

District of Columbia

UNIFORM APPLICATION

FY 2020/2021 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT

and

COMMUNITY MENTAL HEALTH SERVICES

BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 09/10/2021 6.03.33 PM)

Center for Substance Abuse Prevention

Division of State Programs

Center for Substance Abuse Treatment

Division of State and Community Assistance

and

Center for Mental Health Services

Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2021

End Year 2022

State SAPT DUNS Number

Number 014384031

Expiration Date

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

Agency Name Department of Behavioral Health

Organizational Unit

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

City Washington

Zip Code 20002

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Barbara J.

Last Name Bazron

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 barbara.bazron@dc.gov

State CMHS DUNS Number

Number 14384031

Expiration Date

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

Agency Name District of Columbia Department of Behavioral Health

Organizational Unit

Mailing Address 64 New York Avenue, N.E., 2nd Floor

City Washington

Zip Code 20002

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Barbara J.

Last Name Bazron

Agency Name Department of Behavioral Health

Mailing Address 64 New York Avenue, N.E., 3rd Floor

City Washington

Zip Code 20002

Telephone (202) 673-2200

Fax (202) 673-3433

Email Address barbara.bazron@dc.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? Yes No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

V. Date Submitted

Submission Date 9/1/2020 11:49:42 PM

Revision Date 7/21/2021 10:22:50 AM

VI. Contact Person Responsible for Application Submission

First Name Estelle J

Last Name Richardson

Telephone 202-671-1352

Fax

Email Address estelle.richardson@dc.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2021

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
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

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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.
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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 Coastal 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 Clean 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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. 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, daycare, 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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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 other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee¹: _____

Title: _____

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

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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 Coastal 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 Clean 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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. 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, daycare, 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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title X-X, 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 other Certifications summarized above.

State: District of Columbia

Name of Chief Executive Officer (CEO) or Designee: Barbara J. Bazron, Ph.D.

Signature of CEO or Designee: 

Title: Director

Date Signed: 08/31/2020

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

COVID-19 Supplemental Funding Plan for FY 21

1. Identify the needs and gaps of your state SUD prevention, treatment, and recovery services systems in the context of COVID-19.

DBH Response

The COVID-19 pandemic has impacted continuity of care for individuals in need of substance use disorder (SUD) treatment. During the public health emergency, many DC residents with SUD have been unable or unwilling to seek in-person care due to fear of becoming infected with the coronavirus. In addition, many have not had access to the internet, computers, or other devices to receive on-going and necessary services and supports via telehealth.

DBH has implemented several innovations to address gaps in services identified during the pandemic to support continuity of care for this population. This includes the establishment of telehealth satellite sites within provider facilities, the provision of quarantine beds to allow persons in need of care to isolate in a safe environment prior to entering residential treatment, permitting increased take-home dosing consistent with SAMHSA guidelines. However, several gaps in service remain. The agency plans to address these additional needs with the SUD supplemental funding provided through this grant. This includes the following:

- **Electronic Medical Records Upgrade:** DATAWITS, DBH's record keeping system for SUD providers, lacks the requisite internal quality assurance capabilities for more complex data collection, analysis, and reporting. As a result, significant efforts are undertaken each year to address issues around data quality and integrity when reporting SUD treatment participation and client outcomes. DBH purchased enhancements in DATAWITS that will enable SUD providers and DBH staff to view a provider's capacity and census data, for the purpose of client referrals. However, SUD providers often produce inaccurate census data, which prevents DBH from utilizing this client data. Meeting the unmet need of supporting DATAWITS would allow DBH to discharge inactive clients and reduce the daily census calls to the providers, error messages, and technical issues that make it difficult for DBH and provider staff to analyze client data.
- **Residential Treatment Program for Youth:** Establish a level 3.5 substance use disorder treatment in a clinically managed medium intensive (CMMI) residential setting program for youth. The District does not have a residential program to treat youth (12-20 years of age) with SUD. Previously, the District sent youth to Mountain Manor Treatment Center (Baltimore, Maryland) and stopped accepting youth from the District in 2019.

In 2018, referrals for youth for the residential 3.5 Level of Care (LOC) averaged approximately 3-5 per week. Through this grant, The District has an opportunity to provide youth residential treatment services locally, which is a cost savings as transportation to Baltimore was covered by the District through various resources (fleet vehicles, mileage, fuel, FTE labor, etc.). In an effort to fill the gap in services, contracting with a provider will ensure the full continuum of substance use disorder treatment

services are available for youth and young adults during the current drug epidemic within their community.

- Expand access to environmental stability supports: The District has three (3) Environmental Stability (ES) providers. DBH would address an unmet need by supporting additional ES providers. One of the new ES providers would be designated for Youth and Young adults, specifically those being discharged from residential treatment who are in need of up to six (6) months of housing. (See Question #8 Response)

2. Describe how your states spending plan proposal addresses the needs and gaps, including gaps in equity.

DBH Response

- Care Coordination

DBH would allocate grant funds to support care coordination in the following manner

- Dramatically increasing our capacity to provide care via telehealth services
- Providing PPE to providers to facilitate safe treatment and in-person interaction with consumers
- Increased utilization of peers, especially peers of color, with unique understanding of and familiarity with obstacles faced by individuals in recovery and uniquely capable of reaching those individuals despite challenges posed by COVID.
- Additional staffing and resources to Access HelpLine, DBH's 24-7 crisis line operated by behavioral health professionals that can refer individuals in crisis to treatment or activate mobile response teams.
- Focusing resources in areas hardest hit by addiction and gun violence to increase accessibility. Between 2016 and 2020, 84% of all deaths due to opioid use were among African American. Hispanics have seen the largest increase in deaths between 2019 and 2020 at 111%. In 2020, opioid-related fatal overdoses were most prevalent in Wards 5, 6, 7 and 8.

- Withdrawal Management Support

DBH is allocating staff resources to address step downs from withdrawal management programs. This includes assigning staff to monitor withdrawal management providers and care coordination. DBH expects that all clients receiving withdrawal management will be assessed and referred to appropriate follow-up services. DBH will also monitor admissions and re-admissions to withdrawal management programs and will take steps to ensure that as many clients as possible get connected to appropriate levels of care following withdrawal management.

- Electronic Medical Records Update

DBH is currently implementing a series of upgrades or enhancements to DATAWITS, DBH's recordkeeping system for SUD providers, which will include greater internal protections to improve data quality, a new structured communication and referral process for behavioral health providers, a new comprehensive assessment, and more targeted questions regarding pregnancy and HIV. These upgrades are aimed at better care coordination for the recovery population.

3. If your state plans to utilize the funds for crisis services, describe how the state will advance the development of crisis services based on the *National Guidelines for Behavioral Health Crisis Care: Best Practice Tool Kit*.

DBH Response

SAMHSA's *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* provides guidance on how to enhance programs to meet the needs of District residents requiring crisis-specific care. Funding to meet demand and fill financial gaps in the provision of services, would ensure that DBH's SUD services meet the needs of DC residents.

Telephonic Survey for Data Collection: Of the data sources that are available in the District of Columbia that capture substance use trends among adolescents and transitional-aged youth, none of the data consistently addresses ward-level (i.e., for municipal purposes, DC is divided into eight wards) data or makes data publicly available. The lack of ward-level data inhibits DBH's ability to tailor prevention services and social marketing campaigns to a target audience. The District is proposing to conduct a ward-level telephonic survey to better understand the SUD needs of District youth during the pandemic. This would allow for the safe collection of data during COVID-19. Survey questions would center on variables such as age of first use, frequency of use, and perceptions of harm. Funding would support the development of the data collection instrument, the collection of the data, and the final analysis and report. DBH would advance the development of this crisis service based on SAMSHA's Best Practice Toolkit. Specifically, the 'Monitoring System and Provider Performance' aspect of the Best Practice Toolkit would allow DBH administrators and crisis service providers to continuously evaluate performance through the use of shared data systems. System transparency and regular monitoring of key performance indicators – at city and local-levels – would support continuous quality improvement efforts.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training and Support:

In an effort to close the gap between substance use prevention education and substance use treatment pursuant to the Institute of Medicine's (IOM) Substance Abuse Continuum of Care, the District is proposing to provide on-line Screening, Brief Intervention, and Referral to Treatment (SBIRT) training for behavioral health professionals. The purpose of this training is to increase the screening of individuals in need of substance use treatment services, and assisting them with getting connected to the District's providers. Primary care providers, such as Federally Qualified Health Centers (FQHCs), and other community clinics will be targeted. Individuals and providers responsible for conducting outreach and engagement will receive priority for the training. We will work with DC Primary Care Association to develop a plan for training. DBH would use our mobile crisis team to provide screening, assessment, resolution, peer support,

coordination with medical and behavioral health services and crisis planning/follow-up, pursuant to guidelines outlined in SAMHSA's Best Practice Toolkit.

4. If your state plans to utilize the funds for OUD, AUD, and/or TUD space MAT services, describe how the state will implement these evidence-based services. Please reference the SAMHSA Evidence based-practices Resource Center when considering selection of appropriate services.

DBH Response

Among the District's 32 SUD treatment providers, three (3) are community-based Opioid Treatment Programs (OTP). These OTPs are in the process of setting up the ability to prescribe and administer buprenorphine in addition to methadone. With the help of the State Opioid Response (SOR) grant, DBH has implemented various initiatives to:

- reach persons who inject drugs
- enacting 24/7 emergency crisis coverage
- deploy multiple teams to do outreach on the streets and respond to overdoses and overdose spikes
- conduct Screening, Brief Intervention, and Referral to Treatment (SBIRT).

DBH is also engaged in a recently established emergency department and inpatient induction of medication for opioid use disorders (MOUD) initiative at six (6) hospitals, as well as 90-day follow up with individuals who overdosed who refused to seek treatment; the expansion of MOUD at Federally Qualified Health Centers and the jail; and District-wide distribution of naloxone. DBH is also using SOR funding to provide recovery support services at four (4) Peer-Operated Centers and twenty-three faith-based organizations in the District. Finally, DBH is using SOR funding to promote recovery through supported employment, environmental stability, and recovery and re-entry housing.

5. Explain how your state plans to collaborate with other departments or agencies to address the identified need.

DBH Response

DBH and its certified provider network work closely with agencies in the District's Health and Human Services cluster (e.g., the District's Departments of Health, Health Care Finance, and Disability Services) setting standards, updating procedures, improving services and provider licensure. DBH has a robust forensic services program and a strong partnership with the Metropolitan Police Department to train patrol officers on the best and safest approach to help people in a psychiatric crisis. DBH is working with the Department of Corrections on SOR initiatives, including, setting up two (2) SUD units at the jail (one for men, one for women). DBH is also working on a care management program for returning citizens and has established re-entry housing. We collaborate across agencies on development of new programs and key performance indicators, along with data collection and performance monitoring to ensure we meet measurable goals and

provide quality, equitable services to the community. A good example of this is the work we are doing cross-agency on *LIVE. LONG. DC., the District's Strategic Plan to Reduce Opioid Use, Misuse, and Related Deaths*. The current plan has 7 goals and 50 strategies that are assigned to agency across the District.

6. If your state plans to utilize any of the waiver provisions listed above or recommendations listed in this guidance (see SABG COVID Relief Letter), please explain how your state will implement them with these funds and how the waiver will facilitate the state's response to COVID-19 pandemic and its deleterious impacts. (These waivers are only applicable to these COVID Relief supplemental funds and not to the standard SABG funds).

DBH Response

COVID-19 relief supplemental funds will facilitate the District's response to the COVID-19 pandemic by supporting the following Programs -

SUD Unit: Create a pilot SUD unit at long-term care/skilled nursing facility to allow for treatment of individuals unable to receive SUD treatment in this setting. Currently, none of the facilities in the District are willing to serve individuals on MOUD. Individuals on MOUD are being served in Maryland facilities. (See SABG COVID Relief Letter: Treatment, SUD crisis services).

SUD Treatment: Create a pilot weekend SUD treatment center to address the District's need for SUD services not currently offered on weekends. (See SABG COVID Relief Letter: Treatment, SUD crisis services).

Prevention Center Staff Capacity: Increase staff capacity for the District's four (4) prevention centers. These facilities have experienced a scarcity of labor and resources due to COVID-19. Additional staff will allow for improved prevention outreach capacity. (See SABG COVID Relief Letter: Infrastructure, Provision of workforce support.)

Telehealth-Related System Operability: Support providers' data management and telehealth capacity. While there has already been an increase in telehealth utilization, providers are struggling to meet demand for telehealth services. Additional funds for data management and hardware will assist providers in meeting COVID-19 related telehealth demand. (See SABG COVID Relief Letter: Infrastructure, Purchase of increased connectivity).

Behavioral Health Integration Technical Assistance HUB: Prepare providers for the transition to a whole person care model that integrates behavioral health and primary health care. District behavioral health providers are attempting to make the transition to whole person care. However, COVID-19 has compromised providers' ability to prepare for this transition. (See SABG COVID Relief Letter: Prevention, Purchase of Technical Assistance)

Certified Addiction Counselor (CAC) Training: Support tuition and fees for education and training in addictions counseling to increase the number of CACs. Educating additional CACs will better enable the District to address increased demand for SUD services caused by COVID-

19. There is a shortage of CACs in the District. (See SABG COVID Relief Letter: Recovery Support, Specialist Training).

Landlord/Tenant Supports: Assist individuals with SUD to maintain housing. As part of the public health emergency the District has implemented emergency housing measures, including eviction moratoriums and short term emergency housing programs. Landlord and tenant supports will help each navigate these new rules and help individuals with SUD maintain housing, which is critical to their recovery. (See SABG COVID Relief Letter: Hiring of outreach workers for regular check-in for people with SUD).

Residential Services for Youth: Establish residential SUD treatment services for youths. COVID-19 relief supplemental funding will support a six (6) to eight (8) bed facility for six (6) months.

7. If your state plans to make providers stabilization payments, the proposal must include at a minimum the following:
 - a. The period that the payment will be made available i.e., start date and end date.
 - b. The total proposed amount of COVID-19 relief funds for this purpose.
 - c. The methodology for determining support/stabilization payments.
 - d. Provider eligibility criteria (e.g., need based).
 - e. Provider request approach/procedure.

DBH Response: N/A

8. If the states plan to use COVID-19 Relief funds for targeted housing costs, the proposal must include at a minimum the following:
 - a. The proposed amount of award amount for this purpose.
 - b. Methodology for determining rental and security deposit payments.
 - c. Eligibility criteria for payment of rent or security deposit.
 - d. Proposed approach/procedures for individuals to request rental assistance.

DBH Response

COVID -19 Relief funds will be used for targeted housing under an expansion of the District's Environmental Stability Program

- a. The proposed amount of award amount for this purpose.**

Environmental Stability: The per diem rate for expansion of Environmental Stability (ES) Program is \$212.25 weekly/\$849 monthly, and \$1000 monthly for women with children. The rates for ES Housing is the same for individuals who are deaf or hard of hearing.

- b. Methodology for determining rental and security deposit payments.**

Determined by Chapter 63 regulations for service provision and based on DBH's published rates in Ch. 64, Reimbursement Rates for Services provided by the DBH Ch. 63, Certified Substance Use Disorder Providers.

c. Eligibility criteria for payment of rent or security deposit.

Provider must be certified for Environmental Stability by DBH. The individual must have sustained income (i.e., employment, SSA, SSDI) to meet eligibility criteria.

Under Chapter 63, to be eligible for environmental stability housing, DBH lists a number of requirements under 6350.2 – be drug and alcohol free for the 30 days prior to admission, maintain sobriety throughout the program, be 18 or older, be employed or participating in a structured training class or workforce development program deemed clinically appropriate, deposit 30% of net income into an escrow account for post-environmental stability living, be enrolled or active in other certified Recovery Support Services, and be prior authorized by the Department.

d. Proposed approach/procedures for individuals to request rental assistance.

Individual must have been active in treatment with a DBH provider, discharged from treatment or self-report need for recovery support services and ES.

Complete application for rental assistance. If approved, the individual will receive a stipend for up to 3 months of payment.

COVID-19 Supplemental Funding Plan for FY 21

1. Identify the needs and gaps of your state SUD prevention, treatment, and recovery services systems in the context of COVID-19.

DBH Response

The COVID-19 pandemic has impacted continuity of care for individuals in need of substance use disorder (SUD) treatment. During the public health emergency, many DC residents with SUD have been unable or unwilling to seek in-person care due to fear of becoming infected with the coronavirus. In addition, many have not had access to the internet, computers, or other devices to receive on-going and necessary services and supports via telehealth.

DBH has implemented several innovations to address gaps in services identified during the pandemic to support continuity of care for this population. This includes the establishment of telehealth satellite sites within provider facilities, the provision of quarantine beds to allow persons in need of care to isolate in a safe environment prior to entering residential treatment, permitting increased take-home dosing consistent with SAMHSA guidelines. However, several gaps in service remain. The agency plans to address these additional needs with the SUD supplemental funding provided through this grant. This includes the following:

- **Electronic Medical Records Upgrade:** DATAWITS, DBH's record keeping system for SUD providers, lacks the requisite internal quality assurance capabilities for more complex data collection, analysis, and reporting. As a result, significant efforts are undertaken each year to address issues around data quality and integrity when reporting SUD treatment participation and client outcomes. DBH purchased enhancements in DATAWITS that will enable SUD providers and DBH staff to view a provider's capacity and census data, for the purpose of client referrals. However, SUD providers often produce inaccurate census data, which prevents DBH from utilizing this client data. Meeting the unmet need of supporting DATAWITS would allow DBH to discharge inactive clients and reduce the daily census calls to the providers, error messages, and technical issues that make it difficult for DBH and provider staff to analyze client data.
- **Residential Treatment Program for Youth:** Establish a level 3.5 substance use disorder treatment in a clinically managed medium intensive (CMMI) residential setting program for youth. The District does not have a residential program to treat youth (12-20 years of age) with SUD. Previously, the District sent youth to Mountain Manor Treatment Center (Baltimore, Maryland) and stopped accepting youth from the District in 2019.

In 2018, referrals for youth for the residential 3.5 Level of Care (LOC) averaged approximately 3-5 per week. Through this grant, The District has an opportunity to provide youth residential treatment services locally, which is a cost savings as transportation to Baltimore was covered by the District through various resources (fleet vehicles, mileage, fuel, FTE labor, etc.). In an effort to fill the gap in services, contracting with a provider will ensure the full continuum of substance use disorder treatment

services are available for youth and young adults during the current drug epidemic within their community.

- Expand access to environmental stability supports: The District has three (3) Environmental Stability (ES) providers. DBH would address an unmet need by supporting additional ES providers. One of the new ES providers would be designated for Youth and Young adults, specifically those being discharged from residential treatment who are in need of up to six (6) months of housing. (See Question #8 Response)

2. Describe how your states spending plan proposal addresses the needs and gaps, including gaps in equity.

DBH Response

- Care Coordination

DBH would allocate grant funds to support care coordination in the following manner

- Dramatically increasing our capacity to provide care via telehealth services
- Providing PPE to providers to facilitate safe treatment and in-person interaction with consumers
- Increased utilization of peers, especially peers of color, with unique understanding of and familiarity with obstacles faced by individuals in recovery and uniquely capable of reaching those individuals despite challenges posed by COVID.
- Additional staffing and resources to Access HelpLine, DBH's 24-7 crisis line operated by behavioral health professionals that can refer individuals in crisis to treatment or activate mobile response teams.
- Focusing resources in areas hardest hit by addiction and gun violence to increase accessibility. Between 2016 and 2020, 84% of all deaths due to opioid use were among African American. Hispanics have seen the largest increase in deaths between 2019 and 2020 at 111%. In 2020, opioid-related fatal overdoses were most prevalent in Wards 5, 6, 7 and 8.

- Withdrawal Management Support

DBH is allocating staff resources to address step downs from withdrawal management programs. This includes assigning staff to monitor withdrawal management providers and care coordination. DBH expects that all clients receiving withdrawal management will be assessed and referred to appropriate follow-up services. DBH will also monitor admissions and re-admissions to withdrawal management programs and will take steps to ensure that as many clients as possible get connected to appropriate levels of care following withdrawal management.

- Electronic Medical Records Update

DBH is currently implementing a series of upgrades or enhancements to DATAWITS, DBH's recordkeeping system for SUD providers, which will include greater internal protections to improve data quality, a new structured communication and referral process for behavioral health providers, a new comprehensive assessment, and more targeted questions regarding pregnancy and HIV. These upgrades are aimed at better care coordination for the recovery population.

3. If your state plans to utilize the funds for crisis services, describe how the state will advance the development of crisis services based on the *National Guidelines for Behavioral Health Crisis Care: Best Practice Tool Kit*.

DBH Response

SAMHSA's *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* provides guidance on how to enhance programs to meet the needs of District residents requiring crisis-specific care. Funding to meet demand and fill financial gaps in the provision of services, would ensure that DBH's SUD services meet the needs of DC residents.

Telephonic Survey for Data Collection: Of the data sources that are available in the District of Columbia that capture substance use trends among adolescents and transitional-aged youth, none of the data consistently addresses ward-level (i.e., for municipal purposes, DC is divided into eight wards) data or makes data publicly available. The lack of ward-level data inhibits DBH's ability to tailor prevention services and social marketing campaigns to a target audience. The District is proposing to conduct a ward-level telephonic survey to better understand the SUD needs of District youth during the pandemic. This would allow for the safe collection of data during COVID-19. Survey questions would center on variables such as age of first use, frequency of use, and perceptions of harm. Funding would support the development of the data collection instrument, the collection of the data, and the final analysis and report. DBH would advance the development of this crisis service based on SAMSHA's Best Practice Toolkit. Specifically, the 'Monitoring System and Provider Performance' aspect of the Best Practice Toolkit would allow DBH administrators and crisis service providers to continuously evaluate performance through the use of shared data systems. System transparency and regular monitoring of key performance indicators – at city and local-levels – would support continuous quality improvement efforts.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training and Support:

In an effort to close the gap between substance use prevention education and substance use treatment pursuant to the Institute of Medicine's (IOM) Substance Abuse Continuum of Care, the District is proposing to provide on-line Screening, Brief Intervention, and Referral to Treatment (SBIRT) training for behavioral health professionals. The purpose of this training is to increase the screening of individuals in need of substance use treatment services, and assisting them with getting connected to the District's providers. Primary care providers, such as Federally Qualified Health Centers (FQHCs), and other community clinics will be targeted. Individuals and providers responsible for conducting outreach and engagement will receive priority for the training. We will work with DC Primary Care Association to develop a plan for training. DBH would use our mobile crisis team to provide screening, assessment, resolution, peer support,

coordination with medical and behavioral health services and crisis planning/follow-up, pursuant to guidelines outlined in SAMHSA's Best Practice Toolkit.

4. If your state plans to utilize the funds for OUD, AUD, and/or TUD space MAT services, describe how the state will implement these evidence-based services. Please reference the SAMHSA Evidence based-practices Resource Center when considering selection of appropriate services.

DBH Response

Among the District's 32 SUD treatment providers, three (3) are community-based Opioid Treatment Programs (OTP). These OTPs are in the process of setting up the ability to prescribe and administer buprenorphine in addition to methadone. With the help of the State Opioid Response (SOR) grant, DBH has implemented various initiatives to:

- reach persons who inject drugs
- enacting 24/7 emergency crisis coverage
- deploy multiple teams to do outreach on the streets and respond to overdoses and overdose spikes
- conduct Screening, Brief Intervention, and Referral to Treatment (SBIRT).

DBH is also engaged in a recently established emergency department and inpatient induction of medication for opioid use disorders (MOUD) initiative at six (6) hospitals, as well as 90-day follow up with individuals who overdosed who refused to seek treatment; the expansion of MOUD at Federally Qualified Health Centers and the jail; and District-wide distribution of naloxone. DBH is also using SOR funding to provide recovery support services at four (4) Peer-Operated Centers and twenty-three faith-based organizations in the District. Finally, DBH is using SOR funding to promote recovery through supported employment, environmental stability, and recovery and re-entry housing.

5. Explain how your state plans to collaborate with other departments or agencies to address the identified need.

DBH Response

DBH and its certified provider network work closely with agencies in the District's Health and Human Services cluster (e.g., the District's Departments of Health, Health Care Finance, and Disability Services) setting standards, updating procedures, improving services and provider licensure. DBH has a robust forensic services program and a strong partnership with the Metropolitan Police Department to train patrol officers on the best and safest approach to help people in a psychiatric crisis. DBH is working with the Department of Corrections on SOR initiatives, including, setting up two (2) SUD units at the jail (one for men, one for women). DBH is also working on a care management program for returning citizens and has established re-entry housing. We collaborate across agencies on development of new programs and key performance indicators, along with data collection and performance monitoring to ensure we meet measurable goals and

provide quality, equitable services to the community. A good example of this is the work we are doing cross-agency on *LIVE. LONG. DC., the District's Strategic Plan to Reduce Opioid Use, Misuse, and Related Deaths*. The current plan has 7 goals and 50 strategies that are assigned to agency across the District.

6. If your state plans to utilize any of the waiver provisions listed above or recommendations listed in this guidance (see SABG COVID Relief Letter), please explain how your state will implement them with these funds and how the waiver will facilitate the state's response to COVID-19 pandemic and its deleterious impacts. (These waivers are only applicable to these COVID Relief supplemental funds and not to the standard SABG funds).

DBH Response

COVID-19 relief supplemental funds will facilitate the District's response to the COVID-19 pandemic by supporting the following Programs -

SUD Unit: Create a pilot SUD unit at long-term care/skilled nursing facility to allow for treatment of individuals unable to receive SUD treatment in this setting. Currently, none of the facilities in the District are willing to serve individuals on MOUD. Individuals on MOUD are being served in Maryland facilities. (See SABG COVID Relief Letter: Treatment, SUD crisis services).

SUD Treatment: Create a pilot weekend SUD treatment center to address the District's need for SUD services not currently offered on weekends. (See SABG COVID Relief Letter: Treatment, SUD crisis services).

Prevention Center Staff Capacity: Increase staff capacity for the District's four (4) prevention centers. These facilities have experienced a scarcity of labor and resources due to COVID-19. Additional staff will allow for improved prevention outreach capacity. (See SABG COVID Relief Letter: Infrastructure, Provision of workforce support.)

Telehealth-Related System Operability: Support providers' data management and telehealth capacity. While there has already been an increase in telehealth utilization, providers are struggling to meet demand for telehealth services. Additional funds for data management and hardware will assist providers in meeting COVID-19 related telehealth demand. (See SABG COVID Relief Letter: Infrastructure, Purchase of increased connectivity).

Behavioral Health Integration Technical Assistance HUB: Prepare providers for the transition to a whole person care model that integrates behavioral health and primary health care. District behavioral health providers are attempting to make the transition to whole person care. However, COVID-19 has compromised providers' ability to prepare for this transition. (See SABG COVID Relief Letter: Prevention, Purchase of Technical Assistance)

Certified Addiction Counselor (CAC) Training: Support tuition and fees for education and training in addictions counseling to increase the number of CACs. Educating additional CACs will better enable the District to address increased demand for SUD services caused by COVID-

19. There is a shortage of CACs in the District. (See SABG COVID Relief Letter: Recovery Support, Specialist Training).

Landlord/Tenant Supports: Assist individuals with SUD to maintain housing. As part of the public health emergency the District has implemented emergency housing measures, including eviction moratoriums and short term emergency housing programs. Landlord and tenant supports will help each navigate these new rules and help individuals with SUD maintain housing, which is critical to their recovery. (See SABG COVID Relief Letter: Hiring of outreach workers for regular check-in for people with SUD).

Residential Services for Youth: Establish residential SUD treatment services for youths. COVID-19 relief supplemental funding will support a six (6) to eight (8) bed facility for six (6) months.

7. If your state plans to make providers stabilization payments, the proposal must include at a minimum the following:
 - a. The period that the payment will be made available i.e., start date and end date.
 - b. The total proposed amount of COVID-19 relief funds for this purpose.
 - c. The methodology for determining support/stabilization payments.
 - d. Provider eligibility criteria (e.g., need based).
 - e. Provider request approach/procedure.

DBH Response: N/A

8. If the states plan to use COVID-19 Relief funds for targeted housing costs, the proposal must include at a minimum the following:
 - a. The proposed amount of award amount for this purpose.
 - b. Methodology for determining rental and security deposit payments.
 - c. Eligibility criteria for payment of rent or security deposit.
 - d. Proposed approach/procedures for individuals to request rental assistance.

DBH Response

COVID -19 Relief funds will be used for targeted housing under an expansion of the District's Environmental Stability Program

- a. The proposed amount of award amount for this purpose.**

Environmental Stability: The per diem rate for expansion of Environmental Stability (ES) Program is \$212.25 weekly/\$849 monthly, and \$1000 monthly for women with children. The rates for ES Housing is the same for individuals who are deaf or hard of hearing.

- b. Methodology for determining rental and security deposit payments.**

Determined by Chapter 63 regulations for service provision and based on DBH's published rates in Ch. 64, Reimbursement Rates for Services provided by the DBH Ch. 63, Certified Substance Use Disorder Providers.

c. Eligibility criteria for payment of rent or security deposit.

Provider must be certified for Environmental Stability by DBH. The individual must have sustained income (i.e., employment, SSA, SSDI) to meet eligibility criteria.

Under Chapter 63, to be eligible for environmental stability housing, DBH lists a number of requirements under 6350.2 – be drug and alcohol free for the 30 days prior to admission, maintain sobriety throughout the program, be 18 or older, be employed or participating in a structured training class or workforce development program deemed clinically appropriate, deposit 30% of net income into an escrow account for post-environmental stability living, be enrolled or active in other certified Recovery Support Services, and be prior authorized by the Department.

d. Proposed approach/procedures for individuals to request rental assistance.

Individual must have been active in treatment with a DBH provider, discharged from treatment or self-report need for recovery support services and ES.

Complete application for rental assistance. If approved, the individual will receive a stipend for up to 3 months of payment.

District of Columbia Department of Behavioral Health
SABG COVID-19 Relief Supplement Funds (\$6,530,972)
1B08TI083550-01

Budget & Budget Narratives

5% Administrative

20% Prevention

Telephonic Data Collection Survey

Budget Narrative: DBH will conduct a ward-level telephonic survey to assess the SUD needs of District youth during the pandemic. This telephonic survey will be conducted virtually, thus allowing for the safe collection of data during COVID-19. Survey questions will center on variables such as age of first use, frequency of use, and perceptions of harm. Funding would support the development of the data collection instrument, the collection of the data, the final analysis and report.

The ‘Monitoring System and Provider Performance’ aspect of the Best Practice Toolkit will allow DBH administrators and crisis service providers to continuously evaluate performance through the use of shared data systems. System transparency and regular monitoring of key performance indicators – at city and local-levels – would support continuous quality improvement efforts.

25% Interventions

DC Prevention Centers

Budget Narrative: DBH will increase staff capacity for the District’s four (4) prevention centers. These facilities have experienced a scarcity of labor and resources due to COVID-19. Additional staff will allow for improved prevention outreach capacity.

Naloxone Distribution

Budget Narrative: DBH will increase the distribution of naloxone to combat the opioid epidemic during COVID-19. The District’s Office of the Chief Medical Examiner reported that DC residents have been significantly impacted by opioid abuse during the pandemic. Specifically, in FY 2020, there were 411 individuals that died from an opioid overdose, an average of 34 each month and a 46% increase over 2019.

District residents can text LiveLongDC to 888-111 to receive information on accessing free naloxone kits across the District. DC residents can get naloxone at no cost, with no prescription, and no identification at any of the forty (40) participating sites. We also have outreach workers, community- and faith-based organizations, and our mobile services distributing naloxone. The cost of each naloxone kit is \$75.

Fentanyl Test Strips Program Expansion

Budget Narrative: DBH will use funds to purchase fentanyl test strips. The DC Department of Forensic Sciences reported that there is more pure fentanyl in the District's drug supply during the COVID-19 pandemic. Fentanyl test strips could be a useful harm reduction tool for the city. DBH is developing guidance for the use of test strips and have added test strip usage as a strategy to consider in our opioid strategic plan. The cost for one (1) strip range from \$.70 to \$1.00.

25% Treatment (including HIV)

HIV (5%)

Pilot SUD weekend Treatment Center

Budget Narrative: DBH will use funds to create a pilot weekend SUD treatment center to address the District's need for SUD services, HIV screening and testing not currently offered on weekends during COVID-19.

Pilot SUD Weekend Unit at Long-Term Care/Skilled Facility (HIV Screening, Testing)

Budget Narrative: DBH will use funds to create a pilot SUD unit at a long-term care/skilled nursing facility to allow for treatment of individuals unable to receive SUD treatment, HIV screening and testing in this setting during COVID-19. Currently, none of the facilities in the District serve individuals on Medications for Opioid Use Disorder (MOUD). Individuals on MOUD are being served in Maryland facilities.

Treatment: Non-HIV (20%)

Behavioral Health Professionals Screening, Brief Intervention, Referral to Treatment Training

Budget Narrative: In an effort to close the gap between substance use prevention education and substance use treatment pursuant to the Institute of Medicine's (IOM) Substance Abuse Continuum of Care, the District is proposing to provide on-line Screening, Brief Intervention, and Referral to Treatment (SBIRT) training for behavioral health professionals. The purpose of this training is to increase the screening of individuals in need of substance use treatment services, and assisting them with getting connected to the District's providers during the pandemic. Primary care providers, such as Federally Qualified Health Centers (FQHCs), and other community clinics will be targeted. Individuals and providers responsible for conducting outreach and engagement will receive priority for the training.

Certified Addiction Counselor Training

Budget Narrative: DBH will use funds to support tuition and fees for education and training in addictions counseling to increase the number of Certified Addiction Counselors (CACs). Educating additional CACs will better enable the District to address increased demand for SUD services caused by COVID-19.

Care Coordination Support (Withdrawal Management)

Budget Narrative: DBH will use grant funding to allocate additional staff resources to address step downs from withdrawal management programs during COVID-19. This includes assigning staff to monitor withdrawal management providers and care coordination. DBH expects that all clients receiving withdrawal management will be assessed and referred to appropriate follow-up services. DBH will also monitor admissions and re-admissions to withdrawal management programs and will take steps to ensure that as many clients as possible get connected to appropriate levels of care following withdrawal management.

15% Recovery Support

Peer Recovery Specialist – Crisis Hotline Training

Budget Narrative: Peers, individuals with “lived experience,” are an invaluable part of the behavioral health workforce during the COVID-19 pandemic. As such, they need to be provided with opportunities for professional development. All behavioral health staff need to be trained in a number of areas before working a hot line or warm line, but two (2) major areas are how to respond to crisis situations and on how to implement self-care practices because of the challenging nature of the work. Peers have their own experiences with being a consumer of the behavioral health system, therefore, specialized training must be delivered. This training would also include instruction on writing a Wellness Recovery Action Plan (WRAP) so that the peer has a plan for dealing with potential triggers while working and how to navigate in a government setting.

Establish level 3.5 Residential Treatment Youth Program

Budget Narrative: DBH will use funds to establish a level 3.5 substance use disorder treatment in a clinically managed medium intensive residential setting program for youth. The District does not have any residential program to treat youth (12-20 years of age) with SUD needs. Previously, the District sent youth to Mountain Manor Treatment Center, which is located in Baltimore, Maryland and stopped accepting youth from the District in 2019. Providing youth residential treatment services locally will mitigate transportation costs and ensure a full continuum of substance use disorder treatment services during COVID-19.

Environmental Support Providers

Budget Narrative: DBH will use funds to provide three (3) Environmental Stability (ES) providers. DBH would meet an unmet need by supporting additional ES providers during COVID-19. One of the new ES providers would be designated for Youth and Young adults, specifically those being discharged from residential treatment who are in need of up to six (6) months of housing.

10% Infrastructure

Electronic Medical Records Upgrade

Budget Narrative: DBH will use grant funding to implement a series of upgrades or enhancements to DATAWITS, DBH’s recordkeeping system for SUD providers, which will include greater internal protections to improve data quality, a new structured communication and referral process for behavioral health providers, a new comprehensive assessment, and more targeted questions regarding pregnancy and HIV. All of this is aimed at better care coordination for the recovery population. Meeting the unmet need of supporting DATAWITS during COVID-19 would allow DBH to discharge inactive clients and reduce the daily census calls to the providers, error messages, and technical issues that make it difficult for DBH and provider staff to analyze client data.

Telehealth-Related Operability (support providers' data management and telehealth capacity)

Budget Narrative: DBH will use grant funds to support providers' data management and telehealth capacity. While there has already been a more than 400% increase in telehealth utilization during COVID-19, providers are struggling to meet demand for telehealth services. Additional funds for data management and hardware will assist providers in meeting COVID-19 related telehealth demand.

Behavioral Health Integration Technical Assistance HUB

Budget Narrative: DBH will use grant funds to prepare providers for the transition to a whole person care model that integrates behavioral health and primary health care. District behavioral health providers are attempting to make the transition to whole person care. However, COVID-19 has compromised providers' ability to prepare for this transition.

REQUEST (\$6,530,972)

Name	Service	Rate	Other	Cost
Prevention (20%)	1. Telephonic Data Collection Survey			\$1,306, 194
Interventions (25%)	1. DC Prevention Centers 2. Naloxone Distribution Expansion 3. Fentanyl Test Strips Program Expansion			\$1,632,743
Treatment (20%)	1. Behavioral Health Professionals Screening, Brief Intervention, Referral to Treatment Training 2. Certified Addiction Counselor Training (Tuition & Fees) 3. Care Coordination Support (Withdrawal Management)			\$1,306, 194
HIV – Treatment (5%)	1. Pilot SUD weekend Treatment Center 2. Pilot SUD Weekend Unit at Long-Term Care/Skilled Facility			\$326, 548

Recovery Support (15%)	<ol style="list-style-type: none"> 1. Crisis Hotline Funding 2. Peers Recovery Specialist Training 3. Establish level 3.5 Residential Treatment Youth Program 4. Environmental Support Providers 			\$979, 645
Infrastructure (10%)	<ol style="list-style-type: none"> 1. Electronic Medical Records Upgrade (DATAWITS) 2. Telehealth-Related Operability (support providers' data management and telehealth capacity) 3. Behavioral Health Integration Technical Assistance HUB 			\$653, 097
Administrative (5%)	<ol style="list-style-type: none"> 1. Performance 2. Monitoring 3. Evaluation 			\$326, 548
			TOTAL	\$6,530,969

COVID-19 Supplemental Funding Plan for FY 21

1. Identify the needs and gaps of your state SUD prevention, treatment, and recovery services systems in the context of COVID-19.

DBH Response

The COVID-19 pandemic has impacted continuity of care for individuals in need of substance use disorder (SUD) treatment. During the public health emergency, many DC residents with SUD have been unable or unwilling to seek in-person care due to fear of becoming infected with the coronavirus. In addition, many have not had access to the internet, computers, or other devices to receive on-going and necessary services and supports via telehealth.

DBH has implemented several innovations to address gaps in services identified during the pandemic to support continuity of care for this population. This includes supporting evidenced-based programs to better engage youth on substance use prevention trends and methods to remain drug free, expanding the distribution of naloxone to support the implementation of the District's opioid strategic plan, and creating a pilot SUD treatment center to address the District's need for assessment and referral services, HIV screening and testing not currently offered on weekends. However, several gaps in service remain. The agency plans to address these additional needs with the SUD supplemental funding provided through this grant. This includes the following:

- **Electronic Medical Records Upgrade: DATAWITS**, DBH's record keeping system for SUD providers, lacks the requisite internal quality assurance capabilities for more complex data collection, analysis, and reporting. As a result, significant efforts are undertaken each year to address issues around data quality and integrity when reporting SUD treatment participation and client outcomes. DBH purchased enhancements in DATAWITS that will enable SUD providers and DBH staff to view a provider's capacity and census data, for the purpose of client referrals. However, SUD providers often produce inaccurate census data, which prevents DBH from utilizing this client data. Meeting the unmet need of supporting DATAWITS would allow DBH to discharge inactive clients and reduce the daily census calls to the providers, error messages, and technical issues that make it difficult for DBH and provider staff to analyze client data.
- **Residential Treatment Program for Youth:** Establish a level 3.5 substance use disorder treatment in a clinically managed medium intensive (CMMI) residential setting program for youth. The District does not have a residential program to treat youth (12-20 years of age) with SUD. Previously, the District sent youth to Mountain Manor Treatment Center (Baltimore, Maryland) and stopped accepting youth from the District in 2019.

In 2018, referrals for youth for the residential 3.5 Level of Care (LOC) averaged approximately 3-5 per week. Through this grant, The District has an opportunity to provide youth residential treatment services locally, which is a cost savings as transportation to Baltimore was covered by the District through various resources (fleet vehicles, mileage, fuel, FTE labor, etc.). In an effort to fill the gap in services, contracting with a provider will ensure the full continuum of substance use disorder treatment

services are available for youth and young adults during the current drug epidemic within their community.

2. Describe how your states spending plan proposal addresses the needs and gaps, including gaps in equity.

DBH Response

- Care Coordination Support

DBH would allocate grant funds to support care coordination in the following manner

- Dramatically increasing our capacity to provide care via telehealth services
- Providing PPE to providers to facilitate safe treatment and in-person interaction with consumers
- Increased utilization of peers, especially peers of color, with unique understanding of and familiarity with obstacles faced by individuals in recovery and uniquely capable of reaching those individuals despite challenges posed by COVID.
- Additional staffing and resources to Access HelpLine, DBH's 24-7 crisis line operated by behavioral health professionals that can refer individuals in crisis to treatment or activate mobile response teams.
- Focusing resources in areas hardest hit by addiction and gun violence to increase accessibility. Between 2016 and 2020, 84% of all deaths due to opioid use were among African American. Hispanics have seen the largest increase in deaths between 2019 and 2020 at 111%. In 2020, opioid-related fatal overdoses were most prevalent in Wards 5, 6, 7 and 8.

- SUD Provider Electronic Health Records (EHR) System Enhancements

DBH will use grant funding to support SUD provider EHR system enhancement/upgrades to support whole person care and behavioral health system transformation. SUD provider upgrades include enabling a system enhancement, developing data reporting and funding a portion of a system replacement. Providers will be required to participate in the Behavioral Health Integration Readiness Technical Assistance project to be eligible for system enhancement funding. This will allow DBH to assess provider need for system enhancements.

3. If your state plans to utilize the funds for crisis services, describe how the state will advance the development of crisis services based on the *National Guidelines for Behavioral Health Crisis Care: Best Practice Tool Kit*.

DBH Response

SAMHSA's *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* provides guidance on how to enhance programs to meet the needs of District residents requiring crisis-specific care. Funding to meet demand and fill financial gaps in the provision of services, would ensure that DBH's SUD services meet the needs of DC residents.

Telephonic Survey for Data Collection: Of the data sources that are available in the District of Columbia that capture substance use trends among adolescents and transitional-aged youth, none of the data consistently addresses ward-level (i.e., for municipal purposes, DC is divided into eight wards) data or makes data publicly available. The lack of ward-level data inhibits DBH's

ability to tailor prevention services and social marketing campaigns to a target audience. The District is proposing to conduct a ward-level telephonic survey to better understand the SUD needs of District youth during the pandemic. This would allow for the safe collection of data during COVID-19. Survey questions would center on variables such as age of first use, frequency of use, and perceptions of harm. Funding would support the development of the data collection instrument, the collection of the data, and the final analysis and report. DBH would advance the development of this crisis service based on SAMSHA's Best Practice Toolkit. Specifically, the 'Monitoring System and Provider Performance' aspect of the Best Practice Toolkit would allow DBH administrators and crisis service providers to continuously evaluate performance through the use of shared data systems. System transparency and regular monitoring of key performance indicators – at city and local-levels – would support continuous quality improvement efforts.

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coordination with medical and behavioral health services and crisis planning/follow-up, pursuant to guidelines outlined in SAMHSA's Best Practice Toolkit.

4. If your state plans to utilize the funds for OUD, AUD, and/or TUD space MAT services, describe how the state will implement these evidence-based services. Please reference the SAMHSA Evidence based-practices Resource Center when considering selection of appropriate services.

DBH Response

Among the District's 32 SUD treatment providers, three (3) are community-based Opioid Treatment Programs (OTP). These OTPs are in the process of prescribing and administering buprenorphine in addition to methadone. With the help of the State Opioid Response (SOR) grant, DBH has implemented various initiatives to:

- o reach persons who inject drugs
- o enacting 24/7 emergency crisis coverage
- o deploy multiple teams to do outreach on the streets and respond to overdoses and overdose spikes
- o conduct Screening, Brief Intervention, and Referral to Treatment (SBIRT).

DBH is also engaged in a recently established emergency department and inpatient induction of medication for opioid use disorders (MOUD) initiative at six (6) hospitals, as well as 90-day follow up with individuals who overdosed who refused to seek treatment; the expansion of MOUD at Federally Qualified Health Centers and the jail; and District-wide distribution of naloxone. DBH is also using SOR funding to provide recovery support services at four (4) Peer-Operated Centers and twenty-three faith-based organizations in the District. Finally, DBH is using SOR funding to promote recovery through supported employment, environmental stability, and recovery and re-entry housing.

5. Explain how your state plans to collaborate with other departments or agencies to address the identified need.

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DBH and its certified provider network work closely with agencies in the District's Health and Human Services cluster (e.g., the District's Departments of Health, Health Care Finance, and Disability Services) setting standards, updating procedures, improving services and provider licensure. DBH has a robust forensic services program and a strong partnership with the Metropolitan Police Department to train patrol officers on the best and safest approach to help people in a psychiatric crisis. DBH is working with the Department of Corrections on SOR initiatives, including, setting up two (2) SUD units at the jail (one for men, one for women). DBH is also working on a care management program for returning citizens and has established re-entry housing. We collaborate across agencies on development of new programs and key performance indicators, along with data collection and performance monitoring to ensure we meet measurable goals and

provide quality, equitable services to the community. A good example of this is the work we are doing cross-agency on *LIVE. LONG. DC., the District's Strategic Plan to Reduce Opioid Use, Misuse, and Related Deaths*. The current plan has 7 goals and 50 strategies that are assigned to agency across the District.

6. If your state plans to utilize any of the waiver provisions listed above or recommendations listed in this guidance (see SABG COVID Relief Letter), please explain how your state will implement them with these funds and how the waiver will facilitate the state's response to COVID-19 pandemic and its deleterious impacts. (These waivers are only applicable to these COVID Relief supplemental funds and not to the standard SABG funds).

DBH Response

COVID-19 relief supplemental funds will facilitate the District's response to the COVID-19 pandemic by supporting the following Programs -

SUD Unit: Create a pilot SUD unit at long-term care/skilled nursing facility to allow for treatment of individuals unable to receive SUD treatment in this setting. Currently, none of the facilities in the District are willing to serve individuals on MOUD. Individuals on MOUD are being served in Maryland facilities.

DC Prevention Centers: Place an outreach specialist at each of DBH's four (4) DC Prevention Centers (DCPCs). Each DCPC shall receive \$200,000 (\$100,000 per year) to support an outreach specialist that will engage residents within their respective wards to promote, enhance, and expand the substance use prevention services available through the DCPCs.

Behavioral Health Integration Technical Assistance HUB: Prepare providers for the transition to a whole person care model that integrates behavioral health and primary health care. District behavioral health providers are attempting to make the transition to whole person care. However, COVID-19 has compromised providers' ability to prepare for this transition.

Certified Addiction Counselor (CAC) Training: Support tuition and fees for education and training in addiction counseling to increase the number of CACs. Educating additional CACs will better enable the District to address increased demand for SUD services caused by COVID-

19.

Establish Level 3.5 Residential Treatment Youth Program: DBH will use funds to develop a community-based level 3.5 substance use disorder treatment facility for youth in a clinically managed, medium intensive residential program.

7. If your state plans to make providers stabilization payments, the proposal must include at a minimum the following:
- a. The period that the payment will be made available i.e., start date and end date.
 - b. The total proposed amount of COVID-19 relief funds for this purpose.
 - c. The methodology for determining support/stabilization payments.
 - d. Provider eligibility criteria (e.g., need based).
 - e. Provider request approach/procedure.

DBH Response: N/A

8. If the states plan to use COVID-19 Relief funds for targeted housing costs, the proposal must include at a minimum the following:
- a. The proposed amount of award amount for this purpose.
 - b. Methodology for determining rental and security deposit payments.
 - c. Eligibility criteria for payment of rent or security deposit.
 - d. Proposed approach/procedures for individuals to request rental assistance.

DBH Response: N/A

District of Columbia Department of Behavioral Health
SABG COVID-19 Relief Supplement Funds (\$6,530,972)
1B08TI083550-01

Budget & Budget Narratives

5% Administrative

20% Prevention (\$1.4M)

Information Dissemination - \$400,000

Plan. Social Marketing Strategy: The District is seeking to develop a social marketing strategy to promote the prevention of alcohol, tobacco, and other drug use particularly with the ongoing impact of the COVID-19 global pandemic.

Purpose/Issue: Reduce the use of alcohol, tobacco, and other drug use exacerbated by COVID.

Impact: DBH will work with a public relations company that will assist with planning the social marketing strategy that will highlight the risks of using substances as a means of dealing with stress and anxiety and also the increased health complications associated with substance use. The social marketing strategy will consist of print, radio, and digital advertisement.

Education - \$10,000

Plan. Evidence Based Programs: In an effort to better engage youth, DBH will work with its partners to purchase and implement substance use prevention evidence based programs and curricula.

Purpose/Issue: Educate District residents about substance use trends and methods to remain drug free.

Impact: The Prevention branch works with clinicians housed in local middle and high schools that will use the “Too Good for Drugs” curriculum to educate youth on the dangers associated with substance use. In addition, DBH will also work with its DCPC Youth Prevention Leadership Corps (YPLCs) to serve as ambassadors for promoting substance use prevention and using data and fact sheets to educate residents about substance use trends and ways to remain drug free.

Alternatives - \$80,000

Plan. Pop-up Events: With the District moving toward allowing outdoor activities and events to resume, DBH will seek to relaunch its substance use prevention pop-up events that took place throughout the District’s eight (8) wards.

Purpose/Issue: Create positive alternatives for residents as an alternative to engaging in substance use.

Impact: Events will consist of block parties, field day activities, and other safe events where the message of substance use prevention can be promoted in a fun and engaging manner.

Community Based Processes - \$800,000

Plan. DC Prevention Centers: Place an outreach specialist at each of DBH’s four (4) DC Prevention Centers (DCPCs).

Purpose/Issue: Promote, enhance, and expand the substance use prevention services available through the DCPCs.

Impact: Each DCPC shall receive \$200,000 (\$100,000 per year) to support an outreach specialist that will engage residents within their respective wards to promote, enhance, and expand the substance use prevention services available through the DCPCs.

Commented [JM1]: Eric: per our discussion, telephonic data collection is \$100k. Please add projects that link our six core strategies for the remainder of the 20% budget.

Commented [JM2]: See edit.

Environmental Strategies - \$100,000

Plan. Telephonic Survey for Data Collection: The District will conduct a ward-level telephonic survey with this funding.

Purpose/Issue: Of the data sources available in the District that capture substance use trends among adolescents and transitional aged youth, none of the sources collects ward-level information or makes it available to the larger public, but, instead, reflects the District as a whole. The lack of ward level data inhibits DBH from tailoring prevention services and social marketing campaigns. For example, anecdotal data that has been received previously show that the manifestation of opioid misuse among youth vary across the city; some using prescribed pills and others consuming cough syrup.

Impact: This proposal would allow for the safe collection of data during COVID and also for respondents to be more candid in their answers. Survey questions would center on variables such as age of first use, frequency of use, and perceptions of harm. Funding would support the development of a data collection instrument, the collection of the data, and the final analysis and report.

Problem ID and Referral - \$10,000

Plan. With the influx of college students returning back to the District after more than a year of being away due to the COVID, DBH will seek to engage local colleges and universities to establish measures of intervening for individuals in need of prevention education.

Purpose/Issue: Support college students who have not accessed support and prevention services due to COVID.

Impact: Intervention examples include Alcohol.edu which is aimed at raising awareness around the risks associated with alcohol consumption. Other interventions will be for students who have used substances and are in need of redirection.

25% Interventions

Naloxone Distribution Expansion \$1,383,750

Plan: Expand the distribution of naloxone to support the implementation of strategies in LIVE. LONG. DC. Opioid Strategic Plan.

Purpose/Issue: The Office of the Chief Medical Examiner has recently reported that in FY 2020, there were 411 individuals that died from an opioid overdose, an average of 34 each month and a 46% increase over 2019. Opioid-related overdose deaths are preventable. Making sure that everyone has naloxone is an important step in reducing opioid-related deaths. The widespread distribution of naloxone is a key strategy in the District's plan to combat the opioid epidemic. Narcan, the name of a naloxone product that we use in the District of Columbia, is an easy to administer nasal spray. It works quickly, is painless, and is a pre-measured dose to reduce medication dosing errors. It temporarily blocks the effect of opioids and helps a person experiencing an overdose start breathing again. District residents can now text LiveLongDC to 888-111 to get information on where they can access free naloxone kits across the District. You can get naloxone at no cost, with no prescription, and no identification at any of the 40 Text to Live participating sites. You can also get information on where to access treatment. We also have outreach workers, community- and faith-based organizations, and our mobile services distributing naloxone. With all of these outreach and distribution efforts, we estimate that we need 60,000 kits each year. The State Opioid Response (SOR) grant supports most of these efforts, but in future years, there will be a shortage.

Impact: In the first six months of FY2021, 30,219 naloxone kits were distributed; 125 opioid overdoses were reversed. We hope to continue with the trend of saving lives.

Budget: 18,450 kits x \$75per kit = \$1,383,750

Fentanyl Test Strips Program Expansion \$248,993

Plan: Expand the distribution of fentanyl test strips to support the implementation of strategies in LIVE. LONG. DC. Opioid Strategic Plan.

Purpose/Issue: Recently, the Federal government has allowed the use of Federal funds to purchase fentanyl test strips. Test strips are legal in the District and community organizations have been purchasing them with their own private funds. Test strips have been controversial in the District because they do not capture the fentanyl analogs. The data that The DC Department of Forensic Sciences collects shows that there is more pure fentanyl in the drug supply, therefore the data is telling us that test strips could be a useful harm reduction tool for the city. DBH is working on guidance around test strips and will be considering using SOR funds to support initiatives. DBH is in the process of conducting a survey with grantees/community providers to gauge their interest in distributing test strips to their clients so that they can test their drugs for fentanyl. Community providers will be given grant funds to purchase the strips and they will be responsible for tracking the distribution and effectiveness of the initiative.

Impact: Individuals will understand if fentanyl is in their drug supply, which will inform their decision to use or not use. The end goal is to save lives.

Budget: 248,993 strips x \$1.00 = \$248,993

25% Treatment (including HIV)

HIV – Treatment (5%) \$326, 548

Pilot SUD Weekend/Evenings Assessment and Referral Center

Plan: DBH will use funds to create a pilot SUD treatment center to address the District’s need for assessment and referral services, HIV screening and testing not currently offered on weekends.

Purpose/Issue: DBH recognizes the need for assessment and referral (A&R) services to be available in the evenings and on weekends. The Assessment and Referral Center (ARC) as well as other SUD providers are not available in the evening or on weekends to provide A&R services. As a part of A&R, individuals will be tested for HIV. In addition to hiring clinicians and nurses, individuals with lived experience will be hired.

Impact: Individuals will have increased access to services and supports.

Budget: \$326, 548

Commented [EJR3]: Need more specificity here. Are fentanyl strips legal in the District? How will they be used? How will they be stored? Who gets the strips? What is the expected outcome?

Commented [JM4]: See edit.

Commented [EJR5]: A narrative is need here. How will this 5% be used for Early Intervention?

Commented [JM6]: See edit.

Treatment (20%) \$1,306,194

Behavioral Health Professionals Screening, Brief Intervention, Referral to Treatment Training \$200,000

Plan: On-line Screening, Brief Intervention, and Referral to Treatment (SBIRT) training curriculum will be developed and available for behavioral health professionals.

Purpose/Issue: In an effort to close the gap between substance use prevention education and substance use treatment pursuant to the Institute of Medicine’s (IOM) Substance Abuse Continuum of Care, the District is proposing to provide on-line SBIRT training for behavioral health professionals. The purpose of this training is to increase the screening of individuals in need of substance use treatment services, and assist them with getting connected to the District’s providers during the pandemic. Primary care providers, such as Federally Qualified Health Centers (FQHCs), and other community clinics will be targeted. Individuals and providers responsible for conducting outreach and engagement will also receive priority for the training.

Impact: Health care and outreach workers will have the tools to screen for SUD. By creating an online training, more individuals will be trained on SBIRT and receive CEUs/CMEs for their efforts.

Budget: \$200,000

Certified Addiction Counselor Training (Tuition & Fees) \$229,500

Plan: Provide Certified Addiction Counselor training to 45 individuals working in the community.

Purpose/Issue: There is a shortage of Certified Addiction Counselors (CACs) in the District. The Catholic Charities Institute’s Professional Education Counseling Program provides the training curriculum required to become a CAC. The Institute recently tailored the curriculum specifically to opioids to help with the current crisis. The lessons include information about legal and illegal opioid use, the pharmacology of opioids, methods of acquisition and use (especially here in DC), drug culture, effects on users, families and the community, and different treatment modalities. During the pandemic, they have transitioned to virtual courses.

Impact: The number of individuals trained on the CAC curriculum will have the coursework needed to start an internship and take the CAC licensing exam.

Budget: \$2,550 per person x 45 = \$114,750 x 2 years = \$229,500

Care Coordination Support \$876,694

Plan: Fund care management start-up costs and other services that are not Medicaid-billable.

Purpose/Issue: Comprehensive care management can be implemented to both improve outcomes for clients with complex needs moving through levels of care and reduce costs by reducing returns to higher levels of care. For this initiative, DBH aims to partner with grantee(s) who can provide comprehensive care management services to DBH’s most complex and at-risk clients who are diagnosed with a substance use disorder (SUD). The grantee will identify the number of clients to be served based on their experience with clients with complex needs (e.g., lengthy behavioral health treatment history, hospitalizations, and interactions with the criminal justice system) and how they will connect with these individuals. The grantee(s) will be responsible for working with those individuals to manage their care in a way that improves positive outcomes

Commented [EJR7]: Need more information here. How many counselors will be trained? Will they be DBH staff or CSA staff? Is this college certification or DBH certification or credit training?

Commented [JM8]: See edit.

(e.g., retention in behavioral health treatment/recovery support services and improved physical health) and reduces negative outcomes (e.g., returning to higher levels of care). This initiative will serve as a model for other care management-related efforts in the District that are ongoing as part of the transition to a managed care payment system.

Impact: Help the District's most vulnerable residents successfully navigate the physical and behavioral health care systems.

Budget: \$876,694

Treatment: Non-HIV (20%)

Behavioral Health Professionals Screening, Brief Intervention, Referral to Treatment Training \$200,000

Plan: On-line Screening, Brief Intervention, and Referral to Treatment (SBIRT) training curriculum will be developed and available for behavioral health professionals.

Purpose/Issue: In an effort to close the gap between substance use prevention education and substance use treatment pursuant to the Institute of Medicine's (IOM) Substance Abuse Continuum of Care, the District is proposing to provide on-line SBIRT training for behavioral health professionals. The purpose of this training is to increase the screening of individuals in need of substance use treatment services, and assisting them with getting connected to the District's providers during the pandemic. Primary care providers, such as Federally Qualified Health Centers (FQHCs), and other community clinics will be targeted. Individuals and providers responsible for conducting outreach and engagement will also receive priority for the training.

Impact: Health care and outreach workers will have the tools to screen for SUD. By creating an online training, more individuals will be able to trained on SBIRT at a time and will receive CEUs/CMEs for their efforts.

Budget: \$200,000

Certified Addiction Counselor Training (Tuition & Fees) \$229,500

Plan: Provide Certified Addiction Counselor training to 45 individuals working in the community.

Purpose/Issue: There is a shortage of Certified Addiction Counselors (CACs) in the District. The Catholic Charities Institute's Professional Education Counseling Program provides the training curriculum required to become a CAC. The Institute recently tailored the curriculum specifically to opioids to help with the current crisis. The lessons include information about legal and illegal opioid use, the pharmacology of opioids, methods of acquisition and use (especially here in DC), drug culture, effects on users, families and the community, and different treatment modalities. During the pandemic, they have transitioned to virtual courses.

Impact: The number of individuals trained on the CAC curriculum will have the coursework needed to start an internship and in turn take the CAC licensing exam.

Budget: \$2,550 per person x 45 = \$114,750 x 2 years = \$229,500

Commented [EJR9]: Need more information here. How many counselors will be trained? Will they be DBH staff or CSA staff? Is this college certification or DBH certification or credit training?

Commented [JM10]: See edit.

Care Coordination Support \$876,694

Plan: Fund care management start-up costs and other services that are not Medicaid-billable.

Purpose/Issue: Comprehensive care management can be implemented to both improve outcomes for clients with complex needs moving through levels of care and reduce costs by reducing returns to higher levels of care. For this initiative, DBH aims to partner with grantee(s) who can provide comprehensive care management services to DBH’s most complex and at-risk clients who are diagnosed with a substance use disorder (SUD). The grantee will identify the number of clients to be served based on their experience with clients with complex needs (e.g., lengthy behavioral health treatment history, hospitalizations, interactions with the criminal justice system) and how they will connect with these individuals. The grantee(s) will be responsible for working with those individuals to manage their care in a way that improves positive outcomes (e.g., retention in behavioral health treatment/recovery support services and improved physical health) and reduces negative outcomes (e.g., returning to higher levels of care). Ideally, this initiative will serve as a model for other care management-related efforts in the District that are ongoing as part of the transition to a managed care payment system.

Impact: Help the District’s most vulnerable residents successfully navigate the physical and behavioral health care systems.

Budget: \$876,694

15% Recovery Support

Establish level 3.5 Residential Treatment Youth Program

Plan: DBH will use funds to develop a community-based level 3.5 substance use disorder treatment facility for youth in a clinically managed, medium intensive residential program.

Purpose/Issue: The District does not have any residential programs to treat youth (12-20 years of age) with SUD needs. Previously, the District transported youth to Mountain Manor Treatment Center, which is located in Baltimore, Maryland. Mountain Manor Treatment Center stopped accepting youth from the District in 2019.

Impact: Providing youth residential treatment services locally will mitigate referrals outside of the District, limit transportation costs and ensure a full continuum of substance use disorder treatment and recovery services during COVID-19.

Budget: \$979, 645

10% Infrastructure

Behavioral Health Integration Readiness Technical Assistance (\$70,000)

Plan: DBH will use grant funds to assess SUD providers' readiness to participate in a whole person care model that integrates behavioral health and primary health care. DBH will hire a consultant to develop a comprehensive provider Electronic Health Records system assessment tool for SUD providers.

Purpose/Issue: District behavioral health providers attempting to make the transition to whole person care. The assessment tool will identify providers' system gaps (process and data capture) that would hinder full participation in a WPC program.

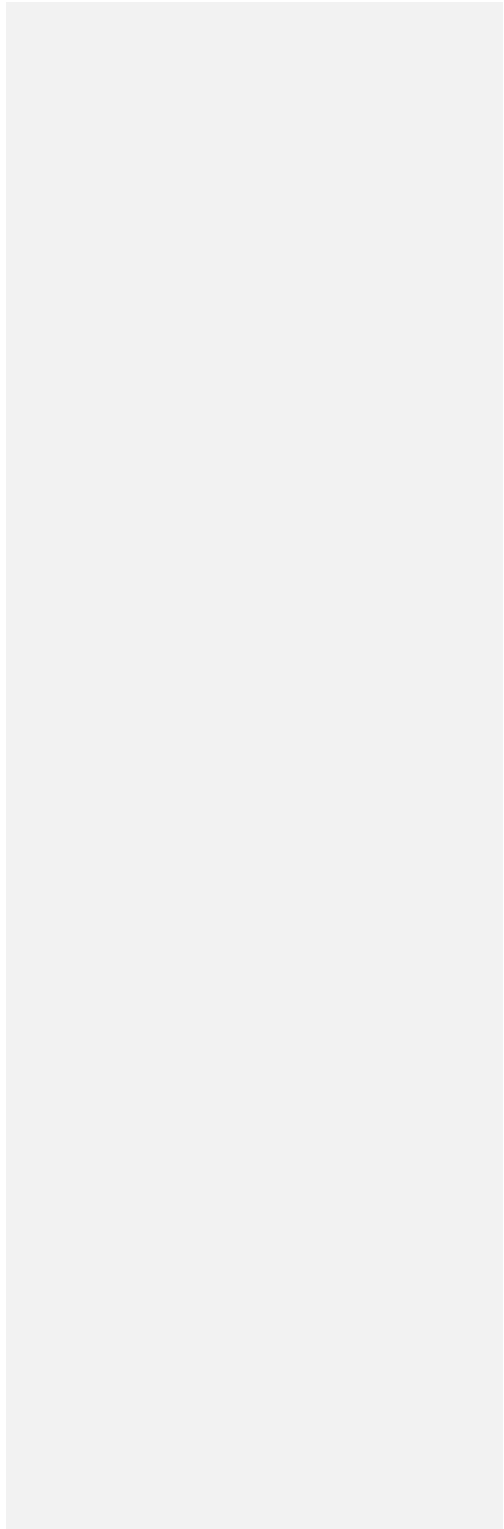
Impact: COVID has compromised providers' ability to prepare for the transition to whole person care. Assessing providers' readiness to participate in a whole person care model will allow DBH to respond to provider deficiencies and gaps.

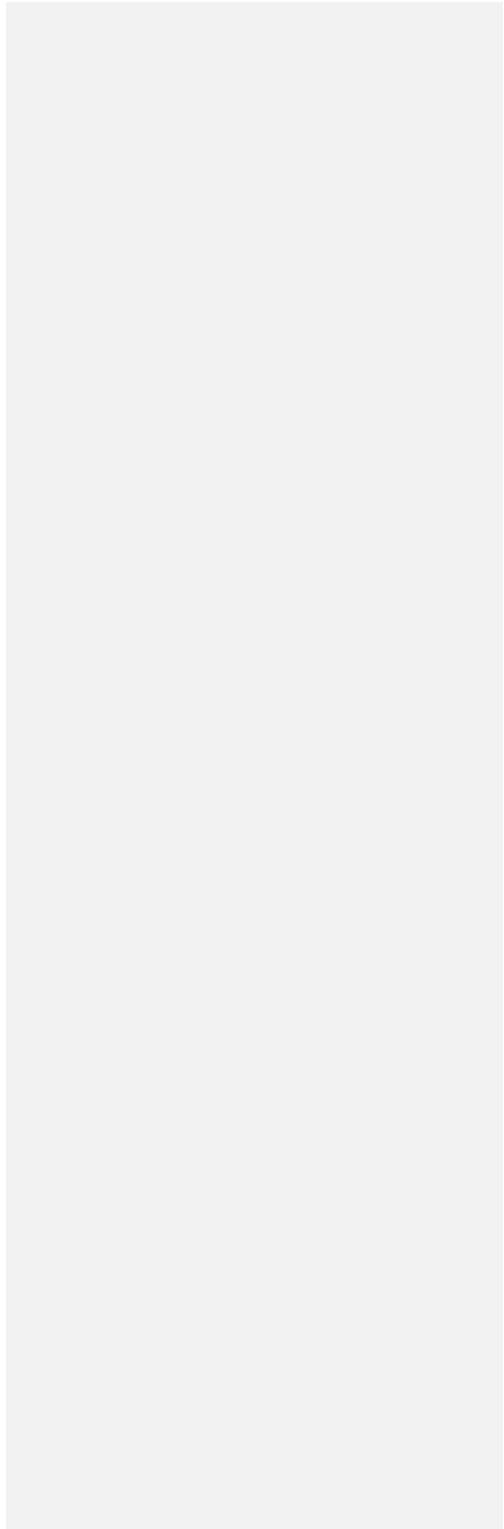
SUD Provider Electronic Health Records (EHR) System Enhancements (\$583, 097)

Plan: DBH will use grant funding to support SUD provider EHR system enhancement/upgrades to support WPC and BH system transformation. SUD provider upgrades include enabling a system enhancement, developing data reporting and funding a portion of a system replacement. Providers will be required to participate in the Behavioral Health Integration Readiness Technical Assistance project to be eligible for system enhancement funding. This will allow DBH to assess provider need for system enhancements.

Issue: SUD providers have struggled with the use of DataWITS, a system mandated by the District. SUD providers need choice in obtaining and using a viable electronic health system to conduct their work and capture data to inform treatment decisions which will support WPC.

Impact: SUD providers will have EHRs to be able to participate successfully in the Districts' BH system transformation and provide WPC.

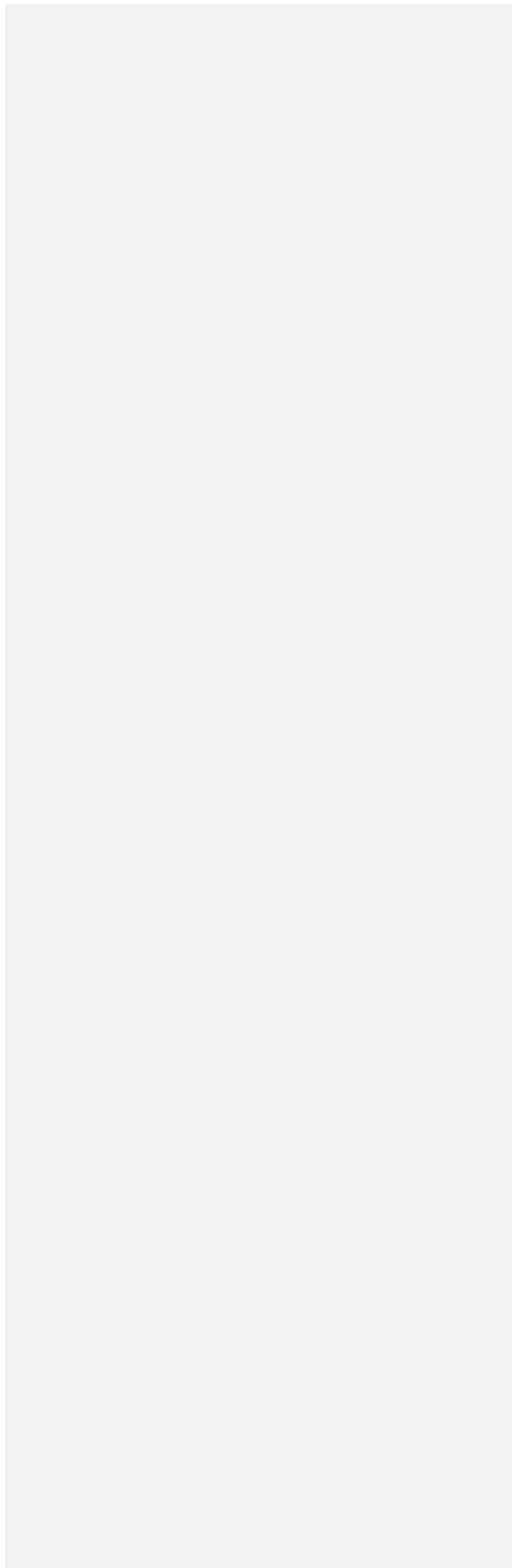




REQUEST (\$6,530,972)

Name	Service	Rate	Other	Cost
Prevention (20%)	<ol style="list-style-type: none"> 1. Information Dissemination - \$400,000 2. Education - \$10,000 3. Alternatives - \$80,000 4. Community Based Processes - \$706,000 5. Environmental Strategies - \$100,000 6. Problem ID and Referral - \$10,000 			\$1,306,000
Intervention (25%)	<ol style="list-style-type: none"> 1. Naloxone Distribution Expansion - \$1,383, 750 2. Fentanyl Test Strips Program Expansion - \$248, 993 			\$1,632,743
Treatment (20%)	<ol style="list-style-type: none"> 1. Behavioral Health Professionals Screening, Brief Intervention, Referral to Treatment Training - \$200,000 2. Certified Addiction Counselor Training (Tuition & Fees) - \$229,500 3. Care Coordination Support (Withdrawal Management) \$876, 694 			\$1,306, 194
Treatment - HIV(5%)	<ol style="list-style-type: none"> 1. Pilot SUD Weekend Unit at Long-Term Care/Skilled Facility 			\$326, 548

Recovery Support (15%)	1. Establish Level 3.5 Residential Treatment Youth Program			\$979, 645
Infrastructure (10%)	1. Behavioral Health Integration Readiness Technical Assistance - \$70,000 2. SUD provider EHR system enhancements to support Whole Person Care (WPC) care and BH system transformation - \$583, 097			\$653, 097
Administrative (5%)	1. Performance 2. Monitoring 3. Evaluation			\$326, 548
			TOTAL	\$6,530,775



COVID-19 Supplemental Funding Plan for FY 21

1. Identify the needs and gaps of your state SUD prevention, treatment, and recovery services systems in the context of COVID-19.

DBH Response

The COVID-19 pandemic has impacted continuity of care for individuals in need of substance use disorder (SUD) treatment. During the public health emergency, many DC residents with SUD have been unable or unwilling to seek in-person care due to fear of becoming infected with the coronavirus. In addition, many have not had access to the internet, computers, or other devices to receive on-going and necessary services and supports via telehealth.

DBH has implemented several innovations to address gaps in services identified during the pandemic to support continuity of care for this population. This includes supporting evidenced-based programs to better engage youth on substance use prevention trends and methods to remain drug free, expanding the distribution of naloxone to support the implementation of the District's opioid strategic plan, and creating a pilot SUD treatment center to address the District's need for assessment and referral services, HIV screening and testing not currently offered on weekends. However, several gaps in service remain. The agency plans to address these additional needs with the SUD supplemental funding provided through this grant. This includes the following:

- **Electronic Medical Records Upgrade: DATAWITS**, DBH's record keeping system for SUD providers, lacks the requisite internal quality assurance capabilities for more complex data collection, analysis, and reporting. As a result, significant efforts are undertaken each year to address issues around data quality and integrity when reporting SUD treatment participation and client outcomes. DBH purchased enhancements in DATAWITS that will enable SUD providers and DBH staff to view a provider's capacity and census data, for the purpose of client referrals. However, SUD providers often produce inaccurate census data, which prevents DBH from utilizing this client data. Meeting the unmet need of supporting DATAWITS would allow DBH to discharge inactive clients and reduce the daily census calls to the providers, error messages, and technical issues that make it difficult for DBH and provider staff to analyze client data.
- **Residential Treatment Program for Youth:** Establish a level 3.5 substance use disorder treatment in a clinically managed medium intensive (CMMI) residential setting program for youth. The District does not have a residential program to treat youth (12-20 years of age) with SUD. Previously, the District sent youth to Mountain Manor Treatment Center (Baltimore, Maryland) and stopped accepting youth from the District in 2019.

In 2018, referrals for youth for the residential 3.5 Level of Care (LOC) averaged approximately 3-5 per week. Through this grant, The District has an opportunity to provide youth residential treatment services locally, which is a cost savings as transportation to Baltimore was covered by the District through various resources (fleet vehicles, mileage, fuel, FTE labor, etc.). In an effort to fill the gap in services, contracting with a provider will ensure the full continuum of substance use disorder treatment

services are available for youth and young adults during the current drug epidemic within their community.

2. Describe how your states spending plan proposal addresses the needs and gaps, including gaps in equity.

DBH Response

- Care Coordination Support

DBH would allocate grant funds to support care coordination in the following manner

- Dramatically increasing our capacity to provide care via telehealth services
- Providing PPE to providers to facilitate safe treatment and in-person interaction with consumers
- Increased utilization of peers, especially peers of color, with unique understanding of and familiarity with obstacles faced by individuals in recovery and uniquely capable of reaching those individuals despite challenges posed by COVID.
- Additional staffing and resources to Access HelpLine, DBH's 24-7 crisis line operated by behavioral health professionals that can refer individuals in crisis to treatment or activate mobile response teams.
- Focusing resources in areas hardest hit by addiction and gun violence to increase accessibility. Between 2016 and 2020, 84% of all deaths due to opioid use were among African American. Hispanics have seen the largest increase in deaths between 2019 and 2020 at 111%. In 2020, opioid-related fatal overdoses were most prevalent in Wards 5, 6, 7 and 8.

- SUD Provider Electronic Health Records (EHR) System Enhancements

DBH will use grant funding to support SUD provider EHR system enhancement/upgrades to support whole person care and behavioral health system transformation. SUD provider upgrades include enabling a system enhancement, developing data reporting and funding a portion of a system replacement. Providers will be required to participate in the Behavioral Health Integration Readiness Technical Assistance project to be eligible for system enhancement funding. This will allow DBH to assess provider need for system enhancements.

3. If your state plans to utilize the funds for crisis services, describe how the state will advance the development of crisis services based on the *National Guidelines for Behavioral Health Crisis Care: Best Practice Tool Kit*.

DBH Response

SAMHSA's *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* provides guidance on how to enhance programs to meet the needs of District residents requiring crisis-specific care. Funding to meet demand and fill financial gaps in the provision of services, would ensure that DBH's SUD services meet the needs of DC residents.

Telephonic Survey for Data Collection: Of the data sources that are available in the District of Columbia that capture substance use trends among adolescents and transitional-aged youth, none of the data consistently addresses ward-level (i.e., for municipal purposes, DC is divided into eight wards) data or makes data publicly available. The lack of ward-level data inhibits DBH's

ability to tailor prevention services and social marketing campaigns to a target audience. The District is proposing to conduct a ward-level telephonic survey to better understand the SUD needs of District youth during the pandemic. This would allow for the safe collection of data during COVID-19. Survey questions would center on variables such as age of first use, frequency of use, and perceptions of harm. Funding would support the development of the data collection instrument, the collection of the data, and the final analysis and report. DBH would advance the development of this crisis service based on SAMSHA's Best Practice Toolkit. Specifically, the 'Monitoring System and Provider Performance' aspect of the Best Practice Toolkit would allow DBH administrators and crisis service providers to continuously evaluate performance through the use of shared data systems. System transparency and regular monitoring of key performance indicators – at city and local-levels – would support continuous quality improvement efforts.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training and Support:

In an effort to close the gap between substance use prevention education and substance use treatment pursuant to the Institute of Medicine's (IOM) Substance Abuse Continuum of Care, the District is proposing to provide on-line Screening, Brief Intervention, and Referral to Treatment (SBIRT) training for behavioral health professionals. The purpose of this training is to increase the screening of individuals in need of substance use treatment services, and assisting them with getting connected to the District's providers. Primary care providers, such as Federally Qualified Health Centers (FQHCs), and other community clinics will be targeted. Individuals and providers responsible for conducting outreach and engagement will receive priority for the training. We will work with DC Primary Care Association to develop a plan for training. DBH would use our mobile crisis team to provide screening, assessment, resolution, peer support,

coordination with medical and behavioral health services and crisis planning/follow-up, pursuant to guidelines outlined in SAMHSA's Best Practice Toolkit.

4. If your state plans to utilize the funds for OUD, AUD, and/or TUD space MAT services, describe how the state will implement these evidence-based services. Please reference the SAMHSA Evidence based-practices Resource Center when considering selection of appropriate services.

DBH Response

Among the District's 32 SUD treatment providers, three (3) are community-based Opioid Treatment Programs (OTP). These OTPs are in the process of prescribing and administering buprenorphine in addition to methadone. With the help of the State Opioid Response (SOR) grant, DBH has implemented various initiatives to:

- o reach persons who inject drugs
- o enacting 24/7 emergency crisis coverage
- o deploy multiple teams to do outreach on the streets and respond to overdoses and overdose spikes
- o conduct Screening, Brief Intervention, and Referral to Treatment (SBIRT).

DBH is also engaged in a recently established emergency department and inpatient induction of medication for opioid use disorders (MOUD) initiative at six (6) hospitals, as well as 90-day follow up with individuals who overdosed who refused to seek treatment; the expansion of MOUD at Federally Qualified Health Centers and the jail; and District-wide distribution of naloxone. DBH is also using SOR funding to provide recovery support services at four (4) Peer-Operated Centers and twenty-three faith-based organizations in the District. Finally, DBH is using SOR funding to promote recovery through supported employment, environmental stability, and recovery and re-entry housing.

5. Explain how your state plans to collaborate with other departments or agencies to address the identified need.

DBH Response

DBH and its certified provider network work closely with agencies in the District's Health and Human Services cluster (e.g., the District's Departments of Health, Health Care Finance, and Disability Services) setting standards, updating procedures, improving services and provider licensure. DBH has a robust forensic services program and a strong partnership with the Metropolitan Police Department to train patrol officers on the best and safest approach to help people in a psychiatric crisis. DBH is working with the Department of Corrections on SOR initiatives, including, setting up two (2) SUD units at the jail (one for men, one for women). DBH is also working on a care management program for returning citizens and has established re-entry housing. We collaborate across agencies on development of new programs and key performance indicators, along with data collection and performance monitoring to ensure we meet measurable goals and

provide quality, equitable services to the community. A good example of this is the work we are doing cross-agency on *LIVE. LONG. DC., the District's Strategic Plan to Reduce Opioid Use, Misuse, and Related Deaths*. The current plan has 7 goals and 50 strategies that are assigned to agency across the District.

6. If your state plans to utilize any of the waiver provisions listed above or recommendations listed in this guidance (see SABG COVID Relief Letter), please explain how your state will implement them with these funds and how the waiver will facilitate the state's response to COVID-19 pandemic and its deleterious impacts. (These waivers are only applicable to these COVID Relief supplemental funds and not to the standard SABG funds).

DBH Response

COVID-19 relief supplemental funds will facilitate the District's response to the COVID-19 pandemic by supporting the following Programs -

SUD Unit: Create a pilot SUD unit at long-term care/skilled nursing facility to allow for treatment of individuals unable to receive SUD treatment in this setting. Currently, none of the facilities in the District are willing to serve individuals on MOUD. Individuals on MOUD are being served in Maryland facilities.

DC Prevention Centers: Place an outreach specialist at each of DBH's four (4) DC Prevention Centers (DCPCs). Each DCPC shall receive \$200,000 (\$100,000 per year) to support an outreach specialist that will engage residents within their respective wards to promote, enhance, and expand the substance use prevention services available through the DCPCs.

Behavioral Health Integration Technical Assistance HUB: Prepare providers for the transition to a whole person care model that integrates behavioral health and primary health care. District behavioral health providers are attempting to make the transition to whole person care. However, COVID-19 has compromised providers' ability to prepare for this transition.

Certified Addiction Counselor (CAC) Training: Support tuition and fees for education and training in addiction counseling to increase the number of CACs. Educating additional CACs will better enable the District to address increased demand for SUD services caused by COVID-

19.

Establish Level 3.5 Residential Treatment Youth Program: DBH will use funds to develop a community-based level 3.5 substance use disorder treatment facility for youth in a clinically managed, medium intensive residential program.

7. If your state plans to make providers stabilization payments, the proposal must include at a minimum the following:
 - a. The period that the payment will be made available i.e., start date and end date.
 - b. The total proposed amount of COVID-19 relief funds for this purpose.
 - c. The methodology for determining support/stabilization payments.
 - d. Provider eligibility criteria (e.g., need based).
 - e. Provider request approach/procedure.

DBH Response: N/A

8. If the states plan to use COVID-19 Relief funds for targeted housing costs, the proposal must include at a minimum the following:
 - a. The proposed amount of award amount for this purpose.
 - b. Methodology for determining rental and security deposit payments.
 - c. Eligibility criteria for payment of rent or security deposit.
 - d. Proposed approach/procedures for individuals to request rental assistance.

DBH Response: N/A

District of Columbia Department of Behavioral Health
SABG COVID-19 Relief Supplement Funds (\$6,530,972)
1B08TI083550-01

Budget & Budget Narratives

5% Administrative

20% Prevention (\$1.4M)

Information Dissemination - \$400,000

Plan. Social Marketing Strategy: The District is seeking to develop a social marketing strategy to promote the prevention of alcohol, tobacco, and other drug use particularly with the ongoing impact of the COVID-19 global pandemic.

Purpose/Issue: Reduce the use of alcohol, tobacco, and other drug use exacerbated by COVID.

Impact: DBH will work with a public relations company that will assist with planning the social marketing strategy that will highlight the risks of using substances as a means of dealing with stress and anxiety and also the increased health complications associated with substance use. The social marketing strategy will consist of print, radio, and digital advertisement.

Education - \$10,000

Plan. Evidence Based Programs: In an effort to better engage youth, DBH will work with its partners to purchase and implement substance use prevention evidence based programs and curricula.

Purpose/Issue: Educate District residents about substance use trends and methods to remain drug free.

Impact: The Prevention branch works with clinicians housed in local middle and high schools that will use the “Too Good for Drugs” curriculum to educate youth on the dangers associated with substance use. In addition, DBH will also work with its DCPC Youth Prevention Leadership Corps (YPLCs) to serve as ambassadors for promoting substance use prevention and using data and fact sheets to educate residents about substance use trends and ways to remain drug free.

Alternatives - \$80,000

Plan. Pop-up Events: With the District moving toward allowing outdoor activities and events to resume, DBH will seek to relaunch its substance use prevention pop-up events that took place throughout the District’s eight (8) wards.

Purpose/Issue: Create positive alternatives for residents as an alternative to engaging in substance use.

Impact: Events will consist of block parties, field day activities, and other safe events where the message of substance use prevention can be promoted in a fun and engaging manner.

Community Based Processes - \$800,000

Plan. DC Prevention Centers: Place an outreach specialist at each of DBH’s four (4) DC Prevention Centers (DCPCs).

Purpose/Issue: Promote, enhance, and expand the substance use prevention services available through the DCPCs.

Impact: Each DCPC shall receive \$200,000 (\$100,000 per year) to support an outreach specialist that will engage residents within their respective wards to promote, enhance, and expand the substance use prevention services available through the DCPCs.

Commented [JM1]: Eric: per our discussion, telephonic data collection is \$100k. Please add projects that link our six core strategies for the remainder of the 20% budget.

Commented [JM2]: See edit.

Environmental Strategies - \$100,000

Plan. Telephonic Survey for Data Collection: The District will conduct a ward-level telephonic survey with this funding.

Purpose/Issue: Of the data sources available in the District that capture substance use trends among adolescents and transitional aged youth, none of the sources collects ward-level information or makes it available to the larger public, but, instead, reflects the District as a whole. The lack of ward level data inhibits DBH from tailoring prevention services and social marketing campaigns. For example, anecdotal data that has been received previously show that the manifestation of opioid misuse among youth vary across the city; some using prescribed pills and others consuming cough syrup.

Impact: This proposal would allow for the safe collection of data during COVID and also for respondents to be more candid in their answers. Survey questions would center on variables such as age of first use, frequency of use, and perceptions of harm. Funding would support the development of a data collection instrument, the collection of the data, and the final analysis and report.

Problem ID and Referral - \$10,000

Plan. With the influx of college students returning back to the District after more than a year of being away due to the COVID, DBH will seek to engage local colleges and universities to establish measures of intervening for individuals in need of prevention education.

Purpose/Issue: Support college students who have not accessed support and prevention services due to COVID.

Impact: Intervention examples include Alcohol.edu which is aimed at raising awareness around the risks associated with alcohol consumption. Other interventions will be for students who have used substances and are in need of redirection.

25% Interventions

Naloxone Distribution Expansion \$1,383,750

Plan: Expand the distribution of naloxone to support the implementation of strategies in LIVE. LONG. DC. Opioid Strategic Plan.

Purpose/Issue: The Office of the Chief Medical Examiner has recently reported that in FY 2020, there were 411 individuals that died from an opioid overdose, an average of 34 each month and a 46% increase over 2019. Opioid-related overdose deaths are preventable. Making sure that everyone has naloxone is an important step in reducing opioid-related deaths. The widespread distribution of naloxone is a key strategy in the District's plan to combat the opioid epidemic. Narcan, the name of a naloxone product that we use in the District of Columbia, is an easy to administer nasal spray. It works quickly, is painless, and is a pre-measured dose to reduce medication dosing errors. It temporarily blocks the effect of opioids and helps a person experiencing an overdose start breathing again. District residents can now text LiveLongDC to 888-111 to get information on where they can access free naloxone kits across the District. You can get naloxone at no cost, with no prescription, and no identification at any of the 40 Text to Live participating sites. You can also get information on where to access treatment. We also have outreach workers, community- and faith-based organizations, and our mobile services distributing naloxone. With all of these outreach and distribution efforts, we estimate that we need 60,000 kits each year. The State Opioid Response (SOR) grant supports most of these efforts, but in future years, there will be a shortage.

Impact: In the first six months of FY2021, 30,219 naloxone kits were distributed; 125 opioid overdoses were reversed. We hope to continue with the trend of saving lives.

Budget: 18,450 kits x \$75per kit = \$1,383,750

Fentanyl Test Strips Program Expansion \$248,993

Plan: Expand the distribution of fentanyl test strips to support the implementation of strategies in LIVE. LONG. DC. Opioid Strategic Plan.

Purpose/Issue: Recently, the Federal government has allowed the use of Federal funds to purchase fentanyl test strips. Test strips are legal in the District and community organizations have been purchasing them with their own private funds. Test strips have been controversial in the District because they do not capture the fentanyl analogs. The data that The DC Department of Forensic Sciences collects shows that there is more pure fentanyl in the drug supply, therefore the data is telling us that test strips could be a useful harm reduction tool for the city. DBH is working on guidance around test strips and will be considering using SOR funds to support initiatives. DBH is in the process of conducting a survey with grantees/community providers to gauge their interest in distributing test strips to their clients so that they can test their drugs for fentanyl. Community providers will be given grant funds to purchase the strips and they will be responsible for tracking the distribution and effectiveness of the initiative.

Impact: Individuals will understand if fentanyl is in their drug supply, which will inform their decision to use or not use. The end goal is to save lives.

Budget: 248,993 strips x \$1.00 = \$248,993

25% Treatment (including HIV)

HIV – Treatment (5%) \$326, 548

Pilot SUD Weekend/Evenings Assessment and Referral Center

Plan: DBH will use funds to create a pilot SUD treatment center to address the District’s need for assessment and referral services, HIV screening and testing not currently offered on weekends.

Purpose/Issue: DBH recognizes the need for assessment and referral (A&R) services to be available in the evenings and on weekends. The Assessment and Referral Center (ARC) as well as other SUD providers are not available in the evening or on weekends to provide A&R services. As a part of A&R, individuals will be tested for HIV. In addition to hiring clinicians and nurses, individuals with lived experience will be hired.

Impact: Individuals will have increased access to services and supports.

Budget: \$326, 548

Commented [EJR3]: Need more specificity here. Are fentanyl strips legal in the District? How will they be used? How will they be stored? Who gets the strips? What is the expected outcome?

Commented [JM4]: See edit.

Commented [EJR5]: A narrative is need here. How will this 5% be used for Early Intervention?

Commented [JM6]: See edit.

Treatment (20%) \$1,306,194

Behavioral Health Professionals Screening, Brief Intervention, Referral to Treatment Training \$200,000

Plan: On-line Screening, Brief Intervention, and Referral to Treatment (SBIRT) training curriculum will be developed and available for behavioral health professionals.

Purpose/Issue: In an effort to close the gap between substance use prevention education and substance use treatment pursuant to the Institute of Medicine's (IOM) Substance Abuse Continuum of Care, the District is proposing to provide on-line SBIRT training for behavioral health professionals. The purpose of this training is to increase the screening of individuals in need of substance use treatment services, and assist them with getting connected to the District's providers during the pandemic. Primary care providers, such as Federally Qualified Health Centers (FQHCs), and other community clinics will be targeted. Individuals and providers responsible for conducting outreach and engagement will also receive priority for the training.

Impact: Health care and outreach workers will have the tools to screen for SUD. By creating an online training, more individuals will be trained on SBIRT and receive CEUs/CMEs for their efforts.

Budget: \$200,000

Certified Addiction Counselor Training (Tuition & Fees) \$229,500

Plan: Provide Certified Addiction Counselor training to 45 individuals working in the community.

Purpose/Issue: There is a shortage of Certified Addiction Counselors (CACs) in the District. The Catholic Charities Institute's Professional Education Counseling Program provides the training curriculum required to become a CAC. The Institute recently tailored the curriculum specifically to opioids to help with the current crisis. The lessons include information about legal and illegal opioid use, the pharmacology of opioids, methods of acquisition and use (especially here in DC), drug culture, effects on users, families and the community, and different treatment modalities. During the pandemic, they have transitioned to virtual courses.

Impact: The number of individuals trained on the CAC curriculum will have the coursework needed to start an internship and take the CAC licensing exam.

Budget: \$2,550 per person x 45 = \$114,750 x 2 years = \$229,500

Care Coordination Support \$876,694

Plan: Fund care management start-up costs and other services that are not Medicaid-billable.

Purpose/Issue: Comprehensive care management can be implemented to both improve outcomes for clients with complex needs moving through levels of care and reduce costs by reducing returns to higher levels of care. For this initiative, DBH aims to partner with grantee(s) who can provide comprehensive care management services to DBH's most complex and at-risk clients who are diagnosed with a substance use disorder (SUD). The grantee will identify the number of clients to be served based on their experience with clients with complex needs (e.g., lengthy behavioral health treatment history, hospitalizations, and interactions with the criminal justice system) and how they will connect with these individuals. The grantee(s) will be responsible for working with those individuals to manage their care in a way that improves positive outcomes

Commented [EJR7]: Need more information here. How many counselors will be trained? Will they be DBH staff or CSA staff? Is this college certification or DBH certification or credit training?

Commented [JM8]: See edit.

(e.g., retention in behavioral health treatment/recovery support services and improved physical health) and reduces negative outcomes (e.g., returning to higher levels of care). This initiative will serve as a model for other care management-related efforts in the District that are ongoing as part of the transition to a managed care payment system.

Impact: Help the District's most vulnerable residents successfully navigate the physical and behavioral health care systems.

Budget: \$876,694

Treatment: Non-HIV (20%)

Behavioral Health Professionals Screening, Brief Intervention, Referral to Treatment Training \$200,000

Plan: On-line Screening, Brief Intervention, and Referral to Treatment (SBIRT) training curriculum will be developed and available for behavioral health professionals.

Purpose/Issue: In an effort to close the gap between substance use prevention education and substance use treatment pursuant to the Institute of Medicine's (IOM) Substance Abuse Continuum of Care, the District is proposing to provide on-line SBIRT training for behavioral health professionals. The purpose of this training is to increase the screening of individuals in need of substance use treatment services, and assisting them with getting connected to the District's providers during the pandemic. Primary care providers, such as Federally Qualified Health Centers (FQHCs), and other community clinics will be targeted. Individuals and providers responsible for conducting outreach and engagement will also receive priority for the training.

Impact: Health care and outreach workers will have the tools to screen for SUD. By creating an online training, more individuals will be able to trained on SBIRT at a time and will receive CEUs/CMEs for their efforts.

Budget: \$200,000

Certified Addiction Counselor Training (Tuition & Fees) \$229,500

Plan: Provide Certified Addiction Counselor training to 45 individuals working in the community.

Purpose/Issue: There is a shortage of Certified Addiction Counselors (CACs) in the District. The Catholic Charities Institute's Professional Education Counseling Program provides the training curriculum required to become a CAC. The Institute recently tailored the curriculum specifically to opioids to help with the current crisis. The lessons include information about legal and illegal opioid use, the pharmacology of opioids, methods of acquisition and use (especially here in DC), drug culture, effects on users, families and the community, and different treatment modalities. During the pandemic, they have transitioned to virtual courses.

Impact: The number of individuals trained on the CAC curriculum will have the coursework needed to start an internship and in turn take the CAC licensing exam.

Budget: \$2,550 per person x 45 = \$114,750 x 2 years = \$229,500

Commented [EJR9]: Need more information here. How many counselors will be trained? Will they be DBH staff or CSA staff? Is this college certification or DBH certification or credit training?

Commented [JM10]: See edit.

Care Coordination Support \$876,694

Plan: Fund care management start-up costs and other services that are not Medicaid-billable.

Purpose/Issue: Comprehensive care management can be implemented to both improve outcomes for clients with complex needs moving through levels of care and reduce costs by reducing returns to higher levels of care. For this initiative, DBH aims to partner with grantee(s) who can provide comprehensive care management services to DBH's most complex and at-risk clients who are diagnosed with a substance use disorder (SUD). The grantee will identify the number of clients to be served based on their experience with clients with complex needs (e.g., lengthy behavioral health treatment history, hospitalizations, interactions with the criminal justice system) and how they will connect with these individuals. The grantee(s) will be responsible for working with those individuals to manage their care in a way that improves positive outcomes (e.g., retention in behavioral health treatment/recovery support services and improved physical health) and reduces negative outcomes (e.g., returning to higher levels of care). Ideally, this initiative will serve as a model for other care management-related efforts in the District that are ongoing as part of the transition to a managed care payment system.

Impact: Help the District's most vulnerable residents successfully navigate the physical and behavioral health care systems.

Budget: \$876,694

15% Recovery Support

Establish level 3.5 Residential Treatment Youth Program

Plan: DBH will use funds to develop a community-based level 3.5 substance use disorder treatment facility for youth in a clinically managed, medium intensive residential program.

Purpose/Issue: The District does not have any residential programs to treat youth (12-20 years of age) with SUD needs. Previously, the District transported youth to Mountain Manor Treatment Center, which is located in Baltimore, Maryland. Mountain Manor Treatment Center stopped accepting youth from the District in 2019.

Impact: Providing youth residential treatment services locally will mitigate referrals outside of the District, limit transportation costs and ensure a full continuum of substance use disorder treatment and recovery services during COVID-19.

Budget: \$979, 645

10% Infrastructure

Behavioral Health Integration Readiness Technical Assistance (\$70,000)

Plan: DBH will use grant funds to assess SUD providers' readiness to participate in a whole person care model that integrates behavioral health and primary health care. DBH will hire a consultant to develop a comprehensive provider Electronic Health Records system assessment tool for SUD providers.

Purpose/Issue: District behavioral health providers attempting to make the transition to whole person care. The assessment tool will identify providers' system gaps (process and data capture) that would hinder full participation in a WPC program.

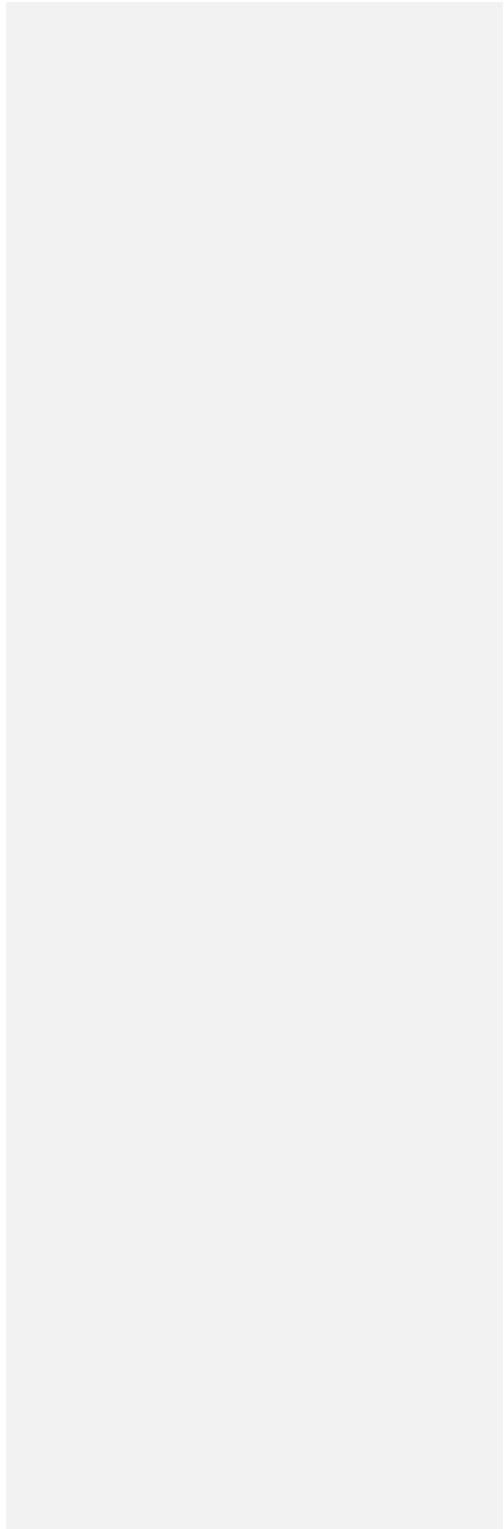
Impact: COVID has compromised providers' ability to prepare for the transition to whole person care. Assessing providers' readiness to participate in a whole person care model will allow DBH to respond to provider deficiencies and gaps.

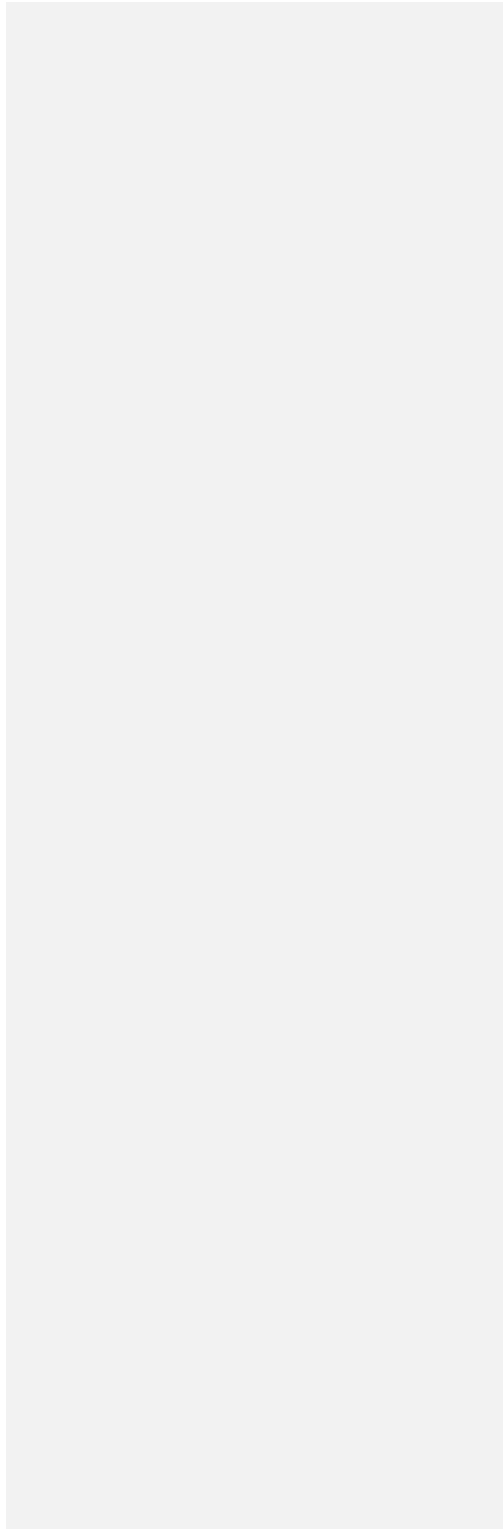
SUD Provider Electronic Health Records (EHR) System Enhancements (\$583, 097)

Plan: DBH will use grant funding to support SUD provider EHR system enhancement/upgrades to support WPC and BH system transformation. SUD provider upgrades include enabling a system enhancement, developing data reporting and funding a portion of a system replacement. Providers will be required to participate in the Behavioral Health Integration Readiness Technical Assistance project to be eligible for system enhancement funding. This will allow DBH to assess provider need for system enhancements.

Issue: SUD providers have struggled with the use of DataWITS, a system mandated by the District. SUD providers need choice in obtaining and using a viable electronic health system to conduct their work and capture data to inform treatment decisions which will support WPC.

Impact: SUD providers will have EHRs to be able to participate successfully in the Districts' BH system transformation and provide WPC.

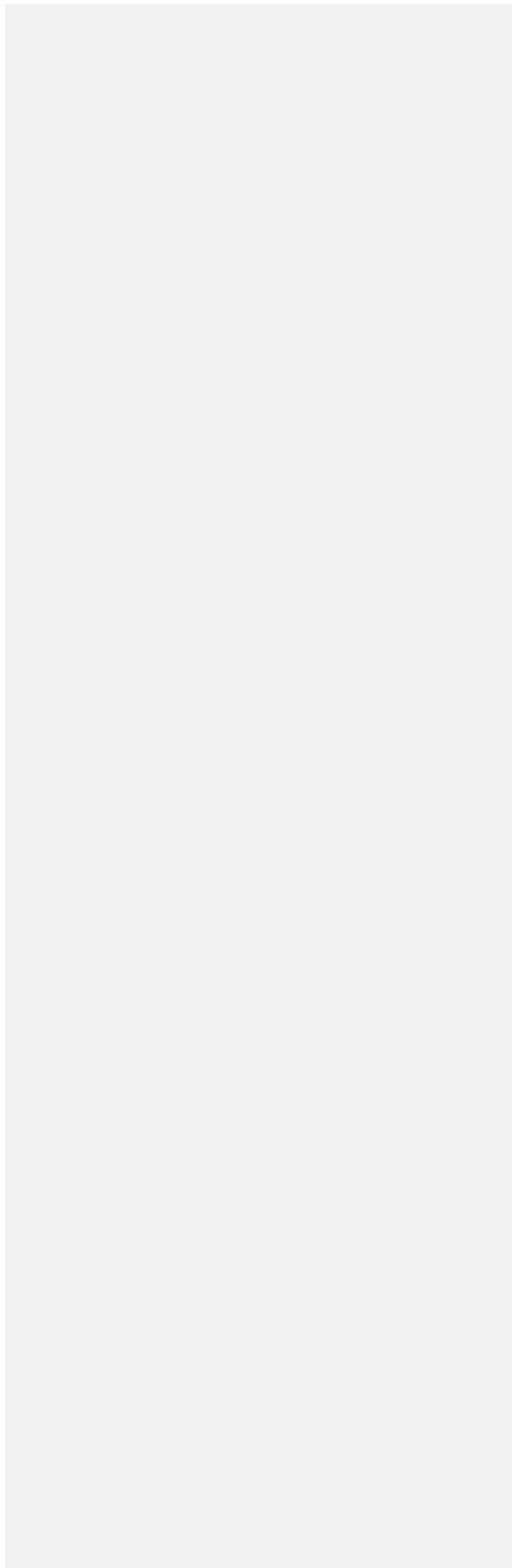




REQUEST (\$6,530,972)

Name	Service	Rate	Other	Cost
Prevention (20%)	<ol style="list-style-type: none"> 1. Information Dissemination - \$400,000 2. Education - \$10,000 3. Alternatives - \$80,000 4. Community Based Processes - \$706,000 5. Environmental Strategies - \$100,000 6. Problem ID and Referral - \$10,000 			\$1,306,000
Intervention (25%)	<ol style="list-style-type: none"> 1. Naloxone Distribution Expansion - \$1,383, 750 2. Fentanyl Test Strips Program Expansion - \$248, 993 			\$1,632,743
Treatment (20%)	<ol style="list-style-type: none"> 1. Behavioral Health Professionals Screening, Brief Intervention, Referral to Treatment Training - \$200,000 2. Certified Addiction Counselor Training (Tuition & Fees) - \$229,500 3. Care Coordination Support (Withdrawal Management) \$876, 694 			\$1,306, 194
Treatment - HIV(5%)	<ol style="list-style-type: none"> 1. Pilot SUD Weekend Unit at Long-Term Care/Skilled Facility 			\$326, 548

Recovery Support (15%)	1. Establish Level 3.5 Residential Treatment Youth Program			\$979, 645
Infrastructure (10%)	1. Behavioral Health Integration Readiness Technical Assistance - \$70,000 2. SUD provider EHR system enhancements to support Whole Person Care (WPC) care and BH system transformation - \$583, 097			\$653, 097
Administrative (5%)	1. Performance 2. Monitoring 3. Evaluation			\$326, 548
			TOTAL	\$6,530,775



The SUD prevention, intervention, treatment, and recovery support services continuum includes various evidence-based services and supports for individuals, families, and communities. Integral to the SABG are its efforts to support health equity through its priority focus on the provision of SUD prevention, treatment, and recovery support services to identified underserved populations. These underserved and marginalized populations include, but are not limited to, pregnant women and women with dependent children; persons who inject drugs; persons using opioids and/or stimulant drugs associated with drug overdoses; persons at risk for HIV, TB, and Hepatitis; persons experiencing homelessness; persons involved in the justice system; persons involved in the child welfare system; Black, Indigenous, and People of Color (BIPOC); LGBTQ individuals; rural populations; and other underserved groups.

1. Identify the needs and gaps of your state's SUD services continuum, related to developing a comprehensive prevention, intervention, treatment, and recovery support services continuum.

DBH Response

The COVID-19 pandemic has impacted continuity of care for individuals in need of substance use disorder (SUD) treatment. During the public health emergency, many DC residents with SUD have been unable or unwilling to seek in-person care due to fear of becoming infected with the coronavirus. In addition, many have not had access to the internet, computers, or other devices to receive on-going and necessary services and supports via telehealth.

DBH has implemented several innovations to address gaps in services identified during the pandemic to support continuity of care for this population. This includes creating policies to enhance telehealth, creating COVID Quarantine Beds, and creating policy to enable professionals from other jurisdictions to treat individuals experiencing SUD issues.

During the Public Health Emergency (PHE), the District created a telehealth policy that allows individuals to use telephones, video platforms such as Google's DUO platform, and Zoom for teleconferencing. The Department also worked in conjunction with DC's Child and Family Services Administration to provide laptops to access video platforms. The District partnered with our Managed Care Organizations to issue personal cellphones to allow individuals to receive telehealth within their homes. In addition, many substance use treatment providers also made adjustments to programming and operations hours to ensure safety with regard to the provision of services.

The Department contracted with 2 of our residential treatment providers to institute the COVID Quarantine/ Emergency bed program. These beds were used to quarantine individuals while they were tested for COVID and awaiting clearance. The program also quarantined individuals who tested positive for COVID for up to 14 days post exposure. After individuals were cleared, they could transfer into a residential treatment program.

During the PHE, the District experienced a shortage of clinicians that were able to treat individuals with a SUD. The District created policy that allowed appropriately licensed clinicians from other jurisdictions and states to practice and treat individuals with a SUD on a temporary basis, without receiving a DC License. Additionally, substance use prevention partners also made a shift to using virtual platforms to continue engaging District residents in an effort to promote substance use prevention. Social marketing avenues such as Facebook, Instagram, and Twitter were used to propose constructive ways for responding to stress and anxiety, especially in light of the Public Health Emergency.

2. Describe how your state's spending plan proposal will address the state's substance use disorder services continuum, including a budget that addresses the needs and gaps related to this continuum.

DBH Response

The District's spending plan proposals addresses our SUD services continuum by addressing Prevention, Intervention, Treatment, Treatment-HIV, Recovery Support, Infrastructure and Administrative.

- The Prevention aspect of the SUD services continuum in DBH's proposal and budget consists of information dissemination, education, alternatives, community based process, environmental strategies and problem ID and referral.
- The Intervention aspect of the SUD continuum in DBH's proposal and budget consists of Community Naloxone Distribution and Harm Reduction Training and Education.
- The Treatment aspect of the SUD services continuum in DBH's proposal and budget consists of Adolescents and Young Adults Intensive Residential Community Based SUD, EMR Trauma and SUD Treatment and EMDR in the Treatment of Trauma among those with Substance Use Disorder.
- The Treatment-HIV aspect of the SUD services continuum in DBH's proposal and budget consists of Pilot SUD Weekend Assessment and Referral Center.
- The Recovery Support aspect of the SUD services continuum in DBH's proposal and budget consists of SUD Community Peer Support and Peer Innovation and Collaboration.
- The Infrastructure aspect of the SUD services continuum in DBH's proposal and budget consists of BH Integration Readiness TA and Provider Electronic Health Record System Enhancements.

See budget and budget narrative below.

3. Describe your state's progress in addressing the rising drug overdose rate in many parts of the country, and what steps the state will be taking to improve access to SUD treatment, by improving identification of persons in need, reducing barriers to admission to treatment, and strengthening mechanisms to promote client engagement and retention in SUD treatment and recovery support services.

DBH Response

Improving Identification

The District has implemented Screening, Brief Intervention, Referral, and Treatment (SBIRT) in six emergency departments and, medication for opioid use disorder (MOUD), in conjunction with peer engagement and referrals to community services and supports. Since program inception (May 2019), 324,569 screenings have been completed. Cumulative data from the participating hospitals show that 13,058 patients with risky alcohol or substance use behaviors were given a brief intervention to assess their willingness to change their behavior since program inception. A total of 159 patients eligible to receive MAT in the ED were induced in the ED since program inception.

The District also implemented Overdose Detection Mapping Application Program (ODMAP) to create an overdose tracking and response system that uses data to inform decision making and enables the deployment of outreach workers to the scene of an overdose. From October 1, 2020 to March 21, 2021, the Rapid Peer Responders (RPRs) made 2,446 client contacts.

Engagement and Retention

DBH expanded peer support across the District to include harm reduction services, treatment, and recovery support by growing the network of peer workers through programs such as RPRs and hospital peers who support patients after an overdose. Twenty-four peers are currently working in six hospitals and there are eight RPRs.

DBH also has expanded outreach capacity to include 6+ outreach teams who are working across the District to connect individuals to needed resources including MOUD, syringe exchange, naloxone, opioid use disorder (OUD) treatment, clothing, housing, and food. In the first half of FY 21, these teams have linked 168 individuals to MOUD through outreach efforts.

4. Describe your state's progress in implementing the increased and widespread use of FDA approved medications for the treatment of opioid use disorder, alcohol use disorder, and tobacco use disorder, in combination with other substance use disorder evidence-based treatments and practices.

DBH Response

In 2019, DBH in partnership with DC's Department of Health Care Finance, collaboratively worked together to remove prior authorization requirements for FDA approved medications used to treat opioid use disorders. The interagency duo also implemented direct Vivitrol services in our Federally Qualified Healthcare Centers (FQHCs). DBH funded the expansion of buprenorphine in eight (8) community clinics and established the Buprenorphine Drug Assistance Plan (BupDAP), a benefit for the uninsured or underinsured. Additionally, the District removed co-pays for MOUD medications and allowed other non-physician medical professionals such as APRNs, Physician Assistants, and RNs to prescribe buprenorphine when treating individuals for an OUD. The District also increased Prescription Drug Monitoring Program (PDMP) registrations due to 2018 legislation requiring mandatory registration for providers: 2,586 users in 2018 → 16,277 users in 2019. Currently, DBH, in partnership with DHCF, has revised the State Plan Amendment (SPA) and made it congruent with CMS standards. The revision ensures that all medication and therapeutic counseling services are included in OTP services. The revision also ensures that specific qualified professionals are permitted to render the services.

5. Explain how your state plans to collaborate with other departments or agencies to address the SUD services continuum.

DBH Response

DBH and its certified provider network work closely with agencies in the District's Health and Human Services cluster (e.g., the District's Departments of Health, Health Care Finance, and Disability Services) setting standards, updating procedures, improving services and provider licensure. DBH has a robust forensic services program and a strong partnership with the Metropolitan Police Department to train patrol officers on the best and safest approach to help people in a psychiatric crisis. DBH is working with the Department of Corrections on SOR initiatives, including, setting up two (2) SUD units at the jail (one for men, one for women). DBH is also working on a care management program for returning citizens and has established

re-entry housing. We collaborate across agencies on development of new programs and key performance indicators, along with data collection and performance monitoring to ensure we meet measurable goals and provide quality, equitable services to the community. A good example of this is the work we are doing cross-agency on LIVE. LONG. DC., the District's Strategic Plan to Reduce Opioid Use, Misuse, and Related Deaths. The current plan has 7 goals and 50 strategies that are assigned to agency across the District.

6. Describe how the state plans to use SABG ARPA funding to promote health equity among identified underserved populations, and how it plans to address health disparities in the planning, delivery, and evaluation of SUD prevention, intervention, treatment, and recovery support services.

DBH Response

DBH plans to use quantitative and qualitative data to guide the development and implementation of planned prevention strategies aimed at promoting substance use prevention throughout the District of Columbia. More specifically, findings from District ward level data will help to better understand the varying needs of underserved populations and the health disparity needs. Strategies are tailored toward the diverse populations through the use of different languages, graphics, and messaging to reach target populations.

7. Describe the state's efforts and plans to promote an increased emphasis on the development, delivery, and support of widespread SUD recovery support services, systems, and mechanisms across the state.

DBH Response

The District launched public education campaigns, including an anti-stigma campaign, to increase awareness about opioid use, treatment, and recovery. The District awarded \$1,150,000 in grants to 23 faith-based institutions to plan for opioid awareness activities and provide information about treatment and recovery services and supports; \$960,000 will be available in FY 21 for 16 additional grants. We expanded peer support across the District to include harm reduction services, treatment, and recovery support by growing the network of peer workers through programs such as Rapid Peer Responders and hospital peers who support patients after an overdose. The District created Supported Employment services for individuals with OUD, which has now become available in March 2020 for individuals with substance use disorders (SUD) under the 1115 Waiver. The District also established four peer-operated centers that are focused on serving the needs of individuals with OUD. Since March 2020, they served 11,339 individuals and conducted 729 group sessions (mainly virtual).

8. Describe other state priorities or activities that the state plans to fund during the performance period of September 1, 2021 through September 30, 2025 using ARPA funds.

DBH Response

The District will have other priorities and activities, specifically, needs and gaps in our mental health services continuum by using ARPA funds for services including, but not limited to

- Outreach and engagement: to bring consumers into mental health services.
- Integration of services: while the District does have mental health Health Homes, not all consumers who need the integration of somatic health and mental health services are served. There are many consumers who could benefit from a primary care liaison who does not need the full interventions of a Health Home.

- Mobile Support Needs (CRT): to address ongoing need to meet individuals where they are to support them with their immediate needs and link them to services. Individuals may need multiple encounters with opportunities for support before they fully engage in treatment.
- Peer Support Workers: DBH-operated direct care sites benefit from the use of peers, who, through lived experience, connect individuals to mental health services.
- Care Coordination for Youth & Families: enhancing services that are community-based will help fill the gap of reduced opportunities for face-to-face services in schools.

9. Describe your state plans for enhancing your state’s prevention infrastructure which may include incorporating work around ACEs and improving substance misuse outcomes among young adults and older adults. (Primary Prevention set-aside)

DBH Response

a. The impact of increased access to marijuana and the state’s strategies to prevent misuse by the underage population.

- The District’s Department of Behavioral Health’s (DBH) Substance Use Disorder (SUD) Prevention Branch will continue developing social marketing strategies to address the legalization of marijuana for recreational use within the District of Columbia. Previous strategies have focused on highlighting both the legal and health risks associated with marijuana consumption. In addition, the Prevention Branch will continue planning alternative activities aimed at creating innovative and safer alternatives to engaging in substance use. Lastly, the District is planning to facilitate the collection and analysis of ward level data around youth substance use trends and perceptions of risk and harm. This data will be critical to the development and execution of the aforementioned strategies.

b. Strategies to reduce the COVID-19 impact of increased alcohol accessibility and misuse.

- The DBH SUD Prevention Branch will do a refresh of its “There’s a Reason” campaign which is focused on addressing underage drinking. This Program’s data collection will assist with assessing the availability and accessibility of alcohol among adolescents. Messaging will be revamped to target caregivers in an effort to increase awareness and to control accessibility.

c. How the state is using equitable strategies to reduce disparities in the state’s prevention planning and approaches.

- The District will continue using both qualitative and quantitative data – such as that which is gathered from ward level data collection – to ensure that it remains committed to reducing disparities in prevention planning and approaches. Ward level data provides guidance on manifestation of substance use across the various wards of the District. In addition, social marketing strategies and campaign materials will continue to be disseminated in multiple languages and through the use different images, graphics, and messaging to ensure that target audiences with various backgrounds and experiences are reached.

10. Describe how the state will use, or considered, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, conformance to Office of the National Coordinator certification criteria in health IT products used or that will be used to support SUD clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and also should consider standards identified in the Interoperability Standards Advisory (<https://www.healthit.gov/isa/>), including but not limited to

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those standards described in the “Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data” section and the “Social Determinants of Health” section.

DBH Response

The District will use ARPA funds to promote health IT standards in the following BH Integration TA and Provider Electronic Health Record System Enhancements. DBH will use grant funds to assess SUD providers’ readiness to participate in a whole person care model that integrates behavioral health and primary health care. DBH will hire a consultant to develop a comprehensive provider Electronic Health Records system assessment tool for SUD providers.

DBH will also use grant funding to support SUD provider EHR system enhancement/upgrades to support WPC and BH system transformation. SUD provider upgrades include enabling a system enhancement, developing data reporting and funding a portion of a system replacement. Providers will be required to participate in the Behavioral Health Integration Readiness Technical Assistance project to be eligible for system enhancement funding. This will allow DBH to assess provider need for system enhancements.

See budget and budge narrative below.

Prevention (20%)

Information Dissemination - \$50,000

Plan: Campaign Materials: The DC Department of Behavioral Health (DBH) is seeking to do a re-print of pamphlets, palm cards, and brochures for social marketing campaigns that address marijuana use, underage drinking, opioid misuse, and synthetic drug use.

Purpose/Issue: Re-printing of social marketing materials that will be disseminated throughout the District.

Impact: District residents will receive social marketing materials that will provide information on the legal and health risks associated with substance use.

Education - \$78,077

Plan: Substance Use Prevention App.: Work with program developer to create an interactive app that will educate youth on the health risks associated with substance use.

Purpose/Issue: The app will be used to engage youth in a meaningful way and provide useful information for abstaining from substance use. The app will provide responses based on quires entered by the user.

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Impact: Youth will have easy access to educational information around the health risks associated with substance use, thus allowing them to make informed decisions.

Alternatives - \$100,000

Plan: Youth Summit: In 2019, the DC Department of Behavioral Health (DBH) held a youth summit with over 200 participants. With restrictions lifting following the COVID pandemic, the District is seeking to hold a follow-up summit during FY2022.

Purpose/Issue: Create a safe space where a target number of 250 District youth can learn about constructive alternatives to engaging in substance use.

Impact: District youth will be equipped with the tools allowing them to be ambassadors for the promotion of substance use prevention throughout the District.

Community Based Processes - \$800,000

Plan: Mini-grants: Provide funding to community based organizations across the District's eight (8) wards to develop and implement community action plans to promote substance use prevention.

Purpose/Issue: To implement activities and programs that will address and reduce the occurrence of substance use throughout the District.

Impact: Each sub-grantee shall receive \$100,000 (\$50,000 per year) to support the development and implementation of evidence based approaches to reduce the use of substances within respective wards.

Environmental Strategies - \$20,000

Plan: Qualitative Data Collection: Through the facilitation of Community Conversations which is an evidence based approach, the District will be able to partner with residents, government agencies, and community based organizations to collect and share qualitative data regarding substance use.

Purpose/Issue: The exchange of qualitative data is critical to guiding the work of substance use prevention within the District of Columbia.

Impact: Qualitative data will provide a narrative to the quantitative data that the District collects regarding substance use. Qualitative data will also assist with using the correct terminology and context in the development of social marketing campaign messaging.

Problem ID and Referral - \$80,000

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Plan: Outreach and Engagement Staff: The District is seeking to hire a staff person who will be responsible for conducting outreach and engagement in an effort to connect youth in need to prevention education resources.

Purpose/Issue: There are youth that fall among the selective and indicated populations who are on the cusp of possibly engaging in heavier substance use.

Impact: An outreach and engagement specialist would be able to identify and connect youth among the selective and indicated populations to prevention education programs in an effort to reduce and ultimately prevent further substance use.

TOTAL REQUEST: \$1,128,077

Intervention (25%)

Community Naloxone Distribution-\$662,539

Plan: Expand the distribution of naloxone, in the community amongst DC Provider agencies, to support the implementation of strategies in LIVE. LONG. DC. opioid strategic plan. This initiative aims to provide an added layer of substance use disorder psychoeducational treatment in the field by increasing access to substance use disorder services, provide care coordination between the Narcan teams and Prestige's substance use provider outpatient treatment teams, bridge the gap of District residents receiving access to treatment, and expanding knowledge-based services. Additionally, providing same-day intake services will aid in expediting treatment to clients.

Purpose/Issue: The Office of the Chief Medical Examiner has recently reported that in FY 2020, there were 411 individuals that died from an opioid overdose, an average of 34 each month and a 46% increase over 2019. Opioid-related overdose deaths are preventable. Making sure that everyone has naloxone is an important step in reducing opioid-related deaths. The widespread distribution of naloxone is a key strategy in the District's plan to combat the opioid epidemic. Narcan, the name of a naloxone product that we use in the District of Columbia, is an easy to administer nasal spray. It works quickly, is painless, and is a pre-measured dose to reduce medication dosing errors. It temporarily blocks the effect of opioids and helps a person experiencing an overdose start breathing again. Improve client's life trajectory and increase retention in substance use treatment with care coordination services will decrease illicit substance/opiate use and other criminal activity amongst people with substance use disorders. Being a community partner, understanding the community needs will decrease attrition towards engaging in first-line treatment for initiation of SUD services.

Impact: In the first six months of FY2021, 30,219 naloxone kits were distributed; 125 opioid overdoses were reversed. We hope to continue with the trend of saving lives.

Harm Reduction Trainer & Educator (LHRTE)- \$352,557

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Plan: Pathways to Housing DC will use Substance Abuse Block Grant funds to create the new position of Lead Harm Reduction Trainer & Educator (LHRTE) to advance and deepen harm reduction work across all of our programs serving 3,500 District residents a year.

Purpose/Issue: Harm reduction incorporates a range of strategies that includes safer use, managed use, abstinence and truly meeting people “where they’re at”. Pathways fully supports the 8 Foundational Principles Central to Harm Reduction created by the National Harm Reduction Coalition. While we see that DC is making incredible strides in supporting and implementing more harm reduction strategies, as evidenced by the Live.Long.DC plan, there is still much work to do to: a.) implement these harm reduction strategies for people with opioid use disorders; and 2.) create harm reduction strategies for people primarily using alcohol and/or other drugs. DC’s current substance use treatment system starts at the “treatment front door”. Pathways recognizes that this leaves out the thousands of District residents who may be in “contemplation” or “pre-contemplation” in regard to their readiness to address their substance use. Harm reduction strategies must be fully implemented to help people stay safe at this point in their lives.

Impact: 75 staff/year will be trained in basic and advanced harm reduction techniques.
All Peers and CACs will become Trainers
Pathways will create a distribution plan for ensuring fentanyl testing strips are delivered along with Narcan to people in our Housing First programs and street outreach.
200+ people each year will receive harm reduction services

TOTAL REQUEST: \$1,015,096

Treatment (20%)

Adolescents and Young Adults Intensive Residential Community Based SUD-.\$800,000

Plan: Establish intensive community based residential substance abuse treatment and essential related services to adolescents and young adults ages 18-21 (up to 24 for TAY) within the District of Columbia.

Purpose/Issue: Within FY 2022 the program can be further developed and certified to additionally provide services to youths beginning at age 16 (sixteen), once additional staff and programming is identified for their other specialized, educational, and other needs.

Impact: Having intensive adolescent residential treatment services located within the District affords the participant:

- easier access to family and care givers for combined therapy sessions and opportunities
- continue accessing already DC planned ancillary services
- better participate in DC government and appropriate community youth activities

EMDR Trauma SUD Treatment-\$125,506

Plan: EMDR in the Treatment of Trauma among those with Substance Use Disorder: Samaritan Inns is seeking funding to expand Trauma-Informed Care in our Residential Treatment Programs, specifically in the Women’s Transitional Treatment Program, the Men’s Transitional Treatment Program, and the Women with Children Program. Studies have shown that Eye Movement Desensitization and Reprocessing (EMDR) is a promising intervention, and can reduce recidivism by half.

Purpose/Issue: In our more than 35 years of operation, Samaritan Inns has helped over 15,000 homeless or at-risk individuals and families who suffer from drug or alcohol addiction, rebuild their lives. But the COVID-19 pandemic has caused an upheaval—relapses and overdoses—primarily because of the trauma inherent in what caused the addictive behavior in the first place. The pandemic was traumatic, and only exacerbated an already tenuous recovery. Most people suffering from substance use disorder turn to alcohol or drugs to self-medicate. Some of the residents in our Long-Term Recovery Program are depressed, extremely anxious, and stressed. As a result of social distancing guidelines, they were forced to maintain physical distance from each other, while going through elevated levels of fear, uncertainty, job loss, and separation from love ones.

Impact: In our more than 35 years of operation, Samaritan Inns has helped over 15,000 homeless or at-risk individuals and families who suffer from drug or alcohol addiction, rebuild their lives. But the COVID-19 pandemic has caused an upheaval—relapses and overdoses—primarily because of the trauma inherent in what caused the addictive behavior in the first place.

EMDR in the Treatment of Trauma among those with Substance Use Disorder-.\$202,571

Plan: Expand Trauma-Informed Care in our Residential Treatment Programs, specifically in the Women’s Transitional Treatment Program, the Men’s Transitional Treatment Program, and the Women with Children Program with DBH provider Samaritan Inns.

Purpose/Issue: Program is in need of assessment expansion.

Impact: Studies have shown that Eye Movement Desensitization and Reprocessing (EMDR) is a promising intervention, and can reduce recidivism by half.

Clients in our programs will be assessed using:

- 1) ACE (Adverse Childhood Experience) survey
- 2) PCL-5 (PTSD Checklist of DSM 5)
- 3) ASI (Addiction Severity Index)
- 4) BDI (Beck Depression Inventory)
- 5) DES (Dissociative Experience Scale) to determine their appropriateness for EMDR therapy.

TOTAL REQUEST: \$1,128,077

Treatment – HIV (5%)

Pilot SUD Weekend Assessment and Referral Center-\$282,019

Plan: DBH will use funds to create a pilot SUD treatment center to address the District’s need for assessment and referral services, HIV screening and testing not currently offered on weekends.

Purpose/Issue: DBH recognizes the need for assessment and referral (A&R) services to be available in the evenings and on weekends. The Assessment and Referral Center (ARC) as well as other SUD providers are not available in the evening or on weekends to provide A&R services. As a part of A&R, individuals will be tested for HIV. In addition to hiring clinicians and nurses, individuals with lived experience will be hired.

Impact: Individuals will have increased access to services and supports.

TOTAL REQUEST: \$282,019

Recovery Support (15%)

SUD Community Peer Support- \$255,534

Plan: Catholic Charities of the Archdiocese of Washington, Inc. (Catholic Charities) seeks to partner with the DC Department of Behavioral Health (DBH) to address the needs and gaps in mental health and substance use disorder (SUD) services for DC residents. By hiring a full-time SUD Peer Support Specialist, Catholic Charities will support DBH in enhancing and expanding services through the effective utilization of Substance Abuse Prevention and Treatment Block Grant (SABG) funds from the Substance Abuse and Mental Health Services Administration (SAMHSA). Through our subsidiary, Anchor Mental Health Association, Inc. (Anchor), Catholic Charities has provided high-quality behavioral health care services for DC residents for over 30 years. As a DBH-certified Core Services Agency (CSA), Anchor offers community-based programming as well as centralized services at our clinic, located at 1001 Lawrence Street in Northeast DC. Anchor’s continuum of services includes comprehensive intake and service planning; psychiatric assessment and medication management; individual and group counseling; evidence-based supported employment; mobile outreach and treatment; tobacco cessation services; shelter-based day treatment; and community support such as mental health education, crisis prevention and intervention, and relapse prevention and coping strategies.

Purpose/Issue: Catholic Charities of the Archdiocese of Washington, Inc. (Catholic Charities) seeks to partner with the DC Department of Behavioral Health (DBH) to address the needs and gaps in mental health and substance use disorder (SUD) services for DC residents. By hiring a full-time SUD Peer Support Specialist, Catholic Charities will support DBH in enhancing and expanding services through the effective utilization of Substance Abuse Prevention and Treatment Block Grant (SABG) funds from the Substance Abuse and Mental Health Services Administration (SAMHSA). Through our subsidiary, Anchor Mental Health Association, Inc. (Anchor), Catholic Charities has provided high-quality behavioral health care services for DC residents for over 30 years. As a DBH-certified Core Services Agency (CSA), Anchor offers community-based programming as well as centralized services at our clinic, located at 1001 Lawrence Street in Northeast DC. Anchor’s continuum of services includes comprehensive

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intake and service planning; psychiatric assessment and medication management; individual and group counseling; evidence-based supported employment; mobile outreach and treatment; tobacco cessation services; shelter-based day treatment; and community support such as mental health education, crisis prevention and intervention, and relapse prevention and coping strategies.

Impact: Recognizing the serious impact of the pandemic on behavioral health, Anchor has seen more deaths from SUD over the past year than ever before. With grant funds, Catholic Charities will hire a full-time SUD Peer Support Specialist to a) use the harm reduction model to educate and support consumers with SUD and b) engage consumers at all stages of SUD treatment contemplation and recovery. For example, in the case of an overdose incident, the SUD Peer Support Specialist will meet with the consumer at the Emergency Department to provide support and discuss his or her needs and potential next steps. We will hire an individual who has the Certified Peer Specialist credential and ideally, who has a lived experience of SUD recovery so he or she can relate to consumers and be able to build a strong rapport with them as a trusted advocate.

Peer Innovation & Collaboration (MPIC)-\$590,523

Plan: Pathways to Housing DC will utilize the funds from this grant to create a new, full time position: Manager of Peer Innovation & Collaboration (MPIC).

Purpose/Issue: Pathways values Peer supports as vital and critical to service delivery at every level and in every program. Pathways' mission is based in the values of "choice" and "self-determination". Nobody better embodies these values than our Peers who walk side-by-side with the people we serve to ignite hope and to help people actualize their dreams. The MPIC will have three main priorities:

1. Expanding and growing the Peer workforce.
2. Supporting the Peer workforce.
3. Educating Supervisors of the Peer workforce on how to better support their staff.

Impact: The program will host 4 Peer Support Foundation Trainings a year, with an estimated 20 people in attendance at each group (80 trained per year).

MPIC will spearhead the Peer Workforce Collaborative, with the goal of hosting monthly virtual/in-person meetings. The goal is to have representation across a diverse representation of settings. The ultimate impact will be a stronger, healthier workforce who can elevate larger policy issues that need to be addressed (e.g., equitable pay and eliminating barriers like criminal background requirements).

The MPIC will serve as a lead resource for Pathways' supervisors with Peers on their teams. This includes our MHRS ACT and Community Support teams, in addition to our Housing First programs, street outreach, and Urgent Care Clinic programs. They will host regular training sessions and act as a mediator if issues arise that need support between Peers and Supervisors. Trainings will be open to other agencies.

TOTAL REQUEST: \$846,057

Infrastructure (10%)

Behavioral Health Integration Readiness TA-\$70,000

Plan: DBH will use grant funds to assess SUD providers' readiness to participate in a whole person care model that integrates behavioral health and primary health care. DBH will hire a consultant to develop a comprehensive provider Electronic Health Records system assessment tool for SUD providers.

Purpose/Issue: District behavioral health providers attempting to make the transition to whole person care. The assessment tool will identify providers' system gaps (process and data capture) that would hinder full participation in a WPC program.

Impact: COVID has compromised providers' ability to prepare for the transition to whole person care. Assessing providers' readiness to participate in a whole person care model will allow DBH to respond to provider deficiencies and gaps.

Provider Electronic Health Record System Enhancements-\$494,038

Plan: DBH will use grant funding to support SUD provider EHR system enhancement/upgrades to support WPC and BH system transformation. SUD provider upgrades include enabling a system enhancement, developing data reporting and funding a portion of a system replacement. Providers will be required to participate in the Behavioral Health Integration Readiness Technical Assistance project to be eligible for system enhancement funding. This will allow DBH to assess provider need for system enhancements.

Issue: SUD providers have struggled with the use of DataWITS, a system mandated by the District. SUD providers need choice in obtaining and using a viable electronic health system to conduct their work and capture data to inform treatment decisions which will support WPC.

Impact: SUD providers will have EHRs to be able to participate successfully in the Districts' BH system transformation and provide WPC.

Deemed Accreditation Support - \$395,000

Plan: DBH proposes the utilization of Substance Abuse Block Grant funds to support provider technical assistance to obtain national accreditation. As DBH moves toward behavioral health integration, we must provide our network with the tools and resources needed to improve the quality of their organizations. National Accreditation from organizations such as the Joint Commission, Council on Accreditation, and the Commission on Accreditation of Rehabilitation Facilities helps to ensure that each provider in our network meets a high standard of care.

Impact: Obtaining national accreditation will strengthen the quality of the provider network, strengthen providers' administrative operations, and improve the quality of behavioral health services available to residents of the District of Columbia. National Accreditation ensures there will be nationally vetted benchmarks and standards for all providers in our network. As part of the grant process, DBH would ensure at minimum that providers met minimum standards for Key

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Performance Indicators, Fiscal Claims Audits, Fidelity Reviews, and line of credit, where applicable.

DBH will offer grants of up to \$10,000 to providers to support technical assistance needed to obtain national accreditation.

TOTAL REQUEST: \$959,038

Name	Service	Cost
Prevention (20%)	<ol style="list-style-type: none"> 1. Information Dissemination 2. Education 3. Alternatives 4. Community Based Processes 5. Environmental Strategies 6. Problem ID and Referral 	<ol style="list-style-type: none"> 1. \$50,000 2. \$78,077 3. \$100,000 4. \$800,000 5. \$20,000 6. \$80,000 <p>Total: \$1,128,077</p>
Intervention (25%)	<ol style="list-style-type: none"> 1. Community Naloxone Distribution 2. Harm Reduction Trainer & Educator (LHRTE) 	<ol style="list-style-type: none"> 1. \$662,539 2. \$352,557 <p>Total: \$1,015,096</p>
Treatment (20%)	<ol style="list-style-type: none"> 1. Intensive Residential Community Based SUD 2. EMDR Trauma SUD Treatment 3. EMDR in the Treatment of Trauma among those with Substance Use Disorder 	<ol style="list-style-type: none"> 1. \$800,000 2. \$125,506 3. \$202,571 <p>Total: \$1,128,077</p>
Treatment – HIV (5%)	<ol style="list-style-type: none"> 1. Pilot SUD Weekend Assessment and Referral Center 	<ol style="list-style-type: none"> 1. \$282,019 <p>Total: \$282,019</p>
Recovery Support (15%)	<ol style="list-style-type: none"> 1. SUD Community Peer Support 2. Peer Innovation & Collaboration (MPIC). 	<ol style="list-style-type: none"> 1. \$255,534 2. \$590,523 <p>Total: \$846,057</p>
Infrastructure (10%)	<ol style="list-style-type: none"> 1. Behavioral Health Integration Readiness TA 2. Provider Electronic Health Record System Enhancements 3. Deemed Accreditation Support 	<ol style="list-style-type: none"> 1. \$70,000 2. \$494,038 3. \$395,000 <p>Total: \$959,038</p>
Administrative (5%)	<ol style="list-style-type: none"> 1. Performance 2. Monitoring 	<ol style="list-style-type: none"> 1. \$282,019

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	3. Evaluation	Total: \$282,019
		Total: \$5,640,383

The SUD prevention, intervention, treatment, and recovery support services continuum includes various evidence-based services and supports for individuals, families, and communities. Integral to the SABG are its efforts to support health equity through its priority focus on the provision of SUD prevention, treatment, and recovery support services to identified underserved populations. These underserved and marginalized populations include, but are not limited to, pregnant women and women with dependent children; persons who inject drugs; persons using opioids and/or stimulant drugs associated with drug overdoses; persons at risk for HIV, TB, and Hepatitis; persons experiencing homelessness; persons involved in the justice system; persons involved in the child welfare system; Black, Indigenous, and People of Color (BIPOC); LGBTQ individuals; rural populations; and other underserved groups.

1. Identify the needs and gaps of your state's SUD services continuum, related to developing a comprehensive prevention, intervention, treatment, and recovery support services continuum.

DBH Response

The COVID-19 pandemic has impacted continuity of care for individuals in need of substance use disorder (SUD) treatment. During the public health emergency, many DC residents with SUD have been unable or unwilling to seek in-person care due to fear of becoming infected with the coronavirus. In addition, many have not had access to the internet, computers, or other devices to receive on-going and necessary services and supports via telehealth.

DBH has implemented several innovations to address gaps in services identified during the pandemic to support continuity of care for this population. This includes creating policies to enhance telehealth, creating COVID Quarantine Beds, and creating policy to enable professionals from other jurisdictions to treat individuals experiencing SUD issues.

During the Public Health Emergency (PHE), the District created a telehealth policy that allows individuals to use telephones, video platforms such as Google's DUO platform, and Zoom for teleconferencing. The Department also worked in conjunction with DC's Child and Family Services Administration to provide laptops to access video platforms. The District partnered with our Managed Care Organizations to issue personal cellphones to allow individuals to receive telehealth within their homes. In addition, many substance use treatment providers also made adjustments to programming and operations hours to ensure safety with regard to the provision of services.

The Department contracted with 2 of our residential treatment providers to institute the COVID Quarantine/ Emergency bed program. These beds were used to quarantine individuals while they were tested for COVID and awaiting clearance. The program also quarantined individuals who tested positive for COVID for up to 14 days post exposure. After individuals were cleared, they could transfer into a residential treatment program.

During the PHE, the District experienced a shortage of clinicians that were able to treat individuals with a SUD. The District created policy that allowed appropriately licensed clinicians from other jurisdictions and states to practice and treat individuals with a SUD on a temporary basis, without receiving a DC License. Additionally, substance use prevention partners also made a shift to using virtual platforms to continue engaging District residents in an effort to promote substance use prevention. Social marketing avenues such as Facebook, Instagram, and Twitter were used to propose constructive ways for responding to stress and anxiety, especially in light of the Public Health Emergency.

2. Describe how your state's spending plan proposal will address the state's substance use disorder services continuum, including a budget that addresses the needs and gaps related to this continuum.

DBH Response

The District's spending plan proposals addresses our SUD services continuum by addressing Prevention, Intervention, Treatment, Treatment-HIV, Recovery Support, Infrastructure and Administrative.

- The Prevention aspect of the SUD services continuum in DBH's proposal and budget consists of information dissemination, education, alternatives, community based process, environmental strategies and problem ID and referral.
- The Intervention aspect of the SUD continuum in DBH's proposal and budget consists of Community Naloxone Distribution and Harm Reduction Training and Education.
- The Treatment aspect of the SUD services continuum in DBH's proposal and budget consists of Adolescents and Young Adults Intensive Residential Community Based SUD, EMR Trauma and SUD Treatment and EMDR in the Treatment of Trauma among those with Substance Use Disorder.
- The Treatment-HIV aspect of the SUD services continuum in DBH's proposal and budget consists of Pilot SUD Weekend Assessment and Referral Center.
- The Recovery Support aspect of the SUD services continuum in DBH's proposal and budget consists of SUD Community Peer Support and Peer Innovation and Collaboration.
- The Infrastructure aspect of the SUD services continuum in DBH's proposal and budget consists of BH Integration Readiness TA and Provider Electronic Health Record System Enhancements.

See budget and budget narrative below.

3. Describe your state's progress in addressing the rising drug overdose rate in many parts of the country, and what steps the state will be taking to improve access to SUD treatment, by improving identification of persons in need, reducing barriers to admission to treatment, and strengthening mechanisms to promote client engagement and retention in SUD treatment and recovery support services.

DBH Response

Improving Identification

The District has implemented Screening, Brief Intervention, Referral, and Treatment (SBIRT) in six emergency departments and, medication for opioid use disorder (MOUD), in conjunction with peer engagement and referrals to community services and supports. Since program inception (May 2019), 324,569 screenings have been completed. Cumulative data from the participating hospitals show that 13,058 patients with risky alcohol or substance use behaviors were given a brief intervention to assess their willingness to change their behavior since program inception. A total of 159 patients eligible to receive MAT in the ED were induced in the ED since program inception.

The District also implemented Overdose Detection Mapping Application Program (ODMAP) to create an overdose tracking and response system that uses data to inform decision making and enables the deployment of outreach workers to the scene of an overdose. From October 1, 2020 to March 21, 2021, the Rapid Peer Responders (RPRs) made 2,446 client contacts.

Engagement and Retention

DBH expanded peer support across the District to include harm reduction services, treatment, and recovery support by growing the network of peer workers through programs such as RPRs and hospital peers who support patients after an overdose. Twenty-four peers are currently working in six hospitals and there are eight RPRs.

DBH also has expanded outreach capacity to include 6+ outreach teams who are working across the District to connect individuals to needed resources including MOUD, syringe exchange, naloxone, opioid use disorder (OUD) treatment, clothing, housing, and food. In the first half of FY 21, these teams have linked 168 individuals to MOUD through outreach efforts.

4. Describe your state's progress in implementing the increased and widespread use of FDA approved medications for the treatment of opioid use disorder, alcohol use disorder, and tobacco use disorder, in combination with other substance use disorder evidence-based treatments and practices.

DBH Response

In 2019, DBH in partnership with DC's Department of Health Care Finance, collaboratively worked together to remove prior authorization requirements for FDA approved medications used to treat opioid use disorders. The interagency duo also implemented direct Vivitrol services in our Federally Qualified Healthcare Centers (FQHCs). DBH funded the expansion of buprenorphine in eight (8) community clinics and established the Buprenorphine Drug Assistance Plan (BupDAP), a benefit for the uninsured or underinsured. Additionally, the District removed co-pays for MOUD medications and allowed other non-physician medical professionals such as APRNs, Physician Assistants, and RNs to prescribe buprenorphine when treating individuals for an OUD. The District also increased Prescription Drug Monitoring Program (PDMP) registrations due to 2018 legislation requiring mandatory registration for providers: 2,586 users in 2018 → 16,277 users in 2019. Currently, DBH, in partnership with DHCF, has revised the State Plan Amendment (SPA) and made it congruent with CMS standards. The revision ensures that all medication and therapeutic counseling services are included in OTP services. The revision also ensures that specific qualified professionals are permitted to render the services.

5. Explain how your state plans to collaborate with other departments or agencies to address the SUD services continuum.

DBH Response

DBH and its certified provider network work closely with agencies in the District's Health and Human Services cluster (e.g., the District's Departments of Health, Health Care Finance, and Disability Services) setting standards, updating procedures, improving services and provider licensure. DBH has a robust forensic services program and a strong partnership with the Metropolitan Police Department to train patrol officers on the best and safest approach to help people in a psychiatric crisis. DBH is working with the Department of Corrections on SOR initiatives, including, setting up two (2) SUD units at the jail (one for men, one for women). DBH is also working on a care management program for returning citizens and has established

re-entry housing. We collaborate across agencies on development of new programs and key performance indicators, along with data collection and performance monitoring to ensure we meet measurable goals and provide quality, equitable services to the community. A good example of this is the work we are doing cross-agency on LIVE. LONG. DC., the District's Strategic Plan to Reduce Opioid Use, Misuse, and Related Deaths. The current plan has 7 goals and 50 strategies that are assigned to agency across the District.

6. Describe how the state plans to use SABG ARPA funding to promote health equity among identified underserved populations, and how it plans to address health disparities in the planning, delivery, and evaluation of SUD prevention, intervention, treatment, and recovery support services.

DBH Response

DBH plans to use quantitative and qualitative data to guide the development and implementation of planned prevention strategies aimed at promoting substance use prevention throughout the District of Columbia. More specifically, findings from District ward level data will help to better understand the varying needs of underserved populations and the health disparity needs. Strategies are tailored toward the diverse populations through the use of different languages, graphics, and messaging to reach target populations.

7. Describe the state's efforts and plans to promote an increased emphasis on the development, delivery, and support of widespread SUD recovery support services, systems, and mechanisms across the state.

DBH Response

The District launched public education campaigns, including an anti-stigma campaign, to increase awareness about opioid use, treatment, and recovery. The District awarded \$1,150,000 in grants to 23 faith-based institutions to plan for opioid awareness activities and provide information about treatment and recovery services and supports; \$960,000 will be available in FY 21 for 16 additional grants. We expanded peer support across the District to include harm reduction services, treatment, and recovery support by growing the network of peer workers through programs such as Rapid Peer Responders and hospital peers who support patients after an overdose. The District created Supported Employment services for individuals with OUD, which has now become available in March 2020 for individuals with substance use disorders (SUD) under the 1115 Waiver. The District also established four peer-operated centers that are focused on serving the needs of individuals with OUD. Since March 2020, they served 11,339 individuals and conducted 729 group sessions (mainly virtual).

8. Describe other state priorities or activities that the state plans to fund during the performance period of September 1, 2021 through September 30, 2025 using ARPA funds.

DBH Response

The District will have other priorities and activities, specifically, needs and gaps in our mental health services continuum by using ARPA funds for services including, but not limited to

- Outreach and engagement: to bring consumers into mental health services.
- Integration of services: while the District does have mental health Health Homes, not all consumers who need the integration of somatic health and mental health services are served.

There are many consumers who could benefit from a primary care liaison who does not need the full interventions of a Health Home.

- Mobile Support Needs (CRT): to address ongoing need to meet individuals where they are to support them with their immediate needs and link them to services. Individuals may need multiple encounters with opportunities for support before they fully engage in treatment.
- Peer Support Workers: DBH-operated direct care sites benefit from the use of peers, who, through lived experience, connect individuals to mental health services.
- Care Coordination for Youth & Families: enhancing services that are community-based will help fill the gap of reduced opportunities for face-to-face services in schools.

9. Describe your state plans for enhancing your state’s prevention infrastructure which may include incorporating work around ACEs and improving substance misuse outcomes among young adults and older adults. (Primary Prevention set-aside)

DBH Response

a. The impact of increased access to marijuana and the state’s strategies to prevent misuse by the underage population.

- The District’s Department of Behavioral Health’s (DBH) Substance Use Disorder (SUD) Prevention Branch will continue developing social marketing strategies to address the legalization of marijuana for recreational use within the District of Columbia. Previous strategies have focused on highlighting both the legal and health risks associated with marijuana consumption. In addition, the Prevention Branch will continue planning alternative activities aimed at creating innovative and safer alternatives to engaging in substance use. Lastly, the District is planning to facilitate the collection and analysis of ward level data around youth substance use trends and perceptions of risk and harm. This data will be critical to the development and execution of the aforementioned strategies.

b. Strategies to reduce the COVID-19 impact of increased alcohol accessibility and misuse.

- The DBH SUD Prevention Branch will do a refresh of its “There’s a Reason” campaign which is focused on addressing underage drinking. This Program’s data collection will assist with assessing the availability and accessibility of alcohol among adolescents. Messaging will be revamped to target caregivers in an effort to increase awareness and to control accessibility.

c. How the state is using equitable strategies to reduce disparities in the state’s prevention planning and approaches.

- The District will continue using both qualitative and quantitative data – such as that which is gathered from ward level data collection – to ensure that it remains committed to reducing disparities in prevention planning and approaches. Ward level data provides guidance on manifestation of substance use across the various wards of the District. In addition, social marketing strategies and campaign materials will continue to be disseminated in multiple languages and through the use different images, graphics, and messaging to ensure that target audiences with various backgrounds and experiences are reached.

10. Describe how the state will use, or considered, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, conformance to Office of the National Coordinator certification criteria in health IT products used or that will be used to support SUD clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and also should consider standards identified in the Interoperability Standards Advisory (<https://www.healthit.gov/isa/>), including but not limited to

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those standards described in the “Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data” section and the “Social Determinants of Health” section.

DBH Response

The District will use ARPA funds to promote health IT standards in the following BH Integration TA and Provider Electronic Health Record System Enhancements. DBH will use grant funds to assess SUD providers’ readiness to participate in a whole person care model that integrates behavioral health and primary health care. DBH will hire a consultant to develop a comprehensive provider Electronic Health Records system assessment tool for SUD providers.

DBH will also use grant funding to support SUD provider EHR system enhancement/upgrades to support WPC and BH system transformation. SUD provider upgrades include enabling a system enhancement, developing data reporting and funding a portion of a system replacement. Providers will be required to participate in the Behavioral Health Integration Readiness Technical Assistance project to be eligible for system enhancement funding. This will allow DBH to assess provider need for system enhancements.

See budget and budge narrative below.

**Prevention (20%)
Information Dissemination - \$50,000**

Plan: Campaign Materials: The DC Department of Behavioral Health (DBH) is seeking to do a re-print of pamphlets, palm cards, and brochures for social marketing campaigns that address marijuana use, underage drinking, opioid misuse, and synthetic drug use.

Purpose/Issue: Re-printing of social marketing materials that will be disseminated throughout the District.

Impact: District residents will receive social marketing materials that will provide information on the legal and health risks associated with substance use.

Education - \$78,077

Plan: Substance Use Prevention App.: Work with program developer to create an interactive app that will educate youth on the health risks associated with substance use.

Purpose/Issue: The app will be used to engage youth in a meaningful way and provide useful information for abstaining from substance use. The app will provide responses based on quires entered by the user.

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Impact: Youth will have easy access to educational information around the health risks associated with substance use, thus allowing them to make informed decisions.

Alternatives - \$100,000

Plan: Youth Summit: In 2019, the DC Department of Behavioral Health (DBH) held a youth summit with over 200 participants. With restrictions lifting following the COVID pandemic, the District is seeking to hold a follow-up summit during FY2022.

Purpose/Issue: Create a safe space where a target number of 250 District youth can learn about constructive alternatives to engaging in substance use.

Impact: District youth will be equipped with the tools allowing them to be ambassadors for the promotion of substance use prevention throughout the District.

Community Based Processes - \$800,000

Plan: Mini-grants: Provide funding to community based organizations across the District's eight (8) wards to develop and implement community action plans to promote substance use prevention.

Purpose/Issue: To implement activities and programs that will address and reduce the occurrence of substance use throughout the District.

Impact: Each sub-grantee shall receive \$100,000 (\$50,000 per year) to support the development and implementation of evidence based approaches to reduce the use of substances within respective wards.

Environmental Strategies - \$20,000

Plan: Qualitative Data Collection: Through the facilitation of Community Conversations which is an evidence based approach, the District will be able to partner with residents, government agencies, and community based organizations to collect and share qualitative data regarding substance use.

Purpose/Issue: The exchange of qualitative data is critical to guiding the work of substance use prevention within the District of Columbia.

Impact: Qualitative data will provide a narrative to the quantitative data that the District collects regarding substance use. Qualitative data will also assist with using the correct terminology and context in the development of social marketing campaign messaging.

Problem ID and Referral - \$80,000

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Plan: Outreach and Engagement Staff: The District is seeking to hire a staff person who will be responsible for conducting outreach and engagement in an effort to connect youth in need to prevention education resources.

Purpose/Issue: There are youth that fall among the selective and indicated populations who are on the cusp of possibly engaging in heavier substance use.

Impact: An outreach and engagement specialist would be able to identify and connect youth among the selective and indicated populations to prevention education programs in an effort to reduce and ultimately prevent further substance use.

TOTAL REQUEST: \$1,128,077

Intervention (25%)

Community Naloxone Distribution-\$662,539

Plan: Expand the distribution of naloxone, in the community amongst DC Provider agencies, to support the implementation of strategies in LIVE. LONG. DC. opioid strategic plan. This initiative aims to provide an added layer of substance use disorder psychoeducational treatment in the field by increasing access to substance use disorder services, provide care coordination between the Narcan teams and Prestige's substance use provider outpatient treatment teams, bridge the gap of District residents receiving access to treatment, and expanding knowledge-based services. Additionally, providing same-day intake services will aid in expediting treatment to clients.

Purpose/Issue: The Office of the Chief Medical Examiner has recently reported that in FY 2020, there were 411 individuals that died from an opioid overdose, an average of 34 each month and a 46% increase over 2019. Opioid-related overdose deaths are preventable. Making sure that everyone has naloxone is an important step in reducing opioid-related deaths. The widespread distribution of naloxone is a key strategy in the District's plan to combat the opioid epidemic. Narcan, the name of a naloxone product that we use in the District of Columbia, is an easy to administer nasal spray. It works quickly, is painless, and is a pre-measured dose to reduce medication dosing errors. It temporarily blocks the effect of opioids and helps a person experiencing an overdose start breathing again. Improve client's life trajectory and increase retention in substance use treatment with care coordination services will decrease illicit substance/opiate use and other criminal activity amongst people with substance use disorders. Being a community partner, understanding the community needs will decrease attrition towards engaging in first-line treatment for initiation of SUD services.

Impact: In the first six months of FY2021, 30,219 naloxone kits were distributed; 125 opioid overdoses were reversed. We hope to continue with the trend of saving lives.

Harm Reduction Trainer & Educator (LHRTE)- \$352,557

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Plan: Pathways to Housing DC will use Substance Abuse Block Grant funds to create the new position of Lead Harm Reduction Trainer & Educator (LHRTE) to advance and deepen harm reduction work across all of our programs serving 3,500 District residents a year.

Purpose/Issue: Harm reduction incorporates a range of strategies that includes safer use, managed use, abstinence and truly meeting people “where they’re at”. Pathways fully supports the 8 Foundational Principles Central to Harm Reduction created by the National Harm Reduction Coalition. While we see that DC is making incredible strides in supporting and implementing more harm reduction strategies, as evidenced by the Live.Long.DC plan, there is still much work to do to: a.) implement these harm reduction strategies for people with opioid use disorders; and 2.) create harm reduction strategies for people primarily using alcohol and/or other drugs. DC’s current substance use treatment system starts at the “treatment front door”. Pathways recognizes that this leaves out the thousands of District residents who may be in “contemplation” or “pre-contemplation” in regard to their readiness to address their substance use. Harm reduction strategies must be fully implemented to help people stay safe at this point in their lives.

Impact: 75 staff/year will be trained in basic and advanced harm reduction techniques.
All Peers and CACs will become Trainers
Pathways will create a distribution plan for ensuring fentanyl testing strips are delivered along with Narcan to people in our Housing First programs and street outreach.
200+ people each year will receive harm reduction services

TOTAL REQUEST: \$1,015,096

Treatment (20%)

Adolescents and Young Adults Intensive Residential Community Based SUD-.\$800,000

Plan: Establish intensive community based residential substance abuse treatment and essential related services to adolescents and young adults ages 18-21 (up to 24 for TAY) within the District of Columbia.

Purpose/Issue: Within FY 2022 the program can be further developed and certified to additionally provide services to youths beginning at age 16 (sixteen), once additional staff and programming is identified for their other specialized, educational, and other needs.

Impact: Having intensive adolescent residential treatment services located within the District affords the participant:

- easier access to family and care givers for combined therapy sessions and opportunities
- continue accessing already DC planned ancillary services
- better participate in DC government and appropriate community youth activities

EMDR Trauma SUD Treatment-\$125,506

Plan: EMDR in the Treatment of Trauma among those with Substance Use Disorder: Samaritan Inns is seeking funding to expand Trauma-Informed Care in our Residential Treatment Programs, specifically in the Women’s Transitional Treatment Program, the Men’s Transitional Treatment Program, and the Women with Children Program. Studies have shown that Eye Movement Desensitization and Reprocessing (EMDR) is a promising intervention, and can reduce recidivism by half.

Purpose/Issue: In our more than 35 years of operation, Samaritan Inns has helped over 15,000 homeless or at-risk individuals and families who suffer from drug or alcohol addiction, rebuild their lives. But the COVID-19 pandemic has caused an upheaval—relapses and overdoses—primarily because of the trauma inherent in what caused the addictive behavior in the first place. The pandemic was traumatic, and only exacerbated an already tenuous recovery. Most people suffering from substance use disorder turn to alcohol or drugs to self-medicate. Some of the residents in our Long-Term Recovery Program are depressed, extremely anxious, and stressed. As a result of social distancing guidelines, they were forced to maintain physical distance from each other, while going through elevated levels of fear, uncertainty, job loss, and separation from love ones.

Impact: In our more than 35 years of operation, Samaritan Inns has helped over 15,000 homeless or at-risk individuals and families who suffer from drug or alcohol addiction, rebuild their lives. But the COVID-19 pandemic has caused an upheaval—relapses and overdoses—primarily because of the trauma inherent in what caused the addictive behavior in the first place.

EMDR in the Treatment of Trauma among those with Substance Use Disorder-.\$202,571

Plan: Expand Trauma-Informed Care in our Residential Treatment Programs, specifically in the Women’s Transitional Treatment Program, the Men’s Transitional Treatment Program, and the Women with Children Program with DBH provider Samaritan Inns.

Purpose/Issue: Program is in need of assessment expansion.

Impact: Studies have shown that Eye Movement Desensitization and Reprocessing (EMDR) is a promising intervention, and can reduce recidivism by half.

Clients in our programs will be assessed using:

- 1) ACE (Adverse Childhood Experience) survey
- 2) PCL-5 (PTSD Checklist of DSM 5)
- 3) ASI (Addiction Severity Index)
- 4) BDI (Beck Depression Inventory)
- 5) DES (Dissociative Experience Scale) to determine their appropriateness for EMDR therapy.

TOTAL REQUEST: \$1,128,077

Treatment – HIV (5%)

Pilot SUD Weekend Assessment and Referral Center-\$282,019

Plan: DBH will use funds to create a pilot SUD treatment center to address the District’s need for assessment and referral services, HIV screening and testing not currently offered on weekends.

Purpose/Issue: DBH recognizes the need for assessment and referral (A&R) services to be available in the evenings and on weekends. The Assessment and Referral Center (ARC) as well as other SUD providers are not available in the evening or on weekends to provide A&R services. As a part of A&R, individuals will be tested for HIV. In addition to hiring clinicians and nurses, individuals with lived experience will be hired.

Impact: Individuals will have increased access to services and supports.

TOTAL REQUEST: \$282,019

Recovery Support (15%)

SUD Community Peer Support- \$255,534

Plan: Catholic Charities of the Archdiocese of Washington, Inc. (Catholic Charities) seeks to partner with the DC Department of Behavioral Health (DBH) to address the needs and gaps in mental health and substance use disorder (SUD) services for DC residents. By hiring a full-time SUD Peer Support Specialist, Catholic Charities will support DBH in enhancing and expanding services through the effective utilization of Substance Abuse Prevention and Treatment Block Grant (SABG) funds from the Substance Abuse and Mental Health Services Administration (SAMHSA). Through our subsidiary, Anchor Mental Health Association, Inc. (Anchor), Catholic Charities has provided high-quality behavioral health care services for DC residents for over 30 years. As a DBH-certified Core Services Agency (CSA), Anchor offers community-based programming as well as centralized services at our clinic, located at 1001 Lawrence Street in Northeast DC. Anchor’s continuum of services includes comprehensive intake and service planning; psychiatric assessment and medication management; individual and group counseling; evidence-based supported employment; mobile outreach and treatment; tobacco cessation services; shelter-based day treatment; and community support such as mental health education, crisis prevention and intervention, and relapse prevention and coping strategies.

Purpose/Issue: Catholic Charities of the Archdiocese of Washington, Inc. (Catholic Charities) seeks to partner with the DC Department of Behavioral Health (DBH) to address the needs and gaps in mental health and substance use disorder (SUD) services for DC residents. By hiring a full-time SUD Peer Support Specialist, Catholic Charities will support DBH in enhancing and expanding services through the effective utilization of Substance Abuse Prevention and Treatment Block Grant (SABG) funds from the Substance Abuse and Mental Health Services Administration (SAMHSA). Through our subsidiary, Anchor Mental Health Association, Inc. (Anchor), Catholic Charities has provided high-quality behavioral health care services for DC residents for over 30 years. As a DBH-certified Core Services Agency (CSA), Anchor offers community-based programming as well as centralized services at our clinic, located at 1001 Lawrence Street in Northeast DC. Anchor’s continuum of services includes comprehensive

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intake and service planning; psychiatric assessment and medication management; individual and group counseling; evidence-based supported employment; mobile outreach and treatment; tobacco cessation services; shelter-based day treatment; and community support such as mental health education, crisis prevention and intervention, and relapse prevention and coping strategies.

Impact: Recognizing the serious impact of the pandemic on behavioral health, Anchor has seen more deaths from SUD over the past year than ever before. With grant funds, Catholic Charities will hire a full-time SUD Peer Support Specialist to a) use the harm reduction model to educate and support consumers with SUD and b) engage consumers at all stages of SUD treatment contemplation and recovery. For example, in the case of an overdose incident, the SUD Peer Support Specialist will meet with the consumer at the Emergency Department to provide support and discuss his or her needs and potential next steps. We will hire an individual who has the Certified Peer Specialist credential and ideally, who has a lived experience of SUD recovery so he or she can relate to consumers and be able to build a strong rapport with them as a trusted advocate.

Peer Innovation & Collaboration (MPIC)-\$590,523

Plan: Pathways to Housing DC will utilize the funds from this grant to create a new, full time position: Manager of Peer Innovation & Collaboration (MPIC).

Purpose/Issue: Pathways values Peer supports as vital and critical to service delivery at every level and in every program. Pathways' mission is based in the values of "choice" and "self-determination". Nobody better embodies these values than our Peers who walk side-by-side with the people we serve to ignite hope and to help people actualize their dreams. The MPIC will have three main priorities:

1. Expanding and growing the Peer workforce.
2. Supporting the Peer workforce.
3. Educating Supervisors of the Peer workforce on how to better support their staff.

Impact: The program will host 4 Peer Support Foundation Trainings a year, with an estimated 20 people in attendance at each group (80 trained per year).

MPIC will spearhead the Peer Workforce Collaborative, with the goal of hosting monthly virtual/in-person meetings. The goal is to have representation across a diverse representation of settings. The ultimate impact will be a stronger, healthier workforce who can elevate larger policy issues that need to be addressed (e.g., equitable pay and eliminating barriers like criminal background requirements).

The MPIC will serve as a lead resource for Pathways' supervisors with Peers on their teams. This includes our MHRS ACT and Community Support teams, in addition to our Housing First programs, street outreach, and Urgent Care Clinic programs. They will host regular training sessions and act as a mediator if issues arise that need support between Peers and Supervisors. Trainings will be open to other agencies.

TOTAL REQUEST: \$846,057

Infrastructure (10%)

Behavioral Health Integration Readiness TA-\$70,000

Plan: DBH will use grant funds to assess SUD providers' readiness to participate in a whole person care model that integrates behavioral health and primary health care. DBH will hire a consultant to develop a comprehensive provider Electronic Health Records system assessment tool for SUD providers.

Purpose/Issue: District behavioral health providers attempting to make the transition to whole person care. The assessment tool will identify providers' system gaps (process and data capture) that would hinder full participation in a WPC program.

Impact: COVID has compromised providers' ability to prepare for the transition to whole person care. Assessing providers' readiness to participate in a whole person care model will allow DBH to respond to provider deficiencies and gaps.

Provider Electronic Health Record System Enhancements-\$494,038

Plan: DBH will use grant funding to support SUD provider EHR system enhancement/upgrades to support WPC and BH system transformation. SUD provider upgrades include enabling a system enhancement, developing data reporting and funding a portion of a system replacement. Providers will be required to participate in the Behavioral Health Integration Readiness Technical Assistance project to be eligible for system enhancement funding. This will allow DBH to assess provider need for system enhancements.

Issue: SUD providers have struggled with the use of DataWITS, a system mandated by the District. SUD providers need choice in obtaining and using a viable electronic health system to conduct their work and capture data to inform treatment decisions which will support WPC.

Impact: SUD providers will have EHRs to be able to participate successfully in the Districts' BH system transformation and provide WPC.

Deemed Accreditation Support - \$395,000

Plan: DBH proposes the utilization of Substance Abuse Block Grant funds to support provider technical assistance to obtain national accreditation. As DBH moves toward behavioral health integration, we must provide our network with the tools and resources needed to improve the quality of their organizations. National Accreditation from organizations such as the Joint Commission, Council on Accreditation, and the Commission on Accreditation of Rehabilitation Facilities helps to ensure that each provider in our network meets a high standard of care.

Impact: Obtaining national accreditation will strengthen the quality of the provider network, strengthen providers' administrative operations, and improve the quality of behavioral health services available to residents of the District of Columbia. National Accreditation ensures there will nationally vetted benchmarks and standards for all providers in our network. As part of the grant process, DBH would ensure at minimum that providers met minimum standards for Key

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Performance Indicators, Fiscal Claims Audits, Fidelity Reviews, and line of credit, where applicable.

DBH will offer grants of up to \$10,000 to providers to support technical assistance needed to obtain national accreditation.

TOTAL REQUEST: \$959,038

Name	Service	Cost
Prevention (20%)	<ol style="list-style-type: none"> 1. Information Dissemination 2. Education 3. Alternatives 4. Community Based Processes 5. Environmental Strategies 6. Problem ID and Referral 	<ol style="list-style-type: none"> 1. \$50,000 2. \$78,077 3. \$100,000 4. \$800,000 5. \$20,000 6. \$80,000 <p>Total: \$1,128,077</p>
Intervention (25%)	<ol style="list-style-type: none"> 1. Community Naloxone Distribution 2. Harm Reduction Trainer & Educator (LHRTE) 	<ol style="list-style-type: none"> 1. \$662,539 2. \$352,557 <p>Total: \$1,015,096</p>
Treatment (20%)	<ol style="list-style-type: none"> 1. Intensive Residential Community Based SUD 2. EMDR Trauma SUD Treatment 3. EMDR in the Treatment of Trauma among those with Substance Use Disorder 	<ol style="list-style-type: none"> 1. \$800,000 2. \$125,506 3. \$202,571 <p>Total: \$1,128,077</p>
Treatment – HIV (5%)	<ol style="list-style-type: none"> 1. Pilot SUD Weekend Assessment and Referral Center 	<ol style="list-style-type: none"> 1. \$282,019 <p>Total: \$282,019</p>
Recovery Support (15%)	<ol style="list-style-type: none"> 1. SUD Community Peer Support 2. Peer Innovation & Collaboration (MPIC). 	<ol style="list-style-type: none"> 1. \$255,534 2. \$590,523 <p>Total: \$846,057</p>
Infrastructure (10%)	<ol style="list-style-type: none"> 1. Behavioral Health Integration Readiness TA 2. Provider Electronic Health Record System Enhancements 3. Deemed Accreditation Support 	<ol style="list-style-type: none"> 1. \$70,000 2. \$494,038 3. \$395,000 <p>Total: \$959,038</p>
Administrative (5%)	<ol style="list-style-type: none"> 1. Performance 2. Monitoring 	<ol style="list-style-type: none"> 1. \$282,019

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	3. Evaluation	Total: \$282,019
		Total: \$5,640,383

State Information

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

Fiscal Year 2021

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Community Mental Health Services Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 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 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		
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

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 Coastal 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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. 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, daycare, 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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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: _____

Signature of CEO or Designee¹: _____

Title: _____

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2021

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Community Mental Health Services Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 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 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		
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

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.
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 17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
 18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
 19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

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 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
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2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
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The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
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5. 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, daycare, 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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The U.S. 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 PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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 Barbara J. Bazron, Ph.D.

Signature of CEO or Designee: 

Title: Director

Date Signed: 08/31/2020

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

GOVERNMENT OF THE DISTRICT OF COLUMBIA

ADMINISTRATIVE ISSUANCE SYSTEM

Mayor's Order 2015-146
May 27, 2015

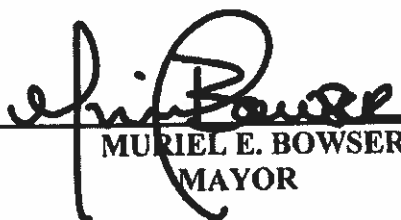
SUBJECT: Delegation of Authority to the Director, Acting Director, or Interim Director, the Department of Behavioral Health, or his or her Designee to Sign Documents Related to the Substance Abuse Prevention and Treatment (SAPT) Block Grant and to sign funding agreements with the U.S. Department of Health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

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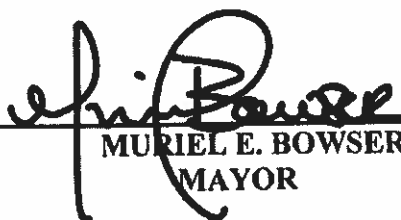
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COVID-19 Supplemental Funding Plan for FY 21

1. Identify the needs and gaps of your state's mental health services in the context of COVID-19.

DBH Response

The District of Columbia (the District) faces challenges in delivering mental health treatment services to people who need them as a result of necessary quarantine, distancing, and isolation precautions. We are seeing a dramatic rise in utilization of telehealth services. Twenty-six percent (26%) of the Medicaid mental health claims paid by January 1, 2021 were delivered through telehealth applications. While it is helpful to be able to utilize technology to deliver mental health services during the pandemic, there are limits to what can be accomplished without in-person treatment.

The Department of Behavioral Health (DBH) providers deliver an array of mental health services in accordance with DC Health and Centers for Disease Control and Prevention (CDC) guidelines. However, DBH has identified the following needs and gaps in the District's mental health treatment services

- **Mobile Support Needs:** DBH's Community Response Team has averaged 110 referrals for outreach to address crises each week during the public health emergency. There is an ongoing need to meet individuals where they are to support them with their immediate needs and link them to services. Individuals may need multiple encounters with opportunities for support before they fully engage in treatment.
- **Peer Support Workers:** DBH-operated direct care sites benefit from the use of peers, who, through lived experience, connect individuals to mental health services. New services such as housing have been implemented in the District, and peers are essential in ensuring consumers and clients can get the services they need while in these programs.
- **Care Coordination for Youth and Families:** the number of children who received a mental health service declined during the public health emergency, likely due to children no longer attending school in person, where many of their services had usually taken place. Enhancing services that are community-based will help fill the gap of reduced opportunities for face-to-face services in schools.

2. Describe how your state's spending plan proposal addresses the needs and gaps.

DBH Response

- **Utilizing Mobile Support Teams**

In 2019, DBH established a 24/7 Community Response Team (CRT), which merges four existing mental health community outreach teams (Homeless Outreach, Mobile Crisis, Pre-Arrest Diversion, and Crisis Outreach Services) to expand access to care. Recognizing that many individuals who need mental health services are unable or unwilling to come into clinical settings

during the COVID-19 public health emergency, DBH utilizes this team to:

- Provide low or no barrier assessment and referral for individuals presenting with developing or untreated mental illness and substance use disorders; and
- Engage with individuals who have treatment providers, but who are not actively engaged with services due to other barriers, and to provide short term support in resolving crises to reduce barriers and increase access to available care.

- Hiring Peer Support Workers

The Centers for Medicare & Medicaid Services recognized peer support an evidence-based model of care in 2007. The role of peer support workers has expanded over the years from offering mutual support through self-help groups and peer-run programs (e.g., drop-in centers) to the provision of services. Peer-delivered services generate superior outcomes in terms of engaging “difficult to reach” individuals, reducing rates of hospitalizations and days spent as an inpatient, and decreasing substance use among persons with co-occurring substance use disorder. Literature informs us that when peers interact with someone in crisis, they can connect the individual to care 40% to 65% of the time; when a professional staff person does, the connection rate drops to 25%. It is clear that peers play a critically important role in our system, and that has become only more evident during the past year during the public health emergency.

DBH has 168 certified peers in the District’s behavioral health system and is committed to increasing this number. The District is now developing plans to deploy peers to our Pandemic Emergency Program for Highly Vulnerable Populations (PEP-V) and Isolation and Quarantine (ISAQ) sites. These sites are hotels in the District that have been utilized as temporary housing for individuals experiencing housing instability who are medically at risk (PEP-V) or have been exposed to or contracted COVID-19 (ISAQ). We believe peers are particularly well-suited to act as advocates and liaisons on behalf of residents.

- Provision of Wraparound Support for Youth and Families

High Fidelity Wraparound is a “a collaborative team-based care planning process where the family and the team implement, track, and adapt an Individualized Plan of Care (IPC) working toward the youth and family’s long term vision for the purpose of achieving positive outcomes in the home, school, and community.” High Fidelity Wraparound is beneficial for children and youth with serious emotional disturbances and their families with complex unmet needs, multisystem involvement, at risk of out-of-home or residential placement, disruption in school setting, and high utilization of acute care. Mental Health Block Grant (MHBG) COVID-19 supplemental relief funds will support HFW’s ability to help children, youth, and their families access promising and evidence-based practices and coordinate income maintenance and community-based services. The District proposes providing this promising practice to families and youth with serious emotional disturbances that have been exacerbating during the pandemic. The goal is to provide in-person support and resources through flex funding to assist with feelings of isolation, anxiety, and loneliness due to pandemic and to keep youth with their families in their communities.

3. Describe how the state will advance the development of crisis services based on the *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit*. The five percent crisis services set-aside applies to these funds.

DBH Response

SAMHSA's *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* provides guidance on how to enhance the programs in place to meet the needs of District residents requiring crisis-specific care. Funding to meet the demand and fill the financial gaps in the provision of services, would ensure that the District's services are available for anyone, anywhere, and anytime.

According to the *Best Practice Toolkit* the use of peers is a critical component of using best practices in operating a behavioral health crisis system. DBH has a robust network of certified peer specialists, to staff the Access HelpLine, DBH's crisis hotline. Peers are fully integrated into the Department's system of service provision in alignment with the *Best Practice Toolkit*. Expansion of this program requires funding for training and supervision of peers. Similarly, the Department provides Mental Health First Aid Training, but expansion of the program for providers and DC residents requires modification of how the training is to be delivered as part of remote learning.

The District expanded access to telehealth during the COVID-19 epidemic to meet crisis needs, but providers still require training and technical assistance on how to provide services using telehealth, integrate their data collection, and conduct outreach. Expansion of telehealth would lead to more system integration, thereby leading to the more efficient using of funds for the best outcomes for District residents.

4. Explain how your state plans to collaborate with other departments or agencies to address the identified needs.

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DBH will utilize recommendations listed in the guidance to fund the following programs:

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- **System Operability:** System operability support will assist mental health providers' data management and telehealth capacity. Many providers recently added telehealth as a treatment delivery option. System operability funding will allow providers to expand this option to their full range of services and have the infrastructure to continue to provide these services.
- **Behavioral Health Outreach:** Provide support to providers to conduct non-billable outreach and engagement to connect residents with behavioral health needs to services. Many consumers have had past negative treatment experiences and are reluctant to enroll in mental health services; thus, funding pre-enrollment outreach and supportive services is important to care coordination. Outreach can be conducted by phone, telehealth, and in person. This outreach would educate individuals about behavioral health service options, the benefits of treatment, and help them understand person-centered treatment delivery.
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The District expanded access to telehealth during the COVID-19 epidemic to meet crisis needs, but providers still require training and technical assistance on how to provide services using telehealth, integrate their data collection, and conduct outreach. Expansion of telehealth would lead to more system integration, thereby leading to the more efficient using of funds for the best outcomes for District residents.

4. Explain how your state plans to collaborate with other departments or agencies to address the identified needs.

DBH Response

DBH and its certified provider network work closely with agencies in the District's Health and Human Services cluster (e.g., the District's Departments of Health, Health Care Finance, Human Services, Aging, and Disability Services) in setting standards, updating procedures, improving services, licensing providers, and other matters. Because of the strong intersection between behavioral health and the criminal justice system, DBH has a robust forensic services program and a strong partnership with the Metropolitan Police Department to train patrol officers on the best and safest approach to help people in a psychiatric crisis who come to their attention. DBH collaborates across agencies on development of new programs and key performance indicators, along with data collection and performance monitoring to ensure DBH meets measurable goals and provides quality, equitable services to the community.

5. If your state plans to utilize any of the waiver provisions or the recommendations listed in this guidance (see MHBG COVID Relief Letter), please explain how your state will

implement these funds. (These waivers are only applicable to the COVID-19 Relief supplement funds and not to regular or FY 2021 MHBG funds. States will be required to provide documentation ensuring these funds are tracked separately.)

DBH Response

DBH will utilize recommendations listed in the guidance to fund the following programs:

- **Crisis Hotline:** DBH will utilize funds to expand the use of peers at crisis hotlines and warm lines. The crisis hotline connects DC residents to services provided by DBH and its certified behavioral health care providers. The crisis hotline can also activate mobile crisis teams to respond to adults and children who are experiencing a psychiatric or emotional crisis and are unable or unwilling to travel to receive behavioral health services.
- **System Operability:** System operability support will assist mental health providers' data management and telehealth capacity. Many providers recently added telehealth as a treatment delivery option. System operability funding will allow providers to expand this option to their full range of services and have the infrastructure to continue to provide these services.
- **Mental Health First Aid Training:** Conduct Train the Trainer sessions to expand the availability of Mental Health First Aid training for providers and District residents. This course teaches providers and District residents how to assist individuals developing a mental health problem or experiencing a mental health problem.

COVID-19 Supplemental Funding Plan for FY 21

1. Identify the needs and gaps of your state's mental health services in the context of COVID-19.

DBH Response

The District of Columbia (the District) faces challenges in delivering mental health treatment services to people who need them as a result of necessary quarantine, distancing, and isolation precautions. We are seeing a dramatic rise in utilization of telehealth services. Twenty-six percent (26%) of the Medicaid mental health claims paid by January 1, 2021 were delivered through telehealth applications. While it is helpful to be able to utilize technology to deliver mental health services during the pandemic, there are limits to what can be accomplished without in-person treatment.

The Department of Behavioral Health (DBH) providers deliver an array of mental health services in accordance with DC Health and Centers for Disease Control and Prevention (CDC) guidelines. However, DBH has identified the following needs and gaps in the District's mental health treatment services

- **Mobile Support Needs:** DBH's Community Response Team has averaged 110 referrals for outreach to address crises each week during the public health emergency. There is an ongoing need to meet individuals where they are to support them with their immediate needs and link them to services. Individuals may need multiple encounters with opportunities for support before they fully engage in treatment.
- **Peer Support Workers:** DBH-operated direct care sites benefit from the use of peers, who, through lived experience, connect individuals to mental health services. New services such as housing have been implemented in the District, and peers are essential in ensuring consumers and clients can get the services they need while in these programs.
- **Care Coordination for Youth and Families:** the number of children who received a mental health service declined during the public health emergency, likely due to children no longer attending school in person, where many of their services had usually taken place. Enhancing services that are community-based will help fill the gap of reduced opportunities for face-to-face services in schools.

2. Describe how your state's spending plan proposal addresses the needs and gaps.

DBH Response

- **Utilizing Mobile Support Teams**

In 2019, DBH established a 24/7 Community Response Team (CRT), which merges four existing mental health community outreach teams (Homeless Outreach, Mobile Crisis, Pre-Arrest Diversion, and Crisis Outreach Services) to expand access to care. Recognizing that many individuals who need mental health services are unable or unwilling to come into clinical settings

during the COVID-19 public health emergency, DBH utilizes this team to engage with individuals who have treatment providers, but who are not actively engaged with services due to other barriers, and to provide short term support in resolving crises to reduce barriers and increase access to available care.

- Hiring Peer Support Workers

The Centers for Medicare & Medicaid Services recognized peer support an evidence-based model of care in 2007. The role of peer support workers has expanded over the years from offering mutual support through self-help groups and peer-run programs (e.g., drop-in centers) to the provision of services. Peer-delivered services generate superior outcomes in terms of engaging “difficult to reach” individuals, reducing rates of hospitalizations and days spent as an inpatient, and decreasing substance use among persons with co-occurring substance use disorder. Literature informs us that when peers interact with someone in crisis, they can connect the individual to care 40% to 65% of the time; when a professional staff person does, the connection rate drops to 25%. It is clear that peers play a critically important role in our system, and that has become only more evident during the past year during the public health emergency.

DBH has 168 certified peers in the District’s behavioral health system and is committed to increasing this number. The District is now developing plans to deploy peers to our Pandemic Emergency Program for Highly Vulnerable Populations (PEP-V) and Isolation and Quarantine (ISAQ) sites. These sites are hotels in the District that have been utilized as temporary housing for individuals experiencing housing instability who are medically at risk (PEP-V) or have been exposed to or contracted COVID-19 (ISAQ). We believe peers are particularly well-suited to act as advocates and liaisons on behalf of residents.

- Provision of Wraparound Support for Youth and Families

High Fidelity Wraparound is a “a collaborative team-based care planning process where the family and the team implement, track, and adapt an Individualized Plan of Care (IPC) working toward the youth and family’s long term vision for the purpose of achieving positive outcomes in the home, school, and community.” High Fidelity Wraparound is beneficial for children and youth with serious emotional disturbances and their families with complex unmet needs, multisystem involvement, at risk of out-of-home or residential placement, disruption in school setting, and high utilization of acute care. Mental Health Block Grant (MHBG) COVID-19 supplemental relief funds will support HFW’s ability to help children, youth, and their families access promising and evidence-based practices and coordinate income maintenance and community-based services. The District proposes providing this promising practice to families and youth with serious emotional disturbances that have been exacerbating during the pandemic. The goal is to provide in-person support and resources through flex funding to assist with feelings of isolation, anxiety, and loneliness due to pandemic and to keep youth with their families in their communities.

3. Describe how the state will advance the development of crisis services based on the *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit*. The five percent crisis services set-aside applies to these funds.

DBH Response

SAMHSA's *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* provides guidance on how to enhance the programs in place to meet the needs of District residents requiring crisis-specific care. Funding to meet the demand and fill the financial gaps in the provision of services, would ensure that the District's services are available for anyone, anywhere, and anytime.

According to the *Best Practice Toolkit* the use of peers is a critical component of using best practices in operating a behavioral health crisis system. DBH has a robust network of certified peer specialists, to staff the Access HelpLine, DBH's crisis hotline. Peers are fully integrated into the Department's system of service provision in alignment with the *Best Practice Toolkit*. Expansion of this program requires funding for training and supervision of peers. Similarly, the Department provides Mental Health First Aid Training, but expansion of the program for providers and DC residents requires modification of how the training is to be delivered as part of remote learning.

The District expanded access to telehealth during the COVID-19 epidemic to meet crisis needs, but providers still require training and technical assistance on how to provide services using telehealth, integrate their data collection, and conduct outreach. Expansion of telehealth would lead to more system integration, thereby leading to the more efficient using of funds for the best outcomes for District residents.

4. Explain how your state plans to collaborate with other departments or agencies to address the identified needs.

DBH Response

DBH and its certified provider network work closely with agencies in the District's Health and Human Services cluster (e.g., the District's Departments of Health, Health Care Finance, Human Services, Aging, and Disability Services) in setting standards, updating procedures, improving services, licensing providers, and other matters. Because of the strong intersection between behavioral health and the criminal justice system, DBH has a robust forensic services program and a strong partnership with the Metropolitan Police Department to train patrol officers on the best and safest approach to help people in a psychiatric crisis who come to their attention. DBH collaborates across agencies on development of new programs and key performance indicators, along with data collection and performance monitoring to ensure DBH meets measurable goals and provides quality, equitable services to the community.

5. If your state plans to utilize any of the waiver provisions or the recommendations listed in this guidance (see MHBG COVID Relief Letter), please explain how your state will

implement these funds. (These waivers are only applicable to the COVID-19 Relief supplement funds and not to regular or FY 2021 MHBG funds. States will be required to provide documentation ensuring these funds are tracked separately.)

DBH Response

DBH will utilize recommendations listed in the guidance to fund the following programs:

- **Crisis Hotline:** DBH will utilize funds to expand the use of peers at crisis hotlines and warm lines. The crisis hotline connects DC residents to services provided by DBH and its certified behavioral health care providers. The crisis hotline can also activate mobile crisis teams to respond to adults and children who are experiencing a psychiatric or emotional crisis and are unable or unwilling to travel to receive behavioral health services.
- **System Operability:** System operability support will assist mental health providers' data management and telehealth capacity. Many providers recently added telehealth as a treatment delivery option. System operability funding will allow providers to expand this option to their full range of services and have the infrastructure to continue to provide these services.
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ARAP Supplemental Funding Plan MHBG
Total Award: \$3,379,225**

ARPA Funding 2021 (MH)

States must spend the MHBG funds based on 42 U.S.C. Chapter 6A, Subchapter XVII, Part B, Subpart I: Block Grants for Community Mental Health Services for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED)

1. Identify the needs and gaps of your state's mental health services continuum including prevention, intervention, access to crisis services, treatment, and recovery support services.

DBH Response

Within the current Medicaid state plan amendments (MHRS and the 1115 waiver) there are supports that consumers of mental health services need, that cannot be reimbursed through Medicaid. For example, there are no recovery support services specifically in the Medicaid service taxonomy for consumers of mental health services. They are built into the SUD service taxonomy. Prevention services are also not a part of any Medicaid state plan amendments and are usually developed and delivered using block grant funds. While access to crisis services and intervention and treatment has recently expanded with adding psychiatric crisis stabilization beds and transition planning for consumers discharging from community hospitals, there is still a significant gap in consumer outreach and engagement.

When a consumer has enrolled in mental health services and then never presented for an intake, or has started services and then dropped out, there is no mechanism in the current Medicaid structure to ensure outreach and engagement occurs. Because services are "fee for service" and not per member per month, providers are only reimbursed for engagement efforts if they achieve a face-to-face contact. Due to this financial disincentive to provide outreach and engagement to bring consumers into care, mental health providers seek block grant or other funding to complete these tasks, or they simply don't do it at all.

True integration of services for consumers is also lacking. While the District does have mental health Health Homes, not all consumers who need the integration of somatic health and mental health services are served. There are many consumers who could benefit from a primary care liaison without the full interventions of a Health Home.

Finally, as the District does not have case management services in any of its Medicaid services taxonomy, case management is often delivered using services such as community support. True case management that allows for care coordination, the infusion of prevention and recovery support interventions are missing in the DC system of care.

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2. Identify the needs and gaps of your state’s mental health services related to developing a comprehensive crisis continuum. Focus on access to your states services through crisis call centers with local knowledge of available services, availability of mobile crisis response teams and crisis receiving and stabilization services.

DBH Response

Much attention and focus to the area of developing a comprehensive crisis continuum has been applied in the past year in the District. DC has the Access Helpline (AHL) which is a crisis hotline for suicide call response, general mental health crisis response, enrollment and authorization for services, and information and referral to resources in the community. The AHL can also deploy the Community Response Teams (CRT) for an in-person response to a mental health crisis staffed by mental health clinicians and peers. The metropolitan police department (MPD) also deploys the CRT for mental health crises in the community. The District also has a dedicated crisis receiving and stabilization site called the Comprehensive Psychiatric Emergency Program (CPEP.) CPEP accepts consumers brought to them by MPD, community providers, and self-referral, for assessment and treatment of acute psychiatric concerns. Dispositions include hospitalization and stabilization with return to community settings.

Recently, District funds have been re-directed to DBH to support a pilot in which 911 calls that come in related to a non-violent mental health support call are re-directed to AHL and often eventually to CRT. While there are additional staff that have been funded for FY22, it is yet unclear whether the additional resources will be sufficient to meet the community need.

Additionally, DC recently added crisis stabilization services for mental health crisis beds to prevent the admission of a consumer to an acute care setting. The beds can also be used to step down from a hospitalization and are sometimes used to stabilize a housing crisis precipitated by a person’s psychiatric symptom presentation. There are only two (2) providers in the District and more beds are needed.

The largest gap in care comes after the crisis is stabilized and the warm hand-off or transition back to “routine care.” While Core Service Agencies (CSAs) are mandated by regulation to participate in treatment planning and participation in these care transitions, most are not certified as transition service providers and those services only apply to hospital levels of care. More service development around supporting the care transitions from highest levels of care to routine levels of care are needed.

3. Identify the needs and gaps of your state’s mental health services related to developing a comprehensive crisis continuum. Focus on access to your states services through crisis call centers with local knowledge of available services, availability of mobile crisis response teams and crisis receiving and

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stabilization services.

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The AHL can also deploy the Community Response Teams (CRT) for an in-person response to a mental health crisis staffed by mental health clinicians and peers. The CRT deploys 62 staff in teams of two from 2 different locations in the city, 24 hours a day 7 days a week. The metropolitan police department (MPD) also deploys the CRT for mental health crisis in the community. The CRT assess the situation, delivers de-escalation and supportive counseling, facilitates voluntary and involuntary admissions to local hospitals, and engages in limited follow up post intervention.

The Access Helpline is staffed 24/7 with mental health counselors, Care Coordinators and Clinical Care Coordinators. This staff is well versed in the behavioral health and other community resources in the District.

Recently, District funds have been re-directed to DBH to support a pilot in which 911 calls that come in related to a non-violent mental health support call are re-directed to AHL and often eventually to CRT. While there are additional staff that have been funded for FY22, it is yet unclear whether the additional resources will be sufficient to meet the community need.

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Finally, the capacity of CSAs to manage crisis for the consumers they serve is lacking. More training and support is needed and CSAs need a path to be able to recruit, train, hire and retain staff who can respond to the after-hours needs of their enrolled consumers. This function falls largely to the first responder type networks (911/AHL/CRT) instead of with the provider who has the relationship with the person and knows them best.

4. Describe how the state will advance the development of crisis and other needed prevention, intervention, treatment and recovery support services so that your state's system is responsive to the needs of your residents with SMI and SED. Refer to the [Guidebook](#) on crisis services.

DBH Response

More short-term residential facilities are needed in the system of care, and the development of Peer-Operated Respite is needed. The District needs to develop a formal crisis system community coordination and collaboration continuum with well-defined roles and responsibilities. More integration of peers into the crisis care continuum and development of recovery support services is also needed.

A focus on planning, training for key members of the system including staff in sister agencies, and communication of the crisis continuum of care with the community and stakeholders will be the focus on continued development, along with developing the services and supports identified in the gaps.

5. Explain how your state plans to collaborate with other departments or agencies to address crisis, treatment, and recovery support services.

DBH Response

DBH and its certified provider network work closely with agencies in the District's Health and Human Services cluster (e.g., the District's Departments of Health, Health Care Finance, Human Services, Aging and Disability Services) in setting standards, updating procedures, improving services and licensing providers. Because of the strong intersection between behavioral health and the criminal justice system, DBH has a forensic services program and a strong partnership with the Metropolitan Police Department to train patrol officers on the best and safest approach to help people in a psychiatric crisis who come to their attention. DBH collaborates across agencies on development of new programs

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and key performance indicators, along with data collection and performance monitoring to ensure DBH meets measurable goals and provides quality, equitable services to the community.

6. Describe how the state plans to spend the ten percent set aside for first-episode psychosis/early SMI and, if applicable, the five percent set aside for crisis services.

DBH Response

The District will spend the ten (10) percent set aside for first-episode psychosis/early SMI by implementing a proposal entitled Support Group for Families Experiencing First Episode Psychosis. Community Connections, a DBH-certified provider, will develop curriculum for Families including clients who are experiencing First Episode Psychosis. This initiative creates a safe environment and provides psycho-education and other supports to families and individuals in the circle of support of clients.

Multi-family groups help family members understand the consumer's illness and identify strategies for handling difficult situations by making use of effective behavioral, cognitive and communication techniques to address issues caused by the illness. It also helps multi-family groups establish a strengths-based environment where all members are respectful, creating an optimal environment for the consumer's recovery from mental illness.

7. Describe other state priorities or activities that the state plans to fund during the performance period using ARPA funds, with consideration given to disproportionately high rates of MH/SUD in certain communities and disparities in COVID-19 BH-related outcomes by race, ethnicity, and other factors.

DBH Response

The District will focus on other priorities and activities, specifically, needs and gaps in our SUD services continuum by using ARPA funds for services including, but not limited to

- Prevention: information dissemination, education, alternatives, community based processes environmental strategies, problem ID and referral.
- Intervention: naloxone distribution expansion, fentanyl test strips program expansion.

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- Treatment: BH Professionals Screening, Brief Intervention, Referral to Treatment Training, Certified Addiction Counselor Training.
 - Care Coordination Support
 - Recovery Support: Establish level 3.5 Residential Treatment Youth Program.
 - Infrastructure: BH Integration Readiness TA, SUD Provider EHR System Enhancements.
8. Describe how the state will use, or consider, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, conformance to Office of the National Coordinator certification [criteria](#) in health IT products used or that will be used to support behavioral health clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and also should consider standards identified in the Interoperability Standards Advisory (<https://www.healthit.gov/isa/>), including but not limited to those standards described in the, the “Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data” section and the “Social Determinants of Health” section.

DBH Response

The District will use ARPA funds to promote health IT standards in the following BH Integration TA and Provider Electronic Health Record System Enhancements. DBH will use grant funds to assess mental health providers’ readiness to participate in a whole person care (WPC) model that integrates behavioral health and primary health care. DBH will hire a consultant to develop a comprehensive provider Electronic Health Records system assessment tool for mental health providers.

DBH will also use grant funding to support mental health provider EHR system enhancement/upgrades to support WPC and BH system transformation. Mental health provider upgrades include enabling a system enhancement, developing data reporting and funding a portion of a system replacement. Providers will be required to participate in the Behavioral Health Integration Readiness Technical Assistance project to be eligible for system enhancement funding. This will allow DBH to assess provider need for system enhancements.

See budget and budge narrative below.

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**Intervention
Request-\$381,113**

Capitol Clubhouse - \$100,000

Plan: To establish partnerships with employers and educational institutions to provide members with opportunities to return to paid employment and/or achieve their educational goals

Purpose: Two generalists to implement our TE program, Assist members in completing education interrupted by mental illness, Assist members in completing education interrupted by mental illness,

Impact: Increased employment, Reduced hospital stays, Reduced incarcerations

B.A.N.K.™ Methodology for Imagine-\$181,113

Plan: MBI is proposing a communication training using the B.A.N.K.™ methodology for Imagine Communications. This revolutionary system has just been validated by San Francisco State University with a recently published white paper proving that B.A.N.K.™ can predict people's behavior which can be leveraged to increase engagement in services.

Purpose: MBI is requesting funds to improve consumer engagement post COVID 19, increase mental health and substance use treatment, reduce provider transfers which disrupts the therapeutic relationship and maximize the treatment milieu and benefits to the consumer, children, and their families. The impact of this proposal will be to: 1) Increase long term engagement in on-gong treatment 2) Reduction in transfers in the system which disrupts treatment 3) improve continuity of care for District residents who are struggling with mental health, substance use disorder or with dual diagnosis, finally 4) Improve treatment outcome for those receiving care by being educated on how to maximize the therapeutic milieu with their Clinicians, Psychiatrist and their Community Support Workers.

Impact: B.A.N.K.™ is a reverse-engineered personality profiling system designed to dramatically improve your communication, accelerate consumer engagement, and retain them in the therapeutic milieu thereby reducing disruption in services, reduce transfers and increase positive outcomes.

- In just 90 seconds B.A.N.K, helps you discover the best way to engage consumers and for your consumer to engage the clinician – no long assessment required.
- Anyone can master our easy-to-customize communication formula and start applying it from
- B.A.N.K has a track record of 15+ years and backed by research studies, the B.A.N.K. Method™ is both practical and scientifically proven to increase people's communication.
- B.A.N.K provides tools and training to customize communication delivery so the message drives conversion every time.

**Access To Care for Seniors
Request-\$100,000**

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Total Award: \$3,379,225**

Plan: To expedite access to care and community resources for individuals ages 50 and above who were recently released from being incarcerated and have found themselves without access to care or housing and mental health resources. due to COVID-19.

Purpose: To provide prompt and targeted access to a population who may have never been linked with services, not have insurance and have co-occurring medical conditions.

Impact: To increase access to care for those who are uninsured, under insured or those who have no current access to care. To prevent recidivism by 70%. This targeted effort will allow symptoms to be addressed as soon as the individuals are released from incarcerated. It will allow a seamless transition to mental health services and promote early assessment and intervention for those who have not yet been diagnosed and/or treated. It will provide them access to needed resources and access to employment and other supports needed.

TOTAL REQUEST: \$381,113

**Treatment
Request-\$490,000**

Jail-Based Competency Program-\$260,000

Plan: The DBH Jail-Based Competency Program (JBCP) is designed to provide competency restoration education and related supports to individuals deemed incompetent to stand trial (IST) by the Courts. The JBCP will consist of a part-time on-site Psychologist director, one full time social worker, one masters-level mental health clinician, a part-time diversion specialist, and one bachelor's level competency education specialist. Participants in the JBCP will attend groups, which may include legal education, conflict resolution, values clarification, basic reading skills, and medication adherence. Individual sessions that focus on court-relevant education and therapeutic intervention to reduce symptom acuity will also be conducted.

Purpose: Jail-based restoration has a number of benefits, including decreased costs of psychiatric hospitalization, reduced wait times for hospital bed space, elimination of incentives to malingering, and ability to manage more behaviorally disruptive individuals who require court-related education to attain competence, or to maintain competence without the need for re-hospitalization.

Impact: Reduce the demand for lengthy, inpatient competency evaluation and restoration services at SEH; Reduce wait times for admissions to SEH, especially for those individuals who are civilly committed and transferring into SEH for long-term care; Decrease incidents of violence at SEH; Support an expeditious pathway to competence and case resolution, and shorten stagnation in the court process that results in reduced liberties for consumers.

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Medherent Remote Monitoring and Prescription Management System-\$230,000

Plan: Terrapin Pharmacy, a specialty pharmacy based in Maryland, has developed and tested a technology tool in recent years that safely dispenses prescription medication using a home based unit that is supported by a care management app that allows for real time remote monitoring and a video- and Bluetooth enabled tablet that facilitates telebehavioral health with WIFI connectivity included.

Purpose: Terrapin Pharmacy has partnered with an investigator at the University of Maryland School of Social Work to demonstrate effectiveness with respect both to medication adherence and ultimately to lower total spending due to decreased inpatient hospitalizations. Testimonials from end-users attest to their satisfaction and sense of empowerment in self-managing their psychiatric illness, being able to maintain independent living and reduce reliance on professional and natural supports.

Impact: Terrapin provides a range of reports through the remote monitoring app regarding adherence (timely machine activation in response to prompts). DBH will also track use of inpatient and emergency services (CPEP, ED, Crisis Residential, inpatient) through CRISP and Medicaid claims analysis to track overall utilization and spending pre and post.

TOTAL REQUEST: \$490,000

Recovery Support Services

Request: \$786,229

Capitol Clubhouse-\$200,000

Plan: To establish partnerships with employers and educational institutions to provide members with opportunities to return to paid employment and/or achieve their educational goals.

Purpose: Two generalists to implement our TE program

Assist members in completing education interrupted by mental illness

Assist members in completing education interrupted by mental illness

Impact: Increased employment, Reduced hospital stays, Reduced incarcerations

Forensic Navigator Program-\$130,000

Plan: A Forensic Navigator Program (FNP) is designed to guide, support and advocate for people who are not competent to stand trial and determined to be suitable for community-based treatment and support. The FNP is consists of Forensic Certified Peers assigned to work with forensic-involved consumers who are referred by the Courts for outpatient competency evaluations, outpatient competency restoration, and other treatment-related transitions to the community.

Purpose: FNP has two main purposes: 1) help divert forensically involved clients out of jails and inpatient treatment settings and into community-based treatment settings, and 2) help to

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ensure that behavioral health services are being delivered to forensic-involved consumers in an appropriate and effective manner.

Impact: This pilot program would support the Director's emphasis on community mental health by diverting forensically-involved defendants away from jails and inpatient treatment settings, and into community-based treatment settings.

Peer Support Program for Formerly Incarcerated Individual (PSP- FII)-\$363,381

Plan: Peer Support Program for Formerly Incarcerated Individual (PSP- FII): The Reentry Peer Specialist training will also offer formerly incarcerated individuals an opportunity to further their own recovery while providing support and hope to other people who may be trying to find their own way through reentry and recovery.

Purpose: The core learning objectives of this training will engage participant's self-exploration relative to: (1) Recovery from a Reentry Perspective, (2) Trauma – 3 types, (3) Recidivism Intervention, (4) What it Means to be a Peer Specialist, and (5) Maintaining a Whole Person Perspective. Upon completion of this training participants must complete and pass a knowledge assessment in order to apply for certification.

Impact: While the majority of individuals that have justice system involvement have some type of mental health challenge, substance use challenge, or both, it is often the shared experience of the trauma associated with incarceration that provides the strongest peer bond. Prestige Healthcare Resources in collaboration with other community stakeholders in across the country developed the training and credential for "Reentry Peer Specialists," which was implemented first in Texas, and are now offering nationwide. This is NOT supplemental training for people who have already been trained as mental health or substance use peer specialists. It is a separate, stand-alone training and certification program.

Psychiatric Crisis Stabilization Residential Program-\$42,848

Plan: Woodley House is seeking funding to hire a Peer Specialist for our Crossing Place Psychiatric Crisis Stabilization Residential program. The Peer Specialist is needed to provide support for individuals who are referred to our program and current residents in the program. Individuals are referred for residential crisis stabilization from a variety of sources, such as emergency rooms, police, other residential programs, the streets and through the Access Helpline.

Purpose: These individuals are experiencing a psychiatric crisis that severely limits their ability to travel, particularly by public transportation or other independent means. The Peer Specialist will provide the ability for referrals to receive a "warm handoff" by meeting the referred person at the location where they have been assessed, quickly developing an in-person rapport, and then physically transporting the individual if they have no other means of travel, to Crossing Place.

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Warm handoffs are an evidence-based practice technique. The direct contact through a warm handoff helps ensure the individual receives the immediate care they need with a welcoming and supportive Peer Specialist helping them along the way and avoids the individual not getting the help they need if they do not have someone they already know and trust available to bring them to the house.

Impact: Crisis Specialists currently accompany residents to appointments and meetings as needed. However, having a peer support specialist also available will allow for residents to attend more meetings and with someone they are likely to feel even more comfortable with, especially if they have a co-occurring substance use disorder. This request is for a full-time Peer Specialist who will be available for scheduled appointments and for referrals who need assistance. Cross Place has a minivan that is available for staff use to transport residents.

Community Museum and Garden-\$50,000

Plan: PSI Services, Inc. is developing a community museum and garden for the residents of the Deanwood area of Ward 7.

Purpose: The museum and garden will strengthen ties within the community by helping residents learn about the history of the community and some of its influential residents. This endeavor will build pride in the community as residents reclaim ownership of their history and land.

Impact: The community museum and garden will fill gaps left as a result of the COVID-19 pandemic. The space will be free and open to residents of the community. The museum will tell the story of noted residents and their contributions to Ward 7, the District, and the nation. The garden will be sub divided into individual plots where residents can grow their own vegetables. The COVID-19 pandemic placed an increased demand on local food pantries as people were economically impacted. This garden will enable people to supplement/replace their store bought vegetables with home grown produce. This also gives individuals a sense of pride and accomplishment when they grow their own food.

TOTAL REQUEST: \$786,229

**Infrastructure
Request: \$1,215,000**

Transition to Managed Care-\$250,000

Plan: Pathways to Housing DC is requesting MHBG funds to create the administrative and operational infrastructure to support the successful transition to Managed Care in October 2022 and beyond. We are requesting a two-year block grant investment to cover the expense of hiring a Healthcare Data Analyst (HDA). The HDA would report directly to our Chief Operating Officer.

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Purpose: The purpose of this request is to improve the health outcomes of persons served – from identifying outcome data to preventing interruption in care during the upcoming transition. Literature points to deeply concerning statistics that people living with serious mental illness and substance use disorders experience poorer health outcomes than people without behavioral health challenges, and the public health capacity of most HER systems is woefully limited. Compounding the potentially poor health outcomes is the fact that 100% of people at Pathways are experiencing chronic homelessness at the time of enrollment in our DBH behavioral health programs.

Impact: Ultimately, a successful transition to MCO contracting will improve outcomes for consumers as we more effectively integrate behavioral and physical health care. We are requesting a five-year block grant given the ever-changing IT and data needs as we make this important transition and grow our partnerships with the MCOs.

Telehealth Training for Providers-\$250,000

Plan: Catholic Charities of the Archdiocese of Washington, Inc. (Catholic Charities) seeks to partner with the DC Department of Behavioral Health (DBH) to address the needs and gaps in mental health and substance use disorder (SUD) services for DC residents. By hiring a full-time Telehealth Trainer and Outreach Specialist, Catholic Charities will support DBH in enhancing and expanding services through the effective utilization of Community Mental Health Services Block Grant (MHBG) funds.

Purpose: Given the data on the significant need for behavioral services due to COVID-19, telehealth services have been essential for helping people cope. Anchor's ability to provide behavioral health services via telehealth has been important in ensuring that consumers continue to have access to Community Support, Counseling, Supported Employment, and Psychiatric services. However, barriers have inhibited the full utilization of telehealth as a viable means of supporting and intervening with consumers while still being conscientious of the continued need for pandemic safety. Barriers include lack of consumer access to appropriate technology (smart phones, reliable high-speed internet, and sufficient data plans) and lack of technology literacy. These barriers are disproportionately experienced by communities already at risk and adversely impacted by COVID-19.

Impact: Benefiting from telehealth services is a necessary step for creating access to much needed behavioral health services. Survey results from consumers who engaged in telehealth over the past year showed overall satisfaction with services. The option for telehealth was especially helpful for consumers who have limited or no access to transportation, have caretaker responsibilities at home, and/or often missed in-office appointments due to challenges with executive functioning skills.

Behavioral Health Integration Readiness TA-\$70,000

Plan: DBH will use grant funds to assess Mental Health providers' readiness to participate in a whole person care model that integrates behavioral health and primary health care. DBH will hire a consultant to develop a comprehensive provider Electronic Health Records system assessment tool for Mental Health providers.

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Purpose/Issue: District behavioral health providers attempting to make the transition to whole person care. The assessment tool will identify providers' system gaps (process and data capture) that would hinder full participation in a WPC program.

Impact: COVID has compromised providers' ability to prepare for the transition to whole person care. Assessing providers' readiness to participate in a whole person care model will allow DBH to respond to provider deficiencies and gaps.

Provider Electronic Health Record System Enhancements-\$250,000

Plan: DBH will use grant funding to support Mental Health provider Electronic Health Record system enhancement/upgrades to support WPC and Behavioral Health system transformation. Mental Health provider upgrades include enabling a system enhancement, developing data reporting and funding a portion of a system replacement. Providers will be required to participate in the Behavioral Health Integration Readiness Technical Assistance project to be eligible for system enhancement funding. This will allow DBH to assess provider need for system enhancements.

Issue: Mental Health providers have struggled with the use of iCAMS, a system mandated by the District. Mental Health providers need choice in obtaining and using a viable electronic health system to conduct their work and capture data to inform treatment decisions which will support WPC.

Impact: Mental Health providers will have Electronic Health Records to be able to participate successfully in the Districts' Behavioral Health system transformation and provide WPC.

Deemed Accreditation Support-\$395,000

Plan: DBH proposes the utilization of Mental Health Block Grant funds to support provider technical assistance to obtain national accreditation. As DBH moves toward behavioral health integration, we must provide our network with the tools and resources needed to improve the quality of their organizations.

Purpose: National Accreditation from organizations such as the Joint Commission, Council on Accreditation, and the Commission on Accreditation of Rehabilitation Facilities helps to ensure that each provider in our network meets a high standard of care.

Impact: Obtaining national accreditation will strengthen the quality of the provider network, strengthen providers' administrative operations, and improve the quality of behavioral health services available to residents of the District of Columbia. National Accreditation ensures there will be nationally vetted benchmarks and standards for all providers in our network.

Impact: As part of the grant process, DBH would ensure at minimum that providers met minimum standards for Key Performance Indicators, Fiscal Claims Audits, Fidelity Reviews, and line of credit, where applicable. DBH will offer grants of up to \$10,000 to providers to support technical assistance needed to obtain national accreditation.

TOTAL REQUEST: \$1,215,000

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**First Episode of Psychosis (10%)
Request: \$337,922**

Support Group for Families Experiencing First Episode Psychosis- \$337,922

Plan: The FEP Program at Community connections will develop curriculum for Families including clients who are experiencing First Episode Psychosis. The group aims to create a safe environment and provide psycho education and other supports to families and individuals in the circle of support of clients.

Purpose/Issue: To establish a respectful, trusting, and helpful relationship with family members and consumer and work to discover possibilities for a better future.

Impact: Multi-family groups help family members better understand their loved one's illness and how to identify strategies for handling difficult situations by making use of effective behavioral, cognitive and communication techniques to address issues caused by the illness and establish a strengths-based environment where all members are respectful of one another, creating an optimal environment for recovery from mental illness.

TOTAL REQUEST: \$337,922

**Administrative (5%)
Request: \$168,961**

- 1. Performance**
- 2. Monitoring**
- 3. Evaluation**

TOTAL REQUEST: \$168,961

TOTAL FEDERAL REQUEST: \$3,379,225

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MHBG Budget \$3,379,225		
Name	Service	Cost
Intervention	<ol style="list-style-type: none"> 1. Care Coordination for Incarcerated Seniors 2. B.A.N.K.™ Methodology for Imagine Communications 3. Access to Care for Seniors 	<ol style="list-style-type: none"> 1. \$100,000 2. \$181,113 3. \$100,000 <p>Total: \$381,113</p>
Treatment	<ol style="list-style-type: none"> 1. Jail-Based Competency Program 2. Medherent Remote Monitoring and Prescription Management System 	<ol style="list-style-type: none"> 1. \$260,000 2. \$230,000 <p>Total: \$490,000</p>
Recovery Support Services	<ol style="list-style-type: none"> 1. Capitol Clubhouse 2. Forensic Navigator Program 3. Peer Support Program for Formerly Incarcerated Individual (PSP- FII) 4. Psychiatric Crisis Stabilization Residential program 5. Community Museum and Garden 	<ol style="list-style-type: none"> 1. \$200,000 2. \$130,000 3. \$363,381 4. \$42,848 5. \$50,000 <p>Total: \$786,229</p>
Infrastructure	<ol style="list-style-type: none"> 1. Transition to Managed Care 2. Telehealth Training for Providers 3. Behavioral Health Integration Readiness TA 	<ol style="list-style-type: none"> 1. \$250,000 2. \$250,000 3. \$70,000

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	<ol style="list-style-type: none"> 4. Provider Electronic Health Record System Enhancements 5. Deemed Accreditation Support 	<ol style="list-style-type: none"> 4. \$250,000 5. \$395,000 	
		Total: \$1,215,000	
FEP (10%)	<ol style="list-style-type: none"> 1. Support Group for Families Experiencing First Episode Psychosis 	Total: \$337,922	
Administrative (5%)	<ol style="list-style-type: none"> 1. Performance 2. Monitoring 3. Evaluation 	Total: \$168,961	
		Total	\$3,379,225

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ARPA Funding 2021 (MH)

States must spend the MHBG funds based on 42 U.S.C. Chapter 6A, Subchapter XVII, Part B, Subpart I: Block Grants for Community Mental Health Services for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED)

1. Identify the needs and gaps of your state’s mental health services continuum including prevention, intervention, access to crisis services, treatment, and recovery support services.

DBH Response

Within the current Medicaid state plan amendments (MHRS and the 1115 waiver) there are supports that consumers of mental health services need, that cannot be reimbursed through Medicaid. For example, there are no recovery support services specifically in the Medicaid service taxonomy for consumers of mental health services. They are built into the SUD service taxonomy. Prevention services are also not a part of any Medicaid state plan amendments and are usually developed and delivered using block grant funds. While access to crisis services and intervention and treatment has recently expanded with adding psychiatric crisis stabilization beds and transition planning for consumers discharging from community hospitals, there is still a significant gap in consumer outreach and engagement.

When a consumer has enrolled in mental health services and then never presented for an intake, or has started services and then dropped out, there is no mechanism in the current Medicaid structure to ensure outreach and engagement occurs. Because services are “fee for service” and not per member per month, providers are only reimbursed for engagement efforts if they achieve a face-to-face contact. Due to this financial disincentive to provide outreach and engagement to bring consumers into care, mental health providers seek block grant or other funding to complete these tasks, or they simply don’t do it at all.

True integration of services for consumers is also lacking. While the District does have mental health Health Homes, not all consumers who need the integration of somatic health and mental health services are served. There are many consumers who could benefit from a primary care liaison without the full interventions of a Health Home.

Finally, as the District does not have case management services in any of its Medicaid services taxonomy, case management is often delivered using services such as community support. True case management that allows for care coordination, the infusion of prevention and recovery support interventions are missing in the DC system of care.

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2. Identify the needs and gaps of your state's mental health services related to developing a comprehensive crisis continuum. Focus on access to your states services through crisis call centers with local knowledge of available services, availability of mobile crisis response teams and crisis receiving and stabilization services.

DBH Response

Much attention and focus to the area of developing a comprehensive crisis continuum has been applied in the past year in the District. DC has the Access Helpline (AHL) which is a crisis hotline for suicide call response, general mental health crisis response, enrollment and authorization for services, and information and referral to resources in the community. The AHL can also deploy the Community Response Teams (CRT) for an in-person response to a mental health crisis staffed by mental health clinicians and peers. The metropolitan police department (MPD) also deploys the CRT for mental health crises in the community. The District also has a dedicated crisis receiving and stabilization site called the Comprehensive Psychiatric Emergency Program (CPEP.) CPEP accepts consumers brought to them by MPD, community providers, and self-referral, for assessment and treatment of acute psychiatric concerns. Dispositions include hospitalization and stabilization with return to community settings.

Recently, District funds have been re-directed to DBH to support a pilot in which 911 calls that come in related to a non-violent mental health support call are re-directed to AHL and often eventually to CRT. While there are additional staff that have been funded for FY22, it is yet unclear whether the additional resources will be sufficient to meet the community need.

Additionally, DC recently added crisis stabilization services for mental health crisis beds to prevent the admission of a consumer to an acute care setting. The beds can also be used to step down from a hospitalization and are sometimes used to stabilize a housing crisis precipitated by a person's psychiatric symptom presentation. There are only two (2) providers in the District and more beds are needed.

The largest gap in care comes after the crisis is stabilized and the warm hand-off or transition back to "routine care." While Core Service Agencies (CSAs) are mandated by regulation to participate in treatment planning and participation in these care transitions, most are not certified as transition service providers and those services only apply to hospital levels of care. More service development around supporting the care transitions from highest levels of care to routine levels of care are needed.

3. Identify the needs and gaps of your state's mental health services related to developing a comprehensive crisis continuum. Focus on access to your states services through crisis call centers with local knowledge of available services, availability of mobile crisis response teams and crisis receiving and

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stabilization services.

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The AHL can also deploy the Community Response Teams (CRT) for an in-person response to a mental health crisis staffed by mental health clinicians and peers. The CRT deploys 62 staff in teams of two from 2 different locations in the city, 24 hours a day 7 days a week. The metropolitan police department (MPD) also deploys the CRT for mental health crisis in the community. The CRT assess the situation, delivers de-escalation and supportive counseling, facilitates voluntary and involuntary admissions to local hospitals, and engages in limited follow up post intervention.

The Access Helpline is staffed 24/7 with mental health counselors, Care Coordinators and Clinical Care Coordinators. This staff is well versed in the behavioral health and other community resources in the District.

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Finally, the capacity of CSAs to manage crisis for the consumers they serve is lacking. More training and support is needed and CSAs need a path to be able to recruit, train, hire and retain staff who can respond to the after-hours needs of their enrolled consumers. This function falls largely to the first responder type networks (911/AHL/CRT) instead of with the provider who has the relationship with the person and knows them best.

4. Describe how the state will advance the development of crisis and other needed prevention, intervention, treatment and recovery support services so that your state's system is responsive to the needs of your residents with SMI and SED. Refer to the [Guidebook](#) on crisis services.

DBH Response

More short-term residential facilities are needed in the system of care, and the development of Peer-Operated Respite is needed. The District needs to develop a formal crisis system community coordination and collaboration continuum with well-defined roles and responsibilities. More integration of peers into the crisis care continuum and development of recovery support services is also needed.

A focus on planning, training for key members of the system including staff in sister agencies, and communication of the crisis continuum of care with the community and stakeholders will be the focus on continued development, along with developing the services and supports identified in the gaps.

5. Explain how your state plans to collaborate with other departments or agencies to address crisis, treatment, and recovery support services.

DBH Response

DBH and its certified provider network work closely with agencies in the District's Health and Human Services cluster (e.g., the District's Departments of Health, Health Care Finance, Human Services, Aging and Disability Services) in setting standards, updating procedures, improving services and licensing providers. Because of the strong intersection between behavioral health and the criminal justice system, DBH has a forensic services program and a strong partnership with the Metropolitan Police Department to train patrol officers on the best and safest approach to help people in a psychiatric crisis who come to their attention. DBH collaborates across agencies on development of new programs

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and key performance indicators, along with data collection and performance monitoring to ensure DBH meets measurable goals and provides quality, equitable services to the community.

6. Describe how the state plans to spend the ten percent set aside for first-episode psychosis/early SMI and, if applicable, the five percent set aside for crisis services.

DBH Response

The District will spend the ten (10) percent set aside for first-episode psychosis/early SMI by implementing a proposal entitled Support Group for Families Experiencing First Episode Psychosis. Community Connections, a DBH-certified provider, will develop curriculum for Families including clients who are experiencing First Episode Psychosis. This initiative creates a safe environment and provides psycho-education and other supports to families and individuals in the circle of support of clients.

Multi-family groups help family members understand the consumer's illness and identify strategies for handling difficult situations by making use of effective behavioral, cognitive and communication techniques to address issues caused by the illness. It also helps multi-family groups establish a strengths-based environment where all members are respectful, creating an optimal environment for the consumer's recovery from mental illness.

7. Describe other state priorities or activities that the state plans to fund during the performance period using ARPA funds, with consideration given to disproportionately high rates of MH/SUD in certain communities and disparities in COVID-19 BH-related outcomes by race, ethnicity, and other factors.

DBH Response

The District will focus on other priorities and activities, specifically, needs and gaps in our SUD services continuum by using ARPA funds for services including, but not limited to

- Prevention: information dissemination, education, alternatives, community based processes environmental strategies, problem ID and referral.
- Intervention: naloxone distribution expansion, fentanyl test strips program expansion.

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- Treatment: BH Professionals Screening, Brief Intervention, Referral to Treatment Training, Certified Addiction Counselor Training.
 - Care Coordination Support
 - Recovery Support: Establish level 3.5 Residential Treatment Youth Program.
 - Infrastructure: BH Integration Readiness TA, SUD Provider EHR System Enhancements.
8. Describe how the state will use, or consider, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, conformance to Office of the National Coordinator certification [criteria](#) in health IT products used or that will be used to support behavioral health clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and also should consider standards identified in the Interoperability Standards Advisory (<https://www.healthit.gov/isa/>), including but not limited to those standards described in the, the “Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data” section and the “Social Determinants of Health” section.

DBH Response

The District will use ARPA funds to promote health IT standards in the following BH Integration TA and Provider Electronic Health Record System Enhancements. DBH will use grant funds to assess mental health providers’ readiness to participate in a whole person care (WPC) model that integrates behavioral health and primary health care. DBH will hire a consultant to develop a comprehensive provider Electronic Health Records system assessment tool for mental health providers.

DBH will also use grant funding to support mental health provider EHR system enhancement/upgrades to support WPC and BH system transformation. Mental health provider upgrades include enabling a system enhancement, developing data reporting and funding a portion of a system replacement. Providers will be required to participate in the Behavioral Health Integration Readiness Technical Assistance project to be eligible for system enhancement funding. This will allow DBH to assess provider need for system enhancements.

See budget and budge narrative below.

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**Intervention
Request-\$281,113**

B.A.N.K.™ Methodology for Imagine-\$181,113

Plan: MBI is proposing a communication training using the B.A.N.K.™ methodology for Imagine Communications. This revolutionary system has just been validated by San Francisco State University with a recently published white paper proving that B.A.N.K.™ can predict people's behavior which can be leveraged to increase engagement in services.

Purpose: MBI is requesting funds to improve consumer engagement post COVID 19, increase mental health and substance use treatment, reduce provider transfers which disrupts the therapeutic relationship and maximize the treatment milieu and benefits to the consumer, children, and their families. The impact of this proposal will be to: 1) Increase long term engagement in on-gong treatment 2) Reduction in transfers in the system which disrupts treatment 3) improve continuity of care for District residents who are struggling with mental health, substance use disorder or with dual diagnosis, finally 4) Improve treatment outcome for those receiving care by being educated on how to maximize the therapeutic milieu with their Clinicians, Psychiatrist and their Community Support Workers.

Impact: B.A.N.K.™ is a reverse-engineered personality profiling system designed to dramatically improve your communication, accelerate consumer engagement, and retain them in the therapeutic milieu thereby reducing disruption in services, reduce transfers and increase positive outcomes.

- In just 90 seconds B.A.N.K., helps you discover the best way to engage consumers and for your consumer to engage the clinician – no long assessment required.
- Anyone can master our easy-to-customize communication formula and start applying it from
- B.A.N.K has a track record of 15+ years and backed by research studies, the B.A.N.K. Method™ is both practical and scientifically proven to increase people's communication.
- B.A.N.K provides tools and training to customize communication delivery so the message drives conversion every time.

Care Coordination for Incarcerated Seniors-\$100,000

Plan: To increase access to care for those who are uninsured, under insured or those who have no current access to care. To prevent recidivism by 70%. This targeted effort will allow symptoms to be addressed as soon as the individuals are released from incarcerated. It will allow a seamless transition to mental health services and promote early assessment and intervention for those who have not yet been diagnosed and/or treated. It will provide them access to needed resources and access to employment and other supports needed.

Purpose: The purpose of this request is to improve the health outcomes of persons experiencing homelessness who have disconnected from their ACT teams. Medicaid does not currently reimburse for outreach services. The current Medicaid fee structure does not support the ability of behavioral health providers to spend the amount of time it takes to locate and engage people

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experiencing homelessness who have the most complicated mental illness and/or co-occurring disorder.

Impact: To increase access to care for those who are uninsured, under insured or those who have no current access to care. To prevent recidivism by 70%. This targeted effort will allow symptoms to be addressed as soon as the individuals are released from incarcerated. It will allow a seamless transition to mental health services and promote early assessment and intervention for those who have not yet been diagnosed and/or treated. It will provide them access to needed resources and access to employment and other supports needed.

TOTAL REQUEST: \$281,113

Treatment

Request-\$490,000

Jail-Based Competency Program-\$260,000

Plan: The DBH Jail-Based Competency Program (JBCP) is designed to provide competency restoration education and related supports to individuals deemed incompetent to stand trial (IST) by the Courts. The JBCP will consist of a part-time on-site Psychologist director, one full time social worker, one masters-level mental health clinician, a part-time diversion specialist, and one bachelor's level competency education specialist. Participants in the JBCP will attend groups, which may include legal education, conflict resolution, values clarification, basic reading skills, and medication adherence. Individual sessions that focus on court-relevant education and therapeutic intervention to reduce symptom acuity will also be conducted.

Purpose: Jail-based restoration has a number of benefits, including decreased costs of psychiatric hospitalization, reduced wait times for hospital bed space, elimination of incentives to malingering, and ability to manage more behaviorally disruptive individuals who require court-related education to attain competence, or to maintain competence without the need for re-hospitalization.

Impact: Reduce the demand for lengthy, inpatient competency evaluation and restoration services at SEH; Reduce wait times for admissions to SEH, especially for those individuals who are civilly committed and transferring into SEH for long-term care; Decrease incidents of violence at SEH; Support an expeditious pathway to competence and case resolution, and shorten stagnation in the court process that results in reduced liberties for consumers.

Medherent Remote Monitoring and Prescription Management System-\$230,000

Plan: Terrapin Pharmacy, a specialty pharmacy based in Maryland, has developed and tested a technology tool in recent years that safely dispenses prescription medication using a home based unit that is supported by a care management app that allows for real time remote monitoring and a video- and Bluetooth enabled tablet that facilitates telebehavioral health with WIFI connectivity included.

Purpose: Terrapin Pharmacy has partnered with an investigator at the University of Maryland School of Social Work to demonstrate effectiveness with respect both to medication adherence and ultimately to lower total spending due to decreased inpatient hospitalizations. Testimonials

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from end-users attest to their satisfaction and sense of empowerment in self-managing their psychiatric illness, being able to maintain independent living and reduce reliance on professional and natural supports.

Impact: Terrapin provides a range of reports through the remote monitoring app regarding adherence (timely machine activation in response to prompts). DBH will also track use of inpatient and emergency services (CPEP, ED, Crisis Residential, inpatient) through CRISP and Medicaid claims analysis to track overall utilization and spending pre and post.

TOTAL REQUEST: \$490,000

Recovery Support Services

Request: \$786,268

Capitol Clubhouse-\$200,000

Plan: To establish partnerships with employers and educational institutions to provide members with opportunities to return to paid employment and/or achieve their educational goals.

Purpose: Two generalists to implement our TE program

Assist members in completing education interrupted by mental illness

Assist members in completing education interrupted by mental illness

Impact: Increased employment, Reduced hospital stays, Reduced incarcerations

Forensic Navigator Program-\$130,000

Plan: A Forensic Navigator Program (FNP) is designed to guide, support and advocate for people who are not competent to stand trial and determined to be suitable for community-based treatment and support. The FNP is consists of Forensic Certified Peers assigned to work with forensic-involved consumers who are referred by the Courts for outpatient competency evaluations, outpatient competency restoration, and other treatment-related transitions to the community.

Purpose: FNP has two main purposes: 1) help divert forensically involved clients out of jails and inpatient treatment settings and into community-based treatment settings, and 2) help to

ensure that behavioral health services are being delivered to forensic-involved consumers in an appropriate and effective manner.

Impact: This pilot program would support the Director's emphasis on community mental health by diverting forensically-involved defendants away from jails and inpatient treatment settings, and into community-based treatment settings.

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Peer Support Program for Formerly Incarcerated Individual (PSP- FII)-\$363,420

Plan: Peer Support Program for Formerly Incarcerated Individual (PSP- FII): The Reentry Peer Specialist training will also offer formerly incarcerated individuals an opportunity to further their own recovery while providing support and hope to other people who may be trying to find their own way through reentry and recovery.

Purpose: The core learning objectives of this training will engage participant’s self-exploration relative to: (1) Recovery from a Reentry Perspective, (2) Trauma – 3 types, (3) Recidivism Intervention, (4) What it Means to be a Peer Specialist, and (5) Maintaining a Whole Person Perspective. Upon completion of this training participants must complete and pass a knowledge assessment in order to apply for certification.

Impact: While the majority of individuals that have justice system involvement have some type of mental health challenge, substance use challenge, or both, it is often the shared experience of the trauma associated with incarceration that provides the strongest peer bond. Prestige Healthcare Resources in collaboration with other community stakeholders in across the country developed the training and credential for “Reentry Peer Specialists,” which was implemented first in Texas, and are now offering nationwide. This is NOT supplemental training for people who have already been trained as mental health or substance use peer specialists. It is a separate, stand-alone training and certification program.

Psychiatric Crisis Stabilization Residential Program-\$42,848

Plan: Woodley House is seeking funding to hire a Peer Specialist for our Crossing Place Psychiatric Crisis Stabilization Residential program. The Peer Specialist is needed to provide support for individuals who are referred to our program and current residents in the program. Individuals are referred for residential crisis stabilization from a variety of sources, such as emergency rooms, police, other residential programs, the streets and through the Access Helpline.

Purpose: These individuals are experiencing a psychiatric crisis that severely limits their ability to travel, particularly by public transportation or other independent means. The Peer Specialist will provide the ability for referrals to receive a “warm handoff” by meeting the referred person at the location where they have been assessed, quickly developing an in-person rapport, and then physically transporting the individual if they have no other means of travel, to Crossing Place.

Warm handoffs are an evidence-based practice technique. The direct contact through a warm handoff helps ensure the individual receives the immediate care they need with a welcoming and supportive Peer Specialist helping them along the way and avoids the individual not getting the help they need if they do not have someone they already know and trust available to bring them to the house.

Impact: Crisis Specialists currently accompany residents to appointments and meetings as needed. However, having a peer support specialist also available will allow for residents to

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ARAP Supplemental Funding Plan MHBG (Revised 7/9/21)**

Total Award: \$3,379,225

attend more meetings and with someone they are likely to feel even more comfortable with, especially if they have a co-occurring substance use disorder. This request is for a full-time Peer Specialist who will be available for scheduled appointments and for referrals who need assistance. Cross Place has a minivan that is available for staff use to transport residents.

Community Museum and Garden-\$50,000

Plan: PSI Services, Inc. is developing a community museum and garden for the residents of the Deanwood area of Ward 7.

Purpose: The museum and garden will strengthen ties within the community by helping residents learn about the history of the community and some of its influential residents. This endeavor will build pride in the community as residents reclaim ownership of their history and land.

Impact: The community museum and garden will fill gaps left as a result of the COVID-19 pandemic. The space will be free and open to residents of the community. The museum will tell the story of noted residents and their contributions to Ward 7, the District, and the nation. The garden will be sub divided into individual plots where residents can grow their own vegetables. The COVID-19 pandemic placed an increased demand on local food pantries as people were economically impacted. This garden will enable people to supplement/replace their store bought vegetables with home grown produce. This also gives individuals a sense of pride and accomplishment when they grow their own food.

TOTAL REQUEST: \$786,268

Infrastructure

Request: \$1,146,000

Transition to Managed Care-\$250,000

Plan: Pathways to Housing DC is requesting MHBG funds to create the administrative and operational infrastructure to support the successful transition to Managed Care in October 2022 and beyond. We are requesting a two-year block grant investment to cover the expense of hiring a Healthcare Data Analyst (HDA). The HDA would report directly to our Chief Operating Officer.

Purpose: The purpose of this request is to improve the health outcomes of persons served – from identifying outcome data to preventing interruption in care during the upcoming transition. Literature points to deeply concerning statistics that people living with serious mental illness and substance use disorders experience poorer health outcomes than people without behavioral health challenges, and the public health capacity of most HER systems is woefully limited. Compounding the potentially poor health outcomes is the fact that 100% of people at Pathways are experiencing chronic homelessness at the time of enrollment in our DBH behavioral health programs.

DC Department of Behavioral Health

ARAP Supplemental Funding Plan MHBG (Revised 7/9/21)

Total Award: \$3,379,225

Impact: Ultimately, a successful transition to MCO contracting will improve outcomes for consumers as we more effectively integrate behavioral and physical health care. We are requesting a five-year block grant given the ever-changing IT and data needs as we make this important transition and grow our partnerships with the MCOs.

Telehealth Training for Providers-\$250,000

Plan: Catholic Charities of the Archdiocese of Washington, Inc. (Catholic Charities) seeks to partner with the DC Department of Behavioral Health (DBH) to address the needs and gaps in mental health and substance use disorder (SUD) services for DC residents. By hiring a full-time Telehealth Trainer and Outreach Specialist, Catholic Charities will support DBH in enhancing and expanding services through the effective utilization of Community Mental Health Services Block Grant (MHBG) funds.

Purpose: Given the data on the significant need for behavioral services due to COVID-19, telehealth services have been essential for helping people cope. Anchor's ability to provide behavioral health services via telehealth has been important in ensuring that consumers continue to have access to Community Support, Counseling, Supported Employment, and Psychiatric services. However, barriers have inhibited the full utilization of telehealth as a viable means of supporting and intervening with consumers while still being conscientious of the continued need for pandemic safety. Barriers include lack of consumer access to appropriate technology (smart phones, reliable high-speed internet, and sufficient data plans) and lack of technology literacy. These barriers are disproportionately experienced by communities already at risk and adversely impacted by COVID-19.

Impact: Benefiting from telehealth services is a necessary step for creating access to much needed behavioral health services. Survey results from consumers who engaged in telehealth over the past year showed overall satisfaction with services. The option for telehealth was especially helpful for consumers who have limited or no access to transportation, have caretaker responsibilities at home, and/or often missed in-office appointments due to challenges with executive functioning skills.

Behavioral Health Integration Readiness TA-\$70,000

Plan: DBH will use grant funds to assess Mental Health providers' readiness to participate in a whole person care model that integrates behavioral health and primary health care. DBH will hire a consultant to develop a comprehensive provider Electronic Health Records system assessment tool for Mental Health providers.

Purpose/Issue: District behavioral health providers attempting to make the transition to whole person care. The assessment tool will identify providers' system gaps (process and data capture) that would hinder full participation in a WPC program.

Impact: COVID has compromised providers' ability to prepare for the transition to whole person care. Assessing providers' readiness to participate in a whole person care model will allow DBH to respond to provider deficiencies and gaps.

**DC Department of Behavioral Health
ARAP Supplemental Funding Plan MHBG (Revised 7/9/21)**

Total Award: \$3,379,225

Provider Electronic Health Record System Enhancements-\$250,000

Plan: DBH will use grant funding to support Mental Health provider Electronic Health Record system enhancement/upgrades to support WPC and Behavioral Health system transformation. Mental Health provider upgrades include enabling a system enhancement, developing data reporting and funding a portion of a system replacement. Providers will be required to participate in the Behavioral Health Integration Readiness Technical Assistance project to be eligible for system enhancement funding. This will allow DBH to assess provider need for system enhancements.

Issue: Mental Health providers have struggled with the use of iCAMS, a system mandated by the District. Mental Health providers need choice in obtaining and using a viable electronic health system to conduct their work and capture data to inform treatment decisions which will support WPC.

Impact: Mental Health providers will have Electronic Health Records to be able to participate successfully in the Districts' Behavioral Health system transformation and provide WPC.

Deemed Accreditation Support-\$326,000

Plan: DBH proposes the utilization of Mental Health Block Grant funds to support provider technical assistance to obtain national accreditation. As DBH moves toward behavioral health integration, we must provide our network with the tools and resources needed to improve the quality of their organizations.

Purpose: National Accreditation from organizations such as the Joint Commission, Council on Accreditation, and the Commission on Accreditation of Rehabilitation Facilities helps to ensure that each provider in our network meets a high standard of care.

Impact: Obtaining national accreditation will strengthen the quality of the provider network, strengthen providers' administrative operations, and improve the quality of behavioral health services available to residents of the District of Columbia. National Accreditation ensures there will nationally vetted benchmarks and standards for all providers in our network.

Impact: As part of the grant process, DBH would ensure at minimum that providers met minimum standards for Key Performance Indicators, Fiscal Claims Audits, Fidelity Reviews, and line of credit, where applicable. DBH will offer grants of up to \$10,000 to providers to support technical assistance needed to obtain national accreditation.

TOTAL REQUEST: \$1,146,000

Crisis Services Set-Aside (5%)

Request \$168,961

Plan: DBH is partnering with the District's Office of Unified Communications (OUC) to devise a pilot to potentially divert certain categories of 911 calls directly to DBH's Access HelpLine and /or the Community Response team, as appropriate and with the caller's consent. We believe this process of redirecting certain calls /situations from 911 to DBH for assessment and intervention by behavioral health clinicians will result in individuals in receiving more timely, effective and appropriate care, as well as resulting in safer dispositions (without police involvement) and avoidance of potential criminal justice involvement.

**DC Department of Behavioral Health
ARAP Supplemental Funding Plan MHBG (Revised 7/9/21)**

Total Award: \$3,379,225

Purpose: The set-aside funding will be utilized to obtain a new phone system that supports the technical specifications required for this initiative. The funding will also be used to upgrade and ensure that the Access Helpline has computers and laptops with the specification needed to operated with the new phone system. This new system, and the computers to interface with it, ensure the inter-operability of OUC's current call center systems and platforms with the systems used by DBH.

Impact: The new phone system modernizes the current AHL phone system to ensure interoperability, robust documentation capability, and reporting metrix to measure initiative success. Upgrading the current AHL computers to ensure interoperability and enhanced operations so that technical issues do not derail the initiative

TOTAL REQUEST: \$168,961

First Episode of Psychosis (10%)

Request: \$337,922

Support Group for Families Experiencing First Episode Psychosis- \$337,922

Plan: The FEP Program at Community connections will develop curriculum for Families including clients who are experiencing First Episode Psychosis. The group aims to create a safe environment and provide psycho education and other supports to families and individuals in the circle of support of clients.

Purpose/Issue: To establish a respectful, trusting, and helpful relationship with family members and consumer and work to discover possibilities for a better future.

Impact: Multi-family groups help family members better understand their loved one's illness and how to identify strategies for handling difficult situations by making use of effective behavioral, cognitive and communication techniques to address issues caused by the illness and establish a strengths-based environment where all members are respectful of one another, creating an optimal environment for recovery from mental illness.

TOTAL REQUEST: \$337,922

Administrative (5%)

1. Performance
2. Monitoring
3. Evaluation

TOTAL REQUEST: \$168,961

TOTAL FEDERAL REQUEST: \$3,379,225

**DC Department of Behavioral Health
 ARAP Supplemental Funding Plan MHBG (Revised 7/9/21)
 Total Award: \$3,379,225**

MHBG Budget \$3,379,225		
Name	Service	Cost
Intervention	1. B.A.N.K.™ Methodology for Imagine Communications (MBI Health Services) 2. Care Coordination for Incarcerated Seniors (Dedicated Care Health Services) 3.	1. \$181,113 2. \$100,000 Total: \$281,113
Treatment	1. Jail-Based Competency Program (Department of Behavioral Health) 2. Medherent Remote Monitoring and Prescription Management System (Department of Behavioral Health)	1. \$260,000 2. \$230,000 Total: \$490,000
Recovery Support Services	1. Capitol Clubhouse 2. Forensic Navigator Program (Department of Behavioral Health) 3. Peer Support Program for Formerly Incarcerated Individual (PSP- FII) (Prestige Healthcare Services) 4. Psychiatric Crisis Stabilization Residential program (Woodley House) 5. Community Museum and Garden (PSI)	1. \$200,000 2. \$130,000 3. \$363,420 4. \$42,848 5. \$50,000 Total: \$786,268
Infrastructure	1. Transition to Managed Care (Department of Behavioral Health)	1. \$250,000

**DC Department of Behavioral Health
 ARAP Supplemental Funding Plan MHBG (Revised 7/9/21)
 Total Award: \$3,379,225**

	<ol style="list-style-type: none"> 2. Telehealth Training for Providers (Catholic Charities) 3. Behavioral Health Integration Readiness TA (Department of Behavioral Health) 4. Provider Electronic Health Record System Enhancements (Department of Behavioral Health) 5. Deemed Accreditation Support (Department of Behavioral Health) 	<ol style="list-style-type: none"> 2. \$250,000 3. \$70,000 4. \$250,000 5. \$326,000 	
		Total: \$1,146,000	
Crisis Services (5%)	<ol style="list-style-type: none"> 1. Crisis Services Set-Aside (Department of Behavioral Health) 	Total: \$168,961	
FEP (10%)	<ol style="list-style-type: none"> 1. Support Group for Families Experiencing First Episode Psychosis (Community Connections) 	Total: \$337,922	
Administrative (5%)	<ol style="list-style-type: none"> 1. Performance 2. Monitoring 3. Evaluation 	Total: \$168,961	
		Total	\$3,379,225

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

N/A

Title

N/A

Organization

N/A

Signature:

Date:

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 1/1/2021 Planning Period End Date: 1/1/2022

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	H. COVID- 19 Relief Funds (MHBG) ^a
1. Substance Abuse Prevention and Treatment								
a. Pregnant Women and Women with Dependent Children								
b. All Other								
2. Primary Prevention								
a. Substance Abuse Primary Prevention								
b. Mental Health Primary Prevention ^b		\$0	\$814,397	\$0	\$24,710,843	\$0	\$0	\$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG) ^c		\$160,301	\$355,558	\$0	\$1,131,913	\$0	\$0	\$195,640
4. Tuberculosis Services								
5. Early Intervention Services for HIV								
6. State Hospital			\$1,261,134	\$3,019,964	\$99,747,656	\$0	\$416,152	\$0
7. Other 24 Hour Care		\$0	\$3,426,741	\$498,790	\$15,006,848	\$0	\$0	\$0
8. Ambulatory/Community Non-24 Hour Care		\$1,282,412	\$26,339,838	\$0	\$11,903,901	\$0	\$1,312,000	\$1,565,114
9. Administration (Excluding Program and Provider Level) ^d		\$80,151	\$20,046	\$4,112,302	\$26,550,182	\$0	\$0	\$97,820
10. Crisis Services (5 percent set-aside) ^e		\$80,151	\$0	\$0	\$0	\$0	\$0	\$97,820
11. Total	\$0	\$1,603,015	\$32,217,714	\$7,631,056	\$179,051,343	\$0	\$1,728,152	\$1,956,394

^a The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the “standard” MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A – G are for the state planned expenditure period of July 1, 2020 – June 30, 2021, for most states.

^b While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

^c Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

^d Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

^e Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

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Footnotes:

3/4/21

Table revised in accordance with FY21 Allocation Table.

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2020 Planning Period End Date: 9/30/2022

Expenditure Category	FFY 2020 SA Block Grant Award	FFY 2021 SA Block Grant Award	COVID-19 Award ¹	ARP Award ²
1 . Substance Use Disorder Prevention and Treatment ³	\$4,877,720	\$4,877,921	\$4,571,680	\$3,948,270
2 . Primary Substance Use Disorder Prevention	\$1,393,635	\$1,393,692	\$1,306,194	\$1,128,077
3 . Tuberculosis Services	\$0	\$0	\$0	\$0
4 < . Early Intervention Services for HIV ⁴	\$348,409	\$348,423	\$326,549	\$282,019
5 . Administration (SSA Level Only)	\$348,409	\$348,423	\$326,549	\$282,019
6. Total	\$6,968,173	\$6,968,459	\$6,530,972	\$5,640,385

¹The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the planning period for the standard SABG expenditures for the FFY 2021 SABG Award is October 1, 2020 - September 30, 2021. For purposes of this table, all COVID-19 Relief Supplemental expenditures between March 15, 2021 and September 30, 2021 should be entered in this column.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2021 "standard" SABG, which is October 1, 2020 - September 30, 2021. The planned expenditures for the period of September 1, 2021 - September 30, 2021 should be entered here.

³Prevention other than Primary Prevention

⁴For 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 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.

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Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2020 Planning Period End Date: 9/30/2022

Strategy	A	B	C		
	IOM Target	FFY 2020 SA Block Grant Award	SA Block Grant Award	FFY 2021 COVID-19 ¹	ARP ²
1. Information Dissemination	Universal	\$150,524	\$150,581	\$63,083	\$63,083
	Selective	\$16,725	\$16,725	\$16,725	\$16,725
	Indicated				
	Unspecified				
	Total	\$167,249	\$167,306	\$79,808	\$79,808
2. Education	Universal	\$83,624	\$83,624	\$83,624	\$83,624
	Selective				
	Indicated				
	Unspecified				
	Total	\$83,624	\$83,624	\$83,624	\$83,624
3. Alternatives	Universal	\$53,624	\$53,624	\$53,624	\$53,624
	Selective				
	Indicated				
	Unspecified				
	Total	\$53,624	\$53,624	\$53,624	\$53,624
4. Problem Identification and Referral	Universal	\$21,812	\$21,812	\$21,812	\$21,812
	Selective				
	Indicated				
	Unspecified				
	Total	\$21,812	\$21,812	\$21,812	\$21,812
	Universal	\$915,514	\$915,514	\$915,514	\$737,397

5. Community-Based Process	Selective				
	Indicated				
	Unspecified				
	Total	\$915,514	\$915,514	\$915,514	\$737,397
6. Environmental	Universal	\$41,812	\$41,812	\$41,812	\$41,812
	Selective				
	Indicated				
	Unspecified				
	Total	\$41,812	\$41,812	\$41,812	\$41,812
7. Section 1926 Tobacco	Universal				
	Selective	\$50,000	\$50,000	\$50,000	\$50,000
	Indicated				
	Unspecified	\$60,000	\$60,000	\$60,000	\$60,000
	Total	\$110,000	\$110,000	\$110,000	\$110,000
8. Other	Universal				
	Selective				
	Indicated				
	Unspecified				
	Total	\$0	\$0	\$0	\$0
Total Prevention Expenditures		\$1,393,635	\$1,393,692	\$1,306,194	\$1,128,077
Total SABG Award*		\$6,968,173	\$6,968,459	\$6,530,972	\$5,640,385
Planned Primary Prevention Percentage		20.00 %	20.00 %	20.00 %	20.00 %

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

¹The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 – March 14, 2023**. Per the instructions, the planning period for the standard SABG expenditures for the FFY 2021 SABG Award is October 1, 2020 – September 30, 2021. For purposes of this table, all COVID-19 Relief Supplemental expenditures between March 15, 2021 and September 30, 2021 should be entered in this column.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2021 "standard" SABG, which is October 1, 2020 - September 30, 2021. The planned expenditures for the period of September 1, 2021 - September 30, 2021 should be entered here.

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Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2020 Planning Period End Date: 9/30/2022

Activity	FFY 2020 SA Block Grant Award	FFY 2021 SA Block Grant Award	COVID-19 Award ¹	ARP Award ²
Universal Direct	\$1,277,884	\$1,276,227	\$1,188,729	\$1,010,612
Universal Indirect	\$55,751	\$57,465	\$57,465	\$57,465
Selective	\$60,000	\$60,000	\$60,000	\$60,000
Indicated				
Column Total	\$1,393,635	\$1,393,692	\$1,306,194	\$1,128,077
Total SABG Award³	\$6,968,173	\$6,968,459	\$6,530,972	\$5,640,385
Planned Primary Prevention Percentage	20.00 %	20.00 %	20.00 %	20.00 %

¹The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the planning period for the standard SABG expenditures for the FFY 2021 SABG Award is October 1, 2020 - September 30, 2021. For purposes of this table, all COVID-19 Relief Supplemental expenditures between March 15, 2021 and September 30, 2021 should be entered in this column.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2021 "standard" SABG, which is October 1, 2020 - September 30, 2021. The planned expenditures for the period of September 1, 2021 - September 30, 2021 should be entered here.

³Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2020 Planning Period End Date: 9/30/2021

	SABG Award	COVID-19 Award ¹	ARP Award ²
Targeted Substances			
Alcohol	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bath salts, Spice, K2)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Targeted Populations			
Students in College	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Military Families	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LGBTQ	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
American Indians/Alaska Natives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
African American	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hispanic	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homeless	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Native Hawaiian/Other Pacific Islanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rural	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



¹The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 – March 14, 2023**. Per the instructions, the planning period for the standard SABG expenditures for the FFY 2021 SABG Award is October 1, 2020 – September 30, 2021. For purposes of this table, all COVID-19 Relief Supplemental expenditures between March 15, 2021 and September 30, 2021 should be entered in this column.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2021 "standard" SABG, which is October 1, 2020 - September 30, 2021. The planned expenditures for the period of September 1, 2021 - September 30, 2021 should be entered here.

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Planning Tables

Table 6 Non-Direct-Services/System Development [SA]

Planning Period Start Date: 10/1/2020 Planning Period End Date: 9/30/2022

Activity	FY 2020			FY 2021				
	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated ¹	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated ¹	D. COVID-19 ²	E. ARP ³
1. Information Systems								
2. Infrastructure Support	\$143,755			\$143,755			\$143,755	\$143,755
3. Partnerships, community outreach, and needs assessment								
4. Planning Council Activities (MHBG required, SABG optional)								
5. Quality Assurance and Improvement								
6. Research and Evaluation								
7. Training and Education								
8. Total	\$143,755	\$0	\$0	\$143,755	\$0	\$0	\$143,755	\$143,755

¹Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

²The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the planning period for the standard SABG expenditures for the FFY 2021 SABG Award is October 1, 2020 - September 30, 2021. For purposes of this table, all COVID-19 Relief Supplemental expenditures between March 15, 2021 and September 30, 2021 should be entered in the FY 2021, Column D.

³The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2021 "standard" SABG, which is October 1, 2020 - September 30, 2021. The planned expenditures for the period of September 1, 2021 - September 30, 2021 should be entered here.

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Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: 10/01/2020 MHBG Planning Period End Date: 09/30/2021

Activity	FFY 2020 Block Grant	FFY 2021 Block Grant	FFY 2021 ¹ COVID Funds
1. Information Systems	\$130,000.00	\$130,000.00	\$130,000.00
2. Infrastructure Support	\$670,326.00	\$670,326.00	\$670,326.00
3. Partnerships, community outreach, and needs assessment	\$499,000.00	\$499,000.00	\$946,068.00
4. Planning Council Activities (MHBG required, SABG optional)	\$10,000.00	\$10,000.00	\$10,000.00
5. Quality Assurance and Improvement	\$50,000.00	\$50,000.00	\$50,000.00
6. Research and Evaluation	\$50,000.00	\$50,000.00	\$50,000.00
7. Training and Education	\$193,689.00	\$193,689.00	\$100,000.00
8. Total	\$1,603,015	\$1,603,015	\$1,956,394

¹The 24-month expenditure period for the COVID-19 Relief Supplemental funding is March 15, 2021 – March 14, 2023, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2020 - June 30, 2021, for most states.

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Footnotes:

Environmental Factors and Plan

15. Crisis Services - Required

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 M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.⁶¹ 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 M/SUD conditions and their families. According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427)⁶²,

"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 M/SUD 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.

⁶¹<http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

⁶²Practice Guidelines: Core Elements for Responding to Mental Health Crises. 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 check those that are used in your state:

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) Peer Support/Peer Bridgers
- b) Follow-up Outreach and Support
- c) Family-to-Family Engagement
- d) Connection to care coordination and follow-up clinical care for individuals in crisis
- e) Follow-up crisis engagement with families and involved community members

- f) Recovery community coaches/peer recovery coaches
- g) Recovery community organization

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

The District of Columbia's Department of Behavioral Health (DBH) manages a comprehensive, robust, and integrated crisis management system and supports which focuses on prevention, assessment and treatment for individuals with severe mental illness and those experiencing behavioral health challenges. DBH's Access HelpLine (our mental health and suicide prevention hotline) is a centrally deployed, 24/7 call center which consist of licensed clinicians and counselors who provide evidence based, crisis counseling, referrals to care, care coordination and linkage to various government programs and agencies. This call center works closely with DBH's clinical, emergency crisis programs such as our Comprehensive Psychiatric Emergency Program (short term residential observation and treatment), out-patient adult and child psychiatric clinics, and our Substance Use Assessment and Referral Center.

As clinically appropriate, the Access HelpLine dispatches our Community Response Team (CRT) to outreach, engage, assess, de-escalate, triage and treat individuals in crisis within the community (and even in their homes at times). The CRT, which operates 24/7 within the community consists of licensed behavioral health clinicians, certified substance use counselors, peer specialists, community service workers and other professionals as indicated. The CRT also links individuals with services across District agencies and follows up with individuals over time to ensure continued engagement to care and adherence to the agreed upon care plan. In addition, the CRT co-responds with the Metro Police Department (MPD) to crisis situations as necessary, trains police officers regarding Mental Health First Aid and de-escalation techniques, and works with MPD to transport individuals to acute care settings when appropriate.

In spite of such a person-centered, integrated and coordinated approach to serving individuals experiencing crises, violence and trauma in the community, all too often, rather than concerned citizens or affected individuals directly calling our AHL Call Center or our Community Response Team, sometimes callers or interested parties reach out to the District's 911 Call Center, which can result in an adverse outcome once officers are the first to respond without proper behavioral health back up or support.

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

To minimize the prevalence of such situations, DBH is working with District government to explore the feasibility of having specially trained behavioral health Community Response Team members become first responders to certain categories of 911 calls which involve behavioral health involved individuals, as well as any resident experiencing an emotional crisis. This dedicated behavioral health crisis management team would work closely with EMT's and police officers when required to ensure the resident's (and everyone else's) safety.

DBH is partnering with the District's Office of Unified Communications (OUC) to devise a pilot to potentially divert certain categories of 911 calls directly to DBH's Access HelpLine and / or the Community Response team, as appropriate and with the caller's consent. We believe this process of redirecting certain calls / situations from 911 to DBH for assessment and intervention by behavioral health clinicians will result in individuals in receiving more timely, effective and appropriate care, as well as resulting in safer dispositions (without police involvement) and avoidance of potential criminal justice involvement.

The funding in question will be utilized to obtain external consultation and technical assistance from other jurisdictions and stakeholders to develop the necessary workflows and clinical, business processes to divert such calls from 911 (OUC) to DBH's crisis services; develop the necessary behavioral screening questions and scenarios appropriate for such diversions; and to leverage external, technological expertise to ensure the inter-operability of OUC's current call center systems and platforms with the systems currently used by DBH. Although DBH appreciates SAMHSA's set aside funding, DBH expects to significantly augment such funding to achieve the above goals.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Responses to Table 15. Crisis Services Revision Request

- **Are there any services specifically for children or are all services for all ages?**

The services outlined in the proposal are not designed to specifically target children or any other specific population, but rather to meet the needs of all District residents experiencing stress or who are difficulty coping with the consequences of trauma or violence experienced in the community.

- **Where is the District on the stages of implementation?**

DBH just recently began meeting with representatives of Office of Unified Communications (OUC) which manages the District's 911 line and Metropolitan Police Department (MPD) to finalize the parameters of the pilot described in the proposal. We expect the initial phase of this pilot to be implemented in early May 2021.

- **What percentage has been implemented already?**

Approximately, 50% of the logistical details and parameters of the pilot have been completed thus far. We expect to finalize the operational details of the pilot by May 1, 2021.

- **Does the District have a clear budget for these services to be provided by the set aside?**

The bulk of DBH's budget for this pilot involves securing external consultation and technical assistance from other jurisdictions and communications experts to develop the necessary workflows and clinical / business processes necessary to seamlessly divert current 911 calls (managed by OUC) to DBH's Access HelpLine (MH call center and Suicide Hot Line). Anticipated costs for this consultation is expected to be \$60K. In addition, we understand that our current Call Center system / platform (Avaya) needs to be upgraded to ensure inter-operability with OUC's call center system and platforms. Estimated cost of such upgrades is \$80K.

**District of Columbia
 Department of Behavioral Health
 FY21 MHBG COVID-19 Relief Spending Plan
 Crisis Services Set-Aside Budget**

DBH is partnering with the District’s Office of Unified Communications (OUC) to devise a pilot to potentially divert certain categories of 911 calls directly to DBH’s Access HelpLine and / or the Community Response team, as appropriate and with the caller’s consent. We believe this process of redirecting certain calls /situations from 911 to DBH for assessment and intervention by behavioral health clinicians will result in individuals in receiving more timely, effective and appropriate care, as well as resulting in safer dispositions (without police involvement) and avoidance of potential criminal justice involvement.

The set-aside funding will be utilized to obtain external consultation and technical assistance from other jurisdictions and stakeholders to develop the necessary workflows and clinical, business processes to divert such calls from 911 (OUC) to DBH’s crisis services; develop the necessary behavioral screening questions and scenarios appropriate for such diversions; and to leverage external, technological expertise to ensure the inter-operability of OUC’s current call center systems and platforms with the systems currently used by DBH. The funding in question will be utilized to obtain external consultation and technical assistance from other jurisdictions and stakeholders to develop the necessary workflows and clinical, business processes to divert such calls from 911 (OUC) to DBH’s crisis services; develop the necessary behavioral screening questions and scenarios appropriate for such diversions; and to leverage external, technological expertise to ensure the inter-operability of OUC’s current call center systems and platforms with the systems currently used by DBH.

Action	Purpose	Cost
Travel for team of 4 staff	Visit CAHOOTS Co-Response Model for 4 days in Eugene Oregon to observe a current operational Program	\$4,500.00
One FTE (half time) Program Coordinator	To support development of program and track results	\$38,700.00 salary and fringe)
Consultation with White Bird Clinic (which started the CAHOOTS program over 30 years ago in Eugene, OR	To provide program development and technical assistance: including policy development, operating procedures and manual, training, and implementation support	\$ 54,619.70
Total		\$97,819.70

2. We request that you indicate what state each of the three elements is in your state and submit this back to us in your application.

	Exploration Planning	Installation	Early Implementation <25% of state population	Middle Implementation ~50% of state population	Majority Implementation >74% of state population	Program Sustainment
Some one to talk to					xxxx	
Some one to respond						xxxx
Place to go					xxxx	

3. Indicate whether there are services planned or to be expanded explicitly for children with SED.

DBH provides a range of Crisis Services for children, youth and families. These include: ChAMPS, or Children Adolescent Mobile Psychiatric Services which provides mobile crisis emergency services 24/7 for children and youth ages 4-21, through a contract with Anchor Mental Health. ChAMPS both assesses, stabilizes and can facilitate evaluation for psychiatric hospitalization when necessary to children and youth who present in crisis either on a voluntarily or involuntarily basis. DBH also provides social workers who support the Juvenile Behavioral Diversion Program and HOPE Court for juveniles involved with the criminal justice system or involved in sex trafficking. In addition, DBH’s provider network includes Prevention Centers, and Child / Youth Urgent BH Clinics and the Healthy Futures Program for younger children.

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).⁶⁹

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

⁶⁹<https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf>

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

The District of Columbia Department of Behavioral Health (DBH) serves as the State Mental Health Authority (SMHA) and the District of Columbia Single State Agency (SSA) for substance use disorders. In the latter role DBH: 1) operates four (4) community prevention centers each serving two (2) of the 8 District wards; 2) provides services and contracts with community providers for substance use disorder (SUD) services and supports; 3) assess and refer adults seeking treatment for SUD to appropriate services; 4) the Mobile Assessment and Referral Center (MARC) visits communities throughout the District to conduct assessments, referral, and HEP-C and HIV testing; 5) annual prevention symposium; 6) adults, young adults and youth substance youth campaigns (marijuana use, synthetic drug use, opioid use); and 7) recovery coaching training.

Launched in 2018, LIVE. LONG. DC., the District's Strategic Plan to Reduce Opioid Use, Misuse, and Related Deaths, is the foundation for a city-wide effort to ensure equitable and timely access to high-quality substance use disorder treatment and RSS through a network of treatment services to meet demand consistent with the criteria of the American Society of Addiction Medicine; educate District residents and key stakeholders on the risk of opioid use disorder (OUD) and effective prevention and treatment; engage health professionals and organizations in the prevention and early intervention of substance use disorder among District residents; support the awareness and availability of, and access to, harm reduction services in the District of Columbia consistent with evolving best and promising practices; develop and implement a shared vision between the District's justice and public health agencies to address the needs of individuals who come in contact with the criminal justice system; and prepare for program sustainability through evaluation, planning, and performance monitoring and training. Further, the Mayor of the District of Columbia, Muriel Bowser, participates with the leadership of Maryland and Virginia to address the regional opioid crisis.

Also, the District has an Epidemiological Outcomes Workgroup (DC EOW).

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? Yes No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? Yes No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The overall goals of the DBH/BHPC is to advise the Department of Behavioral Health as follows:

1. To ensure that individuals in need of mental health and/or substance use disorder services have access to services;
2. To ensure that consumer and family directed services and supports for the prevention and treatment of mental health and substance use disorders maintain a focus on recovery and resilience;
3. To advocate for District residents with serious emotional disturbances, mental health issues, and substance use disorders;
4. To support the integration of mental and substance use disorder prevention, treatment and recovery services and supports into overall health services;
5. To reduce disparities in the prevention and treatment of mental health and substance use disorders;
6. To strengthen the coordination and collaboration with relevant state and community organizations in order to develop systems of care; and
7. To provide input for the development of the SAMHSA Mental Health and Substance Abuse Block Grants.

The DBH/BHPC has achieved this primarily by sharing information, inviting relevant agency presentations and participation, and whenever asked or invited to relevant Departmental endeavors.

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

Technical assistance is needed to fulfill the federal mandate to monitor, review, and evaluate at least once each year the allocation and adequacy of mental health and substance use disorder services within the District, and use the findings to review the Block Grant Plans and make recommendations.

The Behavioral Health Planning Council would also benefit from Technical Assistance focused on participatory-based discussions and input concentrating on continuous improvement and training to develop its relationship with other community-based, citywide/state councils and work groups.

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.⁷⁰

⁷⁰There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

21. State/Advisory Council Input on Mental Health/Substance Abuse Block Grant Application - Attachments

The Behavioral Health Planning Council Planning & Accountability committee's purpose, as outlined in the council's bylaws, is to ensure that the Council continually has a forward-looking, proactive role in improving DC's behavioral health system, including by giving input on DC's Mental Health Block Grant and helping to develop accountability and performance measures. The Council's Planning & Accountability committee directly assisted in the development and review of the state plan and report. The following attachments reflect the ongoing involvement of the Behavioral Health Planning Council concerning Mental Health/Substance Abuse Block Grant issues.



**Department of Behavioral Health
Behavioral Health Planning Council (BHPC)
January Meeting-Rescheduled due to DBH Performance Oversight Hearing
Friday, February 21, 2020 10 AM to 12 PM**

Where:
64 New York Avenue NE Washington DC 20002
In Person DBH-Conference Conference Room 242
Conference Line 1866-803-2312 Participant Code: 27325876

AGENDA

- | | | |
|---------------------|---|--------------------------|
| 10 AM | Call to Order, Welcome, Introductions and Roll | S. Simpson |
| 10:05 -10:10 | Approvals of Agenda & Minutes | S. Simpson |
| 10:10- 10:35 | Department of Behavioral Health Updates
a. Budget Review FY21 | P. Jones |
| 10:35-10:50 | Old Business
I. 35K Ad Hoc Workgroup Final Report | Jackie Richardson |
| 10:50 -11:50 | New Business

I. Status Report of Standing Committees | |
| | 1. Executive Committee | S. Simpson |
| | 2. System & Benefit Design | M. LeVota |
| | 3. Advocacy and Outreach | C. Doby-Copeland |
| | 4. Connection to Care | E. Ford |
| | 5. Planning & Accountability | E. Smith |
| | II. Committees updates on the Clearing Work Plan | |
| | III. DBH Director of Communications | E. Cunningham |
| 11:50 | Announcements & Public Comments (Please limit comments to 3 Minutes) | |
| 12:00 PM | Adjournment | |

Note:

If any council member or public attendee needs an accommodation, please contact Ms. J. Route, Strategic Planning, Policy & Engagement Officer, at Office: (202) 671-3204 Cell: (202) 236-4555 prior to the meeting date.



Department of Behavioral Health Behavioral Health Planning Council (BHPC)
Regularly Scheduled Meeting
Wednesday, December 11, 2019 10:00am-12:00pm
64 New York Avenue NW Washington DC 20002

MINUTES

Meeting Participants:

The in-person participants: Senora Simpson, Mark LeVota, Tonia Gore, Cheryl Copeland, Effie Smith, Esther Ford, Tia Brumsted, Nicole Denny, Luis Diaz, Donna Flenory, Nicole Gilbert, Harry Willis, Jenese Patterson, Tony Crews, Gail Avent, Heather Stowe, Jean Harris, Rosalind Parker, Dianne Lewis, Jaclyn Verner, Dena Hasan, Cavella Bishop, Angela Spinella

Call to Order, Chair Department of Behavioral Health (DBH) Behavioral Health Planning Council (BHPC)

The BHPC was called to order by the Chair, Senora Simpson at 10:05 am. A quorum was ascertained, Jocelyn Route by roll call

Agenda

Motion to approve agenda approved Tonia Gore

Motion to approve minutes approved Senora Simpson

Committee Reports

- **Advocacy and Outreach Committee** –reported
- **Planning and Accountability Committee** – no report
- **System and Benefit Design Committee** –reported
- **Connection to Care Committee** –no report

New Business

1. Introduction of newly appointed Behavioral Health Planning Council members
 - Debby Shore-Prevention Center
 - Nadine Parker, Esq.-Prevention Center
 - Jean Harris-Nami Representative
 - Rosalind Parker- Prevention Center
2. Chair Simpson reported that the Director of DBH (Dr. Barbara Bazron) requests that the BHPC members be more of a working committee and less of a paper people. Committing to do more outside of the monthly meetings. Council and committee efforts to be in conjunction with the mandates of the city and funding sponsors.
3. Chair Simpson emphasized the lack of respondents to information sent to the committee members. Chair Simpson reported more than 1\2 the committee doesn't respond at all or in a timely manner to information sent to them.
4. Chair Simpson wants to form a had-hoc committee, each chair from each committee, with Mark Lovato (V ice-Chair) over-seeing the had-hoc regarding the Orientation process so all new members.
5. Chair Simpson has thoughts on appointing someone to review committee by-laws and committee structure.
6. Per Dr. Bazron (BHPC) members will now
7. Reports, Minutes, Agenda, will be presented at least 2 weeks before regularly scheduled meeting.
8. Chair Simpson requested a location where all documents can be located for anyone requesting ;Reports, Minutes, Agenda

Announcements – There were no public announcements.

Public Comments – No members of the public offered public comments.

Adjournment – The meeting was adjourned at 12:10 PM.

BEHAVIORAL HEALTH PLANNING COUNCIL



Committee on System and Benefit Design

Chair: Mark LeVota, Executive Director, DCBHA (Mark.LeVota@DCBehavioralHealth.org)

DBH Staffer: Teresa Manocchio, Policy Analyst, SPMD (Teresa.Manocchio@dc.gov)

NO REPORT RECEIVED



**Behavioral Health Council
Advocacy & Outreach Committee Report
Friday, February 14, 2020 10 am – 11 am
821 Howard Road SE, Washington, DC 20020**

Present: Cheryl Doby-Copeland, Jaclyn Verner, Donna Flenory, Erica Cunningham, and Senora Simpson
By telephone: Gail Avent, Roz Parker, Nadine Parker, and Jackie Richardson
Staffer: Jackie Richardson

Present: Cheryl Doby-Copeland, Jaclyn Verner, Donna Flenory, Erica Cunningham, and Senora Simpson
By telephone: Gail Avent, Roz Parker, Nadine Parker, and Estelle Richardson

Discussion: Goal A: Everyone in the Community knows how to access services and the 24/7 CRT (Advocacy and Outreach Committee)

Strategy #1: Amplify Communications Platforms - Activities:

- Erica Cunningham is the new DBH Director of Communications and she will be a member of the Advocacy and Outreach Committee.
- All committee members agreed to review the DBH website:
<https://dbh.dc.gov/> as if we were “secret shoppers”, for accuracy, ease of use and breathe of information. Results of the review should be submitted to the committee chair by 2/28/2020, and will then be submitted to Erica Cunningham.
- The CRT press release to community members to increase awareness began with mobile outreach on July 1, 2019

Strategy #2: Amplify marketing for services and supports to the DC community - Activities:

- The committee will work with the Communications Director to support existing social marketing plans – e.g., First Episode of Psychosis
- Gail Avent agreed provide feedback to the committee by 3/6/2020 based on her interactions with churches, barber shops, spiritual leaders and other community based organizations regarding their interest in providing mental health services
- Consideration of bus signs and creating other signage at CSAs to advertise available services was tabled for future discussion.

BEHAVIORAL HEALTH PLANNING COUNCIL



Chair: Esther Ford (estherford777@gmail.com)

DBH Staffer: Raphaelle Richardson (raphaelle.richardson@dc.gov)

NO REPORT RECEIVED

BEHAVIORAL HEALTH PLANNING COUNCIL



Planning and Accountability Committee

Chair: Effie Smith (esmith@can-dc.org)

DBH Staffer: Jocelyn Route (Jocelyn.Route@dc.gov)

NO REPORT RECEIVED



**Department of Behavioral Health
Behavioral Health Planning Council (BHPC)
March Virtual Meeting
Friday, March 27, 2020 10 AM to 12 PM**

Where:
64 New York Avenue NE Washington DC 20002

Conference Line 1866-803-2312 Participant Code: 27325876

AGENDA

- | | | |
|---------------------|--|-----------------------------------|
| 10 AM | Call to Order, Welcome, Introductions and Roll | S. Simpson |
| 10:05 -10:10 | Approvals of Agenda & Minutes
Please see Attachment A | S. Simpson |
| 10:10- 10:45 | Department of Behavioral Health Updates | Director Barbara J. Bazron |
| 10:45-11:00 | Old Business
a. Approved MHBG FY19 & FY20 Projects
Please see Attachments B & C | R. Singh |
| 11:00-11:10 | New Business
a. State Response Opioid Grant
Please see Attachment D | S. Hunt |
| 11:00 -11:30 | Committees updates
<ul style="list-style-type: none"> • Advocacy and Outreach Committee • Planning and Accountability Committee • System and Benefit Design Committee • Connection to Care Committee Please see Attachment E | |
| 11:30 | Announcements & Public Comments (Please limit comments to 3 Minutes) | |
| 11:40 AM | Adjournment | |

Note: If any council member or public attendee needs an accommodation, please contact Ms. J. Route, Strategic Planning, Policy & Engagement Officer, at Office: (202) 671-3204 Cell: (202) 236-4555 prior to the meeting date.

ATTACHMENT A

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH



Department of Behavioral Health Behavioral Health Planning Council (BHPC)
Regularly Scheduled Meeting
Friday February 21, 2020 10:00am-12:00pm
64 New York Avenue NW Washington DC 20002

MINUTES

In Person meeting participants:

The in-person participants: Senora Simpson, Mark LeVota, Tonia Gore, Cheryl Copeland, Effie Smith, Esther Ford(excused), Debby Shore, Luis Diaz, Donna Flenory, Nicole Gilbert, Nadine Parker, Tony Crews, Gail Avent, Heather Stowe, Jean Harris, Jaclyn Verner, Angela Spinella

Phone Participants Harry Willis

Call to Order, Chair Department of Behavioral Health (DBH) Behavioral Health Planning Council (BHPC)

The BHPC was called to order by the Chair, Senora Simpson at 10:05 am. A quorum was ascertained, Jocelyn Route by roll call.

Agenda

Motion to approve agenda approved Mark LeVota

Motion to approve minutes approved Senora Simpson

Committee Reports

- **Advocacy and Outreach Committee –REPORTED**
- **Planning and Accountability Committee – REPORTED**
- **System and Benefit Design Committee –REPORTED**
- **Connection to Care Committee –NON-REPORTED**

Old Business

9. Committee Updated the Clearing Work Plan

10. DBH, Chief Of staff, Phyllis Jones, Budget 2020 Review P. Jones

Presentation from Phyllis Jones, Chief of staff.

11. DBH Director of Communications E. Cunningham

Presentation from Erica Cunningham , Director of Communications

Announcements – There were no public announcements.

Public Comments – No members of the public offered public comments.

Adjournment – The meeting was adjourned at 12:03 PM.

ATTACHMENT B

The Mental Health Block Grant (MHBG), administered by SAMHSA, provides states with the flexibility to design and implement activities and services to address the complex needs of adults with serious mental illness (SMI) and children with serious emotional disturbances (SED). The block grant supports these service needs and are consistent with SAMHSA's vision for a high-quality, self-directed, and satisfying life. MHBG FY19 Funds expire on September 30, 2020.

Available Funds from FY18 MHBG Award	\$1,605,650.00
Minus 10% FEP Set-Aside (based on FY 19 Final Award)	\$160,565.00
Minus 5% Admin Costs Set-Aside (based on FY 19 Final Award)	\$ 80,312.75
TA Supplement	\$134,500.00
Total Amount to Spend	\$1,740,150.00

FY 19 Budget/Project Descriptions

Project/Program	Amount
<p>1. First Episode Psychosis/Early Serious Mental Illness (required by SAMHSA) (Community Connections) The program will support a FEP early intervention program that will change the long-term prognosis for Transitional Age Youth (TAY) coping with schizophrenia. The team approach enhancement will ensure that the offered treatment meets SAMHSA's requirement as a Coordinated Specialty Care program and is guided by Cognitive Behavioral Therapy for Psychosis.</p>	\$166,951.20
<p>2. High Fidelity Wraparound High Fidelity Wraparound (HFW) is a team based planning process which supports children, youth, and their families with severe emotional or behavioral needs. HFW is a promising practice based in an ecological model that draws upon the strengths and resources of a committed group of family, friends, professionals, and community members. Each child or youth is assigned a Care Coordinator responsible for coordinating services, identifying barriers to success, and holding the team accountable for meeting goals they identified. HFW is person centered, family focused, and strength based.</p>	\$438,469.75
<p>3. The Assessment Center The Assessment Center (AC) provides varied forensic assessments to children, youth and families involved in the abuse and neglect System (Child and Family Services Agency), the juvenile justice system (Division of Youth and Rehabilitation Services, Court Social Services), and domestic relations (Family Court Division). The assessments include psychiatric, psychological, psychoeducational, psychosexual, neuropsychological, interactive, and competency for adoption and to stand trial. In all instances, formal referrals for assessments are received by way of the District of Columbia Family Court orders.</p>	\$244,248.75
<p>4. Clubhouse In keeping with DBH's commitment to expanding peer-led supports, DBH will support a prospective DBH-certified Clubhouse Specialty Provider, including by providing support through the DBH and Clubhouse International Accreditation certification process. These Peer Support Centers, led by Peers and Consumers, will serve people living with mental health disorders as they work towards sustainable recovery.</p>	\$70,000.00
<p>5. Peer Operated Center (DC Health and Wellness Center) (amount to pay out at the end of contract) Peer Operated Centers engage consumers, multiple stakeholders and partners to foster an environment that advocates for and supports individuals seeking to initiate or maintain recovery behavioral health services</p>	\$50,727.00

<p>Peer Operated Centers will engage consumers, multiple stakeholders, and partners to foster an environment that advocates for and supports individuals seeking to initiate or maintain recovery behavioral health services. With this approach, individuals take an active role in their own recovery and to enhance their ability to participate fully in the community.</p>	
<p>7. Peer Operated Center (Total Family Care, Yr. 2) Peer Operated Centers will engage consumers, multiple stakeholders, and partners to foster an environment that advocates for and supports individuals seeking to initiate or maintain recovery behavioral health services. With this approach, individuals take an active role in their own recovery and to enhance their ability to participate fully in the community.</p>	\$116,666.00
<p>8. SharePoint DBH will further enhance the intranet to create a shared space for better project management, inter-departmental communications, and information dissemination in an effort to help DBH operate in a more unified and strategic way. This platform offers the opportunity to share tools, ideas, and data to enhance the services provided by DBH to its consumers.</p>	\$125,610.45
<p>9. Behavioral Health Planning Council Equipment</p>	\$5,000.00
<p>10. NASMIHD Dues Annual dues assessment for agency membership for FY 20.</p>	\$8,979.00
<p>11. Support Services for Individuals Involved in the DC Criminal Justice System To enhance the clinical skills of Core Service Agency staff and provide recidivism reduction programming, DBH is introducing the "Thinking for a Change" 4.0 (T4C) integrated cognitive behavioral change program, under a cooperative agreement with the National Institute of Corrections (NIC).</p>	<p>\$105,000.00 (\$205,000 total, \$100K funded from FY20)</p>
<p>12. Behavioral Health Planning Council Technical Assistance - Internal Council Processes Technical assistance is needed to fulfill the federal mandate to monitor, review, and evaluate at least once each year the allocation and adequacy of mental health and substance use disorder services within the District, and use the findings to review the Block Grant Plans and make recommendations</p>	\$50,000.00

ATTACHMENT C

The Mental Health Block Grant (MHBG), administered by SAMHSA, provides states with the flexibility to design and implement activities and services to address the complex needs of adults with serious mental illness (SMI) and children with serious emotional disturbances (SED). The block grant supports these service needs and are consistent with SAMHSA's vision for a high-quality, self-directed, and satisfying life. MHBG FY20 Funds expire on September 30, 2021.

Available Funds from FY18 MHBG Award	\$1,603,015.00
Minus 10% FEP Set-Aside (based on FY 20 Final Award)	\$160,302.00
Minus 5% Admin Costs Set-Aside (based on FY 20 Final Award)	\$ 80,150.75.00
Total Amount to Spend	\$1,603,015.00

FY 20 Budget/Project Descriptions

Project/Program	Amount
<p>13. First Episode Psychosis/Early Serious Mental Illness (required by SAMHSA) (Community Connections) (Disbursed in FY21)</p> <p>The program will support a FEP early intervention program that will change the long-term prognosis for Transitional Age Youth (TAY) coping with schizophrenia. The team approach enhancement will ensure that the offered treatment meets SAMHSA's requirement as a Coordinated Specialty Care program and is guided by Cognitive Behavioral Therapy for Psychosis.</p>	\$166,951.20
<p>14. High Fidelity Wraparound</p> <p>High Fidelity Wraparound (HFW) is a team based planning process which supports children, youth, and their families with severe emotional or behavioral needs. HFW is a promising practice based in an ecological model that draws upon the strengths and resources of a committed group of family, friends, professionals, and community members. Each child or youth is assigned a Care Coordinator responsible for coordinating services, identifying barriers to success, and holding the team accountable for meeting goals they identified. HFW is person centered, family focused, and strength based.</p>	\$523,085.80 (\$167K dispersed in Jan the remaining in March)
<p>15. Peer Operated Center (FAN, Yr. 3)</p> <p>Peer Operated Centers will engage consumers, multiple stakeholders, and partners to foster an environment that advocates for and supports individuals seeking to initiate or maintain recovery behavioral health services. With this approach, individuals take an active role in their own recovery and to enhance their ability to participate fully in the community.</p>	\$283,000
<p>16. Peer Operated Center (Total Family Care, Yr. 3)</p> <p>Peer Operated Centers will engage consumers, multiple stakeholders, and partners to foster an environment that advocates for and supports individuals seeking to initiate or maintain recovery behavioral health services. With this approach, individuals take an active role in their own recovery and to enhance their ability to participate fully in the community.</p>	\$200,000
<p>17. NASMIHD Dues</p> <p>Annual dues assessment for agency membership for FY 21. (Disbursed in FY21)</p>	\$8,979.00
<p>18. Outreach/Care Coordination System Training</p>	\$167,000.00

trainer model for all child serving core service agency's (CSA) community support workers and CBI team members on care coordination.	
19. Integrating Medicaid Payment Strategies for Physical Health and Behavioral Health Services Develop a report detailing the range of options available to DC relative to integrating Medicaid payment strategies for medical/surgical and behavioral health services.	\$99,999.00
20. BHPC Administrative and Equipment (Disbursed in FY21)	\$4,000.00
21. TMACT Training for ACT Providers ACT 101 for providers and DBH staff, Consultation and Support, electronic TMACT fidelity tool usage.	\$50,000.00
22. Support Services for Individuals Involved in the DC Criminal Justice System To enhance the clinical skills of Core Service Agency staff and provide recidivism reduction programming, DBH is introducing the "Thinking for a Change" 4.0 (T4C) integrated cognitive behavioral change program, under a cooperative agreement with the National Institute of Corrections (NIC).	\$100,000.00 (\$205,000 total, \$105K funded from 92)

ATTACHMENT D

CTRL + Click to be brought to the link:

SAMHSA 2020 SOR GRANT

(Document attachment also sent in email)

ATTACHMENT E



Advocacy & Outreach Committee Report

Present: Cheryl Doby-Copeland, Jaclyn Verner, Donna Flenory, Erica Cunningham, and Senora Simpson
By telephone: Gail Avent, Roz Parker, Nadine Parker, and Jackie Richardson
Staffer: Jackie Richardson

The Advocacy and Outreach Committee has not had another meeting since we met on February 14th. At that time we agreed to complete the following:

1. Review the DBH website to ensure it is clear concise and accurate. Two committee members did do this (Donna Flenory and Jaclyn Verner), and their findings were sent to Erica Cunningham on March 6th.
2. Gail Avent agreed to give us a report by March 6th from the perspective of consumers' utilization of the DBH website. I have not received her report as yet.

Given the COVID-19 pandemic, I have not tried to schedule another meeting.

I am also waiting to hear back from Erica Cunningham, the Director of Communications to give us instructions on next steps given the findings of the review of the DBH website.



Planning and Accountability Committee Report

Chair: Effie Smith (esmith@can-dc.org)

DBH Staffer: Jocelyn Route (Jocelyn.Route@dc.gov)

- **The Planning and Accountability Committee met at DBH on March 17, 2020.**
 - **Raessa Singh reviewed the FY19 and FY20 Mental Health Block Grant Budget**
 - **Jackie Richardson and the Planning and Accountability Committee reviewed the proposed Grants Monitoring BHPC process. Jackie Richardson requested a list of BHPC members who will be assigned to monitoring teams for the grant review process.**
 - **Committee questions were answered**

Next Meeting April 12, 2020 at 2:00pm

Conference Line 1866-803-2312 Participant Code: 27325876

- **Agenda**

- **Update on Monitoring Team Assignments**
- **Presentation of Combined Application MHBG and SABG Priorities**

BEHAVIORAL HEALTH PLANNING COUNCIL



Committee on System and Benefit Design Report

Chair: Mark LeVota, Executive Director, DCBHA (Mark.LeVota@DCBehavioralHealth.org)

DBH Staffer: Teresa Manocchio, Policy Analyst, SPMD (Teresa.Manocchio@dc.gov)

Accomplishments

- What have you accomplished since the last committee report? Please include how you are handling parking lot items distributed to you from previous meetings.
- If the committee hasn't yet met, you could provide information on the committee's charge and composition.

The Committee met March 18, 2020. The Committee had an opportunity to review a paper by the Center for Health Care Strategies discussing the national landscape of adoption of value based purchasing in behavioral health, particularly behavioral health care paid by Medicaid, advancing the Committee's conversation about VBP. We received an update on provider participation in health information exchange (HIE), focusing on the substance use disorder (SUD) provider organizations designated as institutes of mental disease (IMD) for purposes of the 1115 waiver and required to adopt HIE as part of the waiver's requirements. We also received an update on the SUD provider electronic health record (EHR) Data/WITS. There was discussion about recreating a Data/WITS User Group to help DBH and providers share information and make plans for Data/WITS updates moving forward.

Next Steps

- What are the 1-2 things the committee is focusing on over the next 2-4 weeks, months?

We will continue to address implementation of the 1115 waiver. We will support more DC agencies and private providers to adopt use of CRISP or other Health Information Exchange (HIE) tools. We will continue our discussion of VBP.

Challenges

- Are you facing any obstacles to accomplishing your next steps that the BHPC needs to be aware of?
None is an acceptable answer.

Across the District, there is a lack of common vocabulary and understanding of VBP. BHPC should be aware that lack of consensus on even terminology makes VBP implementation by October 1, 2020 very difficult to imagine, though DBH might be positioned to move to a new phase of VBP by that date, to seek implementation by perhaps October 1, 2021. iCAMS users, and other provider organizations that independently use Credible as their EHR, face some technological challenges with use of HIE that will need to be addressed separate from the legal process of updating Notifications of Privacy Practices (NPPs).

Assistance needed from the Council

- Do you need any assistance from the council to accomplish your next steps? None is an acceptable answer.

We anticipate significant challenges maintaining DBH staff and stakeholder participation in Committee meetings during the coronavirus outbreak. BHPC should give consideration to the purpose, need, and value of Committee meetings and whether they should be suspended or reduced in frequency, particularly during any time period the mayor has declared an emergency, consistent with her own authority and the recently adopted DC Council legislation authorizing a reduction in frequency of public meetings during the emergency.

Government of the District of Columbia
Department of Behavioral Health



**Department of Behavioral Health
Behavioral Health Planning Council (BHPC)**

May Virtual Meeting
Friday, May 29, 2020 10 AM to 12 PM

Where:
Conference Line 1866-803-2312 Participant Code: 27325876

AGENDA

10 AM	Call to Order, Welcome, Introductions and Roll	S. Simpson
10:05 -10:10 AM	Approvals of Agenda & Minutes Please see Attachment A	S. Simpson
10:10- 11:00 AM	Department of Behavioral Health Updates c. Presentation of FY'21 DBH Budget	Director Barbara J. Bazron
11:00-11:30 AM	New Business 2020-2021 Combined Application Priority Areas & Performance Indicators	
	5. MHBG Please see Attachment B	R. Singh
	6. SABG Please see Attachment C	J. Richardson
11:30 -11:50 AM	Committees Updates <ul style="list-style-type: none">• Advocacy and Outreach Committee• Planning and Accountability Committee• System and Benefit Design Committee• Connection to Care Committee	
11:50 AM	Announcements & Public Comments (Please limit comments to 3 Minutes)	
11:55 AM	Adjournment	

Note: If any council member or public attendee needs an accommodation, please contact Ms. J. Route, Strategic Planning, Policy & Engagement Officer, at Office: (202) 671-3204 Cell: (202) 236-4555 prior to the meeting date.



Department of Behavioral Health Behavioral Health Planning Council (BHPC)
Regularly Scheduled Meeting
Friday March 27, 2020 10:00am-12:00pm
64 New York Avenue NW Washington DC 20002

MINUTES

Phone Participants

The in-person participants: Senora Simpson, Mark LeVota, Tonia Gore, Dr. Barbara Bazron Cheryl Copeland, Effie Smith, Luis Diaz, Donna Flenory, Nicole Gilbert, Nadine Parker, Tony Crews, Gail Avent, Heather Stowe, Jean Harris, Jaclyn Verner, Angela Spinella, Harry Willis, Lynne Smith, Tiana Williams, Cavella Bishop, Theresa Mannocho, Charles Gervin, Raphaelle Richardson, Marsha Lillie Blanton, Ann Chauvin, Roz, Parker, Jackie Richardson, Sharon Hunt,

To assist in the reduce the transmission of the novel Coronavirus COV-19 and out of abundance of caution for the safety and well-being of our Behavioral Health Planning Council Members, a proposal that the March meeting be facilitated via teleconference meeting a Quorum was reached to teleconference.

Call to Order, Chair Department of Behavioral Health (DBH) Behavioral Health Planning Council (BHPC)

The BHPC was called to order by the Chair, Senora Simpson at 10:01 am.

Agenda & Minutes

Approval of Agenda and Minutes: Chair Simpson

Committee Reports

- **Advocacy and Outreach Committee –Reported**
- **Planning and Accountability Committee – Reported**
- **System and Benefit Design Committee –Reported**
- **Connection to Care Committee –No Report**

Old Business

12. Department of Behavioral Health Updates

Director Barbara J. Bazron

Below are the two (2) resources Dr. Bazron referenced on the teleconference meeting.

DBH Warm-Line Available:
1-888-7-WEHELP or 1-888-793-4357

Small Business Recovery Grants:
<https://coronavirus.dc.gov/dc-small-business-recovery-grants>

13. Overview of Block Grant Funds (See attached)

Raessa Singh

New Business

1. State Opioid Response Grant

Susan Hunt

Announcements – Chair Senora Simpson requested a poll for Quarterly or Monthly meetings

Public Comments – No members of the public offered public comments.

Adjournment – The meeting was adjourned at 11:16 PM.

**2020-2021 Combined Application MHBG
Priority Indicators and Performance Indicators**

Overview:

MHBG indicators are goals and objective included in the previously submitted block grant application that DBH must track and report on each December. DBH reports on data from the previous fiscal year (10/1 - 9/30). These indicators, selected by DBH, reflect the work done in priority areas to address the system's unmet needs.

Priority Areas and Annual Performance Indicators:

Priority #: 1 (This is a KPI)

Priority Area: Substance Abuse Prevention and Mental Health Services

Priority Type: Substance Abuse Prevention, Substance Abuse Treatment, Mental Health Services

Population(s): SMI, PWDC, PP, ESMI, PWID, EIS/HIV, TB

Goal of the priority area: Ensure the public behavioral health system is person-centered, and promotes and supports the leadership of peers with lived experience in recovery and the development of the system of care. This objective focuses on the number of active peers with reported employment during the quarter.

Objective: Partner across DBH to incorporate the role of peers into different programs, projects and services. Engage mental health and substance use providers to understand the role and importance of peers. Increase the percent of certified peers employed after receiving certification to ensure that peers are fully utilized in a variety of settings enabling the delivery of services to "difficult to reach" populations. CFAA will conduct job fairs in an attempt to bridge the gap between the peer support workforce and hiring providers. CFAA will also partner with hiring providers to disseminate job opportunities to the peer support workforce.

Strategies to attain the objective:

(a) A baseline measurement: 79%

(b) A first-year target/outcome measurement: 80%

(c) A second-year target/outcome measurement: 80%

Data source: DBH's Consumer and Family Affairs Administration surveys and information (e)

Description of data: The number of active peers with reported employment during the quarter.

Data issues/potential caveats that affect outcome measures: None identified

Priority #: 2 (This is a KPI)

* SMI-Adults with SMI, SED-Children with an SED, ESMI - Individuals with ESMI including psychosis, PWDC-Pregnant women and women with dependent children, PP - persons in need of primary substance use disorder prevention, PWID-Persons who inject drugs (formerly known intravenous drug users (IVDU)), EIS/HIV-Persons with or at risk of HIV/AIDS who are receiving SUD treatment services, TB-Persons with or at risk of tuberculosis who are receiving SUD treatment services, and/or Other- Specify (Refer to section IIIA of the Assessment and Plan).

Priority Area: Ensuring continuity of care for children in community-based mental health treatment

Priority Type: Mental Health Services

Population(s): SED, PWWDC, ESMI

Goal of the priority area: Ensure mental health disorder services across the entire continuum of care from community-based treatment and support services to inpatient hospitalization, including justice-involved consumer competency restoration, to support the behavioral health, wellness and recovery of District residents. The objective specifically focuses on the percentage of children newly enrolled in Mental Health Rehabilitative Services (MHRS) who had their first service within 30 days of enrollment in order to address the District's outlined unmet need on children.

Objective:

(a) A baseline measurement: 71%

(b) A first-year target/outcome measurement: 75%

(c) A second-year target/outcome measurement: 75%

Data source: Claims data will include all payor types (MCO and FFS)

Description of data: Number of newly-enrolled child consumers who had a paid claim within 30 days of enrollment.

Data issues/potential caveats that affect outcome measures: None Identified

Strategies to attain the objective: DBH is requesting provider level Key Performance Indicator data around this objective so that we can see how individual providers are doing and follow up accordingly. Once this happens, DBH will provide Technical Assistance to providers regarding how they are engaging with consumers and coordinating their care.

Priority #: 4 (This is a KPI)

Priority Area: Mental Health Services & Substance Abuse Prevention/Treatment

Priority Type: Substance Abuse and Prevention, Mental Health Services

Population(s): SMI, PWWDC, PP, ESMI, PWID, EIS/HIV, TB

Goal of the priority area: Maximize housing resources and target the most vulnerable District residents with serious behavioral health challenges who are homeless, returning from institutions or moving to more independent living to prevent and minimize homelessness. This objective looks at the number of consumers who remained in the CRF placement for at least 90 days, with no psychiatric hospitalizations, incarcerations, crisis bed placements, or involuntary discharges.

Objective: Maximize housing resources and target the most vulnerable District residents with serious behavioral health challenges who are homeless, returning from institutions or moving to more independent living to prevent and minimize homelessness. This objective looks at the

* SMI—Adults with SMI, SED—Children with an SED, ESMI - Individuals with ESMI including psychosis, PWWDC—Pregnant women and women with dependent children, PP - persons in need of primary substance use disorder prevention, PWID—Persons who inject drugs (formerly known intravenous drug users (IVDU)), EIS/HIV—Persons with or at risk of HIV/AIDS who are receiving SUD treatment services, TB—Persons with or at risk of tuberculosis who are receiving SUD treatment services, and/or Other- Specify (Refer to section IIIA of the Assessment and Plan).

number of consumers who remained in the CRF placement for at least 90 days, with no psychiatric hospitalizations, incarcerations, crisis bed placements, or involuntary discharges

Strategies to attain the objective: The Residential Care Manager will monitor residential programs, support services and work as part of a team to effectively communicate with the DBH Network of provider agencies and other external stakeholders. The Residential Care Manager will collaborate with DHCF regarding certification for CRF placement and processing of Optional State Payment (OSP). The Residential Care Manager will evaluate the mental health, medical, and substance use disorder needs and, in conjunction with the documentation in the CRF packet, review and provide recommendations regarding consumers' treatment needs.

* **SMI**—Adults with SMI, **SED**—Children with an SED, **ESMI** - Individuals with ESMI including psychosis, **PWWDC**—Pregnant women and women with dependent children, **PP** – persons in need of primary substance use disorder prevention, **PWID**—Persons who inject drugs (formerly known intravenous drug users (IVDU)), **EIS/HIV**—Persons with or at risk of HIV/AIDS who are receiving SUD treatment services, **TB**—Persons with or at risk of tuberculosis who are receiving SUD treatment services, and/or **Other- Specify** (Refer to section IIIA of the Assessment and Plan).

ATTACHMENT C

2020-2021 SABG Combined Application
Priority Areas and Performance Indicators

SABG Priority Areas and Performance Indicators

The District of Columbia will focus on three unmet needs related to substance use prevention and treatment. These include: 1) Continuity of Care Following Withdrawal Management; 2) Care Coordination/Case Management of SUD Services; and 3) Services for the District's Transition Age Youth and Young Adults. Within these areas, the District will address the SABG priority populations. As well, the District's priority areas on peers and housing address both mental health services and substance abuse prevention or treatment.

Unmet Need: Continuity of Care Following Withdrawal Management

- DBH served 518 clients in withdrawal management programs in FY 19. Of these clients, 205 were re-admitted to withdrawal management programs in the same fiscal year. Of the 518 clients served, 80% of these clients had previously received services in the SUD system.
- 307 clients had no step down to another level of care after withdrawal management.
- The District will take steps to improve the continuity of care following withdrawal management treatment to ensure clients can fully realize the benefits of the intervention and continue on their path to recovery.

Plan for Meeting the Unmet Need of Continuity of Care Following Withdrawal Management:

- DBH is in the process of 1) allocating staff resources to address step downs from withdrawal management programs, and 2) assigning staff to monitor withdrawal management providers and to work with them on coordinating care.
- DBH expects that all clients receiving withdrawal management will be assessed and referred to appropriate follow up services.
- DBH will also monitor admissions and re-admissions to withdrawal management programs and will take steps to ensure that as many clients as possible get connected to appropriate levels of care following withdrawal management.

Priority number: 3 (This is a KPI)

- **Priority Area:** Improve Continuity of Care for Persons Discharged from Withdrawal Management
- **Goal of Priority Area:**
- **Priority Type:** Substance Abuse Treatment
- **Population(s):** PWWDC, PWID, EIS/HIV, TB, PP*

* SMI—Adults with SMI, SED—Children with an SED, ESMI - Individuals with ESMI including psychosis, PWWDC—Pregnant women and women with dependent children, PP – persons in need of primary substance use disorder prevention, PWID—Persons who inject drugs (formerly known intravenous drug users (IVDU)), EIS/HIV—Persons with or at risk of HIV/AIDS who are receiving SUD treatment services, TB—Persons with or at risk of tuberculosis who are receiving SUD treatment services, and/or Other- Specify (Refer to section IIIA of the Assessment and Plan).

- **Objective:** % of SUD withdrawal management clients who stepped down to a lower level of care within 15 days
 - **A baseline measurement:** 51% (FY18) of clients discharged from withdrawal management had an admission to a lower level of care within 15 days of discharge
 - **First-year target/outcome measurement:** During a fiscal year, 75% of clients discharged from withdrawal management will have an admission to a lower level of care within 15 days of discharge
 - **Second-year target/outcome measurement:** During a fiscal year, 75% of clients discharged from withdrawal management will have an admission to a lower level of care within 15 days of discharge
 - **Data Source:** DC claims data
 - **Description of data:** During a fiscal year, number of clients who were discharged from withdrawal management who had an admission to a lower level of care within 15 days of discharge
 - **Data issues/potential caveats that affect outcome measures:** None identified
- **Strategies to attain the objective:** DBH's strategies include 1) Assigning staff to monitor providers who provide withdrawal management and work with them on care coordination efforts; and 2) Monitoring admissions and re-admissions to withdrawal management.

Unmet Need: Care Coordination/Case Management of SUD Services

- Clinical Care Coordination (CCC) and Case Management services are critical to ensure that the consumer has access to a full range of medical, behavioral health, treatment, and social service supports by both Substance Use Disorder (SUD) providers and mental health providers. Within the SUD network, care coordination is under-utilized, creating gaps in services for clients and consumers.
- In FY18, of the 4,208 SUD clients served, only 517 (12%) received a Clinical Care Coordination service. Thirty-three percent of people served by Samaritan Inns, a facility where pregnant women and mothers with dependent children recovering from substance abuse can receive treatment and family services while establishing a foundation for long-term independent living, received a Clinical Care Coordination Service. For MAT providers, 52% of SUD clients received Clinical Care Coordination. Only 24% of all SUD clients received HIV/TB specific case management services. (Nationally, 9% of all HIV cases are persons who inject drugs (PWID)).

Patients with complex needs tend to have more emergency room and hospital visits. They receive care in a number of medical facilities, in addition to undergoing a variety of lab tests and other procedures. As such, "they are more vulnerable to fragmented care." They experience more emergency room and psychiatric hospital returns. Although there has been some improvement in Clinical Care Coordination in SUD treatment, there is still room for improvement.

Also, DATAWITS, DBH's record keeping system for SUD providers, will require internal quality assurance upgrades for more complex data collection, analysis, and reporting. As a result, significant efforts are undertaken each year to address issues around data quality and integrity in reporting SUD treatment participation and client outcomes.

Plan for Care Coordination/Case Management of SUD Services

- DBH plans to educate providers on the importance of utilization of Clinical Care Coordination services for our clients and monitor their utilization to ensure services are being delivered.
- Additionally, on November 6, 2019, the Centers for Medicare and Medicaid Services (CMS) approved the District's Behavioral Health Transformation demonstration with an effective date of January 1, 2020. This demonstration project expands the availability of Medicaid resources to services and supports that are critical for high quality care, including Recovery Support Services (RSS) and Transition Planning Services.
- The demonstration defines the components of RSS to include goal-setting, case management, coaching, counseling, and other services designed to assist individuals with SUD to successfully implement of their recovery plan in either individual or group settings. DBH has now made RSS a core service for all treatment provider with the hope that this will expand individual access to these services. Under the demonstration, providers of RSS can now bill Medicaid for their case management work.
- The demonstration defines Transition Planning Services as discharge planning and facilitation of transitions of care for individuals leaving institutional treatment settings by providers of community-based behavioral health services. The components of Transition Planning Services include assessment, development of a service plan, and care coordination and case management. Whereas traditionally such services are only provided by the institutions providing treatment, Transition Planning Services allows an individual's community-based service provider to participate in discharge planning and to be reimbursed for their time and effort.
- Over the next 18-months, DBH will complete a series of upgrades or enhancements to DATAWITS, which will include greater internal protections to improve data quality, a new structured communication and referrals process for behavioral health providers, a new comprehensive assessment, and more targeted questions regarding pregnancy and HIV.

Priority number: 5

- **Priority Area:** Increase Clinical Care Coordination in the treatment of PWWDC, HIV/TB at Risk, and PWID.
- **Priority Type:** Substance Abuse Treatment
- **Population(s):** PWWDC, EIS/HIV, TB, PWID
- **Goal of the priority area:** The District aims to increase consumer's linkages to primary care, mental health, and social supports using Clinical Care Coordination for individuals receiving SUD treatment.
- **Objective:**
 - **A baseline measurement:** (FY19 claims data): 40% of clients received at least one Clinical Care Coordination Service during the fiscal year
 - **First-year target/outcome measurement:** 75% of all clients will receive at least one Clinical Care Coordination Service during the fiscal year

- **Second-year target/outcome measurement:** 80% of all clients will receive at least one Clinical Care Coordination Service during the fiscal year
- **Data Source:** Billing and claims data on Clinical Care Coordination
- **Description of data:** Services are billed via CPT codes; DBH can review the data for the system as a whole, and by provider.
- **Data issues/potential caveats that affect outcome measures:** No issues.
- **Strategies to attain the objective:** DBH is in the process of creating a Care Coordination bulletin that explains expectations in regards to providing both Case Management and Clinical Care Coordination services to clients. DBH will be monitoring the services delivered by the providers with particular emphasis on residential providers during this FY.

Priority number: 6

- **Priority Area:** Increase Recovery Support Services, such as Case Management, in the treatment of PWWDC, HIV/TB at Risk, and PWID.
- **Priority Type:** Substance Abuse Treatment
- **Population(s):** PWWDC, EIS/HIV, TB, PWID
- **Goal of the priority area:** The District aims to increase consumer's linkages to primary care, mental health, and social supports using Recovery Support Services such as Case Management for individuals receiving SUD treatment.
- **Objective:**
 - **A baseline measurement (FY19 claims data):** 50% of all clients got at least one Case Management Service during the fiscal year
 - **First-year target/outcome measurement:** 75% of all clients will receive at least one Recovery Support Service during the fiscal year
 - **Second-year target/outcome measurement:** 80% of all clients will receive at least one Recovery Support Service during the fiscal year
 - **Data source:** Billing and claims data on Recovery Support Services
 - **Description of data:** Services are billed via CPT codes; DBH can review the data for the system as a whole, and by provider.
 - **Data issues/potential caveats that affect outcome measures:** No issues.
- **Strategies to attain the objective:** DBH is in the process of creating a Care Coordination bulletin that explains expectations in regards to providing Case Management and Clinical Care Coordination services to clients. DBH will be monitoring the services delivered by the providers with particular emphasis on residential providers during this FY.

Unmet Need: SUD Services for the District's Transition Age Youth and Young Adults

- Transition Age Youth (TAY) and Young Adults (YA) are vulnerable as they transition to adult roles of responsibility. State-based estimates from the 2014-2017 National Household Survey on Drug Use and Health (NSDUH) indicate that District youth ages 12-17 have higher rates of substance use (alcohol, cigarettes, and marijuana) than youth nationally. For example, 10.2% of District youth ages 12-17 report past month use of marijuana, as compared with 6.4% of youth nationally. Moreover, among District young adults aged 18-25, an annual average of 19.5% as compared with 15.1% percent

nationally, during 2014-2017, had a substance use disorder in the past year.¹ Inadequate attention to these needs can have short- and long-term consequences such as poor school performance, physical health-related problems, and even involvement in the criminal justice system.

Anecdotal evidence suggests that many youths with SUD have experienced trauma in their lives and/or have co-occurring substance use and mental health conditions. Analysis of District Medicaid claims provides supporting evidence for high rates of co-occurring disorders in the District. In FY2018, nearly one-third of all Medicaid beneficiaries in the District had a behavioral health diagnosis. Among Medicaid beneficiaries with a behavioral health diagnosis, one in four had a co-occurring substance use disorder and mental illness.²

Plan for Meeting the SUD Service Delivery Needs of the District's Adolescent and Transition Age Youth Populations:

- Currently, individuals ages 12-25 can access services directly from the substance abuse treatment provider closest to their home, school, or job, and every individual accessing substance abuse treatment through the Adolescent Substance Abuse Treatment Expansion Program (ASTEP) is screened for indicators of a mental health disorder using the Global Appraisal of Individual Needs (GAIN). However, to meet the need of the District's youth and young adults, DBH will widen its portfolio of evidence-based treatment and recovery models specifically for consumers ages 12-25.
- To meet unmet SUD services needs for individuals ages 12-25, through discretionary funding (DC City grant), the District proposes to leverage and enhance the system created through the SAMHSA State Adolescent Treatment Enhancement and Dissemination (SAT-ED) grant and the Now is the Time, Healthy Transitions grant. TAY and YA, along with their families, will be systematically screened across multiple settings including schools, juvenile/criminal justice settings, and interactions with child welfare for SUD/Co-Occurring Disorders (COD) and trauma. Dependent on TAY and YA needs, providers will deliver providers will deliver Motivational Enhancement Therapy/Cognitive Behavioral Therapy 5 sessions (MET/CBT 5; low risk); MET/CBT 12; or the Adolescent Community Reinforcement Approach (A-CRA) (moderate/severe risk).

To support individuals navigate substance use treatment, families will engage in initiatives together such as family enrichment activities. This family engagement will also create the opportunity for family members in need of substance use treatment to also take advantage of services.

¹ Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: District of Columbia, Volume 5: Indicators as measured through the 2017 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services. HHS Publication No. SMA-19-Baro-17-DC. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2019.

<https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/District%20of%20Columbia-BH-BarometerVolume5.pdf>

² Government of the District of Columbia, Department of Health Care Finance (2019, April). [DC Medicaid Management Information System Claims Data Extraction].

Priority Number: 7

- **Priority Area:** Provide additional substance use treatment supports for adolescent and transitional age youth populations between the ages of 12-25
- **Priority Type:** Substance Abuse Treatment
- **Population(s):** PP; PWWDC; PWID; Other (District Adolescent and Transitional Age Youth populations between the ages of 12-25)
- **Goal of the priority area:** The District seeks to provide additional substance use treatment supports for adolescent and transitional age youth populations between the ages of 12-25. Simultaneously, there is a goal of removing impediments to accessing those supports. The objective looks to increase the number of individuals ages 12-25 who receive SUD services.
- **Objective:**
 - **A baseline measurement:** 255 youth ages 12-25 received SUD services in FY 2019.
 - **First-year target/outcome measurement:** 280 youth ages 12-25 receiving at least one SUD service in a fiscal year (10% increase from baseline)
 - **Second-year target/outcome measurement:** 322 youth ages 12-25 receiving at least one SUD service in a fiscal year (15% increase from first-year target/outcome measurement)
 - **Data Source:** DC claims data
 - **Description of data:** The number of individuals ages 12-25 who received SUD services.
 - **Data issues/potential caveats that affect outcome measures:** None identified
- **Strategies to attain the objective:**
 - Adolescents and Transitional Age Youth, along with their families, will be systematically screened across multiple settings including schools, juvenile/criminal justice settings, and in interactions with child welfare, for SUD/ Co-Occurring Disorders (COD) and trauma. Dependent on TAY and YA needs, providers will deliver providers will deliver Motivational Enhancement Therapy/Cognitive Behavioral Therapy 5 sessions (MET/CBT 5; low risk); MET/CBT 12; or the Adolescent Community Reinforcement Approach (A-CRA) (moderate/severe risk).

Priority Number: 8

Priority Area: Adoption of Evidence-Based Interventions for SUD Prevention

- **Priority Type:** Substance Abuse Prevention
- **Population(s):** Other (Adolescents w/SA and/or MH, Criminal/Juvenile Justice, Children/Youth at Risk for BH Disorder, Underserved Racial and Ethnic Minorities.
- **Goal of the priority area:** The District seeks to adopt a minimum of two evidence-based interventions aimed at promoting substance use disorders prevention.
- **Objective:** Identify and adopt evidence based interventions that will be effective at engaging youth and young adults residing in urban and diverse areas such as the District of Columbia.
- **A baseline measurement:** 0
 - **First-year target/outcome measurement:** Each sub-grantee will identify and adopt a minimum of one (1) evidence based intervention.
 - **Second-year target/outcome measurement:** Each sub-grantee will identify and adopt a minimum of two (2) evidence based interventions.

- **Data Source:** Programmatic reports from sub-grantees
- **Description of data:** Programmatic reports will detail the identification and selection of evidence-based intervention to promote substance use prevention within designated communities
- **Data issues/potential caveats that affect outcome measures:** None identified
- **Strategies to attain the objective:**
 1. Research what similar jurisdictions have adopted that have proven to be effective.
 2. Pilot promising practices that show evidence of being effective in reaching target populations.
 3. Engage target populations in the identification and selection of evidence based interventions.



**Department of Behavioral Health
Behavioral Health Planning Council (BHPC)**

July Virtual Meeting

Friday, July 31, 2020 10 AM to 12 PM

Where:

WebEx Meeting number (access code): 160 083 6992 Meeting password: 9NjeCk

AGENDA

10 AM	Call to Order, Welcome, Introductions and Roll	S. Simpson
10:05 -10:10 AM	Approvals of Agenda & Minutes Please see Attachment A	S. Simpson
10:10- 10:40 AM	Department of Behavioral Health Updates	Director Barbara J. Bazron
10:40-11:30 AM	Old Business a. 1115 Demonstration Project Update; DHCF b. Assignment of BHPC members to Grant Monitoring Teams	T. Wood J. Route
	New Business a. Building Resiliency and Recovery Grant b. MHBG and SABG Behavioral Health Assessment and Plan c. Technical Assistance for Behavioral Health Planning Council	J. Route J. Richardson J. Richardson
11:30 -11:50 AM	Committees Updates • Advocacy and Outreach Committee • Planning and Accountability Committee • System and Benefit Design Committee • Connection to Care Committee	
11:50 AM	Announcements & Public Comments (Please limit comments to 3 Minutes)	
11:55 AM	Adjournment	

Note: If any council member or public attendee needs an accommodation, please contact Ms. J. Route, Strategic Planning, Policy & Engagement Officer, at Office: (202) 671-3204 Cell: (202) 236-4555 prior to the meeting date.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH



Department of Behavioral Health Behavioral Health Planning Council (BHPC)
Regularly Scheduled Meeting
Friday May 29, 2020 10:00am-12:00pm
64 New York Avenue NW Washington DC 20002

MINUTES

WebEx Participants

BHPC Members: Senora Simpson, Tonia Gore, Gail Avent, Jaclyn Verner, Ann Chauvin, Angela Spinella, Charles Gervin, Mark LeVota, Jaclyn Verner, Heather Stowe, Luis Diaz, Nadine Parker, Nicole Denny, Nicole Gilbert, Roz Parker, Tia Brumstead, Effie Smith, Jean Harris, Donna Flenory, Harry Willis, Tony Crews, Chery Copeland
DBH: Erica Cunningham, Marsha Lillie Blanton, Jelani Murrain, Nevena Minor, Raphaelle Richardson, Raessa Singh, Marina Soto, Phyllis Jones, Lynne Smith, Jackie Richardson, Jocelyn Route, Davida Crockett,
DC Govt: Michael Grier
Public Members: Hilary Anon, Simon Furstenberg

To assist in the reduce the transmission of the novel Coronavirus COV-19 and out of abundance of caution for the safety and well-being of our Behavioral Health Planning Council Members, a proposal that the March meeting be facilitated via teleconference meeting a Quorum was reached to teleconference via WebEx. The meetings remain facilitated via WebEx

Call to Order, Chair Department of Behavioral Health (DBH) Behavioral Health Planning Council (BHPC)

The BHPC was called to order by the Chair, Senora Simpson at 10:01 am.

Agenda & Minutes

Approval of Agenda and Minutes: Chair Simpson; unanimous approval by unanimous consent

Committee Reports

- **Advocacy and Outreach Committee** –Reported
- **Planning and Accountability Committee** – Reported
- **System and Benefit Design Committee** –Reported
- **Connection to Care Committee** –No Report

Old Business

Department of Behavioral Health Updates

Director Barbara J. Bazron

a. **Presentation of FY'21 DBH Budget**

2020-2021 Combined Application Priority Areas & Performance Indicators

1. MHBG

R. Singh

2. SABG

J. Richardson

Announcements – Jean Harris sponsored a motion for the BHPC to draft a letter r thanking the Department during the COVID19 crisis. Tonia Gore seconded the motion. Motion carried by unanimous vote of the Council.

Public Comments – Hilary Anon

Adjournment – The meeting was adjourned at 11:47 PM.

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
 State Vocational Rehabilitation Agency
 State Criminal Justice Agency
 State Housing Agency
 State Social Services Agency
 State Health (MH) Agency.

Start Year: 2021 End Year: 2022

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Gail Avent	Parents of children with SED/SUD		1214 I Street SE Washington DC, 20003 PH: 202-747-8878	Totalfamilycarecoalition@gmail.com
Richard Bebout	State Employees	State Mental Health Agency		
Cavella Bishop	State Employees	Department of Health Care Finance	441 4th Street NW Washington , 20001 PH: 202-724-8936	cavella.bishop@dc.gov
Tia Brumstead	State Employees	State Education Agency OSSE	1050 First Street NE Washington , 20002 PH: 202-714-9812	Tia.Brumsted@dc.gov
Ann Chauvin	Providers		6856 Eastern Ave NW Washington DC, 20012 PH: 202-830-3556	achauvin@woodleyhouse.org
Tony Crews	Providers		4130 Hunt Place, NE Washington DC, 20019 PH: 202-388-4301	tcrews@mbihs.com
Nicole Denny	State Employees		323 Quackenbos St NE Washington DC, 20011 PH: 202-365-0654	nicole.denny@dc.gov
Luis Diaz	State Employees	Criminal Justice Coordinating Council	441 4th Street NW washington , 20003	
Cheryl Doby-Copeland, PhD, ATR-BC, LPC, LMFT	State Employees		821 Howard Road, SE Washington DC, 20032 PH: 202-698-1836	Cheryl.copeland@dc.gov
Donna Flenory	Parents of children with SED/SUD		510 Division Ave NE Washington DC, 20019	dlflenory@gmail.com
Esther Ford	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		4805 first street, SW Washington DC, 20032 PH: 240-640-3903	estherford777@gmail.com

Charles Gervin	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3636 16th Street NW Washington DC, 20010 PH: 202-677-0231	cagervin@gmail.com
Maurice Gibson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1610 16th street NW Washington DC, 20009 PH: 240-210-6776	maurice.gibson@dc.gov
Nicole Gilbert	Youth/adolescent representative (or member from an organization serving young people)	State Social Service Agency	200 I Street, SE Washington DC, 20003	
Jean Harris	Family Members of Individuals in Recovery (to include family members of adults with SMI)	NAMI DC		
Dena Hasan	State Employees	State Housing Agency	64 New York ave NE Washington DC, 20002 PH: 202-698-5281	Dena.Hasan@dc.gov
Mark LeVota	Others (Advocates who are not State employees or providers)		PO Box 33515 Washington DC, 20033	Mark.LeVota@dcbehavioralhealth.org
Dianne Lewis	State Employees	DC Health Benefit Exchange Authority	1225 I Street NW Washington DC, 20005	DLewis@acg-cos.com
Elizabeth Maldonado	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2212 40th Street NW Washington DC, 20007 PH: 410-908-9642	jpgnewpost@gmail.com
Alisa Mathias	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		5003 Hunt Street NE Washington DC, 20019	alisajayne68@gmail.com
Rosalind Parker	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Bridging Resources in Communities		
Nadine Parker	Family Members of Individuals in Recovery (to include family members of adults with SMI)	NCCPUD		
Jenise Patterson	Parents of children with SED/SUD		2421 18th Street NE, Washington DC, 20018 PH: 202-718-4834	parentwatch2010@gmail.com
Debby Shore	Providers	Sasha Bruce Youthwork	PH: 202-675-9340	
Senora Simpson	Family Members of Individuals in Recovery (to include family members of adults with SMI)		323 Quackenbos St. NE Washington DC, 20011 PH: 202-529-2134	Ssimps2100@aol.com
E. Effie Smith	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1300 L Street, NW DC, 20005 PH: 202-842-0001	esmith@can-dc.org
Angela Spinella	State Employees	State Vocational Rehabilitation Agency	250 E Street SW	

Heather Stowe	State Employees	Department of Aging and Community Living	500 K Street, NE Washington DC, 20002 PH: 202-535-1367	Sara.tribe@dc.gov
Jaclyn Verner	Others (Advocates who are not State employees or providers)		220 I Street NE Washington DC, 20002 PH: 202-547-0198	jverner@uls-dc.org
Tamara Weisman	Youth/adolescent representative (or member from an organization serving young people)		1104 Allison Street NW Washington DC, 20011	TWeissman@hscsn.org
Harry Willis	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3722 Ely Pl. SE Washington DC, 20019 PH: 202-638-9231	hwillis38@comcast.net

*Council members should be listed only once by type of membership and Agency/organization represented.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2021 End Year: 2022

Type of Membership	Number	Percentage of Total Membership
Total Membership	29	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	7	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	4	
Parents of children with SED/SUD*	3	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	2	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	16	55.17%
State Employees	10	
Providers	3	
Vacancies	0	
Total State Employees & Providers	13	44.83%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	25	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	4	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	29	
Youth/adolescent representative (or member from an organization serving young people)	2	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

22. 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. The state should provide the permanent URL allowing SAMHSA and the public to view the state's Block Grant plan during plan development and after submission 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
If yes, provide URL:
<https://dbh.dc.gov/page/behavioral-health-services-block-grants>
 - c) Other (e.g. public service announcements, print media) Yes No

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Footnotes:

Environmental Factors and Plan

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction^{1,2} on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the [Consolidated Appropriations Act](#), 2018 (P.L. 115-141) signed by President Trump on March 23, 2018³.

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers⁴. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs⁵: These documents can be found on the Hiv.gov website: <https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs>,

1. [Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016](https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf) from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy <https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf>,
2. [Centers for Disease Control and Prevention \(CDC\) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016](http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf) The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention <http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf>,
3. [The Substance Abuse and Mental Health Services Administration \(SAMHSA\)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs](http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf) <http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf>,

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
 - Include proposed protocols, timeline for implementation, and overall budget
 - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

¹ Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds **only** and is consistent with guidance issued by SAMHSA.

² Section 1931(a)(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C. § 300x-31(a)(1)(F)) and 45 CFR § 96.135(a) (6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the [Federal Register](#) (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

³ Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

⁴ Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

⁵ ***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a [description of the elements of an SSP](#) that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table A

Syringe Services Program SSP Agency Name	Main Address of SSP	Planned Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of Locations (include mobile if any)	Narcan Provider (Yes or No)
No Data Available					

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Footnotes: