positive result supports the initiation of a referral for a full assessment using the Treatment Assignment Protocol (TAP).
Treatment Assignment protocol (TAP): The TAP provides the court with the appropriate placement into substance abuse treatment. Many Courts will rely on DBH's assessment and this can be incorporated into an order or probation requirement. With Client consent we release the assessment and drug screens to the court with appropriate referral information.
Court Urgent Care Clinic (CUCC): Individuals receive immediate access to mental health services in the court house. CUCC provides screenings and mental health assessments for Pre-trial Services Agency (PSA), which recommends release conditions and makes referrals for mental health services to DBH and contacts CSAs for mental health information, screens candidates for Options Program. Individuals are referred from Traffic Court, PSA, Judges, community agencies and others.
Options Program: Individuals who are not currently linked and have a history of non-compliance with court dates are referred to Options.
Competency Assessments and Restoration Services: Competency Restorations occurs on an inpatient or outpatient basis, based upon the specific needs profile of the client, here in D.C.

In an effort to serve District residents who have become involved with the criminal justice system, substance abuse system, and/or the mental health system, DBH and other District Departments responsible for addressing the criminal justice system, have developed, incorporated and implemented recommendations proposed by the Substance Abuse Treatment and Mental Health Services Integration Taskforce (SATMHSIT, 2009-2015). These policies were developed to improve treatment options available to defendants and ex-offenders.
The CUCC, specifically implemented the policies to expand their array of services by offering assessments and referrals to substance abuse treatment programs for individuals with substance use disorders. As it relates to juveniles, The Juvenile Behavioral Diversion Program (JBDP) was established as a problem-solving court. In order to participate in the program, the juvenile or status offender must have an Axis I mental health disorder or be at significant risk of receiving an Axis I diagnosis. The respondent may also have an Axis II developmental disability as long as he or she is able to participate in the program, but they cannot solely have an Axis II diagnosis. The Program is an intensive non-sanction based program designed to link juveniles and status offenders to, and engage them in, appropriate mental health services and supports in the community in order to reduce behavioral symptoms that result in contact with the court and to improve the juvenile's functioning in the home, school, and community.

DBH's Training Institute provides learning opportunities to employees, consumers, providers, criminal justice partners and other partners who support mental health services in the District. The Training Institute mission is to continually strengthen the knowledge, technical skills and the quality of services and supports through the development of a dynamic, culturally and linguistically responsive, performance-based and data-driven learning environment. As well there is a specific training course the Co-Occurring Certification Training (COD) which emphasizes dual diagnosis and co-occurring competent applications of service delivery. With the assistance of DBH, the Metropolitan Police Department (MPD) has trained over 730 MPD officers since the program's inception in April 2009. Approximately 125 new CIOs are trained every year, including people from other law enforcement agencies in the District such as the Capital Police, Protective Services Division, and the Metropolitan Police. In addition to these specially-trained officers, every MPD officer must receive mental health training to learn appropriate techniques to use when responding to calls-for-service involving mentally ill residents.

Please indicate areas of technical assistance needed related to this section.

No, not at this time.

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly, pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? ( ) Yes (●) No

- **a)** ☐ Methadone
- **b)** ☐ Buprenophine, Buprenorphine/naloxone
- **c)** ☐ Disulfiram
- **d)** ☐ Acamprosate
- **e)** ☐ Naltexone (oral, IM)
- **f)** ☐ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

DBH certifies four(4) medicated assisted treatment (MAT) providers in the District, three of which DBH contracts to provide methadone, while the fourth non-contracted Provider has a primary care physician on-site who prescribes suboxone. All MAT providers serve consumers across the eight (8) Wards, delivering opioid replacement therapy (ORT) and counseling services. During the initial client intake process located at an ARC location, counselors provide educational materials and guidance on the availability of MAT services in the District. Educational materials include informing the client about his/her rights, supporting the decision to access services based on individual need.

