

COMBINED BLOCK GRANT

C. Coverage M/SUD Services

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?

In Plan Table 3, the following services will be covered by Medicaid:

- Peer Support under “Recovery Support Services”
- Crisis Residential/Stabilization under “Out of Home Residential Services”
- Medication management under “Medication Services”

2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?

The District’s Automated Treatment and Accounting system (DATA) provides The Addiction Prevention and Recovery Administration (APRA) the ability to conduct eligibility checks i.e. (270/271) for all individuals and families to ensure that all clients get full access and maximum benefits.

3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.

APRA and the Department of Health Care Finance (DHCF) are both responsible for monitoring access to M/SUD services by QHPs. APRA’s DATA system has an in-built business rule which will only allow QHPs to record and bill encounters claims being billed to Medicaid or other payers including the district.

4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?

Yes, the SSA will be involved in reviewing any complaints or possible violations of the MHPAEA.

5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

The state does not have to make any specific changes in consideration of the state's EHB package since the District is currently offering an array of free services for SUD.

D. Health Insurance Marketplaces

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?

As of October 1st, 2013, the Department of Health's Addiction, Prevention & Recovery Administration (APRA) for the District of Columbia, will merge the DC Department of Mental Health (DMH) to form the new Department of Behavioral Health (DBH) within the District. For the remainder of the application, the SSA will be referred to as APRA, with the understanding that a newly merged entity, DBH, will exist after October 1st.

APRA will engage in a partnership with the DC Health Benefits Exchange (HBx) and its HBx navigators to develop outreach benchmarks, and compare identified metrics from baseline to selected time points over the next two years.

2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled? Group

APRA has been engaged in various activities focusing on the broader behavioral and primary care health needs of its client population, to include its MAI-TCE (12 Cities) project. In a collaborative partnership with the Department of Health (DOH), DMH through, and its provider network, APRA is piloting the use of care Navigators. This process is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled. This model, if successful, will be beneficial to our HBx Navigator partnership, and can be rolled out more broadly across the network.

3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?

The State through its DATA system conducts eligibility and enrollment screenings of all clients entering into treatment programs and a (270/271); which is Medicaid's eligibility screen is done to ensure benefit verification and maximization

4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?

The District is currently developing a comprehensive inclusion plan for community behavioral health provider participation in the networks of the QHPs. This will include adequate training, TA and assisting its providers in enrolling in the networks.

5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.

Under the SABG grant, about 311 individuals served are uninsured. This amount is based on the maximum number of clients the block grant is funding for mostly medication management under Opioid treatment services.

6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.

In Current year 2013, 311 individuals are served under the SABG. APRA anticipates serving more individuals CY 2014 and C2015 as the services provided more clients will be paid for under the Medicaid State Plan Amendment (SPA) which will therefore free up more SABG fund which means more clients served.

7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.

Under Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, there are a total of 15 entities identified which include 9 external providers, and 6 government agencies. Of the 9 external providers, there are 5 treatment providers and 4 sub-grantees. All 5 treatment providers out of the 9 providers are currently enrolled with Medicaid as they are treatment providers and are required by law to be Medicaid certified for their Treatment Certification or DCMR Chapter 23. The remaining 4 providers are sub-grantees and do not require Medicaid certifications.

8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

These 5 providers represent only a subset of APRA's portfolio of about 40 treatment providers. All of APRA's treatment providers are required by DCMR Chapter 23 standards to be Medicaid certified. In FY 2014 and FY 2015, all of the about 40 providers will be Medicaid providers or participating in a QHP.

E. Program Integrity

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are

enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

- 1) *Does the state have a program integrity plan regarding the SABG and MHBG?*
Yes, it is part of an integrity plan for all funds.
- 2) *Does the state have a specific staff person that is responsible for the state agency's program integrity activities?*
The state has staff persons tasked with monitoring the use of all funds including the SABG.
- 3) *What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:*
 - a. Budget review: Yes the State conducts budget reviews
 - b. Claims/payment adjudication: Yes, APRA has designated program monitors adjudicating claims within the DATA system
 - c. Expenditure report analysis: Yes the state conducts expenditure analysis
 - d. Compliance reviews: Yes, the Certification and Regulation Division conducts compliance reviews
 - e. Encounter/utilization/performance analysis: The DATA system allows APRA the ability to monitors encounters, utilization rates and conduct performance analysis
 - f. Audits: Yes, the State conducts audits
- 4) *How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?*
The DATA system has an in-built business and adjudication rules to ensure accuracy. Additionally, APRA has a designated Quality Assurance division, which ensures appropriateness and quality of services.
- 5) *How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?*
This is accomplished through the combined work of several divisions, including the Office of Performance Improvement. Out of that office comes the ongoing monitoring of provider best practice from the Quality Assurance staff. This staff monitors program clinical practice, which informs the training and technical assistance resources leveraged for the provider network. Also, this office coordinates other provider oversight and engagement activities, such as the Clinical Director Learning Collaborative, where network performance findings and best practice data are presented and discussed. Activities such as this, also lead to various training and technical assistance interventions. This is supported by the state's Office of Certification and Regulation (OCR), which ensures that Providers are in compliance with program requirements, including quality and safety standards.

- 6) *How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?*

The DATA system provides the State the ability to screen clients for Medicaid eligibility and self- verification for Private Insurance. The block grant is available to clients where there has been a demonstrated lack of insurance and/or underinsurance. SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

F. Use of Evidence in Purchasing Decisions

Does your state have specific staff that is responsible for tracking and disseminating information regarding evidence-based or promising practices?

Through the collaborative work of APRA's Divisions of Prevention, Treatment, Recovery, and Performance Improvement evidence-based and promising practices are tracked, vetted, disseminated, and implemented. The Divisions collectively recommend Evidence Based Practices for Substance abuse prevention, treatment, and recovery that are emerging at the national level which are determined to be best practices for the local demographic. The Divisions work closely together to continuously improve the quality of services under their purview. The Divisions generate status reports that disseminate information regarding formularies of evidence based practices, and recommend trainings, provide technical assistance and guidance, and construct policy according to best practices for substance abuse standards. All providers that the District purchases services from are required to utilize interventions that are registered or approved by SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP). All Substance Abuse treatment and recovery programs are required to be certified through APRA's Certification and Regulation Division (CRD), including private, non-contracted substance abuse treatment and recovery programs. In conjunction with the Office of Quality Assurance and the Treatment Division, the District's training department seeks promising practices and evidence based practices and makes this information available to the provider network.

Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions? a) What information did you use? b) What information was most useful?

The District requires by policy and per contract that all substance abuse treatment providers implement an evidence based practice that is registered or approved by SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP). For the adult treatment system, the District does not specify which EBP that a treatment provider must use. The District, however, will only purchase services that adhere to an EBP. Adult substance abuse treatment providers within the network must use an evidence based screening and assessment tool. Currently, the District is using the Global Assessment of Individual Need – Short Screener (GAIN-SS) for both the adult and adolescent system. The District uses the Treatment Assignment Protocol (TAP) as the standardized assessment tool for level of care (LOC) assessment using the American Society for Addictions Medicine's Patient Placement Criteria (ASAM). The District requires the adolescent system to use the GAIN-I as the standard evidence

based assessment tool for substance use disorders. The most useful resources the District relies on when gathering EBP information is the NREPP website. Our State Subject Matter Experts utilized various aspects of the information on the website such as EBP reviews, summaries, and effectiveness measures. This information helps direct our Quality Assurance process, treatment outcome expectations, and training needs.

APRA Division of Prevention base information for identifying Evidence-Based Program (strategies) is from federal databases, the Institute of Medicine's Preventing Mental, Emotional, and Behavioral Disorders Among Young People, SAMHSA's Leading Change plan, Center for Disease Control and the Society of Prevention Research. EBP's that address the unique needs of an urban environment and culturally diverse populations are integrated into APRA Prevention Request for Applications as requirements.

This information guided the development of four DC Prevention Centers in 2010. The Strategic Prevention Framework State Incentive Grant is the catalyst for pilot strategies that are funded and evaluated to determine long term utility in the District of Columbia. Pilot projects include: four Parent Partnership Grants for selective and indicated populations; 7 Community Evidence-Based Prevention Grants; four CORE Coordinators to assess the need for I Prevention across the 8 wards; and a Synthetic Marijuana public awareness and community action initiative. APRA prevention technical experts use District and ward DC Epidemiological Outcomes Workgroup (DCEOW) data to provide core strategies: information dissemination, education, community processes, environmental, alternatives, and problem identification and referral.

How have you used information regarding evidence-based practices? a) Educating State Medicaid agencies and other purchasers regarding this information? b) Making decisions about what you buy with funds that are under your control?

As stated in the previous question, the District uses EBP reviews, summaries, and effectiveness measures to direct our Quality Assurance process, treatment outcome expectations, and training needs. APRA is the clearinghouse for our State Medicaid Program. The District demonstrates the thoughtfulness of purchasing treatment services by designing our State Plan Amendment (the District plan to pay for substance abuse services through Medicaid) to compliment a variety of services implemented in several EBP's. Acting as the clearinghouse, APRA ensures that treatment funds spent for substance abuse treatment, both federal and local dollars, are only spent on services that are implemented under an evidence based practice.

APRA plans to use evaluation data from the Strategic Prevention Framework State Incentive Grant to make decisions on leveraging using Medicaid funds for evidence-based universal, selective, and indicated prevention strategies.

SECTION G:

Question 1: What additional measures will your state focus on in developing your State BG Plan (up to three)?

- 1) Discharge Type Distribution: The distribution of, specifically, successful completions, dropouts, treatment terminations and referrals to other services.
- 2) Prevention Reach: The number of planned evidence-based prevention strategies implemented through prevention funds across the 8 wards.

Question 2: Please provide information on any additional measures identified outside the core measures and state barometer.

- 1) Length of stay: The number of days between the admission date and the last date of service. This information is consolidated into clusters unique to the facility's level of care. Facility-level aggregates are collected as well as level of care aggregates (all residential, all detox, etc.).
- 2) Continuum of Care Usage: The number of clients successfully completing each residential provider who are connected to outpatient follow-up services as well as the number referred to Recovery Support Services. This metric is presented as a 2 X 2 matrix with the quadrants representing treatment only, recovery support only, both services, neither service. This measure is aggregated at the facility level as well as a combined measure for all residential facilities.
- 3) Tobacco Cessation: The number of calls to the 1-800 DC Quitline.
- 4) Tobacco Cessation: Number of adults over age 18 who complete the 1800-Quitline 30 minute interview to develop a personalized quit plan.
- 5) Tobacco Cessation: The number of individuals who complete the 30 minute interview and schedule an appointment with a tobacco treatment counselor.
- 6) Tobacco Cessation: The number of adults receiving Nicotine Replacement Therapy (NRT).

Question 3: What are your state's specific priority areas to address the issues identified by the data?

- 1) Data Quality and Outcomes: Realize an integrated, inter-agency data strategy for quality improvement in behavioral health care that will inform policy, measure program impact, and lead to improved quality of services and outcomes for individuals, families, and communities in the District.
- 2) Community Recovery Supports: Partner with people in recovery from mental and substance use disorders, as well as their family members, to build and strengthen communities of care which support resiliency, recovery & wellness.
- 3) Access, Screening and Early Intervention: Continue to develop integrated screening and early intervention best practices across the APRA system of care.
- 4) Policy and Prevention: APRA will continue to implement an integrated prevention system to reduce priority risk factors and increase protective factors which reduce substance use by District children, youths, and families. This system includes health promotion activities in the community and the workplace.
- 5) Health and Wellness Integration: Reduce health disparities, and support trauma informed integrated and coordinated care for people with co-occurring disorders within the behavioral health sphere as well as those with other co-occurring health conditions such as HIV/AIDS, Hepatitis, etc.

Question 4: What are the milestones and plans for addressing each of your priority areas?

- 1) APRA/DBH provides data reports to providers surrounding their performance measures as well as providing training as to the interpretation of these data and their use in programming decisions. Additionally, APRA has several trainings planned during the upcoming months on effective treatment planning, as this is one of the core engagement activities. The goals are to reduce the number of treatment episodes with a 0-day length of stay by 20% during the year and the number of outpatient treatment episodes with a length of stay less than 30 days by 15% during FY 14.
- 2) APRA will provide ongoing training and technical assistance around residential treatment providers connecting clients effectively to outpatient treatment services and recovery support services effectively, including addressing a client's unwillingness to engage in these services from a motivational standpoint. Additionally, the merger with the DMH will offer extensive resources and opportunities to assist providers in recognizing co-occurring disorders more effectively and referring clients to the appropriate service more often. A training plan around educating substance use providers on mental health concerns (and vice versa) is already in the drafting process.
- 3) APRA will make revisions and expand DC Strategic Prevention Framework Foundations training and technical assistance to District agency partners and related associations. The trainings include: 1) Foundations of the DC Strategic Prevention Framework 2) Foundations: Assessment, Logic Model and Action Planning and 3) Foundations: Selecting and Implementing Evidence-Based Prevention Strategies and Best Practices.

Section H: TRAUMA

Does your state have policies directing providers to screen clients for a personal history of trauma?

As part of the screening and assessment process with APRA, whether through the agency's Assessment and Referral Center (ARC) or one of its contracted detox service providers, there is a thorough biopsychosocial assessment conducted on each individual entering our system. This process consists of a GAIN SS screen to identify the severity of need for further substance use or mental health challenge assessment. If further assessment is identified, the individual is then assessed using the Treatment Assessment Protocol (TAP), which is a combination of the American Society of Addictions Medicine Patient Placement Criteria (ASAM-PPC) and the GAIN-I. The TAP includes several trauma assessment questions, which directly correlates to the identified problems and subsequent goals on the individual treatment plan. All individuals receiving District funded substance use treatment services are assessed using the TAP, either at the ARC, or at one of the two designated detox entry sites into the treatment system.

As part of the initial APRA-DMH merger to form DBH, APRA is reviewing its Chapter 23 regulations, the foundation for District substance abuse service provision, to include more explicit policies in support the use of specific EBP's including those to address trauma issues. APRA is also currently reviewing its policies around trauma screening, to incorporate screens for Adverse Childhood Experiences (ACE), to better inform individual treatment plans.

Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?

All District funded substance use providers are governed by the agency's Title 29, Chapter 23 Certification Standard, which clearly speaks to the need for providers to coordinate individualized care for the population seeking services, by connecting them to services matched to their identified problem and treatment goals. This policy incorporates the need to match individuals in care with trauma histories, to the appropriate trauma-focused care. This is the only way to ensure that individuals with histories of trauma recognize and acknowledge the role that trauma played in their lives, in order for them to work on changing any negative behaviors associated with the trauma. As part of the initial APRA - DMH merger to form DBH, APRA is reviewing its Chapter 23 regulations to include more explicit policies in support the use of specific EBP's including those to address trauma issues.

Does your state have any policies that promote the provision of trauma-informed care?

The District requires all treatment providers to develop a comprehensive treatment plan via a comprehensive biopsychosocial assessment that identifies certain risk factors which, in turn, identify problematic areas in treatment. Relevant to the comprehensive assessment, the District also requires all substance abuse treatment providers to use the ASAM-PPC to determine the treatment path. Dimension 6 of the ASAM criteria assesses risk factors in the Recovery/ Living environment. Domestic violence, childhood traumas, violence in the home, and the like are major risk factors of continued drug use or potential to relapse. The District requires all substance abuse treatment providers to provide family counseling, crisis intervention, case management, and care coordination as interventions in treatment. In our network of providers, we are developing a Women and Children's program that incorporates Trauma-Informed Care into the treatment regimen. APRA has partnered with our sister agency, Child and Family Services Administration (CFSA) to integrate Trauma-Informed Care into the treatment regimen for Women, Children, and other vulnerable populations that may enter our system. Thus the policies developed for assessment, placement, using EBP's, crisis intervention, family counseling, case management and the like all support the promotion of integrating Trauma-Informed Care into our treatment network.

What types of evidence-based trauma-specific interventions does your state offer across the life-span?

APRA, working with our contracted provider network has identified the initial implementation costs of EBP development as a barrier to greater dissemination of such practices in the District. APRA is prioritizing seeking out a diverse funding stream and community partnerships to assist the providers in overcoming this obstacle. For instance, APRA was recently awarded the SYT Grant which will fund the implementation of the Adolescent Community Reinforcement Approach (A-CRA) in the adolescent treatment network. Similarly, the partnership with DMH has allowed APRA to train some providers in Integrated Dual Diagnosis Treatment and the

partnership with the Child and Family Services Agency will create opportunities for providers to be trained in Trauma Systems Therapy.

What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

APRA has partnered with Child and Family Services (CFSA) the District's child welfare agency to provide trauma informed care training to the adolescent substance abuse providers.

National research has shown that childhood trauma injures a children's brain and impairs physical development and function. The result is that these adverse childhood experiences (ACE) have a negative impact have a conservative estimate of 70 percent of the population. If there's one trauma, there is a 95 percent likelihood that there are other types of trauma. ATOD are often the way children and adolescents cope with trauma. When they are adults, the trauma experienced as a child can become legal or social problems including chronic diseases such as diabetes, heart disease, depression and lung cancer.

APRA prevention is focusing the DCEOW on collecting and analyzing ACE data to identify early childhood risk and protective factors that can be used to target early preventive interventions. DCEOW representatives include a cross-cutting team of District leaders from: the Alcoholic Beverage Regulation Administration, Child and Family Services Administration, Youth Rehabilitation Services, Metropolitan Police Department, Office of the State Superintendent of Education, Department of Health, and the Children and Youth Investment Trust Corporation and the DMH.

This work will set the stage for a renewed look at the risk and protective factor model especially in urban areas and culturally diverse populations. As the developers of the Social Immunization Approach to Public Health and Substance Abuse stated in an editorial published in the Journal of the National Medical Association:

Overall data on illicit drug use hides the fact that residents of some communities are at greater risk than those living elsewhere. For example, we know there is substantially higher prevalence of illicit drug use among inner-city residents than among those who reside in suburban or rural areas. It is essential that these high-risk communities be specifically identified so that the available drug control resources can be provided to them on a priority basis.

The editorial also supported an analysis of epidemiological and census data the zip code level in order to clearly identify affected areas.

While ACE is generally considered a tool to assess individual adult trauma, APRA is focusing prevention efforts on universal, selective and indicated strategies that prevent and reduce the effects of trauma in stressful and high risk community environments.

CFSA has been awarded a \$3.2 million (\$640,000 per year for five years) federal grant, which will be used to make trauma-informed care the foundation of serving children and youth in the District's child welfare system. In collaboration with other youth serving community agencies,

CFSA chose the Trauma Systems Therapy (TST) Model. The TST model focuses on addressing trauma in two ways (1) a traumatized child or youth who cannot regulate his/her emotional state and (2) a social environment/system of care that cannot help contain this dys-regulation. TST focuses on the child and on his/her relationships and surroundings.

JUSTICE I.

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansion?

Yes. The District of Columbia plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansion.

On October 1, 2013, the APRA and DMH will merge to form the new Department of Behavioral Health (DBH). Through the establishment of the new department, we hope to focus public awareness and policy attention on the role of behavioral health by further engaging and enrolling people with substance use and/or mental health disorders who are in the justice system. We know that treatment is effective and recovery is possible, even with criminal justice involvement. Therefore, we are devising a system that best supports healthy individuals and a strong community, which includes extensive partnership with the criminal justice community.

The criminal justice community will greatly benefit from the new Department of Behavioral Health, which will integrate treatment and services for residents with both mental health and substance use disorders. The new Department will continue to provide treatment and supports for individuals with mental health conditions only or substance use disorders only, but will also offer integrated care for the dually diagnosed. A significant number of the criminal justice population has both mental health and substance use disorders at the same time. Treatment and supports currently are delivered separately, which requires people seeking help for both illnesses to navigate two separate agencies, is particularly onerous for individuals with criminal justice involvement. Therefore, with integrated treatment, any combination of needs will be addressed properly. The new integrated system will effectively serve individuals involved in the criminal justice system with co-occurring disorders whether they are seeking help for substance use disorders or mental health conditions.

2. What Screenings and services are provided prior to adjudication and/or sentencing for individuals with mental health and/or substance use disorders?

Currently, both APRA and DMH have separate pre-trial services, but this will change with the merger. Between DMH and APRA, 86 providers treat 35,000 residents for one or the other disorder, with a small number serving both. DBH wants to make sure all pre-trial providers are competent to assess for both mental health and substance use disorders at the same time so we can design the proper treatment. DMH now certifies 36 mental health providers and APRA certifies 50 providers for substance use treatment with a small overlap. The implementation process, over a multiple year time span, will merge separate clinical services and develop an infrastructure within the mental health and substance abuse systems to support integrated pre-trial service delivery.

Currently, APRA pre-trial services include:

- GAIN SS: The Short Screener essentially provides a screening to determine level of substance abuse severity and MH severity. A positive will initiate a referral for a full assessment using the TAP.
- TAP: The TAP provides the court with the appropriate placement into substance abuse treatment. Many Courts will rely on APRA's assessment and this can be incorporated into an Order or probation requirement. With Client consent we release the assessment and drug screens to the court with appropriate referral information.
- Clients are screened at the urgent care clinic at the superior court for substance abuse and mental health. They can immediately access substance abuse treatment services straight from the court house.

Currently, DMH pre-trial services include:

- Court Urgent Care Clinic (CUCC), D.C. Superior Court-Rm 1230, operated by Pathways to Housing. Defendants receive immediate access to mental health services in the court house.
- DMH Court Liaison, co-located at the Court, provides screenings and mental health assessments for Pre-trial Services Agency (PSA), recommends release conditions and makes referrals for mental health services to CUCC and PSA contacts CSAs for mental health information, screens candidates for Options Program. Individuals are referred from Traffic Court, PSA, Judges, community agencies and others.
- Options Program operated by Community Connections. Individuals who are not currently linked and have a history of non-compliance with court dates are referred to Options.
- Competency Assessments and Restoration Services, 35 K St., N.E. and St. Elizabeth's Hospital. Competency Restorations occurs on an inpatient or outpatient basis, based upon the specific needs profile of the client, here in D.C.

3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversions of individuals with mental health and/or substance abuse disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?

As previously stated, On October 1, 2013, the APRA and DMH will merge to form the new Department of Behavioral Health (DBH). DBH knows that treatment is effective and recovery is possible, which is particularly important for those with criminal justice involvement. Therefore, we are putting a system in place that best supports healthy individuals and a strong community, which includes a strong partnership with the criminal justice community.

To better serve District residents who have been involved with the criminal justice system, substance abuse system, and/or the mental health system, APRA, DMH and the criminal justice partners created the Substance Abuse Treatment and Mental Health Services Integration Taskforce (SATMHSIT). Both APRA and DMH are co-chairs of the committee. SATMHSIT was developed to improve the treatment options available to offenders, ex-offenders and defendants with mental illness, substance abuse, and co-occurring issues. In 2008, SATMHSIT finalized the 2009-2015 "Strategic Plan for Persons with Serious and Persistent Health and Substance Use Disorders Involved in the Criminal Justice System in the District of Columbia."

In addition to the SATMHSIT, members of both APRA and DMH attend the partners Healthcare Workgroup. The Physical, Mental, and Substance Abuse (Healthcare) Workgroup was tasked with addressing legislative barriers to hiring returning citizens in the healthcare field, providing mental health and substance abuse training to District agencies that provide reentry services. The group also ensures the dissemination of mental health resource materials to returning citizens and case managers in the DC Jail and Bureau of Prisons (BOP) facilities. With the aid of the workgroup, increased access to an inmate's medical records was achieved and health care providers were able to provide better services to their patients and enhance public safety. The workgroup is also following up on the following recommendations: increasing communication between penal institutions and medical facilities in the District for the continuity of care for returning citizens; employment policy changes; and instituting standardized protocols and best practices for health care services delivered to returning citizens.

APRA's Division of Prevention has supported the Juvenile Justice Administration in coordinating their former Enforcing Underage Drinking Laws (EUDL) network and providing technical guidance; ; work with the Metropolitan Police Department and the Criminal Justice Coordinating Council (CCJC) on the Synthetic Marijuana Initiative; made presentations on the APRA prevention system at CJCC substance abuse and mental health workshops and trainings; and participated in One City initiatives in high risk neighborhoods. The need for more intensive selective and indicated prevention services has been established.

Pro-active e prevention strategies to reduce substance abuse risk mitigate criminal justice activity. Through SPF SIG funds, APRA is piloting an initiative called CORE (Connecting, Outreach, Referral, and Education). The sub-grant places a SPF SIG CORE Coordinator in each of the four DC Prevention Centers to assess the need for I-Prevention Services in the District. I-Prevention was a recipient of one of the exemplary prevention awards during the 2012 National Prevention Research Conference. This model of services is owned by Red Leaf Resource (RR) the sole owner and developers of all training materials, agendas, and manuals. Interview and plan instruments and customized forms are privileged documents and only RR can provide training. Their model is known as Brief Risk Reduction and Interview Model, the overall concept for I-Prevention.

Red Leaf is based in Riverside, California and has contracted with an array of substance abuse prevention and mental health providers g such as the former California Alcohol and Drug Program, California Mental Health Services Act, California Attorney General Violence Prevention funding, Center for Applied Research Solutions (CARS), Community Prevention Institute (CPI), individual counties who want to implement the program as part of their continuum of services, School Climate by the nationally supported Safe Supportive Schools efforts, and California Wellness Foundation.

Red Leaf does not provide a training of trainers option but does provide experienced trainers who can customize the training to address the funders target population, current infrastructure, ongoing training and technical assistance capacity, and staffing.

Because the concept has not been implemented in an urban setting, APRA is assessing the need through a SPF SIG pilot. In summary, the CORE Coordinators will:

- Conduct an assessment of a minimum of 15 assessments with a total of up to 150

participants. CORE staff will assess the need, current services that have potential to duplicate the service, and identification of potential partners. The SPF SIG lead evaluator is designing a uniform tool for facilitating the discussion and documenting the results.

- Participate in a five day onsite training on the I Prevention concept with RR and identify the potential for use in the District with selective or indicated youth.
- Hold focus groups with 15 youth and their caregivers or parents to collect and analyze the utility and adaptability of I Prevention to the DC environment.
- Conduct 10 educational presentations on the I Prevention concept with adults to create awareness with target populations, neighborhoods, and communities.
- Pilot the I Prevention tools with 15 youth and their parent/caregiver to determine adaptations or modifications needed.
- Participate in monthly meetings and conference calls with APRA prevention staff and the SPF SIG evaluation lead,
- Submit monthly DIRS online reports and data crafted to the CORE sub-grants.

Other ways in which the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversions of individuals with mental health and/or substance abuse disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals are:

Mental Health Community Court

In November 2007, DCSC and DMH opened the Mental Health Diversion Court, which serves as an alternative docket for defendants with mental health disorders who have committed low-level crimes. The court's name was changed to the Mental Health Community Court (MHCC) in October 2011. During the third year of the MHCC's operation (November 1, 2009 to October 31, 2010), there were 364 defendants certified to the court which reflected the number of defendants deemed eligible. In October 2010, a major progressive action for the MHCC was taken - defendants charged with non-violent felonies were allowed to be added to the docket for the first time. The inclusion of non-violent felony defendants increased the number of individuals with mental health disorders that have been helped through this diversion effort.

Court Urgent Care Clinic

Created in 2008, the Court Urgent Care Clinic (CUCC) opened as a partnership of DCSC and the DMH. This collaborative program was created to provide court-based services for defendants with mental health disorders. Initially, the CUCC was to provide mentally ill defendants of the District's Misdemeanor and Traffic Community Court with immediate access to mental health services and connection to a DMH mental health provider. After the first few months of the program, the CUCC was expanded to accept referrals from PSA and other courtrooms in the Superior Court of the District of Columbia. In 2010, the CUCC expanded the array of services available by offering assessments and referrals to substance abuse treatment programs for individuals with substance use disorders.

Crisis Intervention Training

The Crisis Intervention Team (CIT) model of law enforcement intervention with mentally ill residents was adopted as a collaborative initiative between MPD and DMH. Called Crisis Intervention Offices (CIO), the CIO trained officers at MPD who are available for deployment for calls for service involving District residents in mental health crisis. The unit works to safely de-escalate a crisis and then link mentally ill residents with DMH for services with community-based providers.

Between January 1 and November 14, 2011, MPD trained 135 CIOs with the assistance of DMH, bringing the total to over 330 MPD officers since the program's inception in April 2009. In addition to these specially-trained officers, every MPD officer will receive mental health training to learn appropriate techniques to use when responding to calls-for-service involving mentally ill residents.

The Juvenile Behavioral Diversion Program (JBDP)

The Juvenile Behavioral Diversion Program (JBDP) was established as a problem-solving court. In order to participate in the program, the juvenile or status offender must have an Axis I mental health disorder or be at significant risk of receiving an Axis I diagnosis. The respondent may also have an Axis II developmental disability if he or she is able to participate in the program, but he cannot solely have an Axis II diagnosis. The Program is an intensive non-sanction based program designed to link juveniles and status offenders to, and engage them in, appropriate mental health services and supports in the community in order to reduce behavioral symptoms that result in contact with the court and to improve the juvenile's functioning in the home, school, and community.

It is estimated that between 65 to 70% of juveniles involved in the delinquency system are diagnosed with a mental health disorder. In addition, many juveniles re-offend, even while they are involved with the juvenile justice system. A diversion program would help connect juveniles with a mental disorder to appropriate mental health services and supports and increase public safety. It is agreed that "it is crucial that we deal not only with the specific behavior or circumstances that bring [juveniles] to our attention, but also with their underlying, often long-term mental health and substance abuse problems." Moreover, a diversion program is consistent with the policy underlying juvenile court, which is the care and rehabilitation of children who violate the law, while protecting the community.

Program Goals

The program's goals are as follows:

- To connect the juvenile and status offender with appropriate mental health services in the community;
- To provide support for and involve the respondent's parents, guardian, or custodian in mental health treatment for their child;
- To provide a period of engagement with mental health services that is monitored by the court in order to increase treatment engagement by respondents and their families;
- To increase the number of respondents able to remain in the community with the appropriate mental health services and supports and to reduce the number of respondents who otherwise without such services and support might be detained;

- To reduce the individual's contact with the criminal justice system as a juvenile and later as an adult; and
- To reduce crime in the community and protect public safety by reducing the number of times that juveniles with mental disorders reoffend.

4. Do the efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?

Yes, the efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems. We are aware that a number of jail inmates will require assistance in applying for health coverage, as they may have limited literacy skills and/or lack experience using computers, or correctional authorities may determine that all enrollment activities should be conducted specifically by jail staff. Since our local jail will have staffing constraints and will be limited personnel available to engage in the additional work associated with conducting the enrollment of eligible inmates, DMH and APRA have collaboratively engaged in developing resources. This includes coordinating local agencies to apply for a Bureau of Justice Assistance (BJA) grant for reentry planning that includes the enrollment process for the incarcerated.

There are, however, a number of challenges to be addressed in terms of developing enrollment processes for incarcerated individuals who will become newly eligible for health coverage through the ACA and there are still unanswered questions related to the law's implementation. Consequently, we are currently developing strategies to enroll the criminal justice population. We are excited that the ACA's expansion of health coverage can better connect individuals involved in the criminal justice system to appropriate behavioral health care services, which in turn has the potential to reduce recidivism rates as well as county jail health care costs. Considering the many possible public health and criminal justice system benefits, counties may want to begin taking incremental planning steps now and continue to move forward on developing enrollment processes and procedures for eligible individuals.

5. What cross-training do you provide for behavioral health providers and criminal justice/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the criminal justice system.

We have conducted and participated in many cross-training activities for behavioral health providers and criminal justice/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the criminal justice system.

APRA and DMH help convene the CJCC SATMHSIT conference entitled, "The Intersection of Mental Health Services, Substance Abuse Recovery, and the Criminal Justice System." This effort was undertaken due to the partner agencies desire to increase understanding between these three systems. The SATMHSIT conference served as a cross-system educational forum on the innovative practices within substance abuse and mental health treatment as it intersects with criminal justice. This full day conference covered the critical roles of APRA, DMH, and the numerous local and federal criminal justice agencies. It provided CJCC partner agencies with

the knowledge and resources to improve District collaboration and continue the vital work around mental health and substance abuse recovery. Continuing Education Unit (CEU) accredited conference topics included:

- Accessing the Substance Abuse Treatment and Recovery Services in the District
- A Healthier Approach through Appropriate and Timely (Mental Health) Care for Those Leaving the Criminal Justice System
- Federal Privacy Regulations: The Myths, Realities, and Best Practices of Substance Abuse and Mental Health Information Sharing.
- Healthy Community Members from Arrest to Return: Further Linking the Substance Abuse, Mental Health, and Criminal Justice Systems
- APRA community prevention system services and the importance of prevention

The conference brought together over 100 practitioners across the substance abuse recovery, mental health, and criminal justice systems {criminal justice system 53.9%; mental health system 18.4%; substance abuse recovery system 18.4%; other 9.2% } with a diversity of agencies and Community Based Organization/ Service Providers.

DMH also has a Training Institute that provides high-quality learning opportunities to employees, consumers, providers, criminal justice partners and other partners who support mental health services in the District. The Training Institute mission is to continually strengthen the knowledge, technical skills and the quality of services and supports through the development of a dynamic, culturally and linguistically responsive, performance-based and data-driven learning environment. With the merger, substance abuse specific training will be formulated and made available.

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Through SPF SIG funds, APRA is piloting an initiative called CORE (Connecting, Outreach, Referral, and Education). The sub-grant places a SPF SIG CORE Coordinator in each of the four DC Prevention Centers to assess the need for I Prevention Services in the District. I Prevention was a recipient of one of the exemplary prevention awards during the 2012 National Prevention Research Conference. The approach is consistent with work underway through the community prevention system on whole populations.

This model of services is owned by Red Leaf Resource (RR) the sole owner and developers of all training materials, agendas, and manuals. Interview and plan instruments and customized forms are privileged documents and only RR can provide training. Their model is known as Brief Risk Reduction and Interview Model, the overall concept for I-Prevention.

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- Pilot the I Prevention tools with 15 youth and their parent/caregiver to determine adaptations or modifications needed.
- Participate in monthly meetings and conference calls with APRA prevention staff and the SPF SIG evaluation lead,
- Submit monthly DIRS online reports and data crafted to the CORE sub-grants.

At the conclusion of the CORE sub-grants and the evaluation, APRA will determine if the preventive intervention is one to be sustained through non-SAPT funds.

J. Parity

1) How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?

States should develop communication plans to educate and raise awareness about parity since the underlying concepts are complex. States should educate all partners: consumers, family members, employers, purchasers, clinicians, policy makers, and the general public regarding the benefits of parity in preventing and treating issues related to mental health and substance abuse. Therefore, an array of partners and community involvement enhanced services, promote greater

understanding and reduce stigma for the individuals and families we support. Some strategic steps include:

- Communicate your new mental health and addiction treatment plan policies in a friendly fashion early and often.
- Communicate all changes to plan members AND providers.
- Focus on quality, access and costs.
- Be prepared to share your medical necessity and level of care guidelines with consumers and providers.
- Properly assess and evaluate “carve-out” contracts and vendors.

Proven broader communication plans for parity education include tactics that advocate from a wide spectrum of strategies:

- Successful legislative campaigns reaching out to and being willing to work with business and insurance plan groups as well as legislators whose interests are closely aligned with these groups. Bipartisan support is a necessity in most states.
- Consider accepting incremental improvements to the requirements of federal parity. Seemingly small steps like getting resources to appropriate regulators to implement the law are a significant victory in tight budget times.
- Know the most current literature on the costs (and costs savings) to employers for mental health parity. Similarly, know the most current literature on the economic (and human) costs of no or inadequate mental health and substance abuse treatment.
- Know individual legislators with a personal connection to mental health and substance abuse treatment and encourage them to use their personal stories to promote improvements to parity legislation.
- Become very familiar with the state's legislative process and the crucial points in the path of legislation and successful ways to cross those steps in the path.
- Recruit constituents, especially constituents in areas of crucial legislators, to tell their stories. Particularly emphasize business and insurance plan leaders who believe in parity and can make the economic argument in favor of it. Individuals adversely affected by a lack of parity can powerfully personalize the legislative fight for parity.
- Develop standardized materials and use them broadly. Use the same cost/benefit estimates in all arguments. Be sure all testimony is on message and emphasizes a few key points.
- Seek the key arguments of opposition leaders and develop materials to refute their arguments if possible. It is also important to acknowledge true differences and just make a forceful argument to support improved parity despite legitimate issues raised by opposition groups.
- Build a coalition of support broader than mental health advocates. For example, include health care providers/organizations, faith-based organizations, chronic disease/disability groups, homeless groups, hospital associations, law enforcement, think tanks, counties, unions, as well as the recovery community.
- Support the Prevention Policy Council and the Tobacco Free Coalition in raising awareness and understanding of the critical role of prevention in reducing health and social costs

2) How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g. service benefits, cost benefits, etc.)?

Adults and children who need mental health treatment and/or substance abuse treatment should have access to the care they need. Both DC law and federal law require health plans to cover diagnosis and treatment of these conditions at equal levels to coverage for medical and surgical services. These laws prevent health plans from placing higher costs or stricter treatment limitations on consumers who need mental health and substance abuse services. Yet, despite these protections, some health plans continue to improperly discourage mental health and substance abuse treatment. Patients and health care providers report that denials of coverage are commonplace. Unduly burdensome health plan approval procedures may also deter treatment, as can cost prohibitive copayments and deductibles.

In order prevent health plans continue to improperly discourage mental health and substance abuse treatment and promote increased awareness, states can coordinate understanding about benefits (e.g. service benefits, cost benefits, etc.) across public and private sector entities in the following manner:

- Get to know insurance department regulators and ensure their familiarity with the federal statute.
- Review processes in state insurance policy implementation to ensure consumers and advocates have meaningful input.
- Assess the power of the state insurance department to enforce federal regulations both statutorily and with resources such as enough personnel and adequate training.
- Identify and establish reimbursable rates for prevention strategies such as tobacco cessation, parenting programs, CORE/I Prevention, Community Evidence-Based Prevention Grants for youth and their families, and Neighborhood Prevention Investment services
- Mental health and substance abuse should be treated like any other medical condition when it comes to insurance coverage for treatment. That is the principle behind the state and federal mental health parity laws.

3) What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audience that is directly impacted by parity?

Including diverse groups in strategic planning, implementation, and policy decision making functions helps to ensure a broad and strategic outreach is made to the appropriate and relevant audience that is directly impacted by parity. Inclusivity developing core values and principles to develop and offer flexible, responsive, and quality services can heighten public awareness. The following methods could be used to outreach is made to the appropriate and relevant audience that is directly impacted by parity.

- Convene strategic stakeholder meetings to discuss and further educate on Medicaid, private coverage, and insurance affordability programs.
- Build a collaborative team that understands both recovery principles and health reform implementation requirements.
- Plan and conduct training events for the provider community.

- Develop State-wide taskforce with state and community partners.
- Enhance Public-Private Agency Partnerships.
- Cultivate affiliations with local colleges for research and other educational purposes.
- Create committees on strategic planning and implementation for parity that includes those who receive mental health and/or substance abuse treatment.
- Organize conferences and summits for integrated community, government, and partner attendance.
- Incorporate discussion and action through the Prevention Policy Council

K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?

The District's State Plan Amendment (SPA) was approved, allowing the Adult Substance Abuse and Rehabilitation Services (ASARS) benefit under Medicaid to pay for substance abuse treatment within our state. The ASARS benefit allows providers to bill Medicaid for several different types of assessments, crisis management, family counseling, clinical care coordination, group counseling, and individual counseling. Certain qualified practitioners are able to provide clinical care coordination services for individuals with substance use disorders. The intent of clinical care coordination is to integrate primary care as a part of treatment planning for this population.

The District is on track in implementing a substance abuse continuum for pregnant, postpartum, and women with dependent children continuum by January 2014. The treatment continuum will include multiple levels of care ranging from residential, intensive outpatient programs, through traditional outpatient programs. The services provided for this population also yields initiative to incorporate prenatal, primary, and well-child care by care coordination with use of the Federally Qualified Health Centers (FQHC) within the District.

As stated in various sections throughout this document, APRA and DMH are merging to form the Department of Behavioral Health (DBH). In doing so, DMH has already started to establish the Health Homes System for individuals with chronic medical conditions in conjunction with behavioral health needs. Under the new department, clients that meet

the criteria of having a qualified somatic health issue along with a chronic behavioral health issue will benefit from the health homes system within the District.

With the establishment of DBH, the District is in the process of redeveloping our system of access to care for individuals needing Co-Occurring treatment. The District was recently awarded a State Youth Treatment grant from SAMHSA that enables our state to enhance Co-occurring treatment within our adolescent treatment network. The District selected the Adolescent- Community Rehabilitation Approach (A-CRA) as the evidence based practice to implement the SYT services in our jurisdiction. The A-CRA model incorporates primary care into the treatment modality as well as various other family and community supports. This initiative will build the capacity of the network as well as the workforce in our adolescent system.

2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?

In November 2012, the District implemented an integrated care approach with the intent to link individuals with HIV or HIV risk factors into specialty care. Under our 12 Cities program, APRA, DMH, and HIV, AIDS, Hepatitis, STDs, and Tuberculosis Administration (HAHSTA) diligently developed a “No Wrong Door” approach to integrate care for individuals that attempt to access care through any of the respective access points. Essentially, this system screens and directs individuals into the appropriate system of care, while at the same time linking them to a plethora of services based on assessment. The system uses an electronic health record that screens, assesses, links, and ensures integration of care for individuals that are served across the multiple systems. Treatment is then linked between various treatment systems, coordinated, and then tracked throughout the networks web of services providers.

3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?

The District purchases substance abuse services from several providers that are also community health centers. One of the centers that provide substance abuse treatment also provides mobile medical services for District residents. Another substance abuse treatment center provides primary health care to District residents. These facilities offer an array of services effectively coordinates primary care, infectious disease, and behavioral health care all under one roof.

In late 2012, APRA, in conjunction with Howard University Hospital, provided SBIRT training to our sister agency Child and Family Services Administration (CFSA). The initial intent was to partner with our community counter parts to offer earlier interventions and treatment for individuals with the onset of an addiction. From this initial interaction, APRA and CFSA entered into an MOU which establishes the

procedure as to how our agencies will effectively integrate behavioral health care for residents that are involved across our systems.

4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.

In a systematic approach between APRA and DMH, our soon to be merged entity, we have begun to identify evidence based models that effectively treat nicotine dependence. A high percentage of individuals with co-occurring disorders are also nicotine dependent. In direct correlation, individuals in this population have other chronic health conditions making them more vulnerable than individuals without this type of comorbidity. The District projects that many of these individuals will benefit from our greatly anticipated health homes model of treatment to integrate medical care with behavioral health care. Nevertheless, as the Department of Behavioral Health develops, the District will begin to integrate these treatment options into our treatment network.

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.

APRA's Prevention Division is expected to play a pivotal role as the merger with DMH into the Department of Behavioral Health (DBH) becomes a reality. Illustrative of that, tobacco prevention and cessation is an important addiction, mental health and physical health issue to be integrated into DBH.

In October 2012, the Department of Health Community Health Administration (CHA) transitioned their Tobacco Control Program (TCP) and five staff to the APRA Division of Prevention. This included the Tobacco Cessation Quitline services that received additional local funds this fiscal year.

The Center for Disease Control (CDC) research shows that calling a quitline can double a smoker's chances of quitting for good, especially when combined with nicotine replacement therapy (NRT). DC residents are provided no-cost QUITLINE Services that include:

- One-on-one private phone counseling session
- A plan to help you quit, made just for the individual
- Tools to help the individual overcome physical and emotional urges to smoke
- Free NicodermCQ patches and Commit lozenges for District residents
- Fax to Quit program for healthcare providers and community organizations to initiate proactive call-backs from Quitline counselors to qualified District smokers
- Local number for Spanish-speaking callers that connects directly to Quitline

When a person calls 1-800-Quitline:

- The smoker goes through a 30 minute interview to help develop a personalized quit plan
- After the interview, an appointment with a tobacco treatment counselor is scheduled

- A series of informational booklets is mailed to the resident
- Free Nicotine Replace Therapy (NRT) is provided after the counseling session
- Residents under the age of 18 do not qualify for NRT; however, phone counseling is available
- The DC Quitline number is also available in Spanish as are brochures and posters promoting the services. The Quitline number has been on all Synar Merchant Education materials including floor mats, folders, adult and youth brochures, cash register materials and window clings.

APRA tobacco prevention and risk reductions services include support for the Tobacco-Free Coalition and focused strategies such as a youth coalition supported by APRA with the Office of the State Superintendent of Education; a Smoke-Free Nursing Home Workgroup; a Smoke-Free Housing Workgroup in cooperation with the DC Housing Authority and Tobacco-Free Coalition; and media campaigns. APRA prevention also coordinates the Food and Drug Administration tobacco contract for DC.

6. Describe how your behavioral health providers are screening and referring for:

a. heart disease, b. hypertension, c. high cholesterol, and/or d. diabetes.

Screening and referring for these chronic health conditions occur in various stages throughout the District’s behavioral health system. All individuals that present at our central point of access site, the ARC, receive an assessment. The nursing includes a brief history and physical, assessment of vital signs, infectious disease screening, and medication review. Individuals seeking service are medically cleared to enter substance abuse services at that juncture. District residents that display present symptoms of any of these chronic health conditions are linked to a community health center or FQHC for treatment.

Once a District resident is referred to a treatment provider, a comprehensive assessment is performed at intake. Individuals that are assessed as having certain medical risk factors are identified as problematic under “Medical” on their Individual Treatment Plan (ITP). Any area that is identified as problematic on the ITP requires a treatment goal. Treatment providers have the ability to implement care coordination for any individual that presents with medical issues, symptomatic and or unresolved. As stated in question 1 under this section, several of the District’s treatment providers are also community health centers. Thus, these providers conduct a complete medical assessment and link individuals needing medical treatment to care. Many of these centers assist individuals needing public health insurance receive benefits.

District residents that require detoxification services receive a comprehensive medical assessment to determine the appropriateness for non-hospital medical detox versus hospital detox. Individuals that are assessed with certain medical conditions are linked with a community health center or a FQHC if they do not have a primary care physician.

SECTION L

1. How will you track access or enrollment in services types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?

The District Automated Treatment Accounting (DATA) System allows for each of these demographic categories to be identified and examined separately in custom data reports. Through SQL Server (fully integrated into DATA), APRA can develop extensive custom reports including those asked about above. Currently, APRA tabulates demographic information monthly by level of care as well as more in-depth demographic reports annually and as needed for specific programmatic and administrative decision-making.

The one exception among this list is clients who are LGBTQ. During FY 2013, APRA recognized the need to develop a means of tracking LGBTQ clients for monitoring and data tracking purposes. As opposed to the other demographics listed, LGBTQ status is not routinely collected within the standard clinical documents in DATA. As such, APRA began training providers on utilizing the Special Initiatives feature within DATA. This feature is designed to track any specific populations which cannot be tracked through more conventional methods. APRA began training providers to use this feature to identify clients who are LGBTQ. FY 2014 will be the first full year of implementation of this policy and will permit improved measurement capability of this subpopulation.

2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?

APRA has the capability through DATA to document every client's primary language. This information can be easily aggregated to assess any trends in primary language entering the system. The largest and most specific cohort of non-English speakers APRA sees in the treatment system is Spanish-speakers. APRA currently contracts with three adult providers and one youth provider with the internal capacity to offer services entirely in Spanish. As of this writing, the Assessment and Referral Center employs two full-time staff members who are fluent in Spanish.

The DATA System also keeps profile information of all provider staff with accounts in the system. Among the data points in this profile is language capacity. Users are required to document which languages they speak and their degree of fluency. This information can be aggregated at will by APRA and clients seeking services at the Assessment and Referral Center, or other APRA intake location, can be matched with programs employing culturally compatible staff.

If these strategies are ineffective at accommodating a client's language needs, the District of Columbia Office of Human Rights offers the Language Line. This is a service which provides no-cost telephonic translation for District services. The language line is staffed with interpreters for every language spoken by a significant number of people in the District. With this service, program staff can communicate with clients with a significant language barrier using a speaker phone.

3. How will you develop plans to address and eventually reduce disparities in access service use, and outcomes for the above disparity-vulnerable subpopulations?

APRA recently signed and executed a Memorandum of Agreement (MOA) with the Child and Family Services Agency (CFSA). CFSA provides services and family stabilization resources to families and children alleged to be abused and/or neglected through the coordination of public and private partnerships. This collaboration is nearing the end of the planning phase. Some elements, such as client screening and data sharing, have already begun implementation and will be fully implemented in FY 2014.

Under this plan, CFSA personnel will conduct screenings on selected cohorts of youth and adults with child welfare involvement using the Global Assessment of Individual Needs Short Screener (GAIN-SS). This screening process has already begun implementation. Those whose screening results indicate that a full assessment is indicated will be referred electronically to the appropriate location for a full assessment and, subsequently, treatment services as appropriate. The screening, referral, and information sharing processes will all take place electronically using the District Automated Treatment Accounting (DATA) System.

The MOA currently in development formalizes these processes. It lays out rules and policies regarding access to the DATA System, data sharing, and protections for confidential information and ongoing communication between the two agencies at the administrative level to monitor and improve the quality of coordination.

This collaboration has high potential to reduce disparities for some of the District's most vulnerable residents. CFSA serves residents who are disproportionately low income African-American women, many of whom are single parents, and their children. Those with child welfare involvement are particularly vulnerable to health disparities. The collaboration under development at present has already improved the capacity to identify substance use disorders through screening with the GAIN-SS, and the training of CFSA front line staff in Screening, Brief Intervention and Referral to Treatment (SBIRT). Treatment access has been improved through a dedicated assessor in the Assessment and Referral Center specifically for child welfare-involved clients. This has already had a demonstrable effect in reducing call-to-appointment time at the Center for CFSA-affiliated clients significantly.

The Office of Quality Assurance has also undertaken a targeted project to build capacity around HIV education, testing, and case management within the treatment network. Building upon the new internal capacity to conduct HIV testing in the Assessment and Referral Center through the Minority AIDS Initiative, this initiative will provide programs with technical assistance around facilitating access to HIV testing, educating clients in the most current information on HIV and providing effective case management to those who are HIV positive (e.g. linkage to primary and specialty medical care).

4. How will you use block grant funds to measure, track, and respond to these disparities?

The District uses a block grant set aside of funds to engage clients that are attempting to access treatment. These set asides will provide priority services for individuals who are IV

drug users (IVDU), women and children, or present with pregnancy, hepatitis, HIV, and tuberculosis. The District attempts to ensure that adequate services are available throughout the state and are represented in areas that are identified as “health disparity” zones. These requirements provide the assurance that the District adequately responds to these disparities.

The District uses a portion of the block Grant funds to ensure access to treatment. The Assessment and Referral Center (ARC) is our central point of entry into treatment for substance use. The District also contracts with three (3) other treatment providers to act as access points. All of our access points ensure that clients have immediate access to treatment. Although the District ensures that IVDU’s, pregnant women and children, and individuals with infectious diseases have priority placement, the District operates under a treatment on demand system.

M. Recovery

Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports services and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

Yes, the District has adopted the principles and definition of recovery according to SAMHSA’s working definition of recovery, “*A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.*” The District has incorporated this definition in all of the recovery support services programs. The District is developing additional principles through the Bringing Recovery Supports to Scale (BRSS) Technical Assistance Center Strategy (TACS) that will encompass the new Department of Behavioral Health vision.

The District is also developing a Recovery Advisory Committee (DC RAC) that is supported by key community stakeholders and persons in recovery. The partners include the Office of Returning Citizens (ORCA), Court Supervision Offender Services Administration (CSOSA), Pre-trial Services, DC Recovery Community Alliance (DCRCA), Gospel Rescue Ministries, La Clinica del Pueblo, Federal City Recovery Services, So Other Might Eat (S.O.M.E.), and several faith based and community prevention centers. The committee will provide oversight and

suggestions on how recovery support services are disseminated, funded and incorporated into existing community based and faith based programs throughout the Districts eight Wards.

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g. in the state Office of Consumer Affairs) within the state behavioral health system?

Yes, the District has documented evidence that persons in recovery are being hired in a leadership role through the District's recovery support services network. The individual programs have a standard policy of recruiting persons in recovery as program staff, directors, supervisors and program monitors. This is verified through the District's Chief of Recovery Support Services and District's Office of Certification and Regulation (OCR).

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

Yes, the District's strategic plan includes the use of person-centered planning and self-direction and participant-directed care in all recovery support services programs verified through program curriculum and all recovery support services. As the District implement the Bringing Recovery Supports to Scale (BRSS) Technical Assistance Center Strategy (TACS) plan in conjunction with the merger of DMH we will enhance our services to strengthen trauma focused practices on the program level. In addition, all treatment planning directly involves client and family participation. For instance, an individual in recovery/ care must sign off on the treatment plan to signify his/ her participation in the development of the plan. Our system is embracing a Recovery Oriented System of Care (ROSC) approach that will include recovery coaches, peer navigators, and other client centered support mechanisms.

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Services Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g. warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

Yes, the District was awarded the Access to Recovery Grants II and III, as a discretionary grant program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT). Recovery support services have been incorporated into the Districts over all substance abuse system of care through prevention and treatment services. The District of Columbia Choosing Options for Recovery and Empowerment (DC CORE) Program Access to Recovery (ATR), has provided substance abuse recovery support services to date to over 16,000 persons in recovery. The DC CORE ATR II program established a legal and regulatory framework in the District to support a culturally-competent recovery-oriented system of care. One way clients are empowered is through free and choice of provider and services. This is the core of the District's service delivery system. The DC CORE ATR III program targeted underserved special populations within the overall service population: youth 12-18 and young adults 19-25, women with dependent children, and the criminal justice (returning citizens) population. The District has also adopted SAMHSA's

initiative on providing recovery support service to members of the Army and Air National Guard and their family members.

The DC CORE ATR II and III Programs has included a variety of recovery support services that meet the holistic needs of those seeking or in recovery and are available an assessable through thirty recovery support services programs throughout the District's 8 Wards. The District monitors and has ensured the following recovery support services are provided:

Service Type:

Recovery Support Evaluation

Evaluate and document a client's individual recovery support service needs, develop a comprehensive individual recovery support plan, and monitor client progress on achievement of goals and objectives.

Care Coordination Services

Assist clients with substance abuse problems on how to access the District of Columbia service network and other community resources available to sustain recovery.

Spiritual Support Group

Provide recovery support, which incorporates faith and specific religious beliefs in the recovery process, based on universal spiritual practices and principles that are not based on specific religious beliefs.

Recovery Mentoring & Coaching

Assist the client in assessing their current situation, defining goals, targeting areas to strengthen or improve, creating an effective life-action plan, understanding triggers and overcoming barriers that may inhibit the recovery process, and assist in obtaining the necessary skills to be a successful and productive member of the community.

Education Support Services (Ind.)

Provide individualized instruction focusing on increasing and expanding a client's knowledge base in substance abuse relapse prevention strategies, employment preparation, reading and writing with comprehension, and working on other social skills to promote healthy living.

Education Support Services (Grp.)

Provide group instruction focusing on expanding a client's knowledge base in specific topic areas (life skills, relapse prevention, GED and employment preparation, money management, health related topics, and family reunification) for drug and substance free living during their recovery process.

Life Skills Support Services (Ind.)

Provide life skills development to equip clients with the skills needed to succeed in day-to-day life. To support person who are re-entering society after short or long term incarceration in a safe and supportive environment with recovery coaches or mentors.

Life Skills Support Services (Grp.)

To support life skills development in a group setting with peers to develop strategies to succeed in the re-integration back into the community after incarceration back into society. This may include: employment skills, coaching and work preparation, daily living skills, and nutrition support.

Parenting Support Services (Ind.)

Provide support to parents in recovery develop and understand child development and parenting skills strategies.

Parenting Support Services (Grp.)

To assist parents in recovery develop parenting skills and encourage networking with other parents with similar circumstances in a group setting.

Family and Marital Services

To help persons in recovery develop an enhanced personal and family skills for work and home; reduce marriage and or family conflict and promote a substance free atmosphere among all family members.

HIV/AIDS Education

To provide education services to persons in recovery on the risks, medical services, statistics, transmission, legal, and financial aspects of the disease.

Child Care

To provide care and supervision, in a licensed day care facility, provided during part of a 24-hour day to a client's child (ren), less than 13 years of age, while the client is participating in recovery support services.

Recovery Social Activities

To provide drug free social activities for persons in recovering (adults and youth).

Transportation (public)

Provide transportation support (metro bus or metro smart trip card) to a client for the purpose of assessing treatment or recovery support services, job interviews, medical appointments, and other recovery support groups or any other activity that supports a client's recovery.

Transportation (private)

Provide transportation of individuals for the purpose of assessing recovery support services, job interviews, medical appointments, 12 step or other support groups, school, work, childcare providers, or any other activity that supports a client's recovery.

Environmental Stability (Individual male/female) \$

Provide limited housing (up to 6 months) to a client (male or female) who is presently drug and substance free and participating in part time or full time employment. Provide individual and group recovery support services, including money management, care coordination services, conflict resolution and relapse prevention strategies.

Environmental Stability (women with dependent children) max 2)

Provide limited housing (up to 6 months) to a woman and child (up to 2 children under age 10 yrs.) who are presently drug and substance free and participating in part time or full time employment. Provide individual and group recovery support services, including money management, care coordination services, parenting skills, and stress management support.

5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

Yes, the District's recovery support services network of community based and faith based providers, deliver peer-driven support services for special populations: women, women with dependent children, youth and young adults and their family members, sex workers, lesbian, gay, bisexual and transgender, Latino & Hispanic, Veterans and Guardsman's, persons living with HIV/AIDS, and homeless families.

Examples of providers that deliver recovery support services to special populations:

- Access Housing, Inc., (Southeast Veterans Service Center), provides housing and substance abuse and mental health referral services for Veterans and Army & Air National Guardsman;
- Angels and Associates, Inc., provides services to women who are recovering sex workers;
- Circulo of Andromeda and La Clinica del Pueblo, provide services to the Latino and Hispanic population;
- Hillcrest Children & Family Center, provides services to youth (12-18) and young adults (19-25) ;
- So Others Might Eat (S.O.M.E.) provides services to the homeless population with co-occurring disorders;

6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services.

Yes, the District's Access to Recovery III program provides through SAMHSA/CSAT's technical assistance (TA) program provides ongoing training for the professionals who work in the recovery-oriented practice and systems. The trainings are provided through the TA contractor Altarum Institute.

A brief listing of trainings provided:

- The Government Performance and Results Act (GPRA) Tool
- Recovery Coaching and Mentoring
- The Recovery Process
- Recovery Support Plan and Client Engagement and Retention
- Care Coordination and Recovery Support Services Practices
- Recovery Support and Youth Services
- Women with Dependent Children and Recovery Support

- Recovery Support Services and The National Guardsman's
- Co-Occurring Disorders/Mental Health & Substance Abuse Integration
- Connecting the Dots: Making The Case for the Provision of Integrated Care
- Boot Camp for the Front Line: Integrated Care for People with Both Mental Health and Substance Use Challenges

Persons who work in the professional workforce in the area of recovery support services also, participate in training through the states training department on:

- Electronic Documentation practices: District Automated Treatment Accounting System
- Substance Abuse Prevention and Treatment Services
- Treatment Plan Development
- Confidentiality and Ethics
- Relapse Prevention 101

7. Does the state have an accreditation program, certification program, or standards for peer-run services?

No, the District has requested technical assistance from SAMHSA/CSAT on how to develop a certified accredited peer-run services program on substance abuse recovery support services. However, the merging of substance abuse services and mental health services will incorporate the present Department of Mental Health's a peer specialist certification program. This will expand upon the merge and include recovery support-peer run certification.

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, service, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

The District's innovative exemplary initiative that can be considered a state-of-the-art in recovery-oriented practice, service, and systems, is our Environmental Stability "Housing" Program. The DC CORE ATR III Program developed a recovery support services program to provide limited housing to individuals and families that are coping with the disease of addiction. The Environmental Stability Program provides a structured and stable recovery support system that includes recovery housing for up to six months, intensive case management and care coordination services, the development of a comprehensive individual and family recovery plan with clear goals and objectives and job skills, life skills and employment readiness training.

Participants in the Environmental Stability Program are provided limited housing (up to 6 months) to individuals who are drug and substance free and participating in part time or full time employment. Participants are provided recovery support services, money management strategies, conflict resolution and relapse prevention strategies and in some cases family reunification classes.

To be eligible to enroll in the DC CORE Environmental Stability program individuals must:

1. Be a District resident
2. Have an Axis I diagnosis of a substance use disorder; and
3. Be in Recovery from a diagnosed substance use disorder

Individuals who are eligible for the Environmental Stability program shall be considered for priority placement in the program if the following criteria are met:

1. Be an individual who has a history of incarceration or is under supervisory release; or
2. Be a woman with a dependent child.

The program provider must establish an escrow account at a federally insured financial institution for monthly income and or savings to be deposited by each individual client or client representative. The purpose of the savings account is to set aside funds for the client to use at the end of six months to establish independent living.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SAHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

Individuals in recovery and their family members who are seeking recovery support services are assessed and included in every aspect of choosing recovery support service(s). Participants decide what recovery support services they would like to participate in, with or without their family member(s), where in their community they would like to receive recovery support services, and how many times week they would like to participate in recovery support services.

Individuals seeking recovery support services and their family members are assessed using the Government Performance and Results Act (GPRA) Tool for recovery support services. If a person is assessed and need treatment services they are referred to the Assessment and Referral Center (ARC) for treatment services. After the client completes treatment services they will be referred back to recovery support services.

Special note: We have found during an assessment of an individual who is accompanied by a family member seeking recovery support services that the family member may also need and or request services.

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

Yes, the District sponsors meetings through the recovery support services providers located throughout the eight Wards of the District of Columbia. Each program can assess and provide services and make appropriate referrals for additional services regarding behavioral health services.

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

Any resident of the District of Columbia can assess recovery support services through the states Assessment and Referral Center (ARC). Clients participate in their individual recovery planning, choice of provider and what recovery support services in which they would like to participate. This is the core of the District's service delivery system. The recovery support services providers located throughout the Districts eight Wards or through the states recovery support services outreach team. The outreach team goes into the eight wards and provides an orientation of the recovery support services available and can enroll persons requesting services on the spot. The outreach team provides referrals for prevention and treatment services follow up of the client's attendance to the program and completion.

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

The development of the District of Columbia Recovery Advisory Committee (DC-RAC) will strengthen and expand the recovery support services organizations. This initiative was formed through the states Bringing Recovery Supports to Scale (BRSS) Technical Assistance Center Strategy (TACS) Grant.

The state also, provides monthly meetings and ongoing trainings to support recovery orientated system of care.

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

The District's DC CORE Access to Recovery III has developed a limited housing program Environmental Stability (ES) Program that will help address the housing needs of persons who may need supportive community support during their recovery process. Participants in the ES Program are provided limited housing (up to 6 months) that is presently drug and substance free and participating in part time or full time employment. The client is provided recovery support services, conflict resolution skills, money management skills, and relapse prevention strategies.

Participation in the ES Program provides the client with the freedom to participate in a non-restrictive environment. The ES Homes are located within drug free zones within the Districts eight Wards and the participants can come and go freely: to work, family and social events, spirituality support services, etc.

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?

The District's Environmental Stability program supports community involvement and the engagement of community stakeholders. If funding allows, we would like to expand this program.

N. Prevention

1. How did the state use data on substance use consumption patterns, consequences, of use, and risk and protective factors to identify the types of primary prevention services needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

APRA continues to make prevention policy and program decisions based on DC Epidemiological Outcomes Workgroup (DCEOW) data and findings from *Community Conversations*. In 2011, the Substance Abuse and Mental Health Services Administration (SAMHSA) provided prevention technical assistance to pilot the Communities That Care Survey in a community setting. Questions were modified to address an urban area and culturally diverse populations. Data from the pilot helped set the stage for identifying and targeting priority risk and protective factors through the DCEOW development.

One of the most persuasive findings in the DCEOW data is consistent with prevention science regarding the age of onset or first use of alcohol, tobacco, and other drugs. APRA DC data documents there are multiple negative effects of early (before age 13) marijuana and alcohol use compared to non-early use.

Early users are more likely to:

- Engage in other risk behaviors such as drinking and driving, binge drinking, and other illicit drug use;
- Carry a weapon;
- Get in physical fights;
- Engage in sexual activity.

During 2010-2012 *Community Conversations*, youth reported that the data presented seemed accurate, that alcohol and marijuana were easily accessible in their communities and use is "no big deal." Many youth refer to marijuana as "medicine" and others report drinking is only a problem if they miss class or work as a result. Youth also report living in families where there is alcoholism or other drug addiction; therefore, there should be no surprise that they use ATOD.

The Community Conversations provided early evidence that DC youth are exposed to multiple areas of risk in their families and their communities and neighborhoods. These findings led to the development of the four DC Prevention Centers (DCPC) that cover all 8 Wards. The Strategic Prevention Framework State Incentive Grant (SPF SIG) DC Strategic Plan was approved in April 2011 and focuses on preventing underage drinking and marijuana use among youth. In 2013, SPF SIG carryover funds were approved to address the use of synthetic marijuana among youth. SAMHSA Strategic Prevention Enhancement funds supported expansion of the DC Office of State Superintendent of Education (OSSE) Youth Risk Behavior Survey. The expansion included a larger sample that produces ward level data; additional risk questions for

middle and high school youth; and questions on synthetic marijuana perceptions, attitudes and use. APRA prevention data is used in guiding the need for and allocation of SPF SIG community level funds, especially pilot projects for selective and indicated populations.

2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected. What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

Since 2009 APRA has used a modified Strategic Prevention Framework to guide the planning process across the 8 wards and within the 120 distinct neighborhoods. Preventive interventions are based on DCEOW data and the spectrum of strategies consistent with the *Institute of Medicine (IOM) Report on Preventing Mental, Emotional, and Behavioral Disorders Among Young People*.

The four DC Prevention Centers (DCPC), the cornerstone of the community prevention system, are universal and target whole populations. Selective and Indicated strategies are funded through both SAPT and Strategic Prevention Framework State Incentive Grant funds. In addition, APRA prevention staff who have expertise in developing and implementing selective and indicated strategies provide targeted support at the District and community levels.

APRA has incorporated the Strategic Prevention Framework (SPF) planning process and IOM spectrum of preventive interventions, in the development of infrastructure and the community prevention system since 2009. To assist in the development of a sustainable system, SAMHSA provided onsite and offsite technical assistance in areas such as: SPF concepts, risk and protective factor research and practical application in urban environments, and the IOM as applied to the SAPT. In addition, the 2009 *Community Conversations* with 350 individuals, agencies and organizations set the stage for a new prevention direction that is consistent with the SAPT yet addresses the unique needs of the District. For example, APRA learned there was a need to educate different audiences on the concept of sustainable infrastructure and a community prevention system; and the spectrum of preventive interventions from the Institute of Medicine's publication on Preventing Mental, Emotional, and Behavioral Disorders Among Young People. APRA also learned that participants were "tired of being part of focus groups in the District when funds and resources were allocated to a few non-profit agencies." APRA also learned that the concept of "coalitions" was not a community priority in DC because historically they were not action-oriented.

In response, APRA funded four DC Prevention Centers in 2010 through SAPT funds. Each DCPC cover two wards each and provides access to universal prevention services which provide an economy of scale. Before 2010, APRA funded 11 prevention grants at \$60,000 that reached an average of 275 participants. The SAPT prevention set-aside supports implementation of the Synar Regulations with the exception of law enforcement.

APRA assessed prevention human and fiscal resources through the SPF SIG Prevention Policy Council and the Strategic Prevention Enhancement Prevention Consortium in 2012, a body composed of 14 District agency leaders. No agency identified financial resources allocated to primary prevention. APRA prevention continues to address opportunities to leverage and coordinate with District agency partners and associations. District government has another

safeguard to avoid duplication of resources. The District has an intensive and extensive external grant and contract process that includes review of financial and programmatic plans by Cabinet level agencies, and then the District's financial office. This review requires planning six months to a year in advance of funding a grant or contract; however, the intent is to avoid duplication and ensure funds are being used for the intended purposes.

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

The DC SPF SIG has provided a source of support for building Strategic Prevention Framework capacity and the use of evidence-based strategies that include policies, programs, and practices. One pilot project is the creation of a DC Prevention Leadership Center (PLC), a priority in the Strategic Prevention Enhancement (SPE) Five Year Strategic Plan.

The PLC has been envisioned as a mechanism to build capacity of the prevention system and the prevention workforce. APRA is rethinking this approach as a result of a focus group findings and the merger to the new Department of Behavioral Health. DMH maintains a Training Institute and discussions are underway to determine the utility of the Training Institute as a mechanism to build prevention workforce capacity. In addition, APRA prevention has an internal change team exploring prevention credentialing and identifying core competencies that align with DC needs. The APRA prevention staff and selected members of the sub-grantee workforce have explored existing ATOD prevention training programs; however, the conclusion was the training was too broad and/or did not address the unique needs of urban or culturally diverse populations.

To address the more immediate need, APRA has supported the development of two interrelated trainings with follow-up technical assistance and coaching: 1) Foundation: DC Strategic Prevention Framework; 2) Foundation: DC Community Assessment, Logic Model and Action Plan Development. This training also provides an understanding of evaluation fundamentals, the SPF SIG evaluation approach, levels of evaluation, epidemiological versus evaluation, use of evaluation feedback loops, and a new emphasis on the Center for Disease Control's Adverse Childhood Experience's study. Both trainings were piloted in summer 2013 and refinements are being made. A third Foundations training is being developed on Using Evidence-Based Strategies and Best Practices in DC SPF Action Planning.

4. What outcome data does the state intend to collect on its prevention system, including the capacity of its workforce?

APRA has identified four levels of outcomes for the community prevention system: 1) changes in perceptions of risk and harm; 2) changes in other priority risk and protective factors; 3) community changes in policies, programs, and practices related to local SPF action plans; 4) changes in distal outcomes. The DC prevention system goal is to prevent the onset and reduce the progression of ATOD risk among DC youth.

The priority risk factors are: 1) Low neighborhood attachment and community disorganization 2) Community laws and norms favorable toward alcohol, tobacco and other drug (ATOD) use among youth 3) Low perceptions of risk and harm and 4) Favorable attitudes toward youth ATOD use.

Through SPF SIG funds, the APRA lead evaluator has designed a portal for sub-grantees to enter monthly data. The Data and Information Report System (DIRS) has a standard data report feature for monthly and year-to-date reports that are used by APRA prevention staff and sub-grantees for monitoring, technical assistance or quality improvement.

APRA has also collaborated on workforce capacity with George Washington University through their public health intern program and with consultants through the Community Anti-Drug Coalitions of America. Data collection on workforce capacity is an area being explored with the SPF SIG lead evaluator and will continue after the merger into the Department of Behavioral Health.

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

The APRA Prevention Division budget is fully supportive of the SPF planning process and has incorporated SPF into Request for Application, training and planning documents.

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests).

APRA continues to allocate SAPT prevention set-aside funds for addressing SAPT Synar regulations, building infrastructure and a community prevention system, strengthening workforce capacity and the utilization of the SPF, evidence-based strategies and best practices.

For example, SAPT set-aside funds are allocated for:

- Four DC Prevention Center sub-grants that provide universal services on the six core strategies across all 8 wards;
- One FTE implements the Synar Regulations (e.g. making onsite visits to ensure accuracy of the tobacco licensee list, conducting compliance checks with trained youth and Metropolitan Police Officers, conducting merchant education, responding to constituent concerns about merchants selling tobacco products to underage youth. Other APRA staff members provide assistance as needed. A community-based prevention sub-grant recruits, trains, and manages eligible youth for up to 1000 Synar compliance checks annually.
- Two prevention staff members provide ATOD prevention training, and technical assistance to community-based organizations and District agency leaders wanting to incorporate ATOD best practices and evidence-based strategies into their work. In 2013, for example, this included an array of potential partners such as training for the Office of State Superintendent of Education central office staff and school bus driver sites across the District; Mayor's Youth Council Summer Enrichment Program; Catholic Charities; DC Parks and Recreation Roving Leaders; National Geographic Documentary producers plans to research and film a documentary on PCP and synthetic narcotic use in Ward 7, 8, and 5; DC Mayor's Cabinet presentation; and DC Youth Summit. The FTE's are assuming training and technical assistance for the DC Prevention Leadership Corps when SPF SIG funding ends in 2014. Previously, they coordinated the

underage drinking prevention network and provided guidance to the District agency allocating Enforcing Underage Drinking Laws funds.

- One prevention FTE coordinate has temporarily assisted in the coordination of prevention information dissemination, education, alternative activities and local events for the Mayor's One City Summer Program that is now year-round. This includes Beat the Streets "Walk-Throughs" with city officials in high risk neighborhoods. APRA has a Community Engagement Workgroup exploring options to better address this growing need after the merge. The current FTE will assume other SAPT activities.
- One FTE supports the Office of the Chief of Prevention on strategic prevention policy and program planning, tracks and reports emerging ATOD trends in DC communities and at the national level, represents prevention at District advisory committee meetings and serves as a program liaison with the DC Prevention Centers, the DCEOW, and Prevention Policy Council; and provides oversight and maintenance for social marketing and prevention website development.

The Chief of Prevention, the National Prevention Network representative, is funded through local dollars. This role provides prevention guidance to District agency partners and serves on District panels such as the Office of State Superintendent Health and Wellness evidence-based program advisory council; the Youth Risk Behavior Advisory Council; the One City planning for the Department of Health (DOH); the DOH Accreditation Domain for Community Health Assessments; DOH representative for the Mayor's Communities and School Advisory Committee; DCRA collaborative Right Choice Initiative on new regulations; and the Criminal Justice Coordinating Council subcommittee on Synthetic Narcotics.

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies.

All prevention set-side funds listed in #6 are evidence-based practices and environmental strategies.

SECTION O

In an ongoing effort to improve the quality of service coordination for young people in the District of Columbia with substance use disorders, the Addiction Prevention and Recovery Administration (APRA) has been fostering partnerships with other youth-serving agencies in the District government.

Currently, the APRA is in the final phases of developing a Memorandum of Agreement (MOA) with the Child and Family Services Agency (CFSA). CFSA provides services and family stabilization resources to families and children alleged to be abused and/or neglected through the coordination of public and private partnerships. This collaboration is nearing the end of the planning phase. Some elements, such as client screening and data sharing, have already begun implementation and will be fully implemented in FY 2014.

Under this plan, CFSA personnel will conduct screenings on selected cohorts of youth and adults with child welfare involvement using the Global Assessment of Individual Needs Short Screener (GAIN-SS). This screening process has already begun implementation. Those

whose screening results indicate that a full assessment is indicated will be referred electronically to the appropriate location for a full assessment and, subsequently, treatment services as appropriate. The screening, referral, and information sharing processes will all take place electronically using the District Automated Treatment Accounting (DATA) System.

The MOA currently in development formalizes these processes. It lays out rules and policies regarding access to the DATA System, data sharing, and protections for confidential information and ongoing communication between the two agencies at the administrative level to monitor and improve the quality of coordination.

Built upon the aforementioned collaboration model with CFSA, APRA is in an earlier planning phase with the Department of Youth Rehabilitation Services (DYRS). DYRS is responsible for the supervision, custody, and care of young people charged with a delinquent act in the District in specific circumstances. Due to certain staff changes at DYRS, the progress on this collaboration has not moved forward as quickly as we had hoped; however, in FY 2014, we look forward to resuming efforts to build this collaboration to assist District residents with both substance use issues as well as juvenile justice involvement.

In addition, APRA has been an active participant in the Behavioral Health Access Team (BHAT), one piece of the Department of Mental Health's SAMHSA System of Care Grant. This grant focuses on establishing a "No Wrong Door" policy in the District and reducing barriers to entry into needed services. The BHAT is a multidisciplinary team with representation of CFSA, DYRS and DC Public Schools among others as well as extensive representation of parent advocates from the community. The deliverables of the team include a shared registration form for use by all youth-serving systems to reduce replication of services and establish a basic platform for assembling a cross-system data pool of service-seeking youth. Another objective of this team is to incorporate the input of consumers/clients and parents into the development of policies, procedures and training plans to enhance the quality of the experience youth and parents receive when seeking out behavioral health services.

APRA also submitted an application for the State Youth Treatment (SYT) Grant earlier this year. As of this writing, the award decision has not yet been announced. If APRA does receive this grant, two of the four adolescent providers will be selected to implement the Adolescent Community Reinforcement approach (ACRA) for adolescent clients with co-occurring disorders. This grant represents a unique opportunity to build capacity for treating adolescents with co-occurring disorders as well as build capacity for family interventions, as this evidence-based practice includes a substantial family component.

Section P: Consultation with Tribes

We recognize that there are both federal and state recognized Indian tribes or groups, that state-recognized Indian tribes are not federally recognized; however, federally recognized tribes may also be state-recognized. Given this understanding, per the Department of Interior, Bureau of Indian Affairs, there are no federally recognized Indian tribes or groups within the Washington DC municipality.

Section Q

- **Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data**

APRA has the current capability to generate extensive custom data reports using SSRS (a SQL Server statistics program fully incorporated into DATA). This capability has already been used in FY 2013 to inform strategic planning, monitoring activities and quality improvement planning. SSRS is sufficient for the majority of APRA's data needs. There are more sophisticated reports which are beyond the capacity of SSRS to complete and these reports are purchased from FEI (the developer of the DATA System). These reports are procured out of the system enhancement budget which is housed under the Department of Performance Management and Quality Improvement.

- **List and briefly describe all unique information technology systems maintained and/or utilized by the state agency**

Currently, APRA utilizes the DATA system as the electronic health record for all treatment and recovery support providers. The District Automated Treatment Accounting System (DATA) is built upon the Web Infrastructure for Treatment Systems (WITS) platform. It is meaningful use certified and is built on an HL-7 platform and therefore compatible with the Affordable Healthcare Act requirements.

- **Provide information regarding its current efforts to assist providers with developing EHRs**

One of the strengths of APRA and the DC treatment network is the District Automated Treatment Accounting System (DATA). Built upon the WITS platform, DATA has been fully implemented in the District since FY 2011. Currently, all providers who are contracted to provide services compensated by public funding streams are required to use this system, document all services, and submit claims through it. This system has the benefit of interoperability between providers, allowing for electronic referrals between programs where appropriate. It also permits APRA to have one set of monitoring protocols which are applied across all providers (with a few exceptions for monitoring indicators unique to specific levels of care). It makes training provider staff on EHRs far more practical, as APRA need train on only one system.

- **Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment**

As mentioned above, there are no significant barriers in place to achieving this outcome. APRA's EHR has been fully operational since FY 2011 and is offered to all contract providers in the District of Columbia at no cost. The system is web-based, so the program is responsible only for the cost of the hardware and internet connection necessary to support access to the system for all clinical and administrative personnel.

APRA has spent FY 2013 preparing for the implementation of the Adult Substance Abuse Rehabilitation Services (ASARS) benefit in the District of Columbia. One of the major areas

of preparation for this important development is to integrate eligibility and billing protocols into APRA policies and procedures. Currently, the Medicaid 837 and 835 protocols which allow the submission of billing and receipt of payment, respectively, are fully operational within DATA for a selected pilot program and will be implemented system-wide during FY 2014. The 270 and 271 protocols which allow the user to inquire as to Medicaid eligibility and receive an eligibility report, respectively, are already fully operational at the current Department of Mental Health (DMH). On October 1, when the two agencies merge to form the new Department of Behavioral Health, the substance abuse system will have full access to this capability and it will be incorporated into eligibility screening policies at the Assessment and Referral Center as well as other current APRA intake sites.

- **Identify the specific technical assistance needs the state may have regarding data and information technology**

As APRA begins the process of merging with DMH, the need for an integrated data system that addresses the co-occurring needs of client will be the priority. Creating a system that will allow for one treatment plan that will guide all parties involved with a client's care will be an important step towards health integration. Guidance and financial assistance from SAMHSA in navigating the federal requirements of HIPAA and 42-CFR will be helpful as we District Automated Treatment Accounting System (DATA). Built upon the WITS platform develop an integrated EMR.

Section R

CQI Plan for FY 2014/2015

In addition to becoming a data driven agency, APRA has adopted a focus of continuous quality improvement. APRA recognizes that it must create a structured process for identifying gaps, analyzing and improving service delivery. Through the Department of Health's PHARB accreditation grant, APRA was able to train 11 employees in CQI tools and methodologies. As a result, APRA has instituted a number of internal and external workgroups that informs the CQI process and helps to promote a Total Quality Management (TQM) environment. Adopting the TQM philosophy will establish a new culture for behavioral health that will promote growth and longevity, build partnerships and meaningful collaborations with community agencies. This will also allow the agency to thrive in the changing healthcare environment and provide personal job satisfaction for internal and external staff by allowing for their input, creativity and efficiency in the work that they do.

There are at eight major principles of the TQM. They include: customer focused mission; strong leadership; recruitment of stakeholders as change agents; system wide process approach; promoting efficient and effective systems; data driven decisions; continual improvement; and, fostering mutually beneficial relationships. Over the past year APRA has been developing a foundation of CQI/TQM that will continue in 2014/15. Our focus is to become a customer focused agency that creates a team of change agents that will be instrumental in accomplishing our goals to improve the system of care for our clients.

Comment [S1]: What is this? Is it an acronym?

Our customers consist of: clients who are seeking treatment or recovery services; providers that look toward the SSA for oversight, guidance and support; community partners that also serve our clients; and, internal staff. In effort to learn more about these stakeholders and become more customer focused, APRA has begun to address the needs of our customers by instituting a process for client satisfaction surveys, provider meetings that illicit structured feedback and creating meaningful partnerships with community agencies. APRA has also created a Clinical Director's Learning Community that facilitates the improvement of clinical practice by fostering peer leadership and encouraging the clinical directors to become change agents within their agency. In 2014/15, the focus of the Clinical Director's Learning Community will be to assist them in incorporating CQI tools into their clinical process and help them to create a culture of quality improvement with their staff.

APRA has developed an internal provider review roundtable to create efficient and effective systems that will move us towards achieving our goals. This is done through a review of all departments' data on provider performance. APRA has also instituted monthly staff meetings that focus on creating teams that are energized and feel like they are actively contributing towards achieving goals. Responsibilities related to the CQI/TQM process will be included in employee performance plans are created to make sure that every person in the agency is working towards achieving the goals for their department that also feed into the overall goal for the agency.

In effort to engage our external stakeholders APRA has created a CQI Council comprised of internal and external staff to identify problems and use CQI tools (e.g., flowcharting, statistical process control, Pareto analysis, cause and effect diagrams, etc.) to improve service delivery. Additionally, APRA has created a Recovery Advisory Council (RAC) comprised of stakeholders and consumers that will advise on long term planning, create a community voice for recovery and participate in creating a recovery oriented system of care in the District of Columbia. Also, APRA has engaged other government partners in the CQI process to improve access and services for the clients we share.

A component of the CQI process is the development of a comprehensive plan to monitor the delivery of all services that APRA delivers. This plan will identify target areas where resource allocation is necessary to align the quality of service with APRA's core strategic objectives and maximize the probability of desired outcomes. There are certain data sources APRA has consistently utilized for planning purposes such as the Treatment Episode Data Set (TEDS) and National Outcome Measures (NOMS). Recovery support services are currently being provided under (and measured through) the Access to Recovery (ATR) grant. However, in anticipation of the ATR grant ending after FY 2014, there are efforts already underway to continue these services under other funding streams. As this process takes shape in FY 2014, and the future of Recovery Support Services in the District becomes clearer, these measures will be refined accordingly to reflect the new landscape. More recently, APRA has developed core metrics to evaluate performance and outcomes achievement for FY 2014. These measures have been informed by; APRA's strategic objectives, programmatic priorities and available staff and IT resources. The measures are as follows:

Treatment:

Comment [AM2]: Judy, will you have any indicators?

- 3) **Discharge Type Distribution:** The distribution of, specifically, successful completions, dropouts, treatment terminations and referrals to other services.
- 4) **Length of stay:** The number of days between the admission date and the last date of service. This information is consolidated into clusters unique to the facility's level of care. Facility-level aggregates are collected as well as level of care aggregates (all residential, all detox, etc.)
- 5) **Continuum of Care Usage:** The number of clients successfully completing each residential provider who are connected to outpatient follow-up services as well as the number referred to Recovery Support Services. This metric is presented as a 2 X 2 matrix with the quadrants representing treatment only, recovery support only, both services, neither service. This measure is aggregated at the facility level as well as a combined measure for all residential facilities.
- 6) **Service Type Distribution:** The number of billed sessions of every service type within a given time frame (group counseling, individual counseling, family counseling, case management, assessment, and treatment plan development and/or modification). Due to the current billing format, this metric can only be applied to outpatient programs.
- 7) **Encounter Note Turnaround Time:** The number of days that pass between the date of the service and the date the note is created. This metric has been developed to give providers feedback on their adherence to the Medicaid requirement of documenting service within 48 hours. These data are presented visually in a column chart with each column corresponding to a specific range of turnaround time. Presented in this manner, the program can learn not only the degree to which it is in compliance of the future rule, but also how close it is to compliance with the rule.

Comment [TM3]: Correct numbering

Recovery:

- 1) What percentage of clients have had new arrests since the onset of services?
- 2) What percentage of clients are in independent living at discharge?
- 3) What percentage of clients are employed at discharge?
- 4) What percentage of clients are attending self-help (e.g. 12-step meetings) in the community at discharge?

Finance:

- 1) Does the program have a documented 90-day cash reserve?
- 2) What is the current asset-to-liabilities ratio? Target for this indicator is 1:1.
- 3) Does the program have a current Clean Hands Status? This status indicates the program is in compliance with all tax obligations.
- 4) Is the Triennial audit current? The Management Letter Comments and provider responses must be included in the documentation for this requirement to be satisfied.

These are APRA's current metrics for evaluating critical outcomes and measuring the effectiveness of services. APRA will monitor these core metrics for every provider regularly over the course of five years. This plan will be revised after one year and the secondary set of metrics will be revisited to match our new improvement initiatives. At that point, metrics may be added if there is a gap in the information necessary to monitor outcomes effectively or if changes in the strategic plan of the agency necessitate new measurements of performance. An existing

metric may be eliminated or replaced if that action is justified by revisions to the agency strategic plan and/or improvements in collection methodology.

The data that emerges from these metrics, trended over time, will give APRA/DBH the information it needs to determine the programmatic improvements occurring within the system. APRA will take this information into account when developing: priorities for training; technical assistance; staffing; enhancements to the EHR; and, procurements of new software for monitoring purposes. Additionally, these metrics will inform the process of developing the Key Performance Indicators (KPIs) for DBH. The KPIs are a set of agency-wide measurements submitted to the City Council and the Office of the Mayor to provide ongoing feedback to the public on the performance of District Government agencies.

APRA will conduct Customer Service Surveys in the Assessment and Referral Center and at contracted treatment providers to evaluate the client perspective on services rendered within the public substance abuse system. This information will inform decisions and priorities in training, technical assistance and further exploration through monitoring. APRA will re-examine the survey content annually and make necessary revisions. This process will: remove any items that are no longer relevant; revise items that require refined wording or clarity; add items that reflect emergent focus areas in customer service; and, take into account client feedback. The data from previous rounds of surveying, and feedback from personnel conducting the survey, will be taken into account when revising the survey items.

APRA's Chief of Policy and Planning processes all complaints. Complaints are documented and submitted on Unusual Incident/Grievance Report Form. The Chief of Policy and Planning reviews the information and a Notice of Investigation is sent to the provider or administration. The facility or administration will have a 10-day period to respond to the Notice of Investigation. The facility or administration must: confirm or deny each stated allegation; provide a detailed explanation of the circumstances relevant to each allegation; take actions to address any allegation for which there is a factual basis; and, take steps to decrease the likelihood of recurrence (both immediate and long-term). In addition, the response must include the documents identified in the attached Request for Documents. If necessary, the facility or administration may request an extension of up to 10 calendar days in order to complete the investigation (29 DCMR § 2330.7(d)). Written findings of the investigation must be submitted to APRA within 24 hours of completing the investigation (29 DCMR § 2330.8). As part of the CQI process, APRA has adopted a standard grievance investigation process that is strictly adhered to. Every person that files a grievance receives a receipt that acknowledges that his or her grievance has been entered in a formalized process. The Risk Manager identifies the issues and makes a determination if actions are needed to prevent additional harm before the investigation begins. The investigative team then gathers and analyzes information to develop recommendations.

APRA has developed a Continuity of Operations Plan (COOP) plan in collaboration with the Department of Homeland Security and Emergency Management Agency. The COOP is initiated in the case of a critical incident. Emergency planning exercises are conducted regularly as APRA believes practicing is essential to ensure effective execution of the COOP during actual critical incidents.

S. Suicide Prevention

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document *Guidance for State Suicide Prevention Leadership and Plans* available on the SAMHSA

APRA recognizes that many District youth experience risk factors associated with suicide that include exposure to violence, trauma, poverty and substance abuse. The DC Department of Health works to prevent youth suicide through its Capital CARES Program (Citywide Alliance to Reduce Risk for and Eliminate Youth Suicide) funded through SAMHSA. Capital CARES provides suicide and mental health screenings in schools and in the community with parental consent, trains adults to recognize when a youth is at risk, and funds community based suicide prevention programs for youth with demographic and/or behavioral risk factors for suicide. In addition, DMH supports a 24/7 emergency crisis service for youth experiencing a psychiatric or emotional crisis. Teams of mental health clinicians respond to emergency calls whether in schools, the home or community. In addition, trained mental health counselors are available by phone 24/7 on the Suicide Prevention Hotline at 1-800-273-8255.

APRA prevention staff participated in the Capital CARES citywide in order to learn more about dispelling myths and encouraging care for youth and their families may be struggling with depression, thoughts of suicide and other mental health issues. APRA is in the process of merging with DMH to create the Department of Behavioral Health. During this juncture, the District plans to reassess the current suicide prevention plan and make revisions as ne

In addition, APRA has met with the DC General of the National Guard followed by meeting with Drug Demand Reduction Program staff. APRA Office of Prevention is identifying areas for long term partnerships including *Stay on Track Program*, Drug Awareness, DDR Lite All in higher risk geographic areas, Drug Education for Education (DEFY), *Plant the Promise*, and the DC National Guard Challenge Program. APRA is planning meeting with the DC National Guard, the new Army National Guard Program Manager based in the DC area, and the DC Prevention Centers.



D.C. Suicide Prevention Plan

Goal 1: Promote awareness that suicide is a serious public health problem and that many suicides are preventable			
• Objectives	• Activities	• Outcomes Expected	• Products/Outcomes as of October 2011

<ul style="list-style-type: none"> • Create culturally competent social marketing campaign on risk factors for suicide and depression 	<ul style="list-style-type: none"> • Create a series of multilingual (Spanish, English, Aramaic etc.) posters, brochures to be distributed to schools, recreation centers, collaborative centers, boys/girls' clubs, barber shops, shopping centers, churches, hospitals, detention centers, pediatrician's offices, health fairs, emergency rooms, workshop sites. • Distribute information about suicide prevention through an advertising campaign utilizing billboards, radio ads, television in Spanish and English 	<ul style="list-style-type: none"> • By 2010, 10% of residents of D.C. will have been exposed to some suicide prevention materials • By 2011, 25% of residents of D.C. will have been exposed to suicide prevention materials • By 2015, all residents of D.C. will have been exposed to some suicide prevention materials • Increased # parents will consent for screening. • Increased # groups will request materials. 	<ul style="list-style-type: none"> • Social Marketing Campaign created: I Am The Difference (posters depict youth of difference ethnicities) • Materials distributed widely • Chat and Chews in community planned for Fall • Radio Ads ran end of Aug thru September on WKYS • Radio to run again Thanksgiving thru Christmas • 750,000 people in DC – at least 10% reached via radio, materials •
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Comment [AM4]: Has this already occurred?

<ul style="list-style-type: none"> • Provide information about suicide prevention and awareness to established groups 	<ul style="list-style-type: none"> • Present DC suicide plan and information on suicide prevention to local working groups such as interfaith boards, Mayor's Reconnecting Disconnected Youth Board, School Health Work Group, relevant Boards and Commissions • Collaborate with local mental health associations to reach DC residents (NAMI DC, Mental Health America DC, Mental Health Association of DC) 	<ul style="list-style-type: none"> • Present to established groups by 2010 • Present yearly to update groups and expand efforts 	<ul style="list-style-type: none"> • Have worked with some groups – Children and Youth Directors, Children's Hospital planned in Oct, School nurses planned in Oct, • NAMI and Mental Health America attended our conference
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<ul style="list-style-type: none"> • Collaborate with local conferences and forums and provide awareness and education about suicide prevention and intervention 	<ul style="list-style-type: none"> • Present at local conferences or meetings • Seek out conferences that incorporate faith community as well as Latino, GLBT, school officials. 	<ul style="list-style-type: none"> • Present at local events each year 	<ul style="list-style-type: none"> • Held DC Youth Suicide Prevention conference • Two migrant partners reaching out to faith community
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<ul style="list-style-type: none"> • Collaborate and partner with other community health programs such as community outreach workers on substance abuse, HIV 	<ul style="list-style-type: none"> • Present jointly at local forums • Train community outreach workers in signs and symptoms of suicide as well as risk factors 	<ul style="list-style-type: none"> • Present at least three local forums or trainings each year 	<ul style="list-style-type: none"> • DOH has a QPR Trainer
Goal 2: Develop broad based support for suicide prevention			
<ul style="list-style-type: none"> • Objectives 	<ul style="list-style-type: none"> • Activities 	<ul style="list-style-type: none"> • Outcomes 	<ul style="list-style-type: none"> • Outcomes/Products as of October 2011

<ul style="list-style-type: none"> • Establish task force to address youth suicide and to initiate goals of this plan. 	<ul style="list-style-type: none"> • Expand the STOP Suicide Advisory Board to include representatives from other agencies including: Mayor's Executive Group, DMH, DOH, DJJ, Chancellor's Office, MPD, DOES, DCPS, residential programs, Universities, primary care, suicide organizations such as AAS and SPAN, community providers, parents, youth. 	<ul style="list-style-type: none"> • Task force will be created and meet at least quarterly 	<ul style="list-style-type: none"> • Coalition meets bimonthly – well supported public/private
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<ul style="list-style-type: none"> • Increase the number of professional, volunteer, faith community, and other groups that integrate suicide prevention activities into their ongoing activities and adopt policies to prevent suicide 	<ul style="list-style-type: none"> • Develop community/neighborhood partnerships • Identify organizations who can outreach to parents, youth • Reach out to church groups (Health Ministries) 	<ul style="list-style-type: none"> • # of groups who request materials, trainings • # groups who incorporate suicide prevention activities into their organizations 	<ul style="list-style-type: none"> • Nine migrant partners • At least 50 different agencies receiving materials • 58 trainings completed • Policy change at CFSA for foster care parents
<p>Goal 3: Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services</p>			
<ul style="list-style-type: none"> • Objectives 	<ul style="list-style-type: none"> • Activities 	<ul style="list-style-type: none"> • Outcomes 	<ul style="list-style-type: none"> • Outcomes/Products as of October 2011

<ul style="list-style-type: none"> • Address beliefs of residents and consumers in D.C. to reduce stigma associated with receiving mental health and substance abuse services 	<ul style="list-style-type: none"> • Develop outreach materials and social marketing campaign that is culturally competent • Create suicide prevention/health and wellness materials for distribution in physicians' offices, schools • Materials will be available in multiple languages • Emphasize neurobiological basis of many mental disorders and promote effective medicines and therapies 	<ul style="list-style-type: none"> • 50% of DC youth referred for therapy by screening program will stay in treatment for at least two appointments • Materials will be distributed during all well visits. • There will be an increase in the percent of parental consents received for screening and education in suicide. 	<ul style="list-style-type: none"> • 84% youth referred were linked within three months and went to at least one appointment • Materials to be given to school nurses in Oct 2011 • Materials to be disseminated to pediatricians • Of 60% of returned consent forms – 58% parents approved
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<ul style="list-style-type: none"> • Provide education for families of youth involved in the mental health system for suicide, substance abuse or other mental health issues • Work with Medicaid Managed Care Organizations to increase identification of covered services for the Medicaid population 	<ul style="list-style-type: none"> • Materials and support groups will be available for families • Work through the local Income Maintenance Administration to develop an MOU to increase oversight of interventions on behalf of the Medicaid population 	<ul style="list-style-type: none"> • At least 2 new support groups will be established in different regions of the city through churches, hospitals, community based organizations or mental health agencies 	<ul style="list-style-type: none"> •
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<ul style="list-style-type: none"> • Increase the number of suicidal youth with underlying mental health disorders who receive appropriate mental health treatment 	<ul style="list-style-type: none"> • Identify youth through screening and education and link to treatment 	<ul style="list-style-type: none"> • 33% of schools will provide screening by 2013 • Schools will sustain screening year to year • Increased # of parents who provide consent for screening and treatment. • Increased # of youth referred for mental health services for depression and suicide. • Improved satisfaction with treatment services. • Referred youth will attend more appointments. 	<ul style="list-style-type: none"> •
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<ul style="list-style-type: none"> • Imbue cultural competence in all prevention strategies 	<ul style="list-style-type: none"> • Identify differences in the ways unique communities in DC respond to suicide prevention and mental health promotion 	<ul style="list-style-type: none"> • All suicide prevention programming will be culturally competent 	<ul style="list-style-type: none"> •
<ul style="list-style-type: none"> • Promote resilience 	<ul style="list-style-type: none"> • Incorporate wellness programs into DCPS health curriculum • Help promote use of youth external supports, inner-strengths, and interpersonal and problem-solving skills 	<ul style="list-style-type: none"> • All schools will conduct health and wellness prevention programs as part of Health classes by 2011 • Families of youth with mental health needs will receive support 	<ul style="list-style-type: none"> •
<p>Goal 4: Identify, develop, implement and evaluate youth suicide prevention programs</p>			
<ul style="list-style-type: none"> • Objectives 	<ul style="list-style-type: none"> • Activities 	<ul style="list-style-type: none"> • Outcomes 	<ul style="list-style-type: none"> •

<ul style="list-style-type: none"> • Develop technical support activities to build the capacity across the District to implement and evaluate suicide prevention programs 	<ul style="list-style-type: none"> • Establish collaborations with local stakeholders to share in training, education, and evaluation 	<ul style="list-style-type: none"> • Key positions and coalition will be established 	<ul style="list-style-type: none"> •
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<ul style="list-style-type: none"> • Create policy changes to increase suicide prevention programming and education 	<ul style="list-style-type: none"> • Work with DCPS to incorporate suicide prevention into health curriculum • Establish a policy that makes suicide prevention training mandatory for all school personnel • Make suicide prevention training available to police, recreation staff and other frontline workers 	<ul style="list-style-type: none"> • Suicide prevention will be taught in all health classes for middle and high school youth • All school personnel will receive at least 2 hours annually in suicide prevention • Auxiliary per 	<ul style="list-style-type: none"> •
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<ul style="list-style-type: none"> • Develop public/private partnerships with local organizations who work with youth at risk for related risk factors for suicide. 	<ul style="list-style-type: none"> • Develop partnership with National Campaign to Prevent Teen Pregnancy, Metro Teen AIDS, Latin American Youth Center 	<ul style="list-style-type: none"> • # organizations who partner • Provide training and/or screening annually. • There will be an increase in helping behaviors by youth affiliated with these organizations 	<ul style="list-style-type: none"> •
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<ul style="list-style-type: none"> • Identify youth at risk for suicide, suicidal behavior, and related risk factors 	<ul style="list-style-type: none"> • Conduct universal screening of depression and suicide in middle and high schools. • Conduct screening through local organizations such as Health ministries • Conduct suicide screening for youth in juvenile detention centers • Conduct suicide screening for youth in CFSA • Conduct suicide screening for youth enrolled in substance abuse treatment through APRA 	<ul style="list-style-type: none"> • Increased # of youth screened for depression and suicide annually. • # of settings conducting screening • # people trained to screen • # screenings held • At least 500 youth screened 	<ul style="list-style-type: none"> •
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<ul style="list-style-type: none"> • Train youth in signs and symptoms suicide and how to talk to friends at risk 	<ul style="list-style-type: none"> • Conduct education based prevention program in schools, community, churches • Train staff of organizations with youth workers such as teen pregnancy, HIV prevention in signs of suicide and how to incorporate into their prevention programming 	<ul style="list-style-type: none"> • The re will be an increase in help seeking behaviors by youth for mental health services. • # youth who receive training • # sites conducting training 	<ul style="list-style-type: none"> •
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<ul style="list-style-type: none"> • Train medical providers to conduct suicide assessments 	<ul style="list-style-type: none"> • Provide training to pediatricians, managed care organizations, school nurses, ER staff on suicide warning signs and risk factors 	<ul style="list-style-type: none"> • All youth will be asked about thoughts of suicide and depression during well visits • # youth identified through screenings in primary care setting s. 	<ul style="list-style-type: none"> •
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<ul style="list-style-type: none"> • Ensure availability of suicide hotlines 	<ul style="list-style-type: none"> • Encourage Department of Mental Health Access Helpline to become a certified crisis line through AAS 	<ul style="list-style-type: none"> • DMH will be a certified crisis hotline for 1800/273-TALK by 2009 	<ul style="list-style-type: none"> •
Goal 5: Promote efforts to reduce access to lethal means and methods of self-harm			
<ul style="list-style-type: none"> • Objectives 	<ul style="list-style-type: none"> • Activities 	<ul style="list-style-type: none"> • Outcomes 	<ul style="list-style-type: none"> •

<ul style="list-style-type: none"> • Reduce deaths by passive suicidal means 	<ul style="list-style-type: none"> • Develop partnerships with organizations to reduce risk factors for passive suicidal behavior such as through violence, HIV exposure, substance abuse • Incorporate training on risk factors related to suicide such as exposure to violence, substance abuse when working with youth, families, schools, and community partners 	<ul style="list-style-type: none"> • Increased # youth and families will recognize risk factors related to suicide behaviors • At least 500 youth annually participate in these activities 	<ul style="list-style-type: none"> •
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Goal 6: Implement training for recognition of at-risk behavior and delivery of effective treatment			
• Objectives	• Activities	•	•

<ul style="list-style-type: none"> • Identify individuals to be trained as “Certified QPR Trainers” 	<ul style="list-style-type: none"> • Establish group of individuals to be trained from diverse agencies within DC – including DCPS, DOH, DMH, DJJ, DOES, MPD, DCPS, CFSA, DYRS, organizations that serve charter schools, church representatives, parents, school nurses, neighborhood/community groups • Identify staff in programs who work with high risk youth to receive training through programs such as Metro TeenAIDS, Campaign to Prevent Teen Pregnancy, GLBT programs, Latino community 	<ul style="list-style-type: none"> • 50 individuals will be trained as certified QPR trainers • Pre/Post - tests by trainees will show increase in knowledge and skills acquisition • Within 5 years, 75% of staff at each of these age 	<ul style="list-style-type: none"> •
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<ul style="list-style-type: none"> • Train medical professionals in signs and symptoms of suicide and depression 	<ul style="list-style-type: none"> • Train pediatricians in signs and symptoms of suicide • Train hospital emergency room workers in signs and symptoms of suicide • Train mobile outreach groups (dental, pediatrics, maternal/child) in signs and symptoms of suicide 	<ul style="list-style-type: none"> • Train at least 100 individuals yearly involved in well visits 	<ul style="list-style-type: none"> •
Goal 7: Develop and promote effective clinical and professional practices			
<ul style="list-style-type: none"> • Objectives 	<ul style="list-style-type: none"> • Activities 	<ul style="list-style-type: none"> • utcomes 	<ul style="list-style-type: none"> •
<ul style="list-style-type: none"> • Enhance the abilities of providers to provide culturally competent, evidence-based management of youth in crisis 	<ul style="list-style-type: none"> • Provide training to DMH, CFSA, DJJ, CSAs and private providers, physicians, nurses • Provide training to all providers of mental health services in the management youth in a suicidal crisis • All training will be based on culturally competent principles 	<ul style="list-style-type: none"> • at least 500 individuals will receive training per year 	<ul style="list-style-type: none"> •

<ul style="list-style-type: none"> • Establish group of individuals who have received training in suicide prevention and identification in schools 	<ul style="list-style-type: none"> • Encourage schools to apply for school-based accreditation through AAS 	<ul style="list-style-type: none"> • At least 5 schools per year will receive accreditation in suicide prevention 	<ul style="list-style-type: none"> •
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<ul style="list-style-type: none"> • Promote therapeutic support for victims of violence and sexual abuse as risk factor for suicidal behavior 	<ul style="list-style-type: none"> • Identify youth who are victims of violence or sexual abuse • Promote linkage between violence and suicide • Youth with histories of violence or sexual abuse will be identified and providers working with these youth will incorporate screening for suicide and depression 	<ul style="list-style-type: none"> • 10% more youth yearly will be identified to mental health providers or receive prevention program from community based organizations with histories of 	<ul style="list-style-type: none"> •
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Goal 8: Improve access to and community linkages with mental health and substance abuse services			
• Objectives	• Activities	• Outcomes	•

<ul style="list-style-type: none"> • Ensure timely and accurate compliance with referrals of all youth referred to local mental health providers. 	<ul style="list-style-type: none"> • Create database and reporting mechanisms for data regarding screening, referral, and compliance with recommendations • Monitor and track length of time from referral to first appointment 	<ul style="list-style-type: none"> • 50 % of youth will be linked to services within one month of screen • 75 % of youth will be linked to service within six months of screen 	<ul style="list-style-type: none"> •
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<ul style="list-style-type: none"> • Determine length of treatment 	<ul style="list-style-type: none"> • Assess whether youth stays in treatment for at least two appointments 	<ul style="list-style-type: none"> • Collaborate with treatment providers to obtain follow-up data on at least 50% of youth referred for treatment 	<ul style="list-style-type: none"> •
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<ul style="list-style-type: none"> • Ensure satisfaction of services rendered 	<ul style="list-style-type: none"> • Conduct parent satisfaction surveys. 	<ul style="list-style-type: none"> • 50 % of parents with youth referred for treatment will complete Satisfaction Survey 	<ul style="list-style-type: none"> •
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<ul style="list-style-type: none"> • Compile and update a guide to DC suicide prevention resources and services 	<ul style="list-style-type: none"> • Update resource list to include local, state, and national organizations with a focus on suicide awareness, prevention, intervention, and aftercare. • Distribute list widely. 	<ul style="list-style-type: none"> • Guide will be available at schools, mental health centers, local organizations, pediatricians by 2012 	<ul style="list-style-type: none"> •
Goal 9: Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media			
<ul style="list-style-type: none"> • Objectives 	<ul style="list-style-type: none"> • Activities 	<ul style="list-style-type: none"> • Outcomes 	<ul style="list-style-type: none"> •

<ul style="list-style-type: none"> • Increase the number of local television programs and news reports that observe recommended guidelines in the depiction of suicide and mental illness 	<ul style="list-style-type: none"> • Provide guidelines from AAS to local media outlets 	<ul style="list-style-type: none"> • Local news agencies will make changes to their reporting 	<ul style="list-style-type: none"> •
Goal 10: Promote and support research on suicide and suicide prevention			
<ul style="list-style-type: none"> • Objectives 	<ul style="list-style-type: none"> • Activities 	<ul style="list-style-type: none"> • Outcomes 	<ul style="list-style-type: none"> •

<ul style="list-style-type: none"> • Promote youth suicide prevention research 	<ul style="list-style-type: none"> • Develop partnerships with universities to collect, analyze, and disseminate data on youth suicide prevention and training 	<ul style="list-style-type: none"> • Data and activities of the DC Suicide Prevention Coalition will be analyzed annually and distributed 	<ul style="list-style-type: none"> •
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<ul style="list-style-type: none"> • Evaluate prevention programs 	<ul style="list-style-type: none"> • Gather data on universal suicide prevention programs on numbers of youth identified with suicidality, depression, substance abuse • Gather data on numbers of youth linked effectively to treatment for mental health services following screening • Gather data on numbers of youth identified as suicidal as a result of gatekeeper training • Gather data on numbers of youth identified through classroom-based peer prevention programs 	<ul style="list-style-type: none"> • Data and activities of the DC Suicide Prevention Coalition will be analyzed annually and distributed • Data will be presented at national and local co 	<ul style="list-style-type: none"> •
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Goal 11: Improve and expand surveillance systems		
• Objectives	• Activities	• Outcomes
<ul style="list-style-type: none"> • Synthesize suicide data for the District 	<ul style="list-style-type: none"> • Obtain data from all relevant stakeholders (hospitals, Child Fatality Review Committee, police, schools, crisis response teams, Access Helpline) with regard to youth suicide (completions, attempts, hotline calls) in the District • Determine STIPDA representative for District • Encourage DC to establish National Violent Death Reporting System 	<ul style="list-style-type: none"> • Stakeholders will provide data to central repository • DC will contribute to NVDRS

<ul style="list-style-type: none"> • Increase the number of hospitals and local service providers that code for external cause of injuries 	<ul style="list-style-type: none"> • Encourage hospitals to code for suicidal behaviors • Encourage police to report on transporting suicide victim 	<ul style="list-style-type: none"> • Hospitals will use codes for external causes of injury 	<ul style="list-style-type: none"> •
<ul style="list-style-type: none"> • Produce an annual report on youth suicide 	<ul style="list-style-type: none"> • Present findings to District leaders (Mayor, City Council) and recommend changes 	<ul style="list-style-type: none"> • Annual report will be distributed yearly 	<ul style="list-style-type: none"> •

T. Use of Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;

How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;

- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

To date, the District has not deployed Interactive Communication Technologies to support recovery. APRA is interested in ensuring that providers utilize text messaging, recovery tools, prompts, and case manager support and guidance to support clients' recovery process. In the next two years, the District will ensure that the aforementioned specific technologies are reviewed for appropriateness and fitness with the populations it serves and includes the use of these technologies as requirements in provider contracts. Providers who implement and use the recommended technologies will be able to demonstrate better outcomes which will in turn allow the provider to be more viable and competitive in a fee-for-service environment.

The District will strengthen its relationships with FQHC's in the next two years and already has identified one FQHC that is included in this application – La Clinica del Pueblo. APRA already has received notification from La Clinica del Pueblo that it is interested in participating in an SBIRT implementation. La Clinica del Pueblo will be a critical partner in the effort to work closely with a local FQHC to integrate behavioral and primary care.

Nonetheless, the APRA has spent much of the past year developing a collaboration with the Child and Family Services Agency (CFSA). CFSA provides services and family stabilization resources to families and children alleged to be abused and/or neglected through the coordination of public and private partnerships. The two agencies have been collaborating around improving the quality of services for those in the child welfare system that also require assessment and treatment for substance use issues.

In September of 2012, APRA funded and hosted training for selected CFSA personnel in Screening, Brief Intervention and Referral to Treatment (SBIRT). In 2013, CFSA, with APRA's guidance, implemented the Global Appraisal of Individual Needs Short Screener (GAIN-SS) for selected cohorts of their population to determine the need for full assessments. In FY 2014, CFSA will begin conducting these screenings electronically through the District Automated Treatment Accounting (DATA) System, the Electronic Health Record for substance abuse services in the District of Columbia. This web-based system for administering the screening instrument will allow the results to be stored in the client's electronic record and scored electronically, eliminating human error. The results can be communicated to other stakeholders using the system through electronic consent. Aggregate data from these screenings can also be compiled to detect trends in the population, particularly the co-occurrence of substance use disorders and other mental illnesses.

CFSA is continuing this year to build internal capacity in the SBIRT framework. They will be training approximately 10 additional staff in the framework at Howard University. The training

program at Howard makes extensive use of interactive technology, as there are simulated scenarios trainees complete which are conducted electronically in a computer lab.

U. Technical Assistance Needs

1. What areas of technical assistance is the state currently seeking?

APRA has a current technical assistance request in process to review literature, facilitate targeted focus groups, and guide the development of a long term strategic plan for the DC Youth Prevention Leadership Corps.

The state's Recovery Support Services Department is currently receiving technical assistance in preparation for the merger of substance abuse and mental health services. To date APRA has facilitated trainings on the following topics:

- Co-Occurring Disorders/Mental Health & Substance Abuse Integration;
- Connecting the Dots: Making The Case for the Provision of Integrated Care;
- Boot Camp for the Front Line: Integrated Care for People with Both Mental Health and Substance Use Challenges.

APRA currently has a technical assistance request in process to review literature, facilitate targeted focus groups, and guide the development of a long term strategic plan for the DC Youth Prevention Leadership Corps.

2. What are the sources of technical assistance?

SAMHSA has been highly supportive in responding to DC prevention technical assistance requests through the Center for Substance Abuse Prevention (CSAP). The State Division management and the DC Project Officer provide quick responses to technical needs or guidance on policy and programmatic questions. In addition, the Center for Disease Control provides technical assistance for APRA's Tobacco Control Grant and the Food and Drug Administration for APRA's tobacco grant.

Additionally, we have received technical assistance for SAMHSA's Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS-TACS) Policy Academy, and CMHS provided technical assistance for the Minority AIDS Initiative Targeted Capacity Expansion (MIA-TCE) program.

The state's Recovery Support Services Department receives technical assistance from SAMHSA/CSAT, Atarum Institute, Inc. grantee contractor.

SAMHSA has been highly supportive in responding to DC prevention technical assistance requests through the Center for Substance Abuse Prevention (CSAP). The State Division management and the DC Project Officer provide quick responses to technical needs or guidance on policy and programmatic questions.

3. What technical assistance is most needed by state staff?

Despite organizational leadership changes, the APRA Prevention Division has made progress in strengthening prevention knowledge, skills, and key competencies. Some training and technical assistance needs are being met through the DC Human Resources training (e.g. Training of Trainers, Building High Performance Teams, Performance management, LGBTQ awareness, Leadership versus Management, Presentation skills development, Technical writing, Diversity training; Sexual Harassment).

As APRA prevention merges into the new Department of Behavioral Health, there is a need to address system-wide prevention development with new tools. Illustrative of that, current federal evidence-based prevention strategies, programs, and practices are needed that address an urban environment and culturally diverse populations.

The treatment staff would benefit from receiving public health leadership technical assistance that will help build a competent workforce that will be able to navigate the uncharted territory of the Affordable Care Act and the implementation of Medicaid. Providing staff with project management skills, change management skills and research and data management skills will create a proactive workforce that will be able to meet the demands of the changes in behavior health field.

APRA is in the process of unrolling three major initiatives that will impact our entire network, integrative care, trauma informed care and Recovery Oriented System of Care. Technical assistance would be beneficial as we attempt to take on these large system changes.

APRA's recovery support staff would like to receive technical assistance that will help them improve their client engagement and follow up strategies, community engagement strategies and staff self-care.

4. What technical assistance is most needed by behavior health providers?

The recovery support services provider network have requested technical assistance on engagement and retention strategies, documentation practices, billing practices, co-occurring disorders and recovery support, trauma informed care, and special populations-LGBTQ, women, parents, youth & young adults, and homeless families.

The substance abuse treatment providers need technical assistance on the Affordable Care Act, Medicaid billing, and trainings that would assist them in becoming fiscally sound in this fee for service environment.

APRA's network of providers will need intense ongoing technical assistance in creating a system of care that is focused on recovery, integrated health and trauma informed care. As we move forward towards focusing on research, data and evidence based programs, our providers will need trainings and technical assistance in order to fully immerse their organizations in this new model.

APRA's strategy for improving clinical services has been to strengthen the clinical directors and lead clinicians in our network by providing trainings on treatment planning, documentation. This has proven to have an impact on clinical care; however, due to funding constraints it is difficult to provide training for our entire network. Technical assistance on creating sustainable training programs, such a webinars and training materials would be helpful to providers that do

not have a budget for ongoing education for their staff. Additionally, behavior health leadership trainings would help the clinical directors become chain agents at their organizations.

APRA's opiate treatment providers have requested technical assistance on integrating additional medication assisted therapies into their services. Also, assistance on how to fully integrate robust primary health and HIV/AIDS services for the opiate addicted population would be helpful as we begin to focus on the health of the clients we serve.

V. Section

In an ongoing effort to improve the quality of service coordination for young people in the District of Columbia with substance use disorders, APRA has been fostering partnerships with other youth-serving agencies in the District government.

Currently, APRA is in the final phases of developing a Memorandum of Agreement (MOA) with the Child and Family Services Agency (CFSA) and the Family Treatment Court (FTC). CFSA provides services and family stabilization resources to families and children alleged to be abused and/or neglected through the coordination of public and private partnerships. This collaboration is nearing the end of the planning phase. Some elements, such as client screening and data sharing, have already begun implementation and will be fully implemented in FY 2014.

Under this plan, CFSA personnel will conduct screenings on selected cohorts of youth and adults with child welfare involvement using the Global Assessment of Individual Needs Short Screener (GAIN-SS). This screening process has already begun implementation. Those whose screening results indicate that a full assessment is indicated will be referred electronically to the appropriate location for a full assessment and, subsequently, treatment services as appropriate. The screening, referral, and information sharing processes will all take place electronically using the District Automated Treatment Accounting (DATA) System.

Additionally, in collaboration with CFSA the Family Treatment Court will use the DATA system as a referral, case management and care coordination tool. The FTC substance abuse coordinator, the CFSA substance abuse coordinator, the Assessment and Referral Center counselor and the treatment counselor will be able to share clinical information electronically through the DATA system.

The MOA currently in development formalizes these processes. It lays out rules and policies regarding access to the DATA System, data sharing, and protections for confidential information and ongoing communication between the two agencies at the administrative level to monitor and improve the quality of coordination.

Built upon the aforementioned collaboration model with CFSA, APRA is in an earlier planning phase with the Department of Youth Rehabilitation Services (DYRS). DYRS is responsible for the supervision, custody, and care of young people charged with a delinquent act in the District in specific circumstances. Due to certain staff changes at DYRS, the progress on this collaboration has not moved forward as quickly as we had hoped; however, in FY 2014, we

look forward to resuming efforts to build this collaboration to assist District residents with both substance use issues as well as juvenile justice involvement.

In addition, APRA has been an active participant in the Behavioral Health Access Team (BHAT), one piece of DMH's SAMHSA System of Care Grant. This grant focuses on establishing a "No Wrong Door" policy in the District and reducing barriers to entry into needed services. The BHAT is a multidisciplinary team with representation of CFSA, DYRS and DC Public Schools among others as well as extensive representation of parent advocates from the community. The deliverables of the team include a shared registration form for use by all youth-serving systems to reduce replication of services and establish a basic platform for assembling a cross-system data pool of service-seeking youth. Another objective of this team is to incorporate the input of consumers/clients and parents into the development of policies, procedures and training plans to enhance the quality of the experience youth and parents receive when seeking out behavioral health services.

APRA also submitted an application for the State Youth Treatment (SYT) Grant earlier this year and was awarded. With this grant, two of the four adolescent providers will be selected to implement the Adolescent Community Reinforcement approach (A-CRA) for adolescent clients with co-occurring disorders. This grant represents a unique opportunity to build capacity for treating adolescents with co-occurring disorders as well as build capacity for family interventions, as this evidence-based practice includes a substantial family component.

Also, APRA is in the final phases of developing a Memorandum of Agreement (MOA) with the Criminal Supervision and Offenders Services Agency (CSOSA) and the District of Columbia Pretrial Service Agency (PSA) in effort to improve the referral, assessment, treatment and recovery services for the criminal justice population in the District of Columbia. The MOA with CSOSA and PSA will ensure that clients are connected to treatment and recovery services, enable APRA to obtain clinical information from collateral sources that will facilitate accurate level of care placement, and allow the treatment providers to communicate with the client's probation/parole officers.

Section W: State Behavioral Health Advisory Council

In lieu of the impending merger of APRA with DMH to form the new Department of Behavioral Health (DBH), and the fact that per the SAPT block grant application, the substance use disorder SSA is not required to establish a Behavioral Health Advisory Council (Council), APRA leadership has decided not to establish a Council at this time. APRA has several advisory bodies in existence, and as part of the planning activities of the merger, is working with DMH to restructure the advisory group infrastructure to ensure a more efficient use of our stakeholders and their time. This process will include reviewing the role of the existing Council for DMH, and possibly how to best integrate other groups into the Council.

X. Enrollment and Provider Business Practices, Including Billing Systems

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- ⊖ • Outreach and enrollment support for individuals in need of behavioral health services.
- ⊖ • Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- ⊖ • Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- ⊖ • Third-party contract negotiation.
- ⊖ • Coordination of benefits among multiple funding sources.

The District provides care coordination at different access points throughout the continuum of care. At The Assessment and Referral Center, clients can expect the following: Nurses meet with everyone who comes for service. If immediate medical assistance is needed, the ARC nurses will make sure the client receives the help needed. Everyone's situation is different. The ARC counselors take the time to learn about each client to make sure the client receives the services best suited to his/her specific needs. Once the program that best suits the client is determined, the client will work with an ARC counselor to choose the best program for that individual. At the provider level, clinicians conduct a comprehensive assessment to determine the plan for treatment. The plan for treatment varies according to the level of care in which the client is assessed. At certain intervals, the treatment plans are updated, and if appropriate, a reauthorization for continued care is required. As clients progress throughout the continuum, their benefits package is adjusted to permit the individual to benefit from appropriate treatment.

The District's electronic health record allows clinicians to select the payor of service according to the client's eligibility. The EHR automatically structures the benefit limit according to the individual's authorization for level of care. Upon intake and nightly, the EHR runs an eligibility report and enrolls the individual into a payor plan. Currently, the District's APRA administration offers the Choice in Drug Treatment Act payor plan (our local and Block Grant funded plan) and Medicaid Adult Substance Abuse Rehabilitation Services (ASARS) plan. The District also leverages funding through our intergovernmental partners as well as sister agencies. All of these funding streams are integrated into a payor plan and pre-set for use in the EHR.

Section Y: Comments

Per Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51), DOH/APRA is providing an opportunity for the public to provide comment on the State Block Grant Plan, by posting the plan to the DOH/APRA website for public review. Along with posting the document, staff contact email will be provided to facilitate public response to the Block Grant Plan. The comments will be compiled and reviewed prior to the final application submission. As required, the final application will also remain on the website for 60 days after the submission.

Planning Steps: Prevention

Planning Steps: Prevention

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

Prevention is a priority in the District's System of Care and expected to expand as the Addiction Prevention and Recovery Administration (APRA) merges with DMH on October 1, 2013 into a new Department of Behavior Health (DBH).

The APRA community prevention system was designed in 2009 following internal and external assessments of need, resources and capacity. In cooperation with two universities, APRA conducted more than 350 *Community Conversations* with individuals, agencies, and community partners. Reports from the focus groups yielded consistent findings across the 8 wards:

- There is confusion about the differences among prevention, intervention and treatment;
- There is minimal prevention presence in communities and a dependence on APRA funding;
- There is a high level of substance abuse across the wards and a low level of prevention resources;
- Prevention resources are fragmented across the wards and focused on short term programs, events and school presentations;
- There is no data-driven strategic planning process for prevention ;
- There is no formal coordination among community groups, APRA and/or intermediaries;
- There is a lack of knowledge about evidence-based strategies (policies practices, and programs including environmental approaches) and culturally appropriate services in communities;
- The current prevention infrastructure has neither the organizational or systems capacity to effectively address National Outcome Measures and District needs;
- There is a high level of support for prevention in communities across the 8 Wards.

APRA conducted an internal assessment around four key prevention infrastructure areas and 17 key indicators. The four areas were: 1) system organization and development; 2) leadership; 3) planning and managing for outcomes; 4) resource development and management.

APRA had issued the same Request for Application for more than 10 years with little or no documented outcomes. Several observations were made when APRA met with the program directors. At that time, APRA funded 11 prevention grants at \$60,000 each.

In general:

- The overall costs of purchasing, administering and implementing evidence-based programs exceed the amount of the grant award;

- Small grant program awards limited participation to an average of 25 individuals, leaving much of the District without prevention coverage;
- Program implementation often lacked fidelity and did not address the unique needs of urban and culturally diverse populations;
- Recruiting and retaining participants was an ongoing challenge despite program incentives;
- Some grant recipients labeled their program as “evidence-based” but did not realize there were definitions or a federal list of programs with that designation;
- With one exception, data collection was limited to process information which was often incomplete or not reported.

APRA had received a Substance Abuse and Mental Health Administration (SAMHSA) DC Epidemiological Outcomes Workgroup (DCEOW) contract; however, the data was primarily focused on the criminal justice system and law enforcement. One important finding from DC survey data was that early users (before age 13) of alcohol and marijuana were more likely than non-users to: engage in risk behaviors such as drinking and driving, binge drinking, other and heavier illicit drug use; carry a weapon; get in physical fights; and sexual activity.

After analyzing all assessment information, APRA began the development of a sustainable prevention infrastructure and community system that is based on the public health, risk and protective factor and Social Immunization Models.

The importance of a researched-based foundation was articulated in the 2010 National Drug Control Strategy. “First, there are robust, research-driven interventions that offer the promise of protecting American’s adolescents from the short and long-term damage of substance abuse. Second, research on adolescent brain development shows there is an at-risk period for the development of substance use disorders; people who not develop a substance use problem by age 21 are unlikely ever to do so. Third, many risk factors for substance use in youth also predict a range of other problems.”

Four DC Prevention Centers (DCPC), the cornerstone of the community prevention system, were funded in 2010 through Substance Abuse Prevention and Treatment Block Grant (SAPT) funds. DCPC strengthen community capacity, address needed community and systems change, reduce risk factors while increasing protective factors, and achieve target outcomes for District youth. These Centers were envisioned as dynamic hubs that engage, support and help connect the many community elements needed to achieve outcomes. Each Center serves two designated wards: Wards 1 and 2; Wards 3 and 4; Wards 5 and 6; Wards 7 and 8.

Within the DCPC context, community prevention is defined in terms of locations where people live, work, and play and often results in partnerships or “prevention networks.” These include but are not limited to: 1) geographic and administrative boundaries (i.e., tracts, political, school districts, neighborhoods, housing developments, recreational catchment areas); 2) boundaries of purposed (parents/families/caregivers; faith organizations, community-based organizations, and prevention program services); 3) language or cultural values and norms.

The community prevention system is supported by a Prevention Policy Council (PPC) consisting of 14 District agency partners who created a five year Strategic Prevention Plan through SAMHSA Strategic Prevention Enhancement (SPE) funds in 2012. The PPC provides guidance

for the District's Strategic Prevention Framework State Incentive Grant (SPF SIG) and workgroups such as the DC EOW.

The development of Ward Prevention Councils is in process and provides a flexible mechanism for sub-state SPF behavioral health prevention planning.

APRA prevention staff provides leadership for policy and program planning and evaluation, community engagement (prevention grants and contract management and monitoring); and tobacco prevention, risk reduction and control.

A primary resource has been the District's SPF SIG Grant administered by APRA and is now in the fifth year of funding. Eighty five percent of the grant award is allocated to community capacity building and piloting evidence-based selective and indicated strategies. Administrative funds support the DCEOW and SPF SIG Evaluation.

Capacity building pilot initiatives include:

- Four SPF SIG Coordinators linked to the DCPC and ongoing SPF training, technical assistance and coaching especially
- Community Leadership Forum for 200 prevention leaders
- DC Youth Prevention Leadership Corps SPF training, peer lead and adults supported community action for 400 youth
- Synthetic Marijuana Initiative
- DC Prevention Leadership Center concept development
- Four Family Partnership Grants for selective and indicated populations
- Seven Community Prevention Evidence-Based Grants targeted toward selective and indicated populations
- Four CORE Coordinators to assess the need and utility of Prevention services for selective and indicated populations

In October 2012 the Department of Health Community Health Administration (CHA) transferred their Tobacco Control Program (TCP) five staff to the APRA Division of Prevention. The addition of TCP provides additional dimension including tobacco cessation strategies to existing tobacco efforts through the DC Prevention Centers, Synar, and the Food and Drug Administration tobacco contract.

Prevention Step 2: Identify the unmet services needs and critical gaps within the current prevention system

DCEOW funds through SPF SIG have provided the most comprehensive data assessment in APRA's history. Ten District agency members, APRA and the APRA contractor, Research Triangle Institute meet regularly to address the following goals: 1) describe the prevalence of ATOD use in DC with an emphasis on age group differences, changes over time, and ward level concerns; 2) examine the consequences of ATOD use; 3) assess where residents in the District and wards face greater exposure to community, family, individual, and school risk factors for ATOD consumption and consequences; 4) look at the relationship between risk and protective factors and particular outcomes.

Through the DCEOW, APRA supported development of a 180 page District data report, a 100 page Ward report and power point presentations on key findings that was delivered to DC policy makers and DCPC. APRA also developed a Memorandum of Understanding (MOU) with the Office of State Superintendent of Education (OSSE) to expand the District's 2012 Youth Risk Behavior Survey (YRBS) random sample. This is the first time the District has had ward level data for strategic prevention planning.

Despite the progress, system wide needs and critical gaps remain for prevention:

- Prevention needs a diversified and expanded base of funding for core infrastructure, community system development and evidence-based strategies. Currently, APRA prevention is dependent on the SAPT and competitive discretionary grants and contracts.
- Prevention needs to expand the Strategic Prevention Framework planning process to encompass the changes in the broader behavioral health system. This direction will still focus on a community-based risk and protective factor approach to prevention and a series of guiding principles that can be adapted to an urban area and culturally diverse populations.
- Prevention needs to sustain and expand the DCEOW to gather broader data on populations that have historically been served through the SAPT. These include but are not limited to youth who have experienced childhood trauma; youth living in families where there is a substance abuse disorder; homeless youth; and lesbian, gay, bisexual and transgendered and questioning youth.
- Prevention needs to strengthen the development and use of technology for program grants management and monitoring; data dashboards for community prevention planning; and community monitoring systems to document the changes in policies, practices, and programs related to local SPF action plans.
- Prevention needs to develop or refine procedures for a new era: 1) identify/design and price an array of universal, selective, and indicate preventive interventions that fit the needs of urban and culturally diverse populations; 2) build the capacity and maintain qualified prevention provider networks; 3) develop continuous quality improvement and performance based outcomes and review systems; 4) process prevention claims and pay providers; 5) determine effective dosages of prevention for whole populations; 6) retool the prevention field by finding more efficient and cost effective ways to deliver prevention, improve access to services, and fully integrate the behavior health research into practice; 7) support the development of prevention program and provider certification process(s).
- Prevention needs to sustain the development of a Prevention Leadership Center located in the District of Columbia that supports new prevention leaders, and provides a forum for innovation and creativity.

Prevention Step 3: Prioritize state planning activities

Goal: Policy and Prevention

Continue to implement an integrated prevention system to reduce priority risk factors and increase protective factors that reduce substance use in the District by children, youths, and families to include health promotion activities in the community and workplace.

Prevention Step 4: Develop objectives, strategies, and performance indicators

Objective A: Develop and sustain a prevention behavioral health infrastructure that functions seamlessly at District and Ward levels.

Strategies:

- Continue to fund DC Prevention Centers as dynamic hubs that engage, support and help connect the many community elements that are needed to prevent the onset and reduce the progression of alcohol, tobacco and other drug (ATOD) and interrelated problems that place youth at risk.
- Revise the membership and continue support for the Prevention Policy Council as a viable mechanism for cross agency policy and program collaboration and coordination.
- Continue development and implementation of the DC Prevention Leadership Corps that is youth led and adult support in DC communities.
- Complete the concept development and implement Ward Prevention Councils as part of the APRA prevention infrastructure and community system.
- Refocus the APRA Prevention Division structure, roles and responsibilities in order to enhance support for of District agency partners and the community prevention system.

Performance Indicators:

- Increase the age of first use (onset) and reduce priority risk factors for ATOD and interrelated behaviors among youth.
- Decrease 30 day alcohol, tobacco, marijuana, and inhalant use among youth.
- Increase the number of community prevention network SPF plans developed and implemented.

Objective B: Develop and sustain a behavioral health prevention data and evaluation system and increase the use of data for prevention planning, evaluation, and resource allocation decisions.

Strategies:

- Provide APRA prevention staff support to continue refining and focusing DC Epidemiological Outcomes Workgroup (DCEOW) to address the prevention goals and the needs as a result of the merger into a new Department of Behavioral Health in the District.
- Continue to use data findings from the DCEOW District and Ward reports and targeted fact sheets for SAPT prevention set-aside sub-grantee SPF planning across 8 Wards and with community prevention networks.
- Strengthen the risk and protective factor data profiles by adding measures of Adverse Childhood Experiences (ACE) and include the findings in prevention behavioral health planning and integration strategies.
- Continue to implement *Community Conversations* and the APRA guidebook as a supplemental tool to assess community perceptions, attitudes and intent to use ATOD..
- Review the need for a modified *Communities That Care* survey and recommend cost effective options for implementing a sample robust enough to yield District and Ward data for policy and program planning.

Performance Indicators:

- Use DCEOW data for APRA and sub-grantee SPF planning.
- Use DCEOW data in targeted media messages and social marketing initiatives.

Objective: Increase prevention capacity to prevent the onset and reduce the progression of risk for alcohol, tobacco and other drug (ATOD) and interrelated adolescent problems.

Strategies:

- Refine content for the three DC Strategic Prevention Framework Foundations training guidance documents to encompass behavioral health directions.
- Make recommendations and develop a work plan on prevention credentialing packages that are applicable to the DC workforce.
- Revise and brand prevention education and social marketing materials to reflect the new Department of Behavioral Health internally and with sub-grantees such as the DC Prevention Centers.
- Fully implement and maintain the APRA prevention interactive website to increase awareness and involvement of District and community prevention customers.

- Fully develop the DC Prevention Network (DCPN) concept that increases awareness and involvement of Ward and community partners in behavioral health prevention.
- Review the current portfolio of APRA prevention strategies (universal, selective, and indicated) and identity strategies to be sustained, and explore the potential for Medicaid reimbursement.
- Support the implementation of Synar regulations and increase efforts for merchant education.

Performance Indicators:

- Number of youth reached through planned prevention strategies.
- Number of adults reached through planned prevention strategies.
- Number of APRA prevention and DC Prevention technical assistance contacts
- Exposure to prevention messages
- Pro-social and community connections to reduce targeted risk
- Retailer Violation Rate for tobacco sales to minors

Objective: Continue to improve the quality and fully implement the DC Strategic Prevention Framework Planning process at District, Ward and community levels.

Strategies:

- Revisit and update the Strategic Prevention Enhancement Five Year Plan to address the merger into the new Department of Behavioral Health.
- Revisit and update the DC Prevention Center sub-grant scope of work in order to address the merger into the new Department of Behavioral Health.
- Implement DC Quality Improvement Processes (QI) to monitor, track and improve APRA planned SAPT prevention services

Performance Indicators:

- Revised five year Strategic Prevention Plan
- Revised DC Prevention Grant online program and data reports

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Note: Treatment and Recovery starts here. Section II Planning Steps

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

Part one: State priorities and goals must be supported by a data driven process

In 2010 APRA began to develop an electronic medical record system that would provide the ability to collect data on our clients and provider performance. APRA has the current capability to generate extensive custom data reports using SSRS (a SQL Server statistics program fully incorporated into DATA). This capability has already been used in FY 2013 to inform strategic planning, monitoring activities and quality improvement planning for treatment and recovery support services for the providers that receive Medicaid or local funding. SSRS is sufficient for the majority of APRA's data needs. There are more sophisticated reports which are beyond the capacity of SSRS to complete and these reports are purchased from FEI (the developer of the DATA System). These reports are procured out of the system enhancement budget which is housed under the Department of Performance Management and Quality Improvement. This information collected from this data source has assisted in identifying critical gaps in our system, which are outlined below.

HIV/AIDS

The Office of Quality Assurance has undertaken a targeted project to build capacity around HIV education, testing, and case management within the treatment network. Most of the clients that receive services in the District of Columbia meet the criteria for high risk of contracting HIV; additionally roughly 8% of identify themselves as being HIV positive during the intake process and 5% report that they do not know their status. Building upon the new internal capacity to conduct HIV testing in the Assessment and Referral Center through the Minority AIDS Initiative, this initiative will provide programs with technical assistance around facilitating access to HIV testing, educating clients in the most current information on HIV and providing effective case management to those who are HIV positive (e.g. linkage to primary and specialty medical care).

As this project develops over the next year, an analysis of the results are likely to produce a model going forward of training and technical assistance around integrated care issues. APRA is looking at the potential of expanding this process to include training and technical assistance around coordinating services for residents with Hepatitis C, sexually transmitted infections and obesity-related illnesses such as Type II Diabetes.

SPANISH

(Maybe Javon or Mark can add to this section, I know that we address the needs of the Spanish population that do not prove their residency with ATR funds in the past, but I am not sure what we are planning to do address their needs. Here is my opinion:)

Comment [TM5]: I addressed some of this in Section L. Feel free to cut and paste as desired.

APRA currently has four providers that work with the Latino population. About five percent of our population identifies as Hispanic under our TEDS ethnicity category. The Latino provider agencies state that clients that are undocumented are not able to receive substance abuse services under APRA funding because they do not meet the residency requirements.

GLBTQ

Currently, our data collection process is unable to identify gay, lesbian, bisexual and questioning clients because we do not have a question about sexual orientation in our EMR. We are able to collect data on clients that identify as transsexual under the TEDS gender category. In efforts to create a culture that is welcoming to the GLBTQ population, first step is to ask the question during the assessment process to help providers identify that this population may need to have their additional interventions to help them with any unique needs that they may have. Training our workforce on cultural diversity and providing them with information on how to identify and treat unique issues that the GLBTQ population may face.

ELDERLY

The elderly substance abuser has unique needs, since 2 % of our population is over the age of 62 an emphasis on integrated care, substance abuse awareness (Judy may be able to add more information here) and medication management would be important to address with this population. This population has significant health needs. APRA has encouraged the substance abuse providers to establish specific group counseling and psycho education groups to address the needs of this population. Collaboration with the DC Office on Aging and healthcare centers will assist in meeting this populations case management and clinical care coordination needs.

WOMEN AND WOMEN WITH CHILDREN

Roughly 31% of APRA's clients are women and there is a significant need to provide specialized services for this population. APRA is in the process of working with two providers that have agreed to provide services for women with children. APRA's provider network has been encouraged to provide women only programming in the currently co-ed agencies so that women have a choice. Additionally, APRA has created a supportive fiscal structure to meet the needs of pregnant women by enabling providers to provide specialized services that will promote intensive case management and integrated health care during pregnancy and postpartum until the infant is three years old.

Comment [TM6]: Do we want to put something in here about the upcoming women and children's program which will open in FY 14?

CRIMINAL JUSTICE POPULATION

Over 25% of clients self report that they are involved in the criminal justice system. APRA is in the final phases of developing a Memorandum of Agreement (MOA) with the Criminal Supervision and Offenders Services Agency (CSOSA) and the District of Columbia Pretrial Service Agency (PSA) in effort to improve the referral, assessment, treatment and recovery services for the criminal justice population in the District of Columbia. The MOA with CSOSA and PSA will ensure that clients are connected to treatment and recovery services, enable APRA to obtain clinical information from collateral sources that will facilitate accurate level of care placement and allow the treatment providers to communicate with the client's probation/parole officers.

CHILD WELFARE INVOLVED PARENTS

APRA has spent much of the past year developing collaboration with the Child and Family Services Agency (CFSA). CFSA provides services and family stabilization resources to families and children alleged to be abused and/or neglected through the coordination of public and private partnerships. The two agencies have been collaborating around improving the quality of services for those in the child welfare system that also require assessment and treatment for substance use issues. This collaboration is a result of a data sharing

In September of 2012, APRA funded and hosted a training for selected CFSA personnel in Screening, Brief Intervention and Referral to Treatment (SBIRT). In 2013, CFSA, with APRA's guidance, implemented the Global Appraisal of Individual Needs Short Screener (GAIN-SS) for selected cohorts of their population to determine the need for full assessments. In FY 2014, CFSA will begin conducting these screenings electronically through the District Automated Treatment Accounting (DATA) System, the Electronic Health Record for substance abuse services in the District of Columbia. This web-based system for administering the screening instrument will allow the results to be stored in the client's electronic record and scored electronically, eliminating human error. The results can be communicated to other stakeholders using the system through electronic consent. Aggregate data from these screenings can also be compiled to detect trends in the population, particularly the co-occurrence of substance use disorders and other mental illnesses.

CFSA is continuing this year to build internal capacity in the SBIRT framework. They will be training approximately 10 additional staff in the framework at Howard University. The training program at Howard makes extensive use of interactive technology, as there are simulated scenarios trainees complete which are conducted electronically in a computer lab.

CFSA has been awarded a \$3.2 million (\$640,000 per year for five years) federal grant, which will be used to make trauma-informed care the foundation of serving children and youth in the District's child welfare system. In collaboration with other youth serving community agencies, CFSA chose the Trauma Systems Therapy (TST) Model. The TST model focuses on addressing trauma in two ways (1) a traumatized child or youth who cannot regulate his/her emotional state and (2) a social environment/system of care that cannot help contain this dys-regulation. TST

focuses on the child and on his/her relationships and surroundings. The substance abuse providers will participate in the TST trainings that CFSA will conduct as part of this grant.

Additionally, APRA has collaborated with the Family Treatment Court (FTC) and CFSA to improve the quality of services for parents in the child welfare system that are in danger of having their parental rights terminated that also require assessment and intensive treatment and case management for substance use issues. Through this collaboration, CFSA, FTC and APRA will conduct subject matter trainings across agencies that will promote a recovery focus for the parents and interagency partnerships that will ensure that our systems interact as a recovery focused partnership. Also, both FTC and CFSA have hired substance abuse coordinators that are dedicated to working with the clients to assist with managing the client's requirements for both agencies and the substance abuse provider.

YOUTH

APRA is beginning to improve services for youth under the age of 21 by collaborating with the juvenile justice agency, Department of Youth Rehabilitation Services (DYRS), the child welfare agency, Child and Family Services Agency (CFSA), and the mental health agency, DMH in the District of Columbia. APRA collaborated with the three systems and identified gaps in assessment and treatment services. The three identified gaps that all parties have agreed to address are, improving the referral process, implementing a universal assessment tool and increasing the length of stay. APRA is currently in the process of developing MOU's with CFSA and DYRS to allow access into APRA DATA system. This will allow the two agencies to make referrals directly to our ASTEP providers and facilitate the referral process to ensure that the youth keeps his or her appointment. It will also allow for accurate data collection on the number of clients that are referred from both agencies. APRA has partnered with DMH on its System of Care initiative for adolescent treatment and had implemented the GAIN SS as a universal screening tool for its clients. Since DMH and APRA will be merging on October 1, 2013, we will continue to address the co-occurring needs of the youth population.

DYRS is responsible for connecting youth that have been detained with mental health and substance abuse services in detention centers or community-based placements. The juvenile justice agency referrals are about 68% of APRA's Adolescent Substance Abuse Expansion Treatment Program (ASTEP) total client population. APRA is in the process of developing an MOU with DYRS around improving the quality of services for youth in the juvenile justice system that requires assessment and treatment services for substance use issues. DYRS has hired a substance abuse coordinator to work directly with APRA's substance abuse providers to facilitate the referral process and case management needs.

CFSA has also hired substance abuse coordinators that will facilitate the referral process, assist with the clinical care coordination and case management for clients that substance abuse concerns. Additionally, CFSA has agreed to use the GAIN SS as a universal screening tool and will train APRA's substance abuse providers on the evidence base model Traumatic System Therapies (TST).

Focusing on integrative healthcare and meeting the youth co-occurring needs would also address the gaps in the current system.

CO-OCCURRING

Approximately 70% of APRA clients have also received mental health services within the same year. This data has facilitated the need to integrate the two systems and address client's needs for co-occurring care. The agencies will merge on October 1, 2013 and the development of a comprehensive integrated system will begin.