DC Council Committee on Health
Councilmember Christina Henderson, Chair
Fiscal Year 2023 Performance Oversight Pre-Hearing Questions
Department of Behavioral Health

Organization and Performance

1. Please provide the current organizational chart for the agency, with information to the activity level. In addition, please identify the number of full-time equivalents (FTEs) at each organizational level and the employee responsible for the management of each program and cost center. If applicable, please provide a narrative explanation of any organizational changes made during FY 2023 and FY 2024, to date.

   DBH Response:
   Please see "Attachment. Organizational Chart"

2. Has DBH identified a primary and alternative sexual harassment officer ("SHO") as required by Mayor's Order 2023-131("Sexual Harassment Order')? If no, why not? If yes, please provide the names of the primary and alternative SHOs.
   a. List and describe any allegations of sexual harassment or misconduct committed by or against its employees received by the agency in FY 2023 and FY 2024, to date, and whether those allegations were resolved.
   b. Has DBH received any requests from staff in an otherwise prohibited dating, romantic, or sexual relationship for a waiver of provisions of the Sexual Harassment Order?
      i. What was the resolution of each request?
      ii. If a request was granted, are there limitations on the scope of the waiver?

   DBH Response:

Has DBH identified a primary and alternative sexual harassment officer ("SHO") as required by Mayor's Order 2023-131("Sexual Harassment Order')? If no, why not? If yes, please provide the names of the primary and alternative SHOs.

- Lisa Tapp, EEO Manager, and Sexual Harassment Officer (SHO)
- Mary Campbell, Risk Manager and Special Service Coordinator, Alternate SHO

a. List and describe any allegations of sexual harassment or misconduct committed by or against its employees received by the agency in FY 2023 and FY 2024, to date, and whether those allegations were resolved.

Please see the chart below.

Type of Case	Sexual Harassment	Fiscal Year	Outcome
Sexual Harassment	Inappropriate language	FY 23	Closed, unsubstantiated
Sexual Harassment	Inappropriate conversation	FY 23	Closed, termination during probation
Sexual Harassment	Inappropriate Language	FY 23	Dismissed, unsubstantiated
Sexual Harassment	Sexual Harassment	FY 23/FY 24	Investigation still in progress
Sexual Harassment	Unwelcome Advances	FY 23	Unit Transfer

b. Has DBH received any requests from staff in an otherwise prohibited dating, romantic, or sexual relationship for a waiver of provisions of the Sexual Harassment Order?

- No.
    i. *What was the resolution of each request?* N/A
    ii. *If a request was granted, are there limitations on the scope of the waiver*? N/A

3. How many performance evaluations did the agency complete in FY 2023? How many performance improvement plans were issued in FY 2023? How many employees have submitted SMART Goals or other relevant workplans in FY 2024? For each question, provide the total number and the percentage of total employees.

DBH Response:

For the FY 23 performance evaluation period, 881 employee evaluations were completed, which represents 82.4 percent of the DBH workforce. Another eight percent were incomplete in PeopleSoft, primarily due to a manager submitting the evaluation too late for processing before the deadline or not completing the evaluation since a review was not held with the employee or the employee did not acknowledge the evaluation. During FY 23, there were no performance improvement plans issued.

For the FY 24 performance review period, 991 performance plans were completed, which represents 78.7 percent of the DBH workforce. The annual performance plan in PeopleSoft is a collaborative process between managers and employees.

4. Please provide the following budget information, in Microsoft Excel, for the agency, including the amount budgeted and actually spent for FY 2023 and FY 2024, to date. In addition, please describe any variance between the amount budgeted and actually spent.
    a. At the agency level, please provide information broken out by source of funds and by Account Group and Account;
    b. At the program level, please provide the information broken out by source of funds and by Account Group and Account; and
    c. At the cost center level, please provide the information broken out by source of funds and by Account Group.

DBH Response:

Please see attached documents titled, "Q4. Attachment 1 of 3. DBH Budget Agency Level FY23 and FY24," "Q4. Attachment 1 of 2. DBH Budget Program Level FY23 and FY24," "Q4. Attachment 1 of 3. DBH Budget Cost Center Level FY23 and FY24."

5. Please provide a complete accounting of all interagency project that the agency was a buyer or seller for during FY 2023 and FY 2024, to date. For each, please provide a narrative description as to the purpose of the project and which programs, cost centers, and services within the agency the project affected.

DBH Response:

Please see attached document titled, "Q5. Attachment 1 of 1. Interagency Projects FY23 and FY24."

6. Please provide a complete accounting of all reprogrammings received by or transferred from the agency in FY 2023 and FY 2024, to date. For each, please provide a narrative description as to the purpose of the transfer and which programs, cost centers, and services within the agency the reprogramming affected.

DBH Response:

Please see attached documents titled, "Q6. Attachment 1 of 1. Reprogramming FY23 FY24."

7. Please provide the following information for grants/sub-grants awarded to and by the agency in FY 2023 and FY 2024, to date, broken down by program and activity:

    a. Grant Number/Title;
    b. Approved Budget Authority;
    c. Funding source;
    d. Expenditures (including encumbrances and pre-encumbrances);
    e. Purpose of the grant;
    f. Organization or agency that received the grant;
    g. Grant amount;
    h. Grant deliverables;
    i. Grant outcomes, including grantee/subgrantee performance;
    j. Any corrective actions taken or technical assistance provided;
    k. Agency program and activity supported by the grant;
    l. Agency employee responsible for grant deliverables; and
    m. Any grants that were reduced in FY 2024, and by how much.

DBH Response:

Please see attached documents titled, "Q7. Attachment 1 of 2. Grants FY23 FY24," and "Q7. Attachment 2 of 2. SubGrants FY23 FY24."

8. Please provide the following information for all contracts, including modifications, active during FY 2023 and FY 2024, to date, broken down by program and activity:
    a. Contract number;
    b. Approved Budget Authority;
    c. Funding source;
    d. Expenditures (including encumbrances and pre-encumbrances);
    e. Purpose of the contract;
    f. Name of the vendor;
    g. Original contract value;
    h. Modified contract value (if applicable);
    i. Whether it was competitively bid or sole sourced;
    j. Final deliverables for completed contracts;
    k. Any corrective actions taken or technical assistance provided;
    l. Agency employee(s) serving as Contract Administrator; and
    m. Any contracts that were reduced in FY 2024, and by how much.

    DBH Response:

    Please see attached document titled, "Q8a. Attachment 1 of 1. Contracts FY23 FY24."

9. Please provide a list of all Department of General Services work orders submitted in FY 2023 and FY 2024, to date, for facilities operated by the agency. Please include the date the work order was submitted, whether the work order is completed or still open, and the date of completion (if completed).

    DBH Response:

    Please see Attachment 1 of 1. DGS DBH Work Orders FY23 FY24 Status."

10. Please provide a complete accounting of all DBH's Special Purpose Revenue Funds for FY 2023 and FY 2024, to date. Please include the following:

    a. Revenue source and code;
    b. Source of the revenue for each special purpose revenue fund (*i.e., license fee, civil fine*);
    c. Total amount of funds generated by each source or program in FY 2023 and in FY 2024, to date;
    d. DBH activity that the revenue in each special purpose revenue source fund supports; and
    e. The FY 2023 and FY 2024, to date, expenditure of funds, including purpose of expenditure.

    DBH Response:

Please find attached document titled, "Q9. Attachment 1 of 1. Special Purpose Revenue FY23 FY24."

11. Please provide copies of any investigations, reviews or program/fiscal audits completed on programs and activities within DBH during FY 2023 and FY 2024, to date. This includes any reports of the DC Auditor, the Office of the Inspector General, or the Office of Accountability. In addition, please provide a narrative explanation of steps taken to address any issues raised by the program/fiscal audits. Please include a chart with the following:
    a. Name of the provider;
    b. Date complaint was received;
    c. Type of complaint;
    d. Referral source;
    e. Type of report;
    f. Summary or complaint or allegations;
    g. Conclusion(s);
    h. Recommended outcomes or actions; and
    i. Date completed.

DBH Response:

See "Q10 Attachment Investigations Chart."

12. Did DBH meet its key performance indicators for FY 2023? Please provide a narrative description of what actions DBH undertook to meet the key performance indicators. For any performance indicators that were not met please provide a narrative description for why they were not met, and any remedial actions taken.
    j. Please provide the agency's key performance indicators for FY 2024 and what actions DBH has undertaken to meet them to date.

DBH Response:

In FY 23, DBH met or nearly met 15, or 71 percent, of 21 Key Performance Indicators. Below is a description of the six performance indicators that were not met and the remedial action taken.

Measure	**FY23 Target**	**FY23 Performance**	**Explanation for Performance and remedial action taken**
1. Percent individuals referred through the emergency department medication assisted treatment	50%	39%	A linkage to treatment is confirmed when a peer recovery coach completes a follow up call to the community provider to assess whether those patients referred showed up for their appointment. Linkages to treatment in the data refers to the total number of patients who showed up to the treatment appointment scheduled for them in the reporting period, 3 days post discharge. In addition to peers being understaffed, peers

programs who went to treatment.			have expressed challenges connecting with community providers to confirm a linkage. Peers have had to decide whether to spend a considerable amount of time on the phone trying to reach community providers or spending time working with patients who have come into the hospital needing their support. Peers have also recently communicated experiencing community providers' unwillingness to disclose if a patient has arrived because of patient confidentiality, despite confirming in the past and despite the agreement MOUD community providers made to hold beds/rooms for our program's patients. In DCHA's Opioid and Substance Use Response (OSUR) Workgroup, we have brainstormed about making the processes more efficient, such as utilizing email to confirm linkages. DCHA continues to work with hospital teams and peers to further develop relationships with providers in order to improve the process for confirming linkages.
2. Percent of MAT clients who were served in two consecutive quarters	90%	79%	None of the three Opioid Treatment Programs (OTPs) (methadone) are meeting the measure, but one is close (84%). One OTP has had major billing issues, which is why its performance rate is 7%, but it is unclear why the third OTP (61%) is not meeting expectations when it met the target in Q3. The State Opioid Treatment Authority will review data with OTPs at its monthly call. The buprenorphine numbers are slightly increasing (80% to 81%) as well as naltrexone (48% to 49%), but individuals on naltrexone are less than 1/3 of those on buprenorphine. The FQHCs are some of our main providers of buprenorphine. The State Opioid Response 3 grant has redesigned the work of the FQHCs and their focus is on engaging and re-engaging clients. The grant monitors host monthly calls to check on progress and conducted site visits in the Spring/early Summer. The SOR team is funding seven organizations to deliver care coordination and case management to individuals with complex co-occurring disorders and/or a history of cycling through intermittent treatment. The goal of this initiative is to keep individuals engaged in care and to prevent future overdose hospitalizations and fatalities. These grantees have partnered with the OTPs to provide re-engagement activities, but now need to restructure their referral process now that DATAWITS has sunsetted.

3. Percent of consumers surveyed in the Behavioral Health Satisfaction Survey who were satisfied with the person-centered planning process	80%	69%	Survey participants expressed concerns that included lack of consistent communication, review of treatment, and/or evidence of plan finalization. DBH is working with providers to address the concerns expressed.
4. Percent of school-based behavioral health partnership schools with a school based behavioral health clinician	80%	63%	DBH has implemented various strategies to incentivize recruitment and retention of clinicians with additional funding for hiring and retention bonuses. There have been small incremental gains in adding to and retaining the workforce, but the challenge of a workforce shortage of licensed clinicians remains in DC and nationally.
5. Percent of substance use disorder (SUD) withdrawal management clients who stepped down to a lower level of care	50%	38%	For Q4, the two DBH certified Withdrawal Management providers individually exceeded the expectation of 50% stepdown for this KPI. The hospital-based provider did not individually meet the expectation. However, the hospital also provides co-occurring psychiatric services, thus consumers may be stepped down to outpatient psychiatric care instead of substance use treatment. This data is not reflected in the score.
6. Average time from 911 call to CRT arrival on the scene of an event for Priority 1 calls	30 minutes	91 minutes	CRT has seen a significant uptick in crisis calls, 37% specifically, from this time last year. In addition, although recruitment efforts have been on-going, the team remains at 60% staffing. Apart from these challenges, the response time does not account for the capture of referral and collateral information, or the attempts to contact other service providers when applicable, such as ACT, for response. We are working to make our data collection process more effective.

Please see "Attachment 1 of 2. FY 23 Performance Plan KPI Report"

Please see "Attachment 2 of 2. FY 24 KPI Report" with actions undertaken to meet the target.

13. Please provide DBH's capital budgets for FY 2023 and FY 2024, including amount budgeted and actual dollars spent. In addition, please provide an update on all capital projects undertaken in FY 2023 and in FY 2024, to date.

DBH Response:

Please see document titled, "Q12. Attachment 1 of 1. Capital Budgets FY23 FY24."

14. For each Mayoral Board, Commission, or Council overseen by DBH, please provide an updated list of members, including when their terms started and end, and their contact information. Please indicate any vacant positions, and include links to the meeting minutes.

DBH Response:

The Opioid Abatement Advisory Commission is overseen by DBH.

The purpose of this commission is to make recommendations to the Mayor and Council regarding the use of opioid litigation settlement proceeds and District-wide goals, objectives, and performance indicators relating to opioid use disorder and co-occurring substance use and mental health disorders.

Administrative Point-of-Contact: Orlando M. Barker, orlando.barker@dc.gov

Membership

The Opioid Abatement Advisory Commission consists of 21 members and is made up of service providers and experts in mental health and substance use disorders as well people in recovery from these diseases and family members.

Please see attachment "Q13 Attachment" for a list of members, their designations, term limits, and contact information.

Vacant Positions

There are currently no vacancies in the Opioid Abatement Advisory Commission.

Meeting Minutes

Wednesday, October 25, 2023
https://dbh.dc.gov/sites/default/files/dc/sites/dmh/page_content/attachments/October%2025%20Meeting%20Minutes.pdf

Wednesday, November 8, 2023

https://dbh.dc.gov/sites/default/files/dc/sites/dmh/page_content/attachments/November%208%20Meeting%20Minutes.pdf

Wednesday, November 29, 2023
https://dbh.dc.gov/sites/default/files/dc/sites/dmh/page_content/attachments/November%2029%20Meeting%20Minutes.pdf

Friday, December 15, 2023
https://dbh.dc.gov/sites/default/files/dc/sites/dmh/page_content/attachments/December%2015%20Meeting%20Minutes.pdf

14. Please provide a list of all FTE positions detailed **to** DBH, broken down by program and activity for FY 2023 and FY 2024, to date. Include a narrative on specific role the detailed staff took at DBH during their detail. In addition, please provide which agency the detailee originated from and how long they were detailed to DBH.

DBH Response:

No employees are detailed to DBH from another agency in FY 2023 and FY 2024, to date.

15. Please provide a list of all FTE positions detailed **from** DBH to another agency in FY 2023 and in FY 2024, to date. In addition, please provide which agency the employee was detailed to, what work they took on, and for how long.

DBH Response:

No employees are detailed from DBH to another agency in FY 2023 and FY 2024, to date.

16. Please provide the following information for grants (regardless of source) awarded to DBH during FY 2023 and FY 2024, to date, broken down by DBH program and activity:
    a. Grant Number/Title;
    b. Approved Budget Authority;
    c. Funding source;
    d. Expenditures (including encumbrances and pre-encumbrances);
    e. Purpose of the grant;
    f. Grant deliverables;
    g. Grant outcomes, including grantee performance;
    h. Any corrective actions taken or technical assistance provided;
    i. DBH program and activity supported by the grant;
    j. Organizations or agencies that received the grants; and
    k. DBH employee responsible for grant deliverables.

DBH Response:

Please see document attached titled, "Q16. Attachment 1 of 1. Grants FY23 FY24."

17. Please provide a complete accounting of all grant lapses including a detailed statement as to why the lapse occurred and any corrective action taken by DBH. Please provide accounting of any grant carryover from FY 2023 to FY 2024 and a detailed explanation as to why it occurred.

DBH Response:

Please find attached document titled, "Q17. Attachment 1 of 1. Grant Lapse Carryover FY23 FY24."

18. Consider one area where your agency collects race information. How does your department use this data to inform decision making?

DBH Response:

As the State Behavioral Health Authority for the District of Columbia, DBH is acutely aware of the structural racial inequities and health disparities experienced by people of color and under-served / represented communities. These historically entrenched inequities hinder individuals within those communities to achieve their full potential across the various spheres of life. For those with mental and behavioral health challenges especially, these healthcare disparities create barriers to accessing and engaging the behavioral health care delivery system, to receive person-centered, integrated health care services, and restrict opportunities for community supports, which would enable them to mitigate their health and social challenges to achieve full, satisfying lives within the community.

As the agency primarily responsible, in partnership with other sister agencies, for promoting and ensuring the mental health and well-being of the residents of the District, DBH realized that in order to meet these challenges within the community, we had to start by looking at ourselves first and to look at everything we do through a racial equity lens. Consequently, we decided to commit to closely examining the make-up of our own workforce, considering potential internal, unconscious biases, as well as policies and workflows which potentially may not be as racially equitable or as impactful as we would like for them to be.

As a result, within the past year, DBH's Director, Dr. Barbara Bazron, committed the organization to working closely with the Office of Racial Equity (ORE) to form an internal Racial Equity Action Team to develop a DBH Racial Equity Action Plan and examine our work through a racial equity lens, as well as recommend changes to the agency's policies, practices, community engagement, and oversight of the behavioral health system which we manage.

The agency appointed Dr. Jean Moise, Deputy Dir of Adult Services, to lead this effort. A broadly diverse team of 10 was composed by the Executive Management Team, representing a broad cross section of the agency at all levels. This Racial Equity Action Team (REAT) met monthly as a group and as part of a broader cohort of agencies working with the Office of Racial Equity. ORE staff provided guidance and support to the DBH team to examine such areas as the Department's Mission / Vision statements, Strategic Plan, Culture, budget, and policies.

The DBH Racial Equity Action Team soon developed a proposed Racial Equity Vision Statement to be presented and reviewed by the Director and Executive Management team. Working with management, the REAT then initiated an "Agency Scan" to examine the agency's past and current culture, policies and practices through a racial equity lens. This Agency Scan is still in process. Once completed, the agency scan, with input from the ORE, will inform the agency's Racial Equity Action Plan (REAP). This Action Plan will then be presented to the Executive Management team for their input. The Racial Equity Action Plan, once modified and finalized by Executive Management, will ensure the agency has a shared vision, clear goals, community engagement strategy, and measurable outcomes in order to address identified challenges and enhance opportunities for the agency to operate in a more racially equitable manner, and support a more equitable and impactful behavioral healthcare delivery system.

19. What legal barriers does your agency face when trying to 1) make progress toward racial equity or 2) better understand racial inequity within the agency's context and operations (if any)?

DBH Response:

DBH has identified no legal barriers that prevent the agency from executing initiatives that will mitigate racial inequities and health disparities present in the population we serve.
The following initiatives exemplify the agency's commitment to address such inequities:

Crisis Stabilization Center Launch – DBH launched the District's first Stabilization Center in October 2023. The expansion of this critical service serves residents suffering from acute drug / alcohol intoxication (disproportionately represented by older African American males) by averting transport to hospital Emergency Depts for brief medical evaluation, and then abruptly being discharged to the streets, with no connection to community-based, on-going care to address their clinical needs. Prior to the Stabilization Center, many of these individuals continuously cycled from one acute care facility to another, while receiving no person-centered care or ongoing support on their recovery journey. This service disrupts this cycle and offers these individuals the long term, integrated care they need following crisis stabilization.

Mental Health CRF Rate Increase – DBH currently manages a network of Mental Health Community Residential Facilities (MHCRF's) that provides housing and support to nearly 600 individuals (most of whom are African American) with severe and persistent mental illness (SPMI) and behavioral health challenges. Recently, CRF operators have struggled to sustain this critical service due to a number of challenges: stagnant reimbursement rates not keeping pace with inflation; increased operating costs; and workforce challenges. DBH plans to implement a rate increase to the operators of these facilities, which ensures that community based, supportive housing remains available for the most vulnerable in our community in order to enhance their wellbeing, health status, and recovery.

SUD Residential Bed Rate Increase - DBH maintains a provider network that offers residential Substance Use Disorder (SUD) services, crisis beds, and "environmental stability" recovery housing for women in recovery, as well as those with children who are struggling with addiction. As a result of DBH's proposed increase, these residential providers will be able to continue to provide this critical service to women struggling with addiction and their children.

Lastly, over the last year, DBH Director, Dr. Barbara Bazron, has committed the agency to working closely with the Office of Racial Equity (ORE) to form an internal Racial Equity Action Team to develop a DBH Racial Equity Action Plan that examines our work through a racial equity lens. This work will result in recommended changes to the agency's policies, practices, community engagement and our oversight of the behavioral health delivery system, which will enhance access to culturally competent, integrated care to all those we serve.

20. How does your agency's spending address existing racial inequities (grant disbursement, procurement/contracting, etc.)?

DBH Response:

As the State Behavioral Health Authority for the District of Columbia, DBH is acutely aware of the structural racial inequities historically experienced by people of color and under-served / underrepresented communities, and the resulting impact on the opportunities of these communities to achieve their full potential across many spheres of life. Such racially based inequities and healthcare disparities cause those with significant behavioral health challenges to have a 25-year shorter life span (on average) than their peers in the community. Further, such disparities especially impact our most at risk, vulnerable District residents and cause them to not be able to access and consistently engage the behavioral health care delivery system for the services they need; not having the social and residential supports to independently function in the community; nor receive the ongoing, continuous, integrated care they need to thrive and recover from severe mental health and substance use disorders.

Mayor Bowser's annual budget makes key investments to improve health care and advance health equity, as well as investments in housing, education, and economic opportunity, all of which help to improve the social and emotional well-being of our communities. DBH's budget supports these goals by promoting access to behavioral health services in all eight wards, working to integrate the treatment of mental health and substance use disorders with primary health care, and reducing stigma associated with these diseases.

DBH works with agencies within the Health and Human Services cluster and throughout government to ensure that all residents have a fair shot at living healthy lives not determined by their ZIP code. This includes specific strategies that support a robust "whole person" healthcare system that addresses the social determinants of health. DBH co-locates staff in service centers to normalize behavioral health as a resource, just like housing or a job, to maintain daily living and to connect people to services when needed. These partnerships are with the Office of the Deputy Mayor for Planning and Economic Development, the Department of Human Services, and the Department of Employment Services.

The DBH budget includes new and ongoing investments that support the strategic transformation underway and positions DBH to move toward an integrated, population-based behavioral health system that provides equitable access for all residents to high quality services and the chance for healthier lives.

DBH's commitment to address such racial inequities and health disparities are exemplified by our focus and financial investment in the following key initiatives:

Crisis Stabilization Center Launch – DBH launched the District's first Stabilization Center in October 2023. The expansion of this critical service serves residents suffering from acute drug / alcohol intoxication (disproportionately represented by older African American males) by averting transportation to hospital Emergency Depts for brief medical evaluation, and then abruptly being discharged to the streets with no connection to community-based, on-going care to address their clinical needs. Prior to the Stabilization Center, many of these individuals continuously cycled from one acute care facility to another, while receiving no person-centered care or ongoing support on their recovery journey. This service disrupts this cycle and offers these individuals the long term, integrated care they need following crisis stabilization.

Mental Health CRF Rate Increase – DBH currently manages a network of Mental Health Community Residential Facilities (MHCRF's) which provides housing and support to nearly 600 individuals with severe and persistent mental illness (SPMI) and behavioral health challenges in a congregate, community based, homelike environment. Recently, CRF operators have struggled to sustain this critical service due to a number of challenges: stagnant reimbursement rates not keeping pace with inflation; increased operating costs; and workforce challenges. Several large operators have contemplated leaving this service line, which would have a significant, deleterious impact on these vulnerable, at-risk individuals, most of whom are African American. The planned rate increase to the operators of these facilities, which is currently going through the final approval process, ensures that community based, supportive housing remains available for the most vulnerable in our community in order to enhance their wellbeing, health status, and recovery.

SUD Residential Bed Rate Increase - DBH maintains a provider network which offers residential Substance Use Disorder (SUD) services, crisis beds, and "environmental stability" recovery housing for women in recovery, as well as those with children struggling with addiction (priority populations). The individuals traditionally accessing this service in the District have historically been underserved, women of color who reside in impoverished neighborhoods. As a result of DBH's proposed increase, residential providers will be financially healthier and in a better position to continue to provide this critical service to women struggling with addiction and their children.

21. What does racial diversity look like within your agency's staff? Please provide data on the racial diversity among leadership and at all staff grade levels.
    a. How does retention differ by race across levels?
    b. How does pay differ by race within levels?

DBH Response:

DBH works to ensure that all District residents have equitable access to high quality, integrated, person-centered, culturally / linguistically competent care, and to achieve a health care system that is equitable and just, without regard to race, ethnicity, gender identity, sexual orientation, socio-economic status, or ability.

In order to achieve this goal, DBH has committed to developing a diverse and inclusive workforce and leadership team. Our workforce is racially, ethnically, culturally and linguistically diverse, and representative of the District's communities we serve. Such a diverse workforce allows DBH to be better aware of the distinctive, culturally determined strengths and needs of the various constituent communities in order to implement more inclusive, and effective policies, workflows, and solutions to address their needs.

In addition, DBH has been actively working with the District's Office of Racial Equity (ORE) over the last year to conduct an "agency scan," through a racial equity lens, in order formulate a Racial Equity Action Plan to better serve our workforce and population at large. We believe this process of self-examination and the commitment to diversity and inclusivity of our leadership team results in new and creative insights and solutions to better achieve the agency's mission. DBH also makes it a priority to focus on maintaining the cultural and ethnic diversity of our workforce over time through retention, as well as providing growth opportunities for all staff to develop new skills and abilities in order to advance with the organization.

Below is the racial makeup of the total workforce and the Executive Team, which include those who report to the Director and the Agency Fiscal Officer and the agency Chief Contracting Officer. It would be difficult to provide the pay difference by race by grade levels since there are differences among the races in the same grade due to length of tenure, within grade step increases, and different pay schedules. We can report data on those who no longer work at the agency and we will explore how we can compare by race across grade levels.

Racial / Ethnic makeup of workforce and leadership

Race / Ethnicity (self-identified)	All Staff	Executive Team	Executive Team
		Male	Female
Black / African Am.	887 (70%)	4	4
White	102 (8%)	3	1
Hispanic / Latino	44 (4%)		
Asian	42 (4%)		
Indigenous	3 -		
Not Specified	183 (14%)		

22. Please provide a narrative explanation of DBH's role in the implementation of Mayor's Order 2023-142 "Declaration of Public Emergency: Opioid Crisis and Declaration of Public emergency: Juvenile Crime" and subsequent extensions of that order. In addition to the narrative explanation, Include for both public emergencies:
    a. DBH's role in facilitating and participating in data sharing with other District agencies;
    b. Detailed accounting of expedited procurement related to the order and subsequent extensions;
    c. Detailed accounting of any grants, partnerships, obligations, expenditures, or other disbursements related to the order and subsequent extensions;
    d. Recommendations made to the City Administrator in accordance with the order and subsequent extensions;
    e. Detailed accounting of any financial assistance sought from federal, private, non-profit, or other agencies of the United States government to recoup expenditures incurred, or obtain funding needed to carry out necessary actions of the order and subsequent extensions;
    f. Description of any activation, implementation, and coordination of mutual aid agreements between DBH and federal, state, or local jurisdictions to assist in the District's response to the order and subsequent extensions; and
    g. Any other assistance by DBH related to the order and subsequent extensions.

DBH Response:

DBH's role in facilitating and participating in data sharing with other District agencies;

In response to the Public Emergency, DBH has executed data sharing agreements with DC Health, Fire and Emergency Medical Services, and Department of Health Care Finance (DHCF) to closely track and share opioid non-fatal overdose incidents and opioid deaths in the District. Along with the Office of the Chief Medical Examiner (OCME), DBH and the above mentioned agencies have already met five times since December 5, 2024, to develop an integrated data dashboard to facilitate tracking, reporting, and oversight of interventions, as well as ongoing treatment on a timely basis for residents suffering from Opioid Use Disorder.

Detailed accounting of any grants, partnerships, obligations, expenditures, or other disbursements related to the order and subsequent extensions;

Though the Public Emergency applies to procurement, DBH expedited the grantmaking process for the targeted opioid outreach grants.

Recommendations made to the City Administrator in accordance with the order and subsequent extensions;

DBH has made no recommendations to the City Administrator to date in accordance with the order.

Detailed accounting of any financial assistance sought from federal, private, non-profit, or other agencies of the United States government to recoup expenditures incurred, or obtain funding needed to carry out necessary actions of the order and subsequent extensions;

DBH has taken no such action to date.

Description of any activation, implementation, and coordination of mutual aid agreements between DBH and federal, state, or local jurisdictions to assist in the District's response to the order and subsequent extensions;

DBH has taken no such action to date.

Any other assistance by DBH related to the order and subsequent extensions;

DBH has requested no such assistance to date.

Providers, Core Service Agencies (CSAs), & Agency Partnerships

23. Please provide a list, in Microsoft Excel, of all DBH providers and Core Service Agencies (CSAs) that serve children, youth, and adults. Include the following information:
    a. Name of provider;
    b. Location(s) (including ward) where services are provided;
    c. Types of services (including whether virtual, in-person, or hybrid);
    d. Populations served (ages, LGBTQ+, seniors, justice involved, experiencing homelessness, newly arrived migrants, returning citizens, etc.); and
    e. Number of individuals served in FY 2023, and in FY 2024, to date.

DBH Response:

DBH certified providers serve all populations. Neighbors Consejo, Latin American Youth Center, La Clinica del Pueblo, and Mary's Center specialize in serving Spanish-speaking residents. Deaf Reach specializes in providing services to deaf and hearing-impaired residents.

Please see the attached spreadsheet for details on location services and number of individuals served in FY 2023 and FY 2024 to date. See "Q23. Attachment. DBH Certified Providers."

24. Please describe all grievances filed against DBH providers and DBH during FY 2023 and FY 2024, to date, including:
    a. Number of external reviews filed;
    b. Number of external reviews found in favor of the consumer; and
    c. Number of external review determinations in favor of the consumer that were approved by the DBH Director.

DBH Response:

DBH received a total of 93 grievances in FY 23, of which 86 were filed against DBH, including 80 against Saint Elizabeths Hospital, and seven were filed against DBH Providers. There has been a total of eight grievances filed in FY 24 to date.

There was a total of four external reviews filed in FY 23, and none to date in FY 24. Two of the external reviews were in favor of the consumer and both were approved by the DBH Director.

25. Please provide a list and narrative description of any DBH partnerships with District agencies in FY 2023 and FY 2024, to date, to support employment for DBH consumers. Please include the following:
    a. The number of individuals served, the types of employment placements available, and the employee(s) responsible for coordinating the partnership;
    b. The number of participants who entered post-secondary or occupation training program, apprenticeships, or District employment programs; and
    a. For DBH's partnership with the Rehabilitation Services Administration (RSA), please provide the names of all organizations or agencies providing services through the Evidence-Based Support Employment program for FY 2023 and FY 2024, to date. Include a breakdown of how many participants were hired and where they were employed. Indicate whether any of the placements were in subsidized or temporary positions.

DBH Response:

The Evidence-Based Supported Employment program serves adult consumers with a serious mental illness or substance use disorder for whom competitive employment has been interrupted or intermittent as a result of significant mental health or substance use challenges. Evidence-Based Supported Employment strives to help enrollees obtain part-time or full- time employment. The consumer receives support in a competitive employment setting that pays at least the minimum wage. The program offers intake, assessment, job development, treatment team coordination, disclosure counseling, benefits counseling and follow-along support for all participants enrolled in the program.

DBH provides this program in partnership with Department of Disabilities Services (DDS), and Rehabilitation Services Administration (RSA) through a memorandum of understanding (MOU). As stipulated in the MOU, RSA provides funding to six DBH-certified Evidence-Based Supported Employment programs using a "pay for performance" methodology. Providers receive payment for meeting specified milestones for the following services: job development, job placement, and job stabilization for shared consumers.

a. The number of individuals served, the types of employment placements available, and the employee(s) responsible for coordinating the partnership;

DBH's Supported Employment programs served a total of 247 consumers in FY 23 and 99 to date in FY 24. In FY 23, 132 consumers received job placement and retention services, while

43 consumers received job placement services to date in FY24.

Employees responsible for coordinating the partnership:
Melody Crutchfield - DBH Supported Employment Program Manager
Catherine Pitts - DBH Supported Employment Program Analyst

b. *The number of participants who entered post-secondary or occupation training program, apprenticeships, or District employment programs:*

Although the goal of DBH's Supported Employment programs is rapid placement into competitive employment, we also placed individuals in training and education programs. Please see Table 1 for the number of individuals placed in training and education programs in FY 2023 and FY 2024.

Table 1. Support Employment: Training and Education		
	FY22	**To Date FY23**
Participants Entered Post-Secondary Education Programs	7	1
Occupational Training Programs	0	1
Participated in Apprenticeships	0	0
Entered District Employment Programs	0	0

c. *For DBH's partnership with Rehabilitation Services Administration (RSA) please provide the names of any organizations or agencies providing services through the Evidence-Based Support Employment program for FY 2023 and FY 2024, to date. Include a breakdown of how many participants were hired and where they were employed. Indicate whether any of the placements were in subsidized or temporary positions.*

The partnership with RSA supports six DBH certified Supported Employment programs. Please see Table 2 for the number of consumers placed by each of the Supported Employment providers.

Table 2. DBH Evidence-Based Support Employment FY 23		
Name of Agency	Number of Placements	Subsidized or Temporary
Anchor	34	0
Community Connections (CC)	0	0
MBI	28	0
PCC	23	0
PSI	16	0
Hillcrest	31	0
DBH Evidence-Based Support Employment FY 24		
Name of Agency	Number of Placements	Subsidized or Temporary

Anchor	N/A	0
Community Connections (CC)	N/A	0
MBI	14	0
PCC	9	0
PSI	4	0
Hillcrest	16	0

Please see Attachment 1 of 1. Placements Report which lists the number and types of placements made by each agency during FY 23 and FY 24.

DBH has partnerships with the following District agencies to help residents with behavioral health challenges obtain and keep employment with ongoing support.

Department of Employment Services (DOES)

DBH partners with the Department of Employment Services (DOES) to provide onsite behavioral health support, screening and referral for DC residents who participate in DOES' Job Readiness Programs, specifically DC Career Connections and Project Empowerment. This partnership promotes behavioral health wellness and prepares participants to have a comprehensive and well-rounded experience leading to long term employment success and economic stability. During FY23, there were two (2) DBH onsite clinicians who screened and referred 620 residents to behavioral health resources and services. In FY24 to date, DBH has screened and referred 65 DC residents.

Office of the Deputy Mayor for Planning and Economic Development (DMPED) New Communities Initiatives

DBH partners with the Office of the Deputy Mayor for Planning and Economic Development (DMPED) New Communities Initiatives (NCI) to support the behavioral health needs of residents living in the following four NCI neighborhoods: Barry Farm, Park Morton, Lincoln Heights/Richardson Dwelling, and Northwest One. DBH provides two onsite Mental Health Clinical Specialists (MHCS) to provide behavioral health support, screenings/assessments, and linkage to supports and services.

During FY23, the two DBH Mental Health Clinical Specialists were co-located at the four NCI Neighborhood designated sites and provided behavioral health support to 91 residents via screening, referral, care coordination and solution focused sessions. They also provided 61 consultations to the case managers and partners working directly with residents impacted by unaddressed behavioral health needs. The MHCS also conducted 15 behavioral health workshops, which yielded a total participation of 147 residents who live in NCI neighborhoods.

In FY24 to date, the Mental Health Clinical Specialists have provided behavioral health support to 47 residents via screening, referral care coordination and brief solution focused sessions. The DBH MHCS provided 22 behavioral health consultations to case managers and partners

working with residents of the NCI neighborhoods. During FY24 to date, four workshops have been conducted serving 44 residents of NCI neighborhoods.

The employee responsible for coordinating the partnerships with the Department of Employment Services (DOES), and Office of the Deputy Mayor for Planning and Economic Development (DMPED) is Kim Ray.

26. Regarding the MOU with the Department of Human Services Economic Security Administration to provide Supported Employment services to individuals with serious mental illness who receive Temporary Assistance for Needy Families (TANF):
    a. How many individuals participated in this program in FY 2023 and in FY 2024, to date?
    b. Please provide a step-by-step process of how DBH helps individuals find employment and then maintain employment.

DBH Response:

How many individuals participated in this program in FY 2023 and in FY 2024, to date?

DBH continues its partnerships with the Department of Human Services (DHS), and Economic Security Administration (ESA) to assist TANF participants experiencing behavioral health challenges to progress in their path to recovery. In FY23, four hundred and eleven (411) TANF customers were screened and referred to providers for ongoing behavioral health services. In FY24 to date, fifty-seven TANF customers have been screened and referred for ongoing behavioral services.

Please provide a step-by-step process of how DBH helps individuals find employment and then maintain employment.

Through our partnership with DHS, DBH administers behavioral health screenings to TANF participants in order to refer and link those in need to appropriate behavioral health services to address mental health related barriers to employment and recovery. Participants are educated regarding strategies to meaningfully engage in work activities, secure employment, and achieve greater degrees of self-sufficiency. In addition, DBH partners with DHS to host TANF Employment Programs (TEP), which provide education and employment training opportunities/programming to support TANF participants' educational and work-related goals.

27. Please provide the list of services currently available as part of the Mental Health Rehabilitation Services (MHRS) system. Please include:
    a. A description of each service;
    b. Whether it is available as part of the Medicaid MHRS program, the non-MHRS program, or both; and
    c. The FY 2024 reimbursement rate for each service.

DBH Response:

Please see attached document titled, "Q27 Attachment 1 of 1. MHRS Services by Payer and Reimbursement Rate."

28. Please provide the monthly MHRS utilization data for FY 2023 and to FY 2024, to date. Please include:
    a. A breakdown of Medicaid MHRS vs. non-Medicaid MHRS;
    b. For Medicaid MHRS, provide a breakdown by managed care vs. fee-for-service (and include a breakdown by specific managed care organization); and
    c. For non-Medicaid MHRS enrollees, indicate whether the individual had coverage via the DC Healthcare Alliance or was uninsured.

DBH Response:

Please see attached document titled, "Q28. Attachment 1 of 1. Monthly MHRS Utilization Data for FY23 and FY24."

29. Please provide for FY 2023 and FY 2024, to date, the name of all certified MHRS providers. For each provider, please indicate whether or not the provider utilizes the Medicaid MHRS program, the locally-funded MHRS program, or both.

DBH Response:

See "Q29. Attachment MHRS Providers Listing."

30. Do CSAs or other mental health providers provide any services that are not currently reimbursed by Medicaid? If so, please indicate whether these services are reimbursed under DC's approved 1115 waiver or could be reimbursed under a 1915(i) state plan option, a waiver, or a demonstration project.

DBH Response:

In 2022, DBH implemented Clinical Care Coordination (CCC) as a Medicaid service. This service replaced such local-only services as transition of care services and treatment planning. On January 9, 2024, DBH received legal sufficiency for Intensive Care Coordination (ICC). This service is the Medicaid version of High-Fidelity Wraparound services for children. When the regulation for ICC is approved, it will be the last local-only behavioral health services to be covered under Medicaid. The regulation is expected to be finalized the first week of February 2024.

There are certain supports that accompany services that can only be paid with local funds. Room and board costs for residential services and flexible spending to assist caregivers and families in covering costs for children receiving ICC must be paid for using local funds. These supports are not eligible to be covered.

31. Please provide the following information for all housing programs administered by DBH:
    a. Name of the program, services provided, and eligibility requirements;

b. Number of individuals served in FY 2023 and FY 2024, to date;
c. Capacity of the program;
d. Performance measures and associated outcomes for each program;
e. The name and title of the DBH employee responsible for administering the program;
f. The average wait time for a consumer to access housing through the program;
g. The number of individuals on waiting lists for the program; and
h. Of those individuals on the wait list, whether any are experiencing homelessness or in other housing programs.

DBH Response:

DC Local Rent Supplement Program (LRSP)
The LRSP is administered by the D.C. Housing Authority (DCHA). The program follows the eligibility requirements and rules and regulations of DCHA's federally funded voucher program. DBH makes referrals for initial occupancy and backfill of vacancies for LRSP vouchers attached to newly renovated or developed units funded with DBH capital dollars for 25 years. The LRSP vouchers are attached to single-room occupancy (SRO) units and to apartments.

Home First Housing Voucher Program
The locally funded Home First Program provides housing rental vouchers for individuals and families who live in an apartment or home of their choice and sign their own rental leases. Consumers pay thirty percent (30%) of their household income to the landlord for their rent and the Home First Program subsidizes the balance of the rental amount.

Supported Residences (Licensed Mental Health Community Residential Facilities):

- Intensive Rehabilitative Residence (IRR)
  An intensive level of care for individuals enrolled in the DBH behavioral health system who have medical issues that put them at risk of needing nursing home care if they do not receive physical health care nursing supports with the appropriate mental health rehabilitation services.

- Supportive Rehabilitative Residence (SRR)
  A SRR CRF provides 24-hour, structured housing support for consumers with severe and persistent mental illness who need an intense level of support to live within the community. The specific services offered include: 24-hour awake supervision; assisting the consumer to obtain medical care; providing training and support to assist consumers in mastering activities of daily living; maintaining a medication intake log to ensure that residents take their medications as prescribed; provision of one-to-one support to manage behaviors or perform functional living skills; transportation to doctor's appointments; assistance with money management; and participation in treatment planning, implementation, and follow-up.

- Supportive Residence (SR)

An SR CRF provides on-site supervision when residents are in the facility; medication monitoring; maintenance of a medication log to ensure that medication is taken as prescribed; assistance with activities of daily living; arrangement of transportation; monitoring behaviors to ensure consumer safety; and participation in treatment planning, implementation, and follow-up.

Number of Individuals Served in FY23 and FY24-1Q and *Capacity of the program*

In FY23, the capacities of the supported housing program and supported residences were adjusted to align with program funding. In FY23 a total of 1,589 people received either a rental or site-based voucher, or lived in a supported residence. In the FY24 Q1, a total of 1,478 people received either a site-based or rental voucher or lived in a supported residence. *(See Table1)*

Table - 1

Supported Housing Program	FY23 Capacity	Consumers Served FY23	FY24 Capacity	Consumers Served FY24 Q1
Site-based Vouchers				
DBH Capital-Funded Housing (LRSP/Site-Based Vouchers)	210	197	220	194
Rental Vouchers				
Home First (Vouchers)	878	792	832	744
Mental Health Community Residential Facilities (MHCRFs)				
Intensive Residence (IR)	8	8	8	8
Supportive Rehabilitative Residence (SRR)	204	201	187	178
Supportive Residence (SR)	402	391	389	354
Total Supported Housing	**1,702**	**1,589**	**1,636**	**1,478**

Performance measures and associated outcomes for each program

DBH Housing Performance Measures /Outcomes for Consumers – FY23 *(See Table2)*

Table - 2

Quality Domain	Performance Measure	Outcome
Housing Tenure/Stability	75% of consumers will maintain community tenure in independent housing for 12 months or longer	92% of consumers maintained community tenure through 9/30/23
Housing Occupancy Rate	DBH will maintain an 80% or greater occupancy rate within its subsidized housing program	FY23 - 94% FY24-Q1: 89%

Availability of Housing Services/Supports	80% of consumers in subsidized housing will enroll with a Core Service Agency (CSA) to receive mental health services and supports	83% enrollment
CRF Placement Stability	90% of consumers who remained in the CRF placement for at least 90 days from move-in date, with no psychiatric hospitalizations, incarcerations, crisis bed placements, or involuntary discharges.	88% stability

Name and title of the DBH employee responsible for administering the program

Brandi Gladden, Director – Housing Development Division, is the DBH employee responsible for administering the DBH housing programs.

The average wait time for a consumer to access housing through the program

The average time between referral and placement is four to six weeks.

The number of individuals on waiting lists for the program

DBH does not maintain a waiting list for housing. DBH requires certified providers to get information about housing needs at the time of intake and individuals indicate whether they want to be considered for housing resources when they become available. Individuals who request a rental housing voucher self-report whether they are homeless, living on the streets or in a shelter, living temporarily with families or friends, or living place to place. They also report if they are rent burdened, at risk of eviction, or living in substandard housing. This information is entered into the consumer's electronic medical record. In the past, this process has been commonly referred to as a "waiting list" but it is a self-report of housing needs. When a rental housing voucher becomes available, DBH notifies providers and works with them to determine eligibility of current consumers. Since interest exceeds available vouchers, consumers experiencing homelessness who are living on the streets or in a shelter are prioritized. This process does not apply to supported residences where placement is determined by level of need.

Of those individuals on the wait list, whether any are homeless or in other housing programs
As indicated above, at the time of intake, individuals self-report their living situation. Individuals who request a rental housing voucher often seek support from other available housing programs as well.

32. Of the total number of consumers that DBH serves, what percentage were experiencing homelessness in FY 2023 and FY 2024, to date?
    a. Of those experiencing homelessness, how many were under the age of 21? Please disaggregate data by age.
    b. Describe how DBH or agency partners count, or account for, homeless youth who need behavioral health services, especially those who are served independently (not in a shelter with a family).

c. Describe how DBH or agency partners count or account for homeless youth who need behavioral health services and who identify as LGBTQIA+.

DBH Response:

In FY23, of the 43,472 people served in the mental health system, 1270 adults were served by the Intensive Care Coordination Team. In FY24 YTD, 190 adults are being served by the Intensive Care Coordination Team. DBH also has a SAMSHA funded Project for Assistance in Transition from Homelessness (PATH) team. In FY23, 275 adult consumers were enrolled in PATH of the 470 persons engaged by the two person PATH team. Eleven (11) of the enrolled PATH consumers were ages 18-23.

a. Based on claims data for FY23, 112 youth under the age of 21 identified as homeless.

Number of Youth Under 21 Identified as "Homeless"	**Age of youth under 21**
6	4 -6
11	7 -9
12	10 -12
15	13 -15
5	16 -18
63	19 -21

b. Homeless consumers are counted and identified in the Point in Time (PIT) count held annually in January by the Community Partnership. Their annual data and report detail the experience of people experiencing homelessness in the District and is used by DBH in conjunction with DHS and The Interagency Council on Homelessness (ICH) to develop the engagement and outreach strategies across agencies to engage and connect consumers to care.

The 2023 PIT data is here: https://community-partnership.org/homelessness-in-dc/#pit-dashboard

For children and youth, during intake, an individual is asked about their living situation. An individual may self-identify as “homeless” if they are living with family or friends, in a shelter, or living on the street. If the child, youth, or family identify as homeless, the provider then works with the child and family to obtain housing resources and support in addition to providing behavioral health services.

When Transition Age Youth (TAY) enter DBH’s Transitional Living Facility, Wayne Place, TAY receive behavioral health services. If the youth are not connected with a behavioral health provider, they are referred and encouraged to connect with a provider while in the independent living facility. The Wayne Place staff teams with the provider to offer comprehensive services.

c. DBH requires all certified providers to offer services (within their scope of practice) to anyone seeking care or to appropriately refer such individuals to a qualified provider. For youth who experience homelessness and identify as LGBTQ, the provider will work with the youth to provide behavioral health and housing resources. The Wayne Place living facility supports all District youth aged 18-24.5 years old. If the LGBTQ TAY identifies that they are not comfortable living at Wayne Place, they are referred to the ICH, and the team advocates for them to receive housing at one of the LGBTQ focused housing programs.

33. In FY 2023 and in FY 2024, to date, what services and support did DBH provide to homeless consumers, including adults, youth, and children? What were DBH's outcomes? How many DBH consumers in FY 2023 and FY2024, to date, who were homeless, were placed in housing?

DBH Response:

DBH sees stable housing as a primary factor in overall recovery. DBH-certified providers get self-reported information about housing needs during intake. In addition, providers include housing needs on treatment plans, make referrals, and take appropriate steps to address the identified housing needs. However, most consumers in the District receiving housing vouchers participate in the Department of Human Services (DHS) program. DBH does not have direct access to DHS's data and serves such consumers upon referral from DHS or if they self – identify as homeless while receiving services from a DBH provider.

In FY23, DBH served 43,472 consumers. Of those active enrollments, 10,118 (23%) self-report as wanting support getting better housing, primarily with a rental housing voucher. DBH has a limited number of rental housing vouchers with little turnover and does not verify eligibility until a voucher becomes available. DBH delivers services to individuals who are homeless—living on the streets, in shelters, or transitional housing—through DBH contracted providers, Assertive Community Treatment (ACT) teams, and government-operated programs to include Intensive Care Coordination teams and the SAMSHA funded PATH program.

In FY23, ACT Teams served 2,442 consumers. Of those active enrollments, 221 (10%) of those consumers were identified as homeless in their service authorization requests. Consumers enrolled with an Assertive Community Treatment team receive intensive outpatient services. ACT teams deliver or coordinate all the services a consumer needs and work in coordination with DHS and the Interagency Council on Homelessness (ICH) to help consumers access housing and housing vouchers.

In FY23, the Intensive Care Coordination (ICC) Teams served 1,270 consumers experiencing homelessness in PEP-V placements and in shelters, of the total 1388 engaged. The ICC team offered support to connect individuals to a Core Service Agency and delivered direct services until the consumer selected agency had seen the consumer a minimum of three times. Seventy-five (75%) percent of the consumers served selected a Core Service agency to work with them regarding their mental health needs. In addition, the ICC team works in partnership with DHS homeless outreach and housing navigation teams and the Interagency Council on Homelessness to support the mental health needs of consumers experiencing homelessness.

The PATH team is a two-person team funded by SAMSHA with the expressed goal of assisting individuals experiencing serious mental illness and homelessness connect to care and housing navigation. In FY23, the PATH team engaged 470 consumers and enrolled 275 in the PATH program. Consumers receive mental health assessment, counseling, community support, and assistance with housing and homeless services system navigation. Nine (9) consumers achieved permanent housing situations, eighteen (18) achieved temporary housing, four (4) were placed in institutional settings to include skilled nursing facilities, and 176 accessed an emergency shelter or a PEP-V site.

The DBH Residential Services and Supports (RSS) Division supports consumers who reside in DBH Community Residence Facilities through care management and care coordination to ensure placement disruptions are minimized. CSAs and ACT teams will contact RSS staff for assistance with consumers who have complex needs and can be better served in independent housing when it is available. These consumers are usually experiencing homelessness and are often in inpatient settings or in temporary housing situations. In FY24, RSS was able to secure housing through DBH vouchers for eleven (11) consumers experiencing homelessness.

Additionally, in FY23, DBH provided residential services and support to 1,082 consumers who resided in community residence facilities. Consumers in this program received room and board, assistance with activities of daily living up to 24 hours a day depending on medical necessity, and coordination of care with their core service agency regarding their mental health treatment.

Community Connections and MBI (DBH certified providers) partnered with District youth shelters to link individuals to behavioral health services and refer Transition Age Youth (TAY) to housing at DBH's Transitional Living Facility, Wayne Place. Wayne Place supports young adults and provides them with the skills and knowledge to learn the necessary skills to transition independently to adulthood. During FY23 and to date in FY24, Wayne Place served 32 TAY youth. Over the course of FY23 and FY24, 21% (10) were discharged from the 18-month independent living program. Of the 21% discharged TAY, 70% (7) were discharged successfully to leased single or shared apartments. Thirty percent (3) of TAY were prematurely discharged and connected to other housing resources that met their needs. Additionally, the TAY team participates in meetings related to youth homelessness which include District's Interagency Council on Homelessness and Community Partnership.

34. In FY 2023 and in FY 2024, to date, what services and support did DBH provide to consumers who identify as LGBTQIA+? Please indicate what services are for children and youth.

DBH Response:

DBH requires that all certified providers offer services (within their scope of practice) to anyone seeking care or to appropriately refer such individuals to a qualified provider, whether an individual identifies as LGBTQIA+ or not. DBH repeatedly emphasizes this mandate in our monthly provider meetings to ensure that that those who identify as LGBTQIA+ do not experience any barriers to accessing necessary care. In addition, DBH has provided specialized grants focused on Expanding Access and Retention in Care for Opioid and/or Stimulant Use

Disorder Treatment to Whitman Walker and HIPS targeting especially the LGBTQIA+ population. This initiative seeks to bring local providers together to implement strategies that reduce barriers to accessing treatment for targeted individuals with Opioid Use Disorder or Stimulant Use Disorder; re-engage consumers who have unexpectedly or prematurely discontinued treatment; and support current consumers to promote retention, and whole-person care. By addressing the known barriers to care, this initiative seeks to reduce health disparities within this underserved community by improving access to needed behavioral health care services.

In FY24, DBH's carryover request to SAMHSA for State Opioid Response funded initiatives within Live.Long.DC. includes an MOU with the Mayor's Office of Lesbian, Gay, Bisexual, Transgender and Questioning Affairs to conduct outreach to residents who are at a greater risk of opioid use, specifically, members of the transgender community, men having sex with men, and individuals experiencing homelessness. Funding would be used to organize community workshops, forums, and events aimed at educating, engaging, and empowering the LGBTQIA+ community regarding opioid use, its risks, and available support services and access to essential resources for prevention, treatment, and recovery. Additionally, funding would be used to develop and implement targeted campaigns using various media platforms to raise awareness about opioid use within the LGBTQIA+ community and disseminate information about harm reduction strategies, treatment options, and recovery resources. The funding would also support the establishment and nurturing of partnerships with LGBTQIA+ organizations, healthcare providers, community centers, and other stakeholders. Training sessions, toolkits, and educational materials for organizations and individuals involved in outreach efforts would be developed to ensure they have the necessary skills and knowledge to effectively engage and assist the LGBTQIA+ community regarding opioid-related issues.

During FY23 and FY24 to date, DBH has especially focused on providing a range of services to children, youth, and adults who identify as LGBTQIA+. Our School Behavioral Health Program (SBHP) clinicians provide prevention, early intervention, and treatment services to children and youth in schools, some of whom identify as LGBTQIA+. SBHP clinicians implemented programming focused on LGBTQIA+ Awareness for students, parents, and staff along with diversity and inclusion programming for students, parents, and staff. SBHP providers also hosted/host LGBTQIA+ early intervention lunch bunch groups. SBHP Providers disseminate important information about LGBTQIA+ topics via newsletters to the school community. Additionally, some report that mental health teams collect and share data for students and faculty surrounding LGBTQIA+ questions (identity, how they feel at school, acceptance, etc.) so all can be informed and feel comfortable and included in the school environment.

The DBH Transitional Age Youth (TAY) Team created several social media posts to provide LGBTQIA+ TAY with behavioral health resources and services. These were posted to the TAY Instagram, Facebook, and Twitter pages. Additionally, the TAY team hosted two LGBTQIA+ trainings for professionals working with the LGBTQIA+ population (i.e., "Working with Young People Who Identify as LGBTQIA+" and "Implementing Anti-racism and Stereo-typing Practices in Youth and Young Adult Mental Health Programs").

35. Please describe any work DBH has conducted or planned related to the behavioral health workforce shortage in the District and/or among its staff, including retention, training, and turnover issues.
    a. Is there a database used to inform behavioral health workforce planning? What types of professions does this include?
    b. Has DBH calculated the need/demand vs. the number of practicing behavioral health professionals? What types of professions does this include?
    c. Please describe DBH's role in the Healthcare Workforce Task Force in both the creation and implementation of recommendations.
    d. Please detail DBH's efforts to recruit, train, or otherwise increase the number of behavioral health professionals actively practicing in FY 2023 and FY 2024, to date.
    e. Please describe efforts to recruit professionals in private or community practice to participate in services for those with low incomes or other barriers to accessing services.

DBH Response:

DBH is a member of the Healthcare Workforce Task Force set up to support recruitment across hard to fill positions across the District government. DBH has identified clinical positions including psychologists, psychiatric nurses, medical doctors, and licensed social workers. DBH participates in career fairs, target recruitment to relevant websites and resources such as the American Psychological Association which reach clinicians in private practice, and use recruiters to support our efforts. Saint Elizabeths has paid resident programs for psychiatrists and psychologists aimed at attracting new employees.

In addition, Collective Bargaining Agreements support recruitment and retention with the specific provisions:

- Competitive salaries and generous benefit packages
- Retention bonuses for psychiatric nurses
- Automatic quality step increase for Nurses who receive additional degrees
- Continuing medical education allowance for doctors
- Salary Increase of $20,000 for all doctors in addition to salary increases
- Reimbursement for Psychiatric Resident's medical training license

There currently are no vacant psychiatrist or medical doctor positions.

36. Please describe how DBH complies with the DC Language Access Act, including:
    a. The number of DBH employees who provide services to consumers in a language other than English, broken down by language and type of service provided;
    b. How many and in which languages DBH services and materials are provided, in both print and online formats;
    c. DBH's capacity and process to serve people who speak languages other than English;
    d. How DBH tracks the languages spoken by those seeking services, and applicable findings for FY2022, FY2023 and FY2024, to date; and

e. DBH's efforts to meet OHR's recommendations to enhance the language accessibility of its website, including posting translated information and how individuals can access interpretation services.

DBH Response:

a. The number of DBH employees who provide services to consumers in a language other than English, broken down by language and type of service provided;

All agency employees have the ability to provide services to consumers in languages other than English via in-person or virtual interpreter.

b. How many and in which languages DBH services and materials are provided, in both print and online formats

Document	Language
CARF Mock Survey	Spanish
Mental Health Hotline Information	Spanish Korean French Vietnamese Amharic Chinese-Written Simplified/Traditional
DBH Direct Services Satisfaction Survey	Spanish Korean French Vietnamese Amharic Chinese-Written Simplified/Traditional
Saint Elizabeths Security Signage	Spanish
Saint Elizabeths Photo Security Notice	Spanish
Visitor Welcome Guide	Spanish
Competency Evaluation	German
Defend in place emergency signage	Spanish Korean French Vietnamese Amharic Chinese-Written Simplified/Traditional

c. DBH's capacity and process to serve people who speak languages other than English;

In FY 2023, the agency supported 21,779 encounters, and 47,418 encounters in FY 22 in twenty-four languages (24).

Language	Bilingual Staff (tot)	In-person Interpreter (tot)	Telephone-Based Interpreter (tot)	Total Encounters (tot)
Amharic	10	289	516	815
Arabic	4	0	2	6
Bosnian	0	0	1	1
Chinese-Cantonese	0	0	125	125
Chinese-Mandarin	8	0	31	39
Chinese-Written Simplified/Traditional	1	0	510	511
Farsi	1	0	10	11
French	72	436	564	1072
German	5	28	0	33
Hindi	3	0	6	9
Igbo	10	31	0	41
Italian	3	2	3	8
Khmer	0	0	1	1
Korean	2	0	25	27
Persian	0	0	30	30
Polish	1	10	0	11
Portuguese (Brazilian or European)	1	0	2	3
Romanian	0	0	1	1
Russian	2	0	16	18
Spanish	367	6779	10,888	18,034
Thai	0	0	2	2
Tigrinya	6	96	14	116
Vietnamese	1	85	299	385
Yoruba	4	0	4	8
Totals (24 groups)	501	7756	13,050	21,307

Process: Staff are able to serve people who speak languages other than English by contacting the agency Language Access Coordinator either by phone or email for an in-person or virtual interpreter. Over the phone telephone interpreter is accessed using Language Line that offers 24/7 immediate access to an interpreter.

d. How does DBH tracks the languages spoken by those seeking services?

The number of individuals requiring language interpretation services are tracked within the agency by reviewing language request data for services from our language line providers (Ad Astra and Language Line Solutions). We also collect data from our providers quarterly as well as collecting data from Data Wits and Avatar

The agency supported 47,418 language encounters in FY2022, and 21,779 encounters FY2023. We are collecting language data for Q1 FY2024.

e. DBH's efforts to meet OHR's recommendations to enhance the language accessibility of its website, including posting translated information and how individuals can access interpretation services.

DBH is working closely with OHR and OCTO on the upcoming installation of a multilingual phone line for each facility that does not offer 24-hour access. The agency has also posted signage in our facilities sharing information on how individuals can access interpretation services.

37. Please provide an updated on DBH's plan to launch an intensive housing case management initiative, as discussed in the FY 2024 budget oversight pre-hearing question responses. Please include the initiative capacity, the number of case managers actively involved in the initiative, and the count of individuals who have benefited from the initiative since its inception.

DBH Response:

In FY23 DBH submitted a request for funding to launch an intensive housing care management program to address the community's concerns related to individuals placed in independent, scattered housing sites who, based on perceived struggles with behavioral health concerns, are at risk of losing independent housing in the community.

This proposal was funded for FY24. These funds recently became available to DBH and we began preparing a solicitation to identify a vendor to deliver intensive housing care management services to the identified target population. The scope of work (SOW) has been drafted and is currently being reviewed and evaluated by the Office of Contract and Procurement (OCP). OCP plans to assign a contract specialist by mid-January 2024 to manage this procurement process. Once the solicitation documents are finalized and a vendor is selected, implementation of this initiative will commence within 30 days of the award. Based on OCP's current work schedule, we anticipate launching this program during the third quarter.

The drafted scope of work (SOW) includes the following requirements:
The selected vendor will provide housing care management services to a panel of no less than 500 people holding either a DBH or a DHS housing voucher AND who are identified as needing intensive behavioral health supports/care management in order to live successfully in their home and maintain community tenure.

The selected vendor will employ Critical Time Intervention (CTI), an evidence-based best practice, to engage consumers identified as requiring such support, and transition them from homelessness to independent apartment living. CTI is a time-determined, graduated best practice which facilitates successful community integration and adherence to ongoing care by ensuring such individuals build and maintain ties to the community and their support systems during such transitions.

The selected vendor will set up and maintain a hotline to address concerns of consumers in housing so that District property managers, key government agencies, as well as other community stakeholders can call to request support for individuals of concern who require support to successfully maintain community tenure.

The selected vendor will also work with consumers and their enrolled behavioral health provider to ensure that the level, frequency and intensity of consumer engagement and support are sufficient to maintain housing in the community. If the identified individual is not enrolled with a behavioral provider, the vendor will provide necessary clinical support in the interim, as they help the consumer select and enroll with a provider.

Behavioral Health Services Transition to Managed Care

38. Please provide a detailed narrative of expected changes to DBH's scope of work as behavioral health services transition to managed care organizations. Please describe:
    a. The aspects of billing and reimbursement that will remain under the purview of DBH post-transition and any notable adjustments or new procedures;
    b. The agency's anticipated role in the provider and professional certification and credentialling processes, including any collaborative efforts with managed care organizations to streamline certification and credentialling;
    c. The expected impact on consumer services, including potential changes in service availability, coordination, and the overall consumer experience; and
    d. The anticipated impact on DBH staffing levels.

DBH Response:

Provider billing and reimbursement is transitioning to the Managed Care Plans (MCP) and the Department of Health Care Finance (DHCF) as of April 1, 2024. While most of the DBH certified provider network currently does business with MCPs and DHCF, we have undertaken ongoing training through RevUp DC and a series of training from provider relations. RevUp DC trains the DBH certified network on claims submission to MCPs. This RevUp training will continue post behavioral health transition to MCPs.

DBH will continue to certify the provider network. DBH is updating provider certification and recertification applications to align with requirements established by the Joint Commission, the Council on Accreditation, and the Commission on Accreditation of Rehabilitation Facilities.

Beginning in February, providers will only submit supplemental documents to DBH that are not collected by the accrediting bodies.

DBH anticipates that transitioning behavioral health services to MCPs will have a positive impact on consumer services through the provision of whole person care. MCPs are experienced and expert at care management and utilization management for their members. This transition improves service availability and coordination by giving District residents access to the broad array of services available from MCPs in addition to the full continuum of behavioral health services.

DBH is not anticipating any reduction in full time equivalents (FTE) because of the behavioral health transition. FTEs will shift within DBH to support changing functions, such as population health management, training, policy development and quality management and oversight but there is no planned reduction in FTEs.

39. Please detail how Substance Use Disorder (SUD) providers will bill for treatment and recovery support services after behavioral health services transition to the managed care organizations, including if a DBH certification is required.

DBH Response:

Currently SUD treatment and Recovery Support Services (RSS) are reimbursed by the Department of Health Care Finance Medicaid Program, if client is Medicaid eligible. Room and Board services are carved out as a locally funded Department of Behavioral Health reimbursed service. SUD treatment and Recovery Support Services will transition as a behavioral health benefit covered by the Managed Care Plans (MCPs) on April 1, 2024. SUD providers will submit claims for reimbursement based on the client's assignment to a MCP.

As of October 2020, per Chapter 63 Recovery Support Services was defined as a core service. All treatment providers are required to render recovery support services as a part of the clients plan of care. All behavioral health providers may apply for certification as an SUD RSS provider only. Certification by DBH is required for all providers billing the District's publicly funded SUD treatment and RSS.

DHCF and DBH are working together to administer a payment process for local only services and non-Medicaid eligible clients directly to DHCF. Costs of the local services and non-Medicaid eligible clients would be reimbursed to DHCF through the MOU process. This plan will streamline the claims submission process for providers and remove DBH from the payment process.

All behavioral health providers have access to the Revenue Cycle Management for Practice Transformation (RevUp DC) Program. RevUp DC provides technical assistance and training on revenue cycle management and assists providers with developing claiming and operational skills for billing the managed care plans. The Rev Up DC Program has been underway since June of 2023 and runs through Mid-March 2024.

40. Please detail how the billing structure for ACT teams has shifted or is anticipated to shift following the transition of behavioral health services to managed care organizations.

DBH Response:

In anticipation of the transition of behavioral health services to the managed care organizations on April 1, 2024, and provider requests for an increase in the Assertive Community Treatment (ACT) rate and a less burdensome and more clinically congruent billing structure, DBH, in partnership with the Department of Health Care Finance (DHCF), made significant changes to the ACT payment methodology last fall.

Effective September 1, 2023, the ACT regulations were amended to change the ACT service from a fee-for-service reimbursement structure (documented and then claimed in fifteen (15) minute increments) to a monthly reimbursement rate structure, contingent on specific clinical and engagement requirements to capture the monthly payment.

The requirements for the new, significantly increased monthly rate include: a minimum of eight (8) contacts in the month (all contacts must be documented), a minimum of which five (5) contacts must be face to face, while up to three (3) contacts may be via telehealth (audio or audio-visual)

To ease the pressure on providers to achieve full compliance with the new billing requirements for the monthly rate during this significant transition, the Directors of DBH and DHCF issued guidance to the ACT providers which allows them to gradually increase the billing requirements from September 2023 through February 2024 in order to capture the full monthly rate. This new billing structure is also more compliant with operating model of the managed care organizations which will take responsibility for behavioral health services effective April 1, 2024. This transition period phases in the number of required contacts and the configuration of the contacts required by licensed staff, giving providers time to ramp up and hire the staff needed to be successful in implementing full fidelity to new ACT reimbursement model. Following the April 1, 2024, transition, the managed care organizations have agreed to honor all previously approved and active DBH ACT authorizations. New managed care authorizations will not be required until after the current ACT authorization has expired.

DBH plans to conduct annual audits of all ACT providers to ensure adherence to fidelity using the TMACT (Tool for the Measurement of ACT) developed by the University of North Carolina (UNC), to ensure that service quality is maintained or enhanced as a result of this change. DBH is currently providing trainings in fidelity to the ACT model which is delivered by UNC in preparation for the carve-in on topics related to: team structure, crisis emergency response expectations, consumer contact expectations, and the efficient use of practice specialists such as employment and housing specialists within the ACT the team.

In late FY 24, through the fidelity audits, DBH will assess initial clinical outcomes related to these changes to determine course corrections needed systemically, as well as corrective action

plans that may be necessary for specific, individual providers due to lack adherence to the fidelity model.

41. Has DBH made any changes to the agency's SUD certification requirements given that providers are required to obtain national certification?

DBH Response:

DBH is updating its provider certification and recertification applications to align with requirements established by the Joint Commission, the Council on Accreditation, and the Commission on Accreditation of Rehabilitation Facilities. Beginning in February 2024, providers will only submit supplemental documents to DBH that are not collected by the accrediting bodies.

Children and Youth Services (Non-School Based Behavioral Health)

42. How many children and youth (age 0-20) received a service through MHRS during FY 2023, and FY 2024, to date? Please include a breakdown by age, race, gender, ethnicity, and ward.

DBH Response:

Please see Attachment 1 of 1 that describes the number of children and youth ages 0-20 who received a service through MHRS in FY23 and FY24 YTD by age, race, gender, ethnicity, and ward.

43. For FY 2022, FY 2023, and FY 2024, to date, please provide the amount budgeted and actually spent on each DBH program, service, or cost center that serves children (ages 0-21). If the program, service, or cost center serves both children (ages 0-21) and adults, please share the funding spent specifically on children (ages 0-21). Additionally, for each program, service, or cost center, please provide a breakdown of the amount of local, federal, private, and special revenue funding for FY 2022, FY 2023, and FY 2024 to date, and a narrative description of the program, cost center, or service, including the specific age group(s) served.

DBH Response:

Below is a description of the CAFS Administration and programs:

Child/Adolescent/Family Services Administration –develops, implements and monitors a comprehensive array of prevention, early intervention, and community-based behavioral health services and supports for children, youth, and their families that are culturally and linguistically competent; and supports resiliency, recovery and overall well-being for District residents who have mental health and substance use disorders.

Behavioral Health Services MH/SUD – oversees development, implementation and monitoring of a comprehensive array of community-based mental health and substance use disorders

services including evidenced-based and promising practices, implemented within the behavioral health provider network to address the needs of adults, children, youth, and their families. Leads the oversight and management of the agency's integrated community-based, prevention, early intervention, and specialty behavioral health programs.

SUD Prevention and Treatment –ensures comprehensive prevention systems by developing policies, programs, and services to prevent the onset of illegal drug use, prescription drug misuse and abuse, alcohol misuse, and abuse, and underage alcohol and tobacco use. Oversees the provision of substance use treatment for children and adolescents and transition-aged youth by ASTEP providers.

School Based Behavioral Health Services – provides school-based, primary prevention services to students and school staff, early intervention and treatment services to students and parents, and consultation to individual teachers and school administrators in public and public charter schools within the District.

Crisis Services– through the ChAMPS contract provide crisis intervention and stabilization services to residents and visitors who are experiencing psychiatric crisis in the community or at home; services include linkage to DBH, psycho education, treatment compliance support, and grief and loss services to individuals after atraumatic event.

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

Early Childhood Services – provides in home and center-based early childhood mental health supports and child and family-centered consultation to child development center staff and families to build their skills and capacity to promote social/emotional development and to prevent, identify, and respond to mental health issues among children in their care.

Specialty Services – provides centralized coordination and monitoring of placement, continued stay, and post-discharge of children and youth in psychiatric residential treatment facilities (PRTF). Oversees the coordination of the PRTF medical necessity review process. Supports Juvenile Court by providing Juvenile Behavioral Diversion Program and Hope Court that conduct mental health and substance use disorder screening, assessments, and referrals for youth, and families involved with the courts ensuring they have easy access to a full continuum of quality behavioral health services and supports. DC MAP supports the provision of screening and psychiatric consultation in pediatric practices. Co-Located Services oversees the co-location of DBH clinician at CFSA to facilitate early behavioral health screenings, assessments, and consultations with CFSA social work staff and to make service referrals to the behavioral health provider network.

Government Operated Services - Howard Road – provides early childhood treatment services through the Parent Infant Early Childhood Enhancement Program (PIECE) program for children

ages 0-7. Provides same day Urgent Care Psychiatric Evaluations for youth ages 0-18 years of age.

Evidence Based Practice (EBP)– provides oversight of the design, development, implementation, and evaluation of a comprehensive continuum of evidence-based practices offered to children and youth with mental health and substance-related issues. In addition, the division provides oversight and support of Community Based Intervention (CBI) services for youth in crisis up to age 21. The Division also assists in the implementation and monitoring of children's assessment tools, Child and Adolescent Functional Assessment Scale and Preschool Early Childhood Functional Assessment Scale.

See attachment 1 of 3. FY 22 budget for CAFS Administration.
See attachment 2 of 3. FY 23 budget for the CAFS Administration.
See attachment 3 of 3. FY 24 budget for the CAFS Administration.

44. Please provide the following information for the Children and Adolescent Mobile Psychiatric Service (ChAMPS) since their contract modification:
    a. Number of DBH staff that administer the program;
    b. Number of individuals served by ChAMPS in FY 2023 and in FY 2024, to date;
    c. The process for determining what calls are deployable and non-deployable;
    d. The response time for deployable calls including the longest and shortest response times that occurred in FY 2023 and FY 2024, to date, as well as the average;
    e. The number of mobile crisis teams;
    f. Any updates regarding how calls are triaged to ensure that a team is available upon request;
    g. Any updates to the relationships and coordination between the 911 call-takers, Access Helpline, and ChAMPS teams;
    h. How the new exclusion of evening and weekend hours has impacted potential users of the service as well as the capacity of the other services that respond to calls during these hours instead of ChAMPS;
    i. All languages in which ChAMPS services are provided; and
    j. The findings of any review or evaluation of these services. Please attached any relevant reports.

DBH Response:

The Department of Behavioral Health utilizes two entities to provide 24 hours of crisis response for children and youth in the District of Columbia. Anchor Mental Health Association provides mobile crises services Monday through Friday from 8:00 a.m. to 8:00 p.m. The Department of Behavioral Health's Community Response Team provides mobile crisis response for children and youth Monday through Friday 8:00 p.m. to 8:00 a.m. and on the weekends. The youth mobile crisis response program helps children and youth ages 6 to 17 years of age and up to 21 for children and youth committed to the District's Child and Family Services Agency (CFSA). The service is designed to help manage emotional and psychiatric crisis including dysregulated behavior and to support families wherever possible to prevent behavior from resulting in a

psychiatric hospitalization or the child otherwise being removed from the home. In cases where a child or youth does require hospitalization, ChAMPS facilitates the referral for both voluntary and involuntary hospitalizations. ChAMPS services include screening for mental health and substance use needs, crisis stabilization, and referral to appropriate resources including longer-term mental health or substance use services. ChAMPs conducts outreach to the community, disseminates information on resources and behavior management supports, and provides consultation to parents, schools, and other community organization regarding available behavioral health services.

Services are provided in the community, schools, or in homes for District residents and children living in Maryland in the care and custody of the CFSA. After the youth mobile crisis program provides a crisis intervention service, ChAMPS follows up with the family or caregiver within 24 hours to check on the child's well-being and may provide follow-up support for up to 30 days post-intervention. The team links children and families to a behavioral health provider for ongoing support. For children already enrolled with a provider, the team communicates the child's status and recommendations based on the intervention. ChAMPS also offers Family Peer Specialist services to support families in the stabilization of their child's behavior and to promote a culture that recognizes, understands, and respects the family's views and preferences.

a. All CRT staff received additional training to be equipped to respond effectively to ChAMPS calls when covering overnight and weekends, but no dedicated positions were added to CRT when the contract was restructured. The Department of Behavioral Health has a primary clinical point of contact and a designated contract administrator for the Catholic Charities contract. Finally, DBH's Chief Clinical Officer, Dr. Jonathan Shepherd, is available to the ChAMPS program for consultation. Dr. Shepherd is dual-boarded in Adult and Child & Adolescent Psychiatry.

b. See the table below for total number of calls to Anchor Mental Health for FY23 and FY24 Quarter 1.

Fiscal Year	Total Calls	Individual Number of Children and Youth Served
FY23	1321	245
FY24 Q1	356	60

c. Each call that is routed into ChAMPS through Anchor Mental Health is received by a Licensed Clinical Manager who is trained and equipped to make a clinical determination on how to manage crisis calls. In making their clinical determination, the Licensed Clinical Manager considers the following: whether there is an active mental health or behavioral crisis; the current safety concerns; whether there is a mental health clinician present; whether the client has an ongoing mental health provider; whether there are any current concerns that may require immediate medical attention; and whether the client is under the influence of any illegal substance. All calls deemed to involve children and youth experiencing a psychiatric crisis are deployable calls which result in an onsite response by a clinical team. ChAMPS also provides clinical consultation via telephone to child serving agencies seeking support for concerns such as

family conflict, oppositional defiant behavior, and emotional dysregulation of children and or youth. Non-deployable calls include requests for information about program services or resources only or instances in which a caregiver declines an on-site assessment.

d. The table below shows response to calls:

Service	FY 23	FY24 Q1
Deployments	267	69
Deployments – No intervention	40	12
Cancelled Calls	115	30
Clinical Consultations	632	108
Information Only	314	25
Total Deployments	307	81
Total Calls Not Deployable	1012	163
Total Calls	1320	488

In FY23, ChAMPS reported that the average deployment time was 38 minutes. The longest response time was 95 minutes, and the shortest time was 6 minutes. To date in FY24, the average deployment time is 35 minutes. The longest response time was 89 minutes, and the shortest time was 7 minutes. The requirement is to arrive at all deployments within one hour or less during the week and within 2 hours for overnight and weekend shifts.

e. Contractually, the ChAMPS team through Catholic Charities is required to have five teams when fully staffed. They continue to actively interview and hire staff for the program. Currently, there are five vacancies for the master's Level Crisis Specialist position, one vacancy for the Clinical Manager position and two vacancies for the Peer Specialist position. All the bachelor's level Crisis Specialist positions are filled.

f. To assist with the availability of teams upon request through Catholic Charities/Anchor Mental Health, and to assist with the high volume of calls through the schools, Catholic Charities has designated a specific crisis team that only responds to schools. This has decreased the number of times a school is informed no team is available. In addition, to address understaffing, Clinical Managers will deploy with a team when necessary to ensure a team provides support within an hour of the request.

g. Catholic Charities continues to have a working relationship with 911, MPD, Access Helpline (AHL) and other District entities. Most calls for Crisis Services are made directly to the dedicated ChAMPS line. However, AHL transferred 23 calls for children's mobile crisis in FY23 as well as two in the first quarter of FY24. Conversely, Catholic Charities often joins the parent or guardian when initiating calls to AHL for assistance in linking the youth and family to ongoing services. Catholic Charities receives two types of calls from MPD, first to request routine consultation or resource brokering. Other times MPD officers have been deployed but recognize that law enforcement involvement is not the most appropriate response so ChAMPS will deploy and assume responsibility for addressing psychiatric needs of children and youth in

the field. In addition, when a child or youth is aggressive, Catholic Charities will rely on MPD for support and transportation when FD-12 is required. In addition, Catholic Charities conducts information sessions about crisis services and advertises the program throughout the community, encouraging the public and private sector to use these services when needed.

h. During FY23, the ChAMPS contract was revised to require the vendor to provide support only Monday through Friday from 8:00 a.m. to 8:00 p.m. To ensure 24-hour crisis services for youth, DBH CRT team now answers calls from the dedicated ChAMPS line from 8:00 p.m. to 8:00 a.m. Monday through Friday and on weekends. The DBH CRT and Catholic Charities have established a strong partnership and work jointly to address the crisis needs of children and youth in the District which allows for continuous access to 24-hour crisis services for children and youth. During this transition, DBH's CRT and Catholic Charites established a monthly meeting to address any possible recurring challenges and concerns. Additionally, there is a clinician-to-clinician telephone conversation any time CRT has deployed in response to a child/youth crisis that the Catholic Charities team needs to follow-up within 24 hours and for up to 30-days. During the planning phase and now during monthly meetings, the teams have worked to align processes and procedures to ensure both teams are deploying staff who are child and youth trained and are implementing developmentally appropriate supports for youth and families. CRT and Catholic Charities will continue to meet to problem-solve any challenges to ensure comprehensive crisis services. We believe the contract revision and shared administration of the program has been minimally disruptive and has safely reduced the unnecessary expense and staffing imposed by the previous contract related to overnight and weekend staffing requirements.

i. Catholic Charities can provide services in the following languages with support of the Jeenie App: Akateko, Albanian, American Sign Language (ASL), Amharic, Arabic (Algerian Moroccan & Tunisian), Arabic (Egyptian or Sudanese), Arabic (Gulf), Arabic (Iraqi), Arabic (Levantine), Arabic (Modern Standard), Armenian, Bengali, Bosnian, Cape Verdean Creole, Chinese (Cantonese), Chinese (Mandarin), Dari (Persian), Farsi (Persian), French, Greek, Gujarati, Haitian Creole, Hebrew, Hindi, Hmong, Hungarian, Indonesian, Italian, Japanese, K'iche', Karen, Kinyarwanda, Korean, Lao (Laotian), Mam, Nebaj Ixil, Nepali, Oromo, Pashto, Polish, Portuguese, Portuguese (Brazil), Punjabi, Q'anjob'al / Kanjobal ,Q'eqchi, Romanian, Russian, Serbian, Somali, Spanish, Swahili, Sylheti, Tagalog (Filipi), Thai, Tigrinya, Turkish, and Vietnamese. CHAMPS also has one Spanish speaking licensed clinician who can provide services and supports. DBH's CRT also has access to Language Access Line and a contract with Ad Astra Interpreting which supports youth and families who may speak different languages.

j. Catholic Charities conducts monthly surveys regarding the quality of care received by contacting the parents or caregiver of a child or youth after the case has been discharged. Catholic Charities created and used a Likert Scale survey that asks if they were satisfied with the services provided, did they and/or child feel they were treated with dignity and respect and were the services received in a manner that demonstrated consideration for their beliefs, values, and cultural background. Of the surveys received, 98% of the participants reported that they were satisfied with the services that were provided by Catholic Charities.

45. For individuals served by ChAMPS, how many times did receipt of service result in psychiatric hospitalization in FY 2023 and in FY 2024, to date? Of the individuals who were hospitalized, how many of those hospitalizations were involuntary (FD-12) and what agency, if any, had custody? Of the individuals who were hospitalized, how many had a diagnosis of "serious emotional disturbance." Please provide the same information for any other Youth Mobile Crisis provider.

DBH Response:

The goal of emergency crisis support is to stabilize children and youth experiencing a behavioral health crisis and avoid inpatient hospitalization or placement disruptions in the case of children and youth in the care and custody of the child welfare system. In FY23, 43 children and youth who received crisis services through Catholic Charities, DBH's contracted provider, resulted in a psychiatric hospitalization. Of the total number (43) of those receiving the crisis service 28 were initiated through FD12. In quarter 1 of FY24, 15 children and youth who received crisis response services through Catholic Charities, resulted in a psychiatric hospitalization. Of the total number (15) of those receiving the crisis services 10 were initiated through FD12. The data does not capture what agency had custody of the child at the time that they were hospitalized. The agency who had custody and the classification of "serious emotional disturbance" is not captured in our data.

The Department of Behavioral Health's Community Response Team provides Mobile Crisis Services for children and youth Monday through Friday evenings from 8:00 p.m. to 8:00 a.m. and throughout the weekend. In FY23, a total of 22 youth who received ChAMPS services through CRT were taken to the hospital pursuant to an FD12. In the first quarter of FY24, CRT facilitated hospitalization for 9 children/youth via FD12. As stated elsewhere, iCAMS forms used by CRT are to be modified in Q2 of FY24 but voluntary hospitalizations are not recorded in a searchable data field at present. Please note, "Serious Emotional Disturbance" is a term that refers to a diagnosable mental, behavioral, or emotional condition that leads to significant functional impairment and is not a diagnosis itself, per se. It is generally not appropriate to make this determination in the midst of a crisis episode and, along with custodial status, is not captured by CRT.

46. During FY 2022, FY 2023. and FY 2024, to date, how many calls to ChAMPS and any other Youth Mobile Crisis providers were initiated by:
    a. MPD;
    b. DCPS or a public charter school;
    c. Family members;
    d. The child or youth affected; and
    e. Others.

DBH Response:

The chart below reflects calls received in FY22, FY23 and to date in FY24 that were initiated by MPD, schools, family members, child/youth, and others to contracted provider, Anchor Mental

Health Association. The data reflects that schools and families remain the highest referral sources for mobile crisis services for children and youth.

Table 1

Fiscal Year	MPD	School	Family	Child/Youth	Other
FY 22	123	474	631	36	293
FY 23	73	474	106	14	654
FY24	13	144	122	4	58

The Department of Behavioral Health's Community Response Team provides Mobile Crisis Services for children and youth Monday through Friday evenings from 8:00 p.m. to 8:00 a.m. and the weekends. CRT is working with the DBH iCAMS team to modify forms in order to enable us to more easily and reliably capture and report referral source, call type (e.g., ChAMPS, 911 BH Diversion Calls, involuntary hospitalizations), disposition, volume and location. These modifications are expected to be completed during Q2 and may enable us to review data from Q1 retroactively.

47. How many hiring and retention bonuses have been paid to ChAMPS staff in FY 2023 and FY 2024, to date? Please provide a breakdown of the bonuses by hiring or retention category, including the total bonus amounts for each category.

DBH Response:

The FY 2023 budget did not include funding for hiring and retention bonuses for ChAMPS. The DBH FY 2024 budget includes a one-time increase of $100,000 to provide signing/retention bonuses for the child and adolescent mobile psychiatric service delivered through a contract with Anchor Mental Health Association, a certified DBH provider. The funds will be made available to the Anchor through a modification to the contract that began on January 15, 2024, approved by the Council on December 28, 2023. DBH will disburse the funds to Anchor on a cost-reimbursable basis with supporting documentation.

48. Please provide the following information on the Access Helpline for FY 2023, and FY 2024, to date:
    a. The number of days, on average, between when a family or child calls the Access Helpline and when they are referred to a Core Service Agency;
    b. The number days, on average, between when a family or child is enrolled and their intake appointment with a Core Service Agency;
    c. At what point a child or family considered "enrolled" in services or "linked;"
    d. The number of days, on average, between when a family or child is enrolled and when they receive a diagnostic needs assessment;
    e. The number of days, on average, between when a family or child is enrolled and when they receive their first service as part of a treatment plan;
    f. Please provide a breakdown of (e) by service type, including medication management, CBI, community support, counseling, and psychiatrist appointment;
    g. All languages in which Access Helpline services are provided; and

h. The number of children who were moved around to more than one CSA.

DBH Response:

Calls to AHL result in same-day referral and linkage. In FY23, the average time between a referral and an intake appointment was 19 days. To date in FY 24, the average time between linkage and intake appointment has been 12 days. DBH continues to work closely with providers to streamline processes to support timely completion of intake appointments via virtual platforms as well as in person.

In FY23, the average time between an intake and a diagnostic assessment with a Core Service Agency was 46 days. For FY24 YTD, the average number of days has been 10 days. To support providers, DBH provided technical assistance to streamline intake processes. In addition, timeliness data is shared with providers annually to guide changes to intake protocols and procedures. DBH works with providers to utilize flexible scheduling, streamlined processes, and telehealth platforms to reduce the lag time between referral and intake appointment and from the intake appointment to completion of the diagnostic assessment. DBH is unable to report data on the type or lag time for the first clinical service provided as part of a treatment plan.

DBH/AHL contracts with two language line providers—Ad Astra and Language Line Solutions—to support consumers needing services in languages other than English via a virtual interpreter or through live telephone support from an interpreter. AHL accommodated all requests for language assistance in FY2022 and FY2023. Though we cannot yet report FY24 Q1 data, AHL looks forward to continuing to meet the language access needs of callers in the future. In FY 2023, DBH and its providers supported 21,779 encounters in twenty-four (24) different languages.

DBH facilitated language-line services in the following languages in FY23:

• Amharic • Arabic • Bosnian • Chinese-Cantonese • Chinese-Mandarin • Chinese-Written Simplified/Traditional • Farsi • French • German • Hindi • Igbo • Italian	• Khmer • Korean • Persian • Polish • Portuguese • Romanian • Russian • Spanish • Thai • Tigrinya • Vietnamese • Yoruba

In FY23, the number of children who were transferred from one CSA to another was 569. Thus far in FY24 (through Q1), the number of children who have transferred from one CSA to another is 78.

49. During FY 2022, FY 2023, and FY 2024, to date, how many and what percentage of children discharged from a hospital for psychiatric conditions were seen in the community within seven days? When children are not seen until after the 7-day deadline, what are the reasons? If DBH does not capture this data, please explain what steps DBH is taking to obtain this data or otherwise coordinate with hospitals regarding post-discharge services for children.

DBH Response:

In FY22, 73 (41%) children who were discharged from a hospital for psychiatric conditions were seen in the community within seven days. In FY23, 93 (47%) children were seen within seven days and in FY24 to date, 9 (33%) children were seen within seven days. While the percentage of youth being seen within 7 days after being discharged increased from FY22 to FY23, over half of the youth have still not been seen in the community within seven days. The delay is likely due to several factors including workforce challenges, staff turnover, and lack of effective communication between the hospital and the behavioral health provider network. CSAs have experienced difficulty hiring staff for behavioral health positions due to the national workforce shortage. In addition, when CSAs are able to hire staff, they report having challenges retaining staff. As a result, some CSAs have limited capacity for therapy and other core services, and as a result it can be challenging for youth to be seen within 7 days. In addition, DBH does not currently receive live notifications of children's admissions and discharges from either Childrens' National Hospital or the Psychiatric Institute of Washington. As a result, it has been challenging to collaborate and ensure youth who are being discharged are connected and have a scheduled appointment with a behavioral health provider. DBH has been collaborating with the Integrated Care Division (ICD) to work with the contracted community hospitals and the community provider to ensure discharge planning begins upon admission and that discharge plans are safe and appropriate. DBH will continue to work to strengthen relationships with the hospitals to ensure they are knowledgeable of the full continuum of behavioral health services and are aware of how to access services.

50. Please explain the work DBH is doing with Child and Family Services Agency to better serve the behavioral health needs of foster children and their families in the District. Please provide the following information for FY 2023 and FY 2024, to date:
    a. The number of children/youth in out-of-home placements DBH served;
    b. The number of children/youth in in-home care DBH served;
    c. The percentage of children/youth who were screened within 30 days of entering or re-entering care;
    d. The number of days it took for a child who has been identified as needing behavioral health services to be connected to those services;
    e. The services DBH provides to parents and guardians whose children are being served through in-home or out-of-home care;
    f. The number parents and guardians that received services;

g. The services DBH provides to resource providers;
h. The number of resource providers who received services from DBH;
i. Whether there has been an increase or decrease in time to linkage to first services from FY 2021 to FY 2024, to date; and
j. Whether and how services provided by DBH or CFSA are trauma-informed.

DBH Response:

In FY23, DBH and CFSA continued to collaborate to better serve the mental health needs of foster children in the district. DBH continued to have a staff member co-located at CFSA to support the linkage, enrollment and follow up of behavioral health services to children, youth and families needing services. In FY23, DBH received 546 referrals for children, youth and adults involved with CFSA. In the first two months of FY24, DBH received 586 referrals.

a. and b. The tables below show the numbers of CFSA children, youth, and adults in FY23 and FY24, October through November, who engaged in DBH services.

FY23		
Placement	DBH services	CFSA Cases
Foster Care	202	537
In-Home	187	1162
Total	389	1699

FY24 (October and November 2023)		
Placement	DBH services	CFSA Cases
Foster Care	82	490
In-Home	67	898
Total	149	1388

c. Starting in FY20, CFSA has conducted screenings since its mental health redesign which included three mental health clinicians positions to administer mental health screenings and to provide direct therapeutic interventions.

d. Of the CFSA involved youth who were referred directly through the DBH co-located staff the average time from referral to linkage of behavioral health services is less than one day.

e, f, g, h. Services are provided to parents, guardians and resource parents of children and youth involved in the child welfare system, but this data is not aggregated in our database system. The adults have access to services available in the DBH network to address their own needs in addition to psychoeducation and behavior management strategies that will support parenting and family dynamics.

i. There has been no change in time of linkage to first service connection with CSA (Core Service Agency) and remains within 1 day and less of response time from the period of FY 21 to date of quarter 1 FY24.

j. DBH continues to provide trauma informed and evidence-based programs (EBPs) services. These services include: Parent-Child Interactive Therapy, Trauma Focus –Cognitive Based Therapy, Trauma Systems Therapy, Child-Parent Psychotherapy , Functional Family Therapy, Multi-Systemic Therapy, Transition to Independence Program, and Attachment Biobehavioral Catch-Up. The EBPs provide youth and families with the skills and knowledge necessary to overcome traumatic events and experiences.

51. How is DBH working with DHCF and CFSA to ensure clear pathways for foster children and youth to receive services, including those placed in Maryland?
    a. What is the timeline for the transition of CFSA-involved youth to be moved into managed care?
    b. What is being done to ensure they stay enrolled and receive care in their current provider network?

DBH Response:

DBH and DHCF continue to work closely together regarding the system redesign. Both DBH and DHCF participate in joint monthly Provider Meetings to provide information regarding structure and processes of system redesign and answer any questions from the Providers.

a. Both DBH and DHCF are unaware of any changes to current contracts for CFSA children and youth. Only the covered benefits in the contract will change which will include a full complement of behavioral health services and Providers. Children and youth under the care and custody of CFSA, who are placed in the state of Maryland, will continue to receive services within their Managed Care Program.

b. Per the response above, we don't expect any changes to the contract that would affect coverage.

52. For DBH's early childhood mental health projects, please provide the following information for FY 2023 and FY 2024, to date:
    a. For the Parent Child Infant Early Childhood Enhancement Program, please provide:
        i. The provider(s);
        ii. Description of the services provided
        iii. Type(s) and numbers of clinicians employed;
        iv. Capacity and number of children served; and
        v. Number and percentage of outcomes for cases (e.g., successful completion, closure for lack of attendance, etc.)
    b. For the Early Childhood Mental Health Consultation Project, Healthy Futures:
        i. Provider(s);
        ii. List of childcare centers, homes, and schools that are participating;
        iii. Services each site has received and any progress/outcome measure available;

iv. The number of teachers, administrators, families, and children being served each year; and
v. Amount of funding DBH has allocated to subsidize other costs associated with early childhood mental health consultation (ECMHC), such as certification and training in early ECMHC.

DBH Response:

a. The Parent Infant Early Childhood Enhancement Program (PIECE) was established based on the findings from the 2007 Washington D.C. Early Childhood Mental Health White Paper, which identified the lack of existing mental health services in the District of Columbia for children under the age of five.

i. The PIECE Program recognizes early childhood intervention programs have the potential to address cognitive, emotional and behavioral challenges in the lives of young children. The PIECE Program is certified by DBH to provide early intervention and treatment to young children and their families from birth to seven years old. The goal of the program is to intervene early with comprehensive services designed to prevent social emotional/behavioral challenges and reduce stressors within the parent-child relationship and family that might adversely affect the developing child.

ii. The PIECE program provides family focused behavior management, individual and family therapy/counseling, art and play therapy, developmental screenings, diagnostic assessments, psychiatric/medication management, home/school visitation, and mental health services for prenatal and postpartum women.

The staff of the PIECE Program are trained and certified to provide several early childhood evidence-based practices for children and their families. The following is a list of these programs and a brief description of each of them.

Parent Child Interaction Therapy (PCIT) is a parent coaching program that teaches caregivers skills and techniques to improve their child's disruptive and non-compliant behavior. In PCIT caregivers are coached in specific skills by the therapist through an earpiece while the therapist observes the caregiver and child playing together in a separate room.

PCIT with Toddlers (PCIT-T) is an adaptation of PCIT, that combines attachment theory, play therapy, family systems, and cognitive-behavioral approaches with nurturing and sensitive caregiving. PCIT-T is an in-vivo coaching approach utilized with parents of children ages 12 months to three years to address disruptive behaviors and as a prevention model for caregivers experiencing stress.

Child Parent Psychotherapy (CPP) is a therapy for parents with infants, toddlers and preschoolers who have experienced trauma(s). CPP is also offered in a hybrid manner including the use of on-line stories art making via white board virtual adaptations and other telehealth applications in addition to in-person sessions.

Attachment & Biobehavioral Catch-up (ABC) is offered to parents and caregivers of babies who are between six and 24 months old. ABC strengthens the parent child relationship while helping the child to learn to regulate behaviors and emotions. The ABC approach helps parents/caregivers identify and respond to their baby's signals. As a result, the parent's relationship with their child is supported to address stress and early challenges.

iii. The PIECE staff includes 6 clinicians. The credentials of the clinicians are as follows, 1 clinical psychologist, 3 Licensed Independent Clinical Social Workers, 1 Licensed Graduate Social Worker, and 1 PhD with multiple credentials as a Licensed Professional Counselor, Licensed Marriage and Family Therapist, and is also a board-certified art therapist. In addition, two Board Certified Child Psychiatrists provide evaluation, and medication management services to children and adolescents for both the PIECE Program and the Urgent Care Clinic. In addition, two administrative staff and one mental health specialist provide support to the PIECE clinicians.

iv. The PIECE Program has the capacity to provide services to 125 children and their families. During FY 23 the PIECE Program provided services to 284 children and their families.

v. During FY 23 the program discharged 79 families, of which 53 (67%) were successful and 26 (33%) were unsuccessful due to a lack of attendance, relocation, and dropping out for personal reasons. To date in FY 24, 1st quarter, the program has provided 115 services to children and families.

b. The Healthy Futures Program provides consultation services to Child Development Centers (CDCs) and home childcare providers as well as directly to children and families. These services are provided by a mental health professional. The goals of the program are: (1) building professional skills and capacity of caregivers to promote social emotional development and prevent escalation of challenging behaviors (2) reducing the number of early childhood expulsions and (3) increasing appropriate referrals for additional assessments and services to support child and family functioning.
i. The Healthy Futures Infant and Early Childhood Mental Health Consultants (IECMHC) are comprised of independently licensed mental health clinicians (LICSW, LPC, LMFT), license eligible clinicians (LGSW, LGPC, etc.) and clinicians certified in IECMHC.

ii. See Attachment 1 for the list of Healthy Futures child development facilities.

iii. During FY 23 the Healthy Futures program provided services in 95 child development centers and 16 home providers for a total of 111 locations.

The early childhood mental health specialists served 3,025 children across 111 facilities. Healthy Future specialists provided 364 staff and parent workshops, 447 parent consultations and 1,795 director consultations. Centers referred 196 children to Healthy Futures for child-specific support and 166 of those children's families signed consent to allow individual observations and interventions. The Devereux Early Childhood Assessment (DECA) was completed for children

who received child-specific consultation services. Of the 166 children whose family signed consent 137 received an initial DECA and 25 received a post DECA. Of those children with follow-up DECAs, all showed improvement in at least one area of concern (attachment, initiative, and self-regulation). During FY24, Healthy Future clinical specialists are focusing on better outcomes for the child-specific cases. Teacher turnover and insufficient parental engagement have been identified as challenges. See Attachment 2. Utilization data.

Healthy Futures continues to provide consultation and education to early childhood directors on the positive impact of working with children that exhibit challenging behaviors rather than expelling them from their programs. Through Healthy Futures, CDC staff developed policies, skills and resources that help minimize expulsion as an option for children with challenging behaviors. In FY 23 there were three expulsions of the 3,025 children served from child development facilities where the Healthy Futures Program was implemented; no children have been expelled from a child development center in FY 24 to date.

Healthy Futures has continued its collaboration with the Office of the State Superintendent Office's (OSSE) Quality Improvement Network (QIN) and Pre-K Enhancement program (PKEEP). Through this collaboration with OSSE and the QIN Hubs (UPO and Easter Seals) the Healthy Futures consultants provide self-care and trauma informed practices workshops to the staff of the participating child development centers and homes.

iv. During FY23, Healthy Futures staff supported 111 administrators, 706 teachers, 166 families, and 3,025 children through child-specific consultation. Data for FY24 is still being collected.

v. The Healthy Futures Program allocated $81,000 to provide the following trainings and certificate programs to the Infant and Early Childhood Mental Health Consultants:

- **The Certificate in Infant & Early Childhood Mental Health Consultation (IECMHC)** Provides advanced training for mental health clinicians in the specialized role of consulting in early childhood settings. Consultants learned approaches to promote mental health in the early childhood years and how the role of consultant is unique from other mental health clinician roles, as well as how consultation aims to build the capacity of early childhood professionals, settings, and systems to support young children's mental health.

- **Institute of African American Mindfulness (IAAMS):** IAAMs will lead mindfulness circles with Healthy Futures clinicians to promote individual and collective healing and well-being. The series will introduce mindfulness practices to encourage compassionate interactions and relationship-building within Healthy Futures and the larger community. Mindful Professionals at the Department of Behavioral Health circles support community-building and the cultivation of self-care and resiliency as clinicians deepen their personal mindfulness practice.

- **Devereaux:** Through this webinar series, Healthy Futures will learn how to use the Devereux Early Childhood Assessment for Infants and Toddlers (DECA) program to

promote young children's social and emotional development and to enhance the overall quality of early childhood programs. Strategies for effectively involving families and for building the resilience of adults caring for young children are also addressed.

- **Trauma Research Foundation: Traumatic Stress Studies Certificate Program:** This course provides an overview of the basic biological and psychological processes at work in trauma responses. Participants will learn effective treatment approaches and address issues of assessment, culture, race, spirituality, families and other contextual issues.

- **Conscious Discipline:** Conscious Discipline is an evidence-based, trauma-informed approach. Healthy Futures participants will learn sustainable, brain compatible SEL and classroom management practices that increase connection, cooperation, self-regulation, equity, mental health, belonging and achievement.

- **Kimochiis:** Participants will learn how to help schools build a strong, positive, communicative school culture and climate. Healthy Futures will learn how to give children the knowledge, skills, and attitudes they need to recognize and manage their emotions, demonstrate care and concern for others, establish positive relationships, make responsible decisions, and handle challenging situations constructively.

- **Challenging Behaviors (Barbara Kaiser):** Twenty (20) Early Childhood Consultants will participate in the Certificate in Infant & Early Childhood Mental Health Consultation (IECMHC) with Barbara Kaiser to obtain additional knowledge and strategies in working with children with challenging behaviors. The instructor will provide advanced training for mental health clinicians in the specialized role of ways to work with children and teachers on how to address concerns when they arise.

53. For FY 2022, FY 2023, and FY 2024, to date, please provide the amount budgeted and spent on Healthy futures, including a cost breakdown. Include a breakdown of the amount of local, federal, provide, and special revenue funding across all sites. Please include:
    a. Evaluation data of Healthy Futures;
    b. Updates on hiring for Healthy Futures; and
    c. Obstacles to expanding Healthy Futures to all subsidized child development centers and home providers.

DBH Response:

See attachment 1 of 3 for FY 22 budget information.
See attachment 2 of 3 for FY 23 budget information.
See attachment 3 of 3 for FY 24 budget information.

a. In FY 23 Georgetown University was selected to evaluate the Healthy Futures Program. The evaluation is underway, and a final report will be completed in FY24. FY23 program highlights are below:

- The Healthy Futures program provided services in 95 child development centers and 16 home providers for a total of 111 locations.
- Healthy Futures served 3,025 children across 111 facilities.
- Healthy Futures provided 161 parent workshops and 203 staff workshops.
- Healthy Futures provided 447 parent consultations, 2,531 teacher consultations, and 1,795 director consultations.
- Centers referred 196 children to Healthy Futures for child-specific support

b. Healthy Futures continued expansion efforts in FY23. Funding for FY 23 supported 26 early childhood clinical specialists, three supervisors, and a Program Manager. Two of three leadership positions are currently filled and 13 of the 26 early childhood clinical specialist positions are filled. When fully staffed with 26 Early Childhood Clinical Specialists, Healthy Futures will have a maximum capacity of 182 CDCs.

During FY23 the leadership team was completed with three supervisors along with the program Manager, however, one supervisor left the program in FY 23 and a new supervisor will join the team in FY 24. In FY 23, three early childhood consultants left the program to work in other mental health programs that provide a full-time telework option.

c. Recruitment, hiring, and retention of staff consultants are the main obstacles in serving the remaining child development centers. In an effort to increase hiring options, Healthy Futures is considering students who have completed the Georgetown Infant and Early Childhood Mental Health Consultation certificate program.

54. Please provide an update on the DC MAP program, including the transition to a new provider in the previous fiscal year. Please include for FY 2022, FY 2023, and FY 2024, to date:
    a. Number of referrals made to the DC MAP program;
    b. The most common diagnoses for referrals;
    c. Number of patients served;
    d. Cause of any discrepancy between the number of referrals and the actual services delivered;
    e. Average number of days between when a referral is issued and the patient receives services, including the longest wait time experienced in FY 2022, FY 2023, and FY 2024, to date;
    f. Number of practicing clinicians in DC MAP's current provider, including their credentials and number of vacancies; and
    g. Summary of findings of any review or evaluation of these services. Please attach any relevant reports, including feedback related to the quality and delivery of services from patients and referring providers.

DBH Response:

Paving the Way Multi Service Institute is contracted to provide DC MAP services since November 2021. DCMAP offers primary pediatric care providers (PPCPs) telephone consultation (Monday-Friday, 9am-5pm) from a team of mental health professionals, including

psychiatrists, psychologists, social workers, and care coordinators. In addition to answering mental health-related inquiries about specific children (e.g., questions about community resources that would be appropriate for the family, medication questions), the DC MAP team also provides education and technical assistance for PPCPs to identify and address mental health issues in primary care.

DC Health is providing funding through its HRSA grant to support the DCMAP initiative. This includes funding to expand training opportunities for PPCPs on the use of telehealth and cultural competency; to establish a regional consortium of telehealth practices that includes the Virginia Mental Health Access Program (VMAP) and the Maryland Behavioral Health Integration in Primary Care Program (BHIPP); to create new data entry fields in the software platform managed by DCMAP which will allow the collection of information on every patient served and track connections to care and referrals; develop a referral system to school-based mental health for patients identified as needed behavioral health services and supports; and develop partnership and be a telehealth resource that addresses the needs of children, birth through five years of age with DC Health Help Me Grow. To meet the requirements of DC Health's HRSA grant, Paving the Way continues its collaborations with other MAP programs and with local community partnerships including the DC Collaborative for Integration of Mental Health in Pediatric Primary Care.

Another aspect of the HRSA grant is for grant recipients to provide training on behavioral health topics to pediatric primary care providers and to produce a PPCP telehealth manual. Paving the Way is working in collaboration with Concert Health, as stipulated in their joint agreement, to provide this service.

a. Total number of referrals.

Year	# of Referrals
FY22	933
FY23	881
FY24 to date	200

b. The most common diagnoses for referral were: 1) Depressive Disorders, 2) Anxiety Disorders, and 3) Attention Deficit Hyperactive Disorder.

c. The DCMAP program does not provide direct service delivery; however, brief intervention is provided within the Help Me Grow and School-Based Health Center expansion programs. Since FY22, a total of 26 patients were served within the Help Me Grow Program. A total of eight students have been served in the school-based health center expansion since its inception in August 2023. A total of 138 consultations were provided to primary care providers from the DCMAP Psychiatrist or a DCMAP licensed mental health provider.

d. DCMAP provides consultation by a psychiatrist and licensed mental health clinicians to primary care providers. Currently, there are no discrepancies regarding consultations. There have been delays in MD-to-MD response time. The performance measure indicator for MD-to-MD

turnaround time is 30 minutes. The program leadership continues to work with the internal psychiatrist to meet this indicator through robust process improvement activities.

e. DCMAP tracks the total number of appointments attended and the number of referrals provided. The program does not track the number of days between when the referral was issued and when the patient received services. During FY22, 1% of the patients who received referrals followed up and attended the appointment, whereas 12% in FY23 and 8% in FY24 to date, followed up and attended the appointments. The primary reason for lack of follow-through on referrals was that the patient and/or family was not in agreement with recommendations.

f. There are five licensed mental health providers on the DC MAP team: two LICSWs, two LGSWs, and one LGPC. The DCMAP team also includes three Child and Adolescent Psychiatrist who are board certified psychiatrists in the District of Columbia and two Care Coordinators who have a bachelor's degree in human services or psychology. The DCMAP team is currently fully staffed and does not have any vacancies.

g. The evaluation of DCMAP will be completed through the HRSA grant with DC Health. DBH will receive the report once it is finalized. The pediatric primary care provider's level of satisfaction was measured through a satisfaction survey. A total of 135 surveys were sent to pediatric primary care providers who utilized the District of Columbia Pediatric Mental Health Access Program to assess their attitudes and views of DCMAP. Based on FY23 data, 85% of providers rated they were "very satisfied" with DC MAP services.

55. Please describe all substance abuse services offered to children and youth, the process for obtaining these services, and how DBH partners with District schools (DCPS, charters, and private schools) to provide services and education to children and youth on the dangers and harm of substance abuse. Please provide any updates regarding how DBH uses data from the DC Youth Risk Behaviors and Academic Achievement Report (YRBS) to inform the work. Please include:
    a. The total number of children and youth who received substance abuse services in FY 2022, FY 2023 and FY 2024, to date. Please breakdown by age, home ward, ward where services took place, how many were in-person/virtual/hybrid, and the types of services;
    b. The total number of agencies or organizations that provided substance abuse services to children and youth. Please provide (via Excel spreadsheet) a list of the agencies and organizations that provide substance abuse services to children and youth. Include their grant/contract amount, location, Ward, how many children and youth they served in FY 2023 and FY 2024 to date, the format of their services (virtual/in-person/hybrid), what services they provided, and contact information (staff contact, email address, phone number, and website);
    c. Plans in FY 2024 to expand the types of substance abuse services offered to children and youth; and
    d. The number children and youth who received services through the Adolescent Community Reinforcement Approach (A-CRA) in FY 2023 and FY 2024, to date.

DBH Response:

The substance use services offered to children and youth within the District of Columbia include substance use disorder (SUD) prevention services, treatment, and recovery support services (RSS). SUD prevention services are delivered primarily through DBH's four (4) DC Prevention Centers (DCPCs) and the youth treatment and recovery support services are made available through DBH's two (2) Adolescent Substance use Treatment Expansion Program (ASTEP) providers. Each DCPC covers two (2) wards to provide coverage for all of the District's eight (8) wards. The two (2) ASTEP providers include Latin American Youth Center (LAYC) with a location in Northwest and Hillcrest Children and Family Center with locations in both Northwest and Southeast.

DBH has provided sub-grants to both its prevention and youth treatment providers through the federal funding received from the Substance Abuse and Mental Health Services Administration (SAMHSA). The DC Prevention Centers focus specifically on educating residents about the dangers and harms of substance use in order to prevent and/or delay the onset of alcohol, tobacco, and other drug use. The ASTEP providers, through the Federal SAMHSA grant, DC Changing and Improving Treatment for our Youth (DC-CITY), offer non-Medicaid billable services such as outreach and engagement for youth referred to SUD treatment and Recovery Support Services (RSS).

The SUD prevention services provided by the four Prevention Centers include workshops and trainings on SAMHSA's Strategic Prevention Framework (SPF) – an approach for developing strategies aimed at addressing and preventing substance use among District youth, engaging and conducting outreach to residents through community events such as health fairs, and fostering the leadership skills of youth via the respective Youth Prevention Leadership Corps (YPLCs). The DCPCs have also worked to create formal partnerships with local middle and high schools within their wards to promote the prevention of substance use. The Centers have been able to work directly with the Community Based Organizations (CBOs) and School Based Clinicians to expand their efforts to include a focus of substance use prevention. This includes conducting presentations in classrooms and school assemblies on the harms and dangers of substance use, the adoption of curricula aimed at preventing drug use "Too Good for Drugs," and establishing school specific YPLCs.

The two ASTEP providers, Hillcrest Children and Family Center and LAYC, provide both mental health and substance use services to youth within the community and schools. Both providers have created a mechanism for making internal referrals to youth SUD treatment and recovery support services for those students who may be in need. In FY2023, school referrals made up just over 20% of the total number of referrals made to the ASTEP providers for service. The ASTEP providers also receive referrals from individuals making self-referrals, agencies such as the DC Department of Youth Rehabilitation Services (DYRS) and the Child and Family Services Agency (CFSA), and from other youth serving entities. Once referrals are made, the ASTEP providers conduct outreach and engagement, assess the youth to determine the appropriate level of care, and then enroll youth into the services that can best address their substance use needs.

The Youth Risk Behavior Survey (YRBS) data which is compiled and analyzed by the Office of the State Superintendent for Education (OSSE) is critical to DBH's SUD efforts. One of the ways in which these data have been used is in the development and targeting of social marketing strategies. For example, one key data variable in the YRBS reports is the initiation age of marijuana and alcohol use. Additionally, the team studies the results of reported past 30-day substance use for middle and high school students as this provides guidance on the substances presenting as the greatest risks for youth. These two (2) data points in particular were vital as DBH began working with a contractor to develop the "Pause, Play" social marketing campaigns aimed at addressing substance use and promoting positive alternatives to engaging in substance use. In addition, the YRBS data has also been critical with informing which grade levels to target when purchasing of the "Too Good for Drugs" curricula.

a. DBH has a full continuum of substance use services for youth which includes prevention, treatment, and recovery. Regarding prevention services rendered, *Table A* below shows that during FY2022, the DC Prevention Centers (DCPCs) served a total of 6,266 individuals aged 24 and younger through information dissemination, social marketing engagement, and Youth Prevention Leadership Corps (YPLC) activities. Over the course of FY2023, a total of 4,094 individuals were served, and during the first quarter of FY2024, 223 young residents were reached. As historically, broader reaching events have taken place in the spring and summer months, we anticipate that the number of children and youth reached will increase significantly during the third and fourth quarters of FY2024.

Table A

Substance Use Prevention Services Offered to Children and Youth in FY2022			
Number of Youth	Service Wards	Delivery Method	Types of Services
6,266	Wards 1&2 = 775	Hybrid (combination of virtual and in person sessions)	Information dissemination, social marketing engagement, and YPLC activities
	Wards 3&4 = 1,357		
	Wards 5&6 = 3,257		
	Wards 7&8 = 877		
Substance Use Prevention Services Offered to Children and Youth in FY2023			
Number of Youth	Service Wards	Delivery Method	Types of Services
4,094	Wards 1&2 = 210	Hybrid (combination of virtual and in person sessions)	Information dissemination, social marketing engagement, and YPLC activities
	Wards 3&4 = 1,246		
	Wards 5&6 = 1,812		
	Wards 7&8 = 826		
Substance Use Prevention Services Offered to Children and Youth in FY2024 (to date)			
Number of Youth	Service Wards	Delivery Method	Types of Services
283	Wards 1&2 = 11	Hybrid (combination of virtual and in person sessions)	Information dissemination, social marketing engagement, and YPLC activities

As it pertains to youth treatment and Recovery Support Services (RSS), DBH continued partnering with its two (2) Adolescent Substance Use Treatment Expansion Program (ASTEP) providers throughout FY2023 and into FY2024. As noted in the table below (*Table B*), in FY2022, a total of 119 youth enrolled in services. During FY2023, 70 additional youth enrolled in services. The slight dip in the number of enrollments can be attributed to (1) the need for a modifier that would make a distinction for youth and adult services in order for providers to submit claims and (2) the need for new and additional ASTEP provider staff to be trained in the GAIN-I, the screening tool used to determine the level of care required.

With regard to the need for a modifier, DBH and DHCF collaborated to create codes in order for the ASTEP providers to bill for SUD treatment and recovery support services rendered to youth. As the modifiers were not made available to providers until the beginning of FY2024, this posed a challenge to providers being able to enroll clients and be compensated. Pertaining to the GAIN-I training, due to staff turnover across the two (2) ASTEP provider agencies, additional staff needed to be trained and certified to screen referred youth and subsequently enroll them into services. To address and overcome this challenge, providers were able to leverage support from other agencies and in addition, DBH was able to secure another GAIN-I training for current ASTEP provider staff during the last quarter of FY2023.

As a unique identifier is used to identify the youth who receive services from the ASTEP providers, only the location of the agency that rendered the service is recorded. As a result, the addresses for clients are not captured or reflected in this data. The wards corresponding with where the ASTEP provider's physical buildings are located and the subsequent services that were rendered are included in the table. It should be noted that ASTEP providers see youth from all Wards, and serve them within their physical locations, in schools, and through telehealth applications.

Table B

Substance Use Treatment and Recovery Support Services Offered to Children and Youth in FY2022					
Number of Clients	Age		Service Wards	Delivery Method	Types of Services
119	11 y/o = 1	17 y/o = 23	Wards 1, 2, and 8 (location of provider offices)	Hybrid (combination of virtual and in person sessions)	Individual Counseling, Group Counseling, A-CRA, RSS
	12 y/o = 1	18 y/o = 19			
	13 y/o = 5	19 y/o = 14			
	14 y/o = 10	20 y/o = 8			
	15 y/o = 23	21 y/o = 4			
	16 y/o = 11				
Substance Use Treatment and Recovery Support Services Offered to Children and Youth in FY2023					
Number of Clients	Age		Service Wards	Delivery Method	Types of Services
70	13 y/o = 8	20 y/o = 3	Wards 1, 2, and 8	Hybrid (combination of	Individual Counseling,
	14 y/o = 9	21 y/o = 3			

	15 y/o = 7	22 y/o = 2	(location of provider offices)	virtual and in person sessions)	Group Counseling, A-CRA, RSS MET/CBT
	16 y/o = 4	23 y/o = 1			
	17 y/o = 5	24 y/o = 1			
	18 y/o = 2	Unknown = 35			
	19 y/o = 2	[redacted]			

Substance Use Treatment and Recovery Support Services Offered to Children and Youth in FY2024 (to date)				
Number of Clients	Age	Service Wards	Delivery Method	Types of Services
7	Unknown = 7	Wards 1, 2, and 8 (location of provider offices)	Hybrid (combination of virtual and in person sessions)	Individual Counseling, Group Counseling, A-CRA, RSS MET/CBT

b. To provide substance use disorder (SUD) prevention, youth treatment, and recovery support services, DBH works with a number of partners. This includes four (4) DBH funded Prevention Centers (DCPCs) which are strategically located throughout the District of Columbia and provide services to all eight (8) wards. Additionally, DBH provides supplemental funding to the Adolescent Substance use Treatment Expansion Program (ASTEP) providers to support SUD treatment and recovery support services for youth. In FY2023, DBH had two (2) ASTEP providers.

As requested, information for the organizations providing SUD services for children and youth is included in Attachment 1.

c. Plans in FY 2024 to expand the types of substance abuse services offered to children and youth:

In FY2024, DBH will continue striving towards expanding the types of SUD services offered to children and youth, and also access points for these services. One example of this expansion includes the training in the Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT) an evidence-based intervention which is slated for the end of January 2024. Though this training has taken place previously for the ASTEP providers, the forthcoming MET/CBT training will be expanded to include DBH's School Based Clinicians and several transitional aged youth service providers.

Additionally, DBH has focused on the development and implementation of initiatives and activities aimed at providing positive alternatives to engaging in substance use. One initiative has been working with the DC Department of Parks and Recreation (DPR) to host a series of wellness events for the entire family at various recreation centers throughout DC. These wellness events which were piloted at the end of FY2023 included exercise programs such as

hip-hop aerobics and artistic expression activities such as painting and designing t-shirts with positive messages. DBH's SUD Prevention Team will continue partnering DPR to continue the wellness events during the spring and summer of 2024.

Also, and in support of promoting positive activities, DBH has also launched the new social marketing campaign, "Pause, Play." Relying on data from focus groups with youth that identified some of the stressors and challenges faced by District youth which, for a number, have led to substance use, the emphasis of this campaign has been to promote "pausing" on risky behaviors such as substance use and pressing "play" on positive activities such as bike riding or joining a sports team. Print, radio, and social media outlets will be used as vehicles for getting this campaign out to District residents. DBH will host in person activities that also fall under the "Pause, Play" theme.

To expand the reach of universal, selective, and indicated prevention interventions in community settings, DBH has been intentional with regard to not only engaging and partnering with groups and organizations housed strategically throughout the District's eight (8) wards, but also by inviting these groups to apply for funding opportunities released by the agency. In addition to funding its four (4) DC Prevention Centers (DCPCs), with supplemental block grant funding, DBH released a solicitation entitled "Community Approaches to Prevention" for smaller groups and organizations to adopt evidence-based interventions and environmental strategies also aimed at promoting prevention, yet on a more direct scale (e.g., within specific neighborhoods, schools, etc.). DBH plans to make eight (8) awards, one for each ward of the District of Columbia.

In addition, DBH will post a solicitation for a 3.5 SUD Youth Residential facility within the next few days. This facility will support youth aged 21 and under who are experiencing significant challenges in their daily functioning due to a substance use disorder.

d. The number children and youth who received services through the Adolescent Community Reinforcement Approach (A-CRA) in FY 2023 and FY 2024, to date:

Due to staff turnover at the ASTEP provider organizations, there were no staff certified to provide A-CRA as an intervention tool in FY2023, and thus, no children or youth received the service. Notwithstanding the fact that there were no certified staff, it should be noted that A-CRA is only one of the services provided by the ASTEP providers. Other services include individual counseling, group counseling, and the adoption of additional evidence-based interventions such as the Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT) which providers will be trained in again in January. DBH will explore the possibility of training providers in A-CRA during FY24.

56. Please provide the following information for the DC Prevention Centers in FY 2023 and FY 2024, to date:
    a. Locations of centers;
    b. Number of youth served at each Center, broken down by age, grade, race/ethnicity, ward, and gender;

c. Number of youth participating in the DC Prevention Center Leadership Councils; Please provide names, schools attended, and email addresses; and
d. Activities and programs provided by each DC Prevention Centers, including but not limited to Narcan training, community events, and school related initiatives.

DBH Response:

Please see "Attachment 1 of 1. DC Prevention Centers."

57. Please provide the FY 2023 and FY 2024, to date, budget, expenditures, and outcomes for DBH's pilot treatment services for the eight child development centers in the areas of the District most impacted by the COVID-19 pandemic.

DBH Response:

The Healthy Futures Treatment Pilot project supported with ARPA funds for the first time offers on-site treatment along with consultation support. Clinicians will be trained in early childhood evidence-based treatments and also have experience providing trauma informed treatment approaches for our young children and their families who have complex needs or may be involved with the Child and Family Services Agency. One of the two full-time treatment clinicians was hired in FY 23 and the second full-time clinician will join the team in January 2024.

During FY24, Quarter 1, the clinician provided treatment services to three children and 21 individuals therapy sessions and held two parent sessions, eight collaborative meetings, and 18 center director check-ins.

In addition to the two full time clinicians, the budget supports IT equipment, supplies and an evaluation through a contract with Georgetown University.

See attachment 1 of 2. FY23 Healthy Futures Treatment Pilot budget
See attachment 2 of 2. FY24 Healthy Futures Treatment Pilot budget

Ward	Name of Center	Address	Director Name/ Contact Information
8	Sunshine	4224 6th St. SE 20032	Ms. Tiffany Bell t.bell@sunshinedc.org (202) 561-8706
8	National Children's Center	3400 Martin Luther King Junior Avenue SE 20032	Yasmin Shaffi yshaffi@marthastable.org (202) 328-6608

8	Martha's Table	2375 Elvans RD, SE 20020	Rosa Moraes rmoraes@marthastable.org (202)-328-6608
8	Bright Beginnings	3640 Martin Luther King Jr Ave SE, 20032	Angela Hamilton ahamilton@bbidc.org (202) 842-9090
7	Educare of Washington, DC	640 Anacostia Ave NE,20019	Jamal Berry jberry@educaredc.org (202) 727-5604
6	Board of Child Care	308 15th Street SE, 20003	Mayra Ramirez mramirez@boardofchildcare.org (202) 291-3330
2	Edward C. Mazique Parent Child Center, Inc. @ the Ruth E. Rucker Bld.	1719 13th ST NW, 20009	Ms. Lettie Williams lmwilliams@ecmpcc.org 202-462-3375
1	Rosemount	2000 Rosemount Ave NW 20010	Cornett Roberts-Njoku croberts-njoku@rosemount.com 202-265-9885

58. Please provide an update on the online behavioral health training program for child development facilities and public schools that was launched in FY 2015. How many teachers and other personnel completed the online training in FY 2023 and FY 2024, to date?

DBH Response:

DBH continues to provide the online behavioral health training through the portal: http://www.supportdcyouth.com and all DC administrators and teachers are required to complete the mandated training modules on the same two-year cycle. All District public and public charter school teachers and principals must complete three DC Youth Behavioral Health Program courses once every two years to be compliant with the legislative mandate. Additionally, it is highly recommended for educators to take the *Step In Speak Out* course for challenges and concerns related to LGBTQ students. This is an additional module that is available within the portal. Early childhood educators, child development center staff, and child development center administrators, must complete *At-Risk for Early Childhood Educators.* This simulation is for those administrators, staff, and educators who work with young children and builds understanding, knowledge, and skills in mental health and behavior management. The Division of Early Learning within the Office of the State Superintendent of Education (OSSE) has the completion of the *At-Risk for Early Childhood Educators* module as part of the yearly

health and safety requirements, and all educators must complete their health and safety requirements by September 30, each year.

In FY23, 18,266 DC Public School (DCPS) teachers and other personnel completed the online training and 102 have completed the training in FY24 to date. For DC Public Charter Schools (DCPCS), 11,955 teachers and other personnel completed the training in FY23 and 1,501 have completed the training in FY24 to date.

In FY23, there were 864 DC Child Development Center Administrators and staff who completed the on-line training. And, in FY24 to date, 134 Administrators and staff have completed the training. The chart below provides information on the number of DC Public School, DC Public Charter School, and DC Child Development Center teachers and other personnel who have completed the online training in FY23 and FY24 to date.

	FY23				**FY24 to date**		
	DCPS	**DCPCS**	**CDC**		**DCPS**	**DCPCS**	**CDC**
At Risk Early Childhood	945	839	844		21	79	127
At Risk for Elementary School Educators	3690	1593	0		0	0	0
At Risk for Middle School Educators	907	825	0		0	0	0
At Risk for High School Educators	1336	768	0		0	0	0
Referral Process - District of Columbia	5700	3491	8		21	376	3
Resilient Together: Coping with loss at School	2	8	0		0	0	0
Step In, Speak Up!	50	339	2		11	335	1
Coping with Loss (Elementary)	3715	1784	3		17	263	0
Coping with Loss (Secondary)	1918	1740	1		9	109	1
Emotional & Mental Wellness for Elementary/Middle	3	422	3		16	318	1
Emotional & Mental Wellness for High School	0	146	3		7	21	1

59. Please provide an update on the progress of selecting a contractor to operate a community-based level 3.5 SUD treatment facility for youth. Please include how many applications were received in response to the RFA.
    a. Has a specific building or physical location been identified for the treatment facility?

DBH Response:

DBH is working with the Office of Contracting and Procurement to post the solicitation for the 3.5 Youth SUD Residential Facility. The solicitation is expected to be posted the week of January 16, 2024, and applications with be due in February 2024.

60. Please provide an update on the collaborative efforts between DBH and Dr. Sivabalaji Kaliamurthy, Attending Physician at Children's National Medical Center. According to DBH's FY 2022 performance oversight responses, the focus of this partnership is to broaden outpatient options for youth facing challenges with opioids, especially those in need of additional support beyond the care provided by ASTEP providers.

DBH Response:

During FY2023, DBH continued partnering with Dr. Sivabalaji Kaliamurthy and his team at Children's National Hospital (Children's). Since the winter of FY2023, Dr. Kaliamurthy has been a critical part of DBH's youth planning meetings under the State Opioid Response (SOR) grant. Through this effort, DBH has provided funding to Children's to conduct SUD screenings in the emergency department and also facilitate brief interventions and referrals to treatment. These meetings created an opportunity to identify service gaps, better conceptualize the specialties of all partners, and make referrals to SUD treatment and support as appropriate. DBH assisted partners such as Court Social Services and the DC Department of Human Services to connect youth who needed more intensive SUD treatment services with Dr. Kaliamurthy's team.

Additionally, DBH's Prevention Services partnered with Dr. Kaliamurthy to facilitate trainings and co-present during panels. This collaboration allowed both entities to present on the full range of SUD services available to District youth and transitional aged youth. During FY23, they presented to DBH's Children's Roundtable; during Court Social Service's Division's staff training for probation officers, judges, attorneys, and juvenile court staff; for Community of Practice's monthly meeting; and on DC Public Schools' Parent University panel. Dr. Kaliamurthy also provided guidance as DBH explored partnering with DCPS to include on-site SUD treatment services in the DCPS's policy addressing substance use in and around schools. DBH's director also presented on a panel at Howard University on promising practices for serving youth with substance use disorders.

61. Please describe efforts to establish the full continuum of psychiatric care for children, including acute care, crisis stabilization, and intensive outpatient care in the District, including the following services, specifically for children less than 18 years. What is the status of the following:
    a. Crisis stabilization unit, with an extended observation unit;
    b. Bridging Clinic for youth who are being discharged from inpatient psychiatric units;
    c. Therapeutic group home/community residence;
    d. Intensive outpatient programs;
    e. Partial hospitalization or day hospital;
    f. A local Psychiatric Residential Treatment Facility (PRTF); and
    g. Substance Use Disorder treatment inpatient or outpatient facility.

DBH Response:

DBH and the Department of Health Care Finance, DC's state Medicaid agency, began partnering in 2020 to plan for the full integration of behavioral health services in the Managed Care

Organizations (MCO) service delivery. The Behavioral Health Integration is a District-wide effort to provide a full continuum of whole-person care to youth. As part of the system redesign efforts and transition to managed care, a comprehensive rate study was conducted by DHCF's vendor, PCG. The rate study reviewed fifty-three services and their corresponding rates to include services completely new to the District. DBH and DHCF are currently in the phase of integrating the continuum of behavioral health services into managed care programs, effective April 1, 2024.

a. A crisis stabilization unit with an extended observation unit is not currently available within the District. Children are treated in hospitals and are assigned to a designated unit based on their clinical presentation. Youth who are in crisis are placed on a unit to resolve the crisis being experienced. Continued stays are provided in the hospital to youth based on clinical presentation if they meet the medical necessity criteria for continued hospitalization.

b. The District does not have facilities that designate themselves as bridging clinics. Transition and discharge planning are covered services within the District's Medicaid plan. DBH has an established discharge policy which provides the required procedures for providers for effective and safe discharges for children and youth. The child/youth's Core Service Agency or (CSA) and/or Community-Based Intervention (CBI) provider is required to participate in the development of an appropriate discharge plan with the individual's family and the hospital staff. The DBH's PRTF Branch Staff Members provide support to youths (and their family) throughout their treatment in a Psychiatric Residential Treatment Facility (PRTF) as well as during and after discharge. Prior to discharge the DBH staff will ensure that the youth is linked to a Core Service Agency and supports the assessment of need for additional behavioral health services as recommended by the treating PRTF's clinical team.

c. DBH does not provide therapeutic group homes/community residence for youth. DBH partners with agencies to include the Department of Youth Rehabilitative Services (DYRS) and the Child and Family Services Agency (CFSA) that provide therapeutic group homes/community residence for youth under their supervision. DBH works with certified providers to ensure service delivery is consistent across community settings for youth and families.

d. DBH continues to certify providers who serve as core service agencies that offer a full continuum of services to include therapy, medication management, and community support. As a part of the rate study, new services were added to include Intensive Care Coordination, Dialectical Behavioral Therapy, and Attachment-Biobehavioral Catch-up. As part of the behavioral health integration, youth will have access to intensive outpatient programs within their MCO network.

e. DBH does not have a current provider for Partial Hospitalization for youth. Partial Hospitalization is a covered service within the MCO network and DBH will work collaboratively with partners to explore the possibility of providing partial hospitalization services for youth in the future. PIW has indicated interest in developing this service.

f. The District does not have a local Psychiatric Residential Treatment Facility (PRTF); however, DBH has been collaborating with DYRS and CFSA to explore additional options for youth needing more intensive behavioral health supports. During FY24, DBH will reach out to PRTFs in neighboring states to explore the possibility of securing increased access to resources for District youth.

g. DBH is currently seeking a youth SUD residential treatment facility provider to support youth 21 years old and younger who have been diagnosed with a substance use disorder and need inpatient treatment services. Applications will be due in February of 2024 and the vendor shall be selected in March 2024.

62. Please provide a list of DBH's transition-age youth (TAY) services and programs.
    a. How is DBH ensuring DC residents are aware of these programs?
    b. What are the sustainable funding opportunities for transition-age youth services and supports in the District?
    c. How is DBH working in conjunction with Managed Care Organizations to ensure there are a sufficient number of community-based providers who are certified to provide TAY-specific behavioral health support?
    d. How is DBH working to increase TAY-specific services and supports?
    e. Is DBH exploring new evidence-based behavioral health services specific to TAY to address social determinants of behavioral health and trauma and incorporate youth voice?

DBH Response:

a. DBH's TAY team participates in both live and virtual outreach events so that the community is aware of TAY services. In FY 23 they participated in over 45 events across all wards of the District. In FY 23, presentations were made to 4,080 community members. Of the 4,080 community members to whom the TAY team made presentations, they connected with 20 % (n=830) of the individuals one-on-one.

b. Many of the TAY services are already Medicaid billable. These services have been adjusted to meet the needs of young adults. The newer services, Group and Family-based-Cognitive Behavioral Therapy (GF-CBT), Illness Management and Recovery (IMR), and Seeking Safety, may also fall within existing billable codes. DBH will work with DHCF to add modifiers to identify them for TAY usage.

c. DBH will continue to collaborate with MCOs, DHCF, and DBH certified providers to ensure specific services and supports are available for TAY. DBH will continue to provide training and technical assistance for evidence-based programs focused on the TAY population and support providers to ensure a comprehensive continuum of services are billable through the MCOs. DBH will continue to explore additional ways to increase the number of TAY providers.

d. The DBH TAY team provides on-going oversight, support, technical assistance, and guidance to ensure the TAY provider is implementing comprehensive TAY services to youth in the district. When challenges are identified, the provider and DBH team work together to problem solve and resolve the issue. Additional trainings will be made available to ensure providers have

appropriate tools necessary to provide services to TAY. Providers will continue to provide outreach to TAY youth, build relationships with the youth, and enroll youth in services when appropriate.

e. During FY24, DBH will use federal funds to provide additional support and training in programs targeting TAY. The following programs will be supported: Group and Family-based Cognitive Behavioral Therapy, NAVIGATE, Illness Management and Recovery, and Seeking Safety. The TAY programs address trauma, posttraumatic stress disorder, substance misuse, motivation and commitment to change, skills to cope with mental health conditions and self-efficacy. See the attachment for a list of TAY services and supports.

63. Please provide the following information for SUD services in FY 2023 and FY 2024, to date, for youth ages 18-24:
    a. Number of consumers who used detox, outpatient, and residential services;
    b. Number of service providers providing services to this age group, including their names, respective capacities, and locations;
    c. Average wait times to begin services; and
    d. DBH's strategies for expanding both capacity and accessibility of services, and addressing barriers to this age group.

DBH Response:

The substance use disorder services offered to youth ages 18-24 within the District of Columbia include prevention services, treatment, and recovery support services (RSS). SUD prevention services are delivered primarily through DBH's four DC Prevention Centers (DCPCs) who serve all eight wards and the youth treatment and recovery support services are made available through DBH's two Adolescent Substance use Treatment Expansion Program (ASTEP) providers. However, youth who are 21 years and older are able to access treatment and recovery support services through DBH's Adult Substance Use Rehabilitative Services (ASURS) program.

Number of consumers who used detox, outpatient, and residential services;

In FY 23, there were a total of 163 consumers aged 18-24 who utilized withdrawal management, outpatient and residential treatment services across the substance use continuum. Thus far in FY24, there has been a total of 31 consumers aged 18-24 who have accessed outpatient treatment services. At this time, DBH is awaiting paid claims data from withdrawal management and residential treatment service providers in order to determine the total number of consumers aged 18-24 who have utilized these services.

	Withdrawal Management	Residential	Outpatient

FY23	18	22	123
FY24YTD	0	0	31

During FY 2023, a total of fourteen (14) consumers aged 18 – 24 were served through DBH's two Adolescent Substance use Treatment Expansion Program (ASTEP) providers. During Q1 of FY 2024, five consumers aged 18-24 were served by these providers. Additionally, consumers over 21 years old can also be served by adult substance use treatment providers.

Number of service providers providing services to this age group, including their names, respective capacities, and locations;

ASTEP Providers	Location	Age Group	Capacity
Hillcrest Children & Family Center	915 Rhode Island Avenue, NE Washington, DC 20001 3029 Martin Luther King Jr. Avenue, SE Washington, DC 20032	12-25	80
Latin American Youth Center (LAYC)	1419 Columbia Road, NW Washington, DC 20009	12-25	12

Average wait times to begin services;

The average wait time to initiate services is contingent upon a number of different factors. These factors include the personal preferences of the individual being referred, availability for an intake assessment at their preferred location, and the individual's commitment to treatment. DBH's expectation and communication to providers is that consumers should be connected to a provider within approximately one (1) week and commence treatment soon thereafter.

DBH's strategies for expanding both capacity and accessibility of services, and addressing barriers to this age group.

DBH is aggressively working to increase accessibility to outpatient SUD services. In an efforts to do so, DBH has provided ASTEP providers funding through the DC CITY TREE grant which was funded by

SAMHSA to expand their outreach and to increase enrollments into youth SUD treatment and recovery support services. This additional funding supports non-Medicaid billable activities such as outreach, engagement, and follow-ups with clients who are no longer engaged in treatment. This funding also supports other efforts such supplies for the respective provider's drop-in centers and family engagement activities. DBH is also training ASTEP providers and transitional aged youth serving organizations in evidence-based interventions such as Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT) which have proven to be effective among older youth populations. The combination of these efforts will be critical in addressing barriers which impede youth and transitional aged youth from seeking services.

The District of Columbia Stabilization Center ("DCSC"), operated by Community Bridges, Inc. (CBI) in partnership with DBH, opened in October 2023, offers immediate, 24 hours/day, 365 days/year, no cost, low-barrier access to Crisis Substance Use Disorder (SUD) services for individuals 18 years of age and older, regardless of gender, insurance, and citizenship status. Transition aged youth 18 years or older can utilize the Center's services.

The DCSC provides individuals experiencing an SUD crisis with person-centered and a recovery-oriented alternative to unnecessary encounters at emergency departments or interactions with law enforcement. The DCSC ensures those individuals seeking or referred for services receive integrated and comprehensive care to address their specific needs in a supportive clinical and recovery-oriented environment.

With regard to increasing capacity and addressing barriers to this age group, DBH continues to work with the Office of Contracting and Procurement (OCP) to secure a vendor to provide SUD residential treatment services (i.e., 3.5 level of care) for youth under 21 years of age. These services will support youth with a substance use disorder needing a higher level of care and supports. It is anticipated that the solicitation will be advertised January 26, 2024.

64. The former Department of Mental Health created the District's first comprehensive "Children's Plan," which was last updated in May 2012. Please provide information on any plans to update or re-create a strategic plan for children's behavioral health in DC.

DBH Response

The Department of Behavioral Health will begin working with team members from other child-serving government agencies, community behavioral health providers, private and non-profit child-serving organizations, child advocates, and youth and families to update a strategic plan for children's behavioral health services in the District of Columbia in the spring. We anticipate this will be a year-long process and a revised plan will be published by the end of FY25.

65**.** How is DBH ensuring that District children with private insurance can access the full continuum of mental health services?

e. Is the agency collaborating with insurance companies to guarantee access to intensive outpatient services for children who do not require residential treatment?

DBH Response:

DBH continues to certify providers who serve as core service agencies (CSA) providing a full continuum of services to include therapy, medication management, and community support. In addition, providers are certified to provide specialty services to include community-based interventions, and trauma-informed services for early childhood, adolescence, and transition aged youth. In FY23, DBH completed presentations to CSAs and MCOs on the full continuum of mental health services available to children in the District.

DBH is not collaborating directly with private insurance companies; however, as the District's Behavioral Health Authority, DBH will continue to explore ways to inform private insurances of the full range of behavioral health services. If private insurances do not offer specific services such as community-based interventions, and a youth needs more intensive services, DBH, the private insurance company and community providers will work together to explore ways to ensure the youth receives the appropriate care.

During open enrollment of DC Health Link, DBH promotes behavioral