The District continues to develop and implement various marketing tools to educate the community on the use and abuse of opioids and other synthetic drugs, to include access to both treatment and preventive medications such as naloxone. Mediums for communicating information to include public services ads (PSA's), handbills, social media, and television and fact sheets. The message targets both access, use and treatment, such as medicated assisted treatment therapies, related to opioid use. Many of the campaigns focus on a targeted population, to ensure he appropriate message is delivered and received by the audience. Currently, DBH has on-going communications with the provider network, through scheduled monthly Provider meetings and or conference calls and monthly meetings specifically for MAT providers. DBH clinical and non-clinical outreach teams, in collaboration with the local Fire and Emergency Services (FEMS) office also, during a scheduled series of educational outreach efforts, used the Screening, Brief, Intervention and Referral Treatment (SBIRT) tool to conduct brief screenings and provide referral to treatment, to include MAT.

In the District, women with children and pregnant women have priority access to treatment. Under the District Court system in the CUCC clinicians test for pregnancy and if positive the client is linked to SUD treatment and primary care for the unborn child and

mother. In addition, DBH has co-located license clinical social worker (LICSW) to the local s a Mobile Assessor (Social Worker) at the Child and Family Services Administration (CFSA), government agency focusing on women's needs for SUD screening and assessments to refer to treatment. Thus, access to SUD treatment for women has s increased in that the women can be screened in multiple locations.

DBH requires that all certified MAT provider follow- the requirements under SAMHSA, DEA and FDA to ensure that approved medications are prescribed and dispensed appropriately. Providers must be certified through the DBH Accountability Administrating, which includes submission of all certifications supporting the Providers application for providing MAT and other control medicated assisted treatment therapies used to treat consumers within the MAT network system.

To support this effort, DBH applied for and was awarded an Opioid State Targeted Response (STR) grant to implement the District Opioid Targeted Strategy (DOTS), which will address all individuals in the District with or at risk for Opioid Use Disorders (OUDs). DOTS will specifically target middle-aged heroin-using African-American males because local data indicate they are most affected. Per best practices and District regulations, individuals receiving MAT must also receive other core treatment services (e.g., counseling, case management etc.) However, DBH estimates that, for as many as 300 QMB clients, while methadone providers can receive reimbursement for the methadone dosage through Medicaid/Medicare, the clinically recommended core treatment services are not covered. In addition, the District is not permitted to pay for those services out of local funds because, per local regulation, clients are only eligible for local funds if they are not eligible for Medicaid, Medicare, or another third-party insurance program. To address this barrier, the District will use grant funds to support counseling and other services for 125 high-need QMB clients annually. Medical Home Development Group (MHDG) received a sub-grant under DOTS to refer clients to primary care doctors within their primary care practice as well as coordinate their holistic care. The Clinical Care Coordinator (CCC) at MHDG will work with the CCCs at the three DBH-funded methadone clinics to transition QMB clients into care. MHDG also acquired an office at United Medical Center (UMC) Hospital to address the high number of individuals overdosing and being transported to urgent care during non-traditional hours. At discharge from UMC, clients will receive care coordination services by a qualified practitioner. This will ensure that clients can have a seamless transition to buprenorphine-based MAT in an office setting, if they choose. CCCs will not require this transition; however, they will explain the objective realities of the District methadone system and OMB clients' insurance coverage, if applicable.

Please indicate areas of technical assistance needed to this section.

No, not at this time.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

Footnotes:

Environmental Factors and Plan

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.[64] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[65],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

[64] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[65] Practice Guidelines: Core Elements for Responding to Mental Health Crisis. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please respond to the following items:

1. Crisis Prevention and Early Intervention

- **a)** ☐ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☐ Psychiatric Advance Directives
- **c)** ☐ Family Engagement
- **d)** ☐ Safety Planning
- **e)** ☐ Peer-Operated Warm Lines
- **f)** ☐ Peer-Run Crisis Respite Programs
- **g)** ☐ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☐ Assessment/Triage (Living Room Model)
- **b)** ☐ Open Dialogue
- **c)** ☐ Crisis Residential/Respite
- **d)** ☐ Crisis Intervention Team/Law Enforcement
- **e)** ☐ Mobile Crisis Outreach
- **f)** ☐ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☐ WRAP Post-Crisis
- **b)** ☐ Peer Support/Peer Bridges
- **c)** ☐ Follow-up Outreach and Support
- **d)** ☐ Family to Family Engagement

- **e)** ☐ Connection to care coordination and follow-up clinical care for individuals in crisis
- **f)** ☐ Follow-up crisis engagement with families and involved community members
- **g)** ☐ Recovery community coaches/peer recovery coaches
- **h)** ☐ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual?s mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.
SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:
Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders**.
States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Peer-run respite services
- Peer-run crisis diversion services
- Telephone recovery checkups
- Warm lines
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Shared decision making
- Person-centered planning
- Self-care and wellness approaches
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Room and board when receiving treatment

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.
Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? ( ) Yes (●) No

c) Block grant funding of recovery support services. (●) Yes ( ) No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

Persons in recovery including peers and family members are involved in the planning and implementation of the M/SUD system. This involvement includes the peer, family and youth peer certification programs and the recovery coach training.

2. Does the state measure the impact of your consumer and recovery community outreach activity? ( ) Yes (●) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Through DBH, the District certifies 14 recovery support service (RSS) providers with a total of 37 facilities. Of the certified RSS providers, eight currently provide District-funded RSS. In addition, all but one of the certified RSS providers are also DBH-certified SUD treatment providers. There are certified RSS providers in every ward except Ward 3.

In the District of Columbia, adults with SMI and youth with SED are eligible for the same standard non-clinical Recovery Support Services as individuals in substance use treatment. Our system of care encourages integrated and coordinated care between substance use and mental health providers. Consumers seeking SUD Recovery services must be admitted to SUD services. Additionally, DBH implemented youth peer certification process that will allow youth peers to support other youth currently in treatment.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

In the District of Columbia, non-clinical services are provided to an individual by a certified RSS provider to assist him/her in achieving or sustaining recovery from an SUD. There are eight (8) billable recovery support services:
1. RECOVERY SUPPORT EVALUATION
2. RECOVERY SUPPORT MANAGEMENT
3. RECOVERY COACHING (Recovery Mentoring & Coaching)
4. RECOVERY SUPPORT SERVICE: LIFE SKILLS SUPPORT SERVICES
5. SPIRITUAL SUPPORT SERVICES
6. EDUCATION SUPPORT SERVICES
7. RECOVERY SOCIAL ACTIVITIES
8. ENVIRONMENTAL STABILITY

5. Does the state have any activities that it would like to highlight?

No, not at this time.

Please indicate areas of technical assistance needed related to this section.

No, not at this time.

Footnotes:

Environmental Factors and Plan

18. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

Please respond to the following items

1. Does the state's Olmstead plan include :

housing services provided.	(•) Yes ( ) No
home and community based services.	(•) Yes ( ) No
peer support services.	(•) Yes ( ) No
employment services.	(•) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (•) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Department of Health Care Finance (DHCF)- The DHCF is the District's Medicaid agency and the primary payer for all long term services and supports (LTSS) the city provides. In FY 2016, the District spent a total of $796 million in Medicaid funds on these services; $241 million (or 30%) were local dollars. These funds pay for care in institutional settings including nursing facilities and Intermediate Care Facilities for individuals with Intellectual and Developmental Disabilities (ICF/IDDs), as well as a variety of home and community-based services (HCBS). Approximately 44% of total Medicaid funds spent on LTSS were spent on institutional care while 56% were spent on home and community-based services.
D.C. Office on Aging (DCOA- The DCOA manages the Aging and Disability Resource Center (ADRC) and funds the Senior Service Network, which together consist of more than 20 community-based organizations, operating 37 programs for District residents age 60 and older, people with disabilities (age 18-59), and their caregivers. In addition, ADRC provides information, coordinates service access, and provides direct social work services to help people move to the community and/or stay in the community for as long as possible. In FY 2015, the ADRC served 11,290 people, 9.38% of whom were 18-59 living with a disability. The remaining individuals served by ADRC are people age 60 and older who may also have a disability.
Department on Disability Services (DDS)- The DDS oversees and coordinates services for District residents with disabilities through a network of community-based, service providers. Within DDS, the Developmental Disabilities Administration (DDA) coordinates person-centered home and community services so each person can live and work in the neighborhood of his or her choice. DDA promotes health, wellness and a high quality of life through service coordination and monitoring, clinical supports, and a robust quality management program. In FY 2016, DDA served 2,363 people.

DDS's Rehabilitation Services Administration (RSA) provides comprehensive, person-centered employment services and supports for people with disabilities, pre-employment and transition services for youth with disabilities, independent living services and services for people with visual impairments. In FY 2016 RSA served 7,309 people.
Office of Disability Rights (ODR)- The ODR assesses and evaluates all District agencies' compliance with the ADA and other

disability rights laws, providing informal pre-complaint investigation and dispute resolution. ODR also provides expertise, training and technical assistance regarding ADA compliance and disability sensitivity and rights training to all D.C. agencies. ODR's current initiatives include efforts to increase access to District-owned and leased facilities, worksites and community spaces; leading monthly disability-wellness seminars and managing the District's Mentoring Program for students with disabilities.

Does the state have any activities related to this section that you would like to highlight?

• District of Columbia Olmstead Plan 2017-2020
Since 2007, the District's Office of Disability Rights (ODR) has had the responsibility of developing and submitting the city's Olmstead Compliance Plan to the Mayor for approval. In August 2015, Mayor Muriel Bowser created an Olmstead Working Group charged with making recommendations for revisions to future iterations of the District's Olmstead Plan to support this effort, and to include a broad array of voices in the process. In 2016, during its first full year of existence, the Olmstead Working Group focused its efforts on determining what data the District should track to allow for a comprehensive picture of what transition looks like for individuals leaving institutionalized care and attempting to access long-term services and supports in the District. The Group concentrated its efforts and discussion around data collection that would aid the District in its effort to create a seamless system across agencies that tracks a person's progress toward independence in a meaningful, understandable way.
? Improving Long-Term Care in the District- The District is engaged in a multi-year effort to design and implement a seamless process for accessing Long Term Services and Supports. The new system embraces the principles of No Wrong Door and will ensure that individuals receive accurate information regardless of where they enter the system. Efforts are underway to streamline and simplify the eligibility process. These efforts are supported by federal grants including a three year, No Wrong Door Implementation Grant awarded by the Administration on Community Living and CMS, as well as a major grant awarded to the Department of Health Care Finance to support the procurement of a new, multi-agency case management system. These system improvements will reduce fragmentation and the time it takes to connect to needed services.

The Olmstead Plan details remaining system challenges and lays-out specific action steps in nine (9) strategic areas. That work will take place within the context of a number of on-going District-level initiatives aimed at systems improvement. These include: Age-Friendly DC; DHCF's system reform efforts; Employment First State Leadership Mentoring; National Core Indicators work; and DC's No Wrong Door Initiative. In addition, a strong advocacy community lends its support and oversight, led by groups such as the DC Developmental Disabilities Council (DDC), Project ACTION!, the DC State Rehabilitation Council (DC SRC), and the DC Statewide Independent Living Council (SILC).

? The 2017 Olmstead Plan- The Olmstead Working Group created a multi-year Plan based on the same 9 priority areas that was the focus of the 2016 Plan: 1) A Person-Centered Culture; 2) Community Engagement, Outreach and Training; 3) Employment; 4) Housing; 5) Intake, Enrollment and Discharge Processes; 6) Medicaid Waiver Management and Systems issues; 7) Quality of Institutional and Community-Based Services, Providers and Workforce; 8) Supporting Children and Youth; and 9) Wellness and Quality of Life.
Each action step in each priority area has a measurable, trackable, and meaningful goal that will lead the District into 2020 with a cross-agency system that is more relatable, comprehensive, and based more on an individual's preferences and concrete goals while in transition.
Government Agencies- The primary District agencies are described below.
Department of Behavioral Health (DBH)- The DBH provides prevention, screening and assessment, intervention, and treatment and recovery services and supports for children, youth, and adults with mental health and/or substance use disorders. Services include emergency psychiatric care, residential services and community-based outpatient care. DBH also operates Saint Elizabeths Hospital, which is the District's inpatient psychiatric facility.
Department of Health (DOH)- The DOH Health and Intermediate Care Facility Divisions administer all District and federal laws and regulations governing the licensure, certification and regulation of all health care facilities in the District. In this role, Health Regulation and Licensing Administration (HRLA) staff inspect health care facilities and providers who participate in the Medicare and Medicaid programs, certified per District and federal laws, respond to consumer and self-reported facility incidents and/or complaints, and conduct investigations, if indicated. When necessary, HRLA takes enforcement actions to compel facilities, providers and suppliers to come into compliance with District and Federal law.

Department of Health Care Finance (DHCF)- The DHCF is the District's Medicaid agency and the primary payer for all long term services and supports (LTSS) the city provides. In FY 2016, the District spent a total of $796 million in Medicaid funds on these services; $241 million (or 30%) were local dollars. These funds pay for care in institutional settings including nursing facilities and Intermediate Care Facilities for individuals with Intellectual and Developmental Disabilities (ICF/IDDs), as well as a variety of home and community-based services (HCBS). Approximately 44% of total Medicaid funds spent on LTSS were spent on institutional care while 56% were spent on home and community-based services.
Department of Human Services (DHS)- The DHS routinely serves people with disabilities. For example, in FY 2014 approximately 17% of applicants were assessed as likely to have a mental disorder of some magnitude, and 4% to have a learning disability in income-based programs such as TANF, SNAP, and Medicaid. In the homeless services program, 40% of singles and 16% of adult head of families entering shelters were assessed to have a disability in at least one of eight (8) categories. In the Adult Protective Services program (investigates reports of abuse, neglect, exploitation and self-neglect) and provides temporary services and supports) and in some founded cases -- an estimated 45% of those served were assessed to have a disability.
D.C. Office on Aging (DCOA- The DCOA manages the Aging and Disability Resource Center (ADRC) and funds the Senior Service Network, which together consist of more than 20 community-based organizations, operating 37 programs for District residents

age 60 and older, people with disabilities (age 18-59), and their caregivers. In addition, ADRC provides information, coordinates service access, and provides direct social work services to help people move to the community and/or stay in the community for as long as possible. In FY 2015, the ADRC served 11,290 people, 9.38% of whom were 18-59 living with a disability. The remaining individuals served by ADRC are people age 60 and older who may also have a disability.
Department on Disability Services (DDS)- The DDS oversees and coordinates services for District residents with disabilities through a network of community-based, service providers. Within DDS, the Developmental Disabilities Administration (DDA) coordinates person-centered home and community services so each person can live and work in the neighborhood of his or her choice. DDA promotes health, wellness and a high quality of life through service coordination and monitoring, clinical supports, and a robust quality management program. In FY 2016, DDA served 2,363 people.

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Office of Disability Rights (ODR)- The ODR assesses and evaluates all District agencies' compliance with the ADA and other disability rights laws, providing informal pre-complaint investigation and dispute resolution. ODR also provides expertise, training and technical assistance regarding ADA compliance and disability sensitivity and rights training to all D.C. agencies. ODR's current initiatives include efforts to increase access to District-owned and leased facilities, worksites and community spaces; leading monthly disability-wellness seminars and managing the District's Mentoring Program for students with disabilities.
Office of the State Superintendent for Education (OSSE)- The OSSE is the District's state education agency. OSSE is responsible for ensuring that all education-related public agencies identify and evaluate children who may have a disability and provide an education that meets the children's individualized needs alongside peers without disabilities to the maximum extent appropriate. OSSE also has oversight of non-public special education schools -- the most restrictive educational placements for children with disabilities. In FY 2015, 12,173 children with qualifying disabilities ages 3- 21 were served. In addition, OSSE oversaw IDEA Part C early intervention services for approximately 700 infants and toddlers. Finally, OSSE operated hundreds of buses that traveled 34,000 miles per day to transport more than 3,000 students with disabilities to their schools across the region.
Other Agencies- Many other District agencies serve and support people with disabilities. In doing so, they interface on a regular basis with the agencies listed above. The other government agencies include: 1) D.C. Housing Authority (independent agency), 2) D.C. Public Libraries, 3) D.C. Public Schools, 4) Department of Child and Family Services Agency, 5) Department of Corrections, 6) Department of Housing and Community Development, 7) Department of Employment Services, 8) Department of Parks and Recreation, 9) Department of Youth Rehabilitation Services, and 10) D.C. Department of Transportation.

Please indicate areas of technical assistance needed related to this section.

No, not at this time.

Footnotes:

Environmental Factors and Plan

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community[66]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24[67]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death[68].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21[69]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs[70].

According to data from the 2015 Report to Congress[71] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[66]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[67]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593?602.

[68]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[69]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[70]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010**

[71] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? (●) Yes ( ) No

b) The recovery and resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:

a) Child welfare? (●) Yes ( ) No

b) Juvenile justice? (●) Yes ( ) No

c) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult behavioral health system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The Adolescent Substance Abuse Treatment Expansion Program (ASTEP) is the District of Columbia's adolescent substance abuse treatment. ASTEP has made substance abuse treatment more accessible by giving adolescents, as well as their families and caregivers, the ability to go directly to any ASTEP treatment program for a substance abuse assessment. Every adolescent accessing substance abuse treatment through ASTEP will be screened for indicators of a mental health disorder. Adolescents can choose the program that best fits their lives; whether the program they choose is closest to home, offers convenient hours, or provides recovery support services to help them maintain sobriety. DBH was awarded the State Youth Treatment grant from SAMHSA to enhance co-occurring treatment within the adolescent treatment network. The Evidence based practice selected to implement the SYT Services in our jurisdiction is the Adolescent –Community Rehabilitation Approach (A-CRA). The A-CRA model incorporates primary care into the treatment modality as well as the various other family and community supports. This initiative has built capacity within the network as well as the workforce in our adolescent system. In FY17 and continuing into FY18 DBH is expanding these services to the Transitional Aged Youth (TAY) in our Adult Substance Abuse Rehabilitation Services (ASARS) programs, which is Medicaid reimbursable.

Currently, DBH has a Memorandum of Understanding (MOU) between DBH and the Child and Family Services Agency (CFSA), the public child welfare agency in the District of Columbia responsible for protecting child victims and those at risk of abuse and neglect and assisting their families; CFSA personnel conducts screenings on selected cohorts of youth and adults with child

welfare involvement using the Global Assessment of Individual Needs Short Screener (GAIN-SS). For positive screening results, an electronic referral is made to the appropriate SUD treatment provider for a full assessment and, corresponding, treatment services as clinically appropriate.

7. Does the state have any activities related to this section that you would like to highlight?

No, not at this time.

Please indicate areas of technical assistance needed related to this section.

No, not at this time.

Footnotes:

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2018 End Year: 2019

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Benita Blaine	Parents of children with SED		DC,	
Doris Carter	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		915 Allison Street, NW #201 Washington DC, 20011 PH: 202-832-8336	DCarter@calvaryhealthcare.org
Yuliana Del Arroyo	State Employees	Office of the State Superintendent of Education	810 First Street NE, 9th Floor Washington DC, 20002 PH: 202-741-0478	Yuliana.delarroyo@dc.gov
Nicole Denny	State Employees		2435 Alabama Avenue, SE Washington DC, 20020 PH: 202-671-6140	Nicole.denny@dc.gov
Luis Diaz	State Employees	Criminal Justice Coordinating Council	441 Fourth St NW Washington DC, 20001	luis,diaz@dc.gov
Cheryl Doby-Copeland	State Employees		DC,	
Donna Flenory	Parents of children with SED		510 Division Avenue, NE Washington DC, 20019 PH: 202-497-3097	dlflenory@gmail.com
Mimi Gardner	Providers		DC,	
Julie Kozminski	Providers		1220 12th Street, SE, Suite 120 Washington DC, 20003 PH: 202-715-7966	jkozminski@unityhealthcare.org
Tammi Lambert	Others (Not State employees or providers)		905 6th Street, SW, Apt. 708B Washington DC, 20024 PH: 202-724-5454	Lambert.tammi@gmail.com
Evan Langholt	Providers		2100 New York Avenue, NE Washington DC, 20002 PH: 202-269-6333	evan_langholt@uss.salvationarmy.org
			220 I Street, NE,	

Jennifer Lav	Others (Not State employees or providers)		Suite 130 Washington DC, 20002 PH: 202-547-0198	jlav@uls-dc.org
Diane Lewis	State Employees	District of Columbia Health Benefit Exchange Authority	1225 I Street, NW 4TH FLOOR Washington DC, 20005 PH: 202-966-7516	dlewis@acg-cos.com
Marie Morilus-Black	State Employees	Child and Family Services Agency	200 I Street, SE Washington DC, 20003 PH: 202-442-6002	marie.morilus-black@dc.gov
Maria Newman	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1363 Spring Road NW Washington DC, 20010 PH: 202-865-3796	m_newman@howard.edu
Lynne Person	Others (Not State employees or providers)		601 E Street, NW T3-314 Washington DC, 20049 PH: 202-434-2140	lperson@aarp.org
Andrew Reese	State Employees	Department on Disability Services	1125 15th Street, NW, 4th Floor Washington DC, 20005 PH: 202-442-8606	andrew.reese@dc.gov
Timothy Robinson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1511 E Street, SE Washington DC, 20003 PH: 202-569-0151	Timrobinsonskate64@gmail.com
Evelyn Sands	Parents of children with SED		4030 Livingston Road, SE #301 Washington DC, 20032 PH: 202-271-6032	esands231@gmail.com
Claudia Schlosberg	State Employees	Department of Health Care Finance	441 Fourth Street, NW 900 South Washington DC, 20001 PH: 202-442-9075	Claudia.schlosberg@dc.gov
Senora Simpson	Family Members of Individuals in Recovery (to include family members of adults with SMI)		323 Quackenbos, NE Washington DC, 20001 PH: 202-529-2134	Ssmimp2100@aol.com
Effie Smith	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Consumer Action Network	1300 L Street, NW, Suite 1000 Washington DC, 20005 PH: 202-842-0001	esmith@can-dc.org
Sakina Thompson	State Employees	Department of Human Services	64 New York Avenue, NE 6th Floor Washington DC, 20002 PH: 202-671-4451	Sakina.thompson@dc.gov
			1133 North Capitol	

Adrienne Todman	State Employees	District of Columbia Housing Authority	Street, NE Washington DC, 20002 PH: 202-535-1513	ATodman@dchousing.org
Sara Tribe Clark	State Employees	District of Columbia Office on Aging	500 K Street, NE Washington DC, 20002 PH: 202-535-1367	Sara.tribe@dc.gov
Tamara Weissman	Providers		1104 Allison Street NW Washington DC, 20011 PH: 202-722-1815	tweissman@gafsc-dc.org
Miya Wiseman	Family Members of Individuals in Recovery (to include family members of adults with SMI)		3105 18th Street, NE Washington DC, 20018 PH: 202-270-6173	Miya714@yahoo.com
James Wotring	State Employees	DC Department of Behavioral Health	64 New York Ave. NE Washington DC, 20002	

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018 End Year: 2019

Type of Membership	Number	Percentage
Total Membership	**28**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	3	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED*	3	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	3	
Total Individuals in Recovery, Family Members & Others	**12**	
State Employees	12	
Providers	4	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	**16**	
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Persons in recovery from or providing treatment for or advocating for substance abuse services	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?
The Planning Council will be reviewing the application and any comments received will be incorporated as part of the District's revision process.

Footnotes:

Environmental Factors and Plan

23. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a)	Public meetings or hearings?	○ Yes ◉ No
b)	Posting of the plan on the web for public comment?	◉ Yes ○ No
c)	Other (e.g. public service announcements, print media)	○ Yes ◉ No

If yes, provide URL:

The Department of Behavioral Health has posted the draft of the application available at the URL below: https://dbh.dc.gov/page/behavioral-health-services-block-grants

Any comments received will be incorporated as part of the District's revision process.

Footnotes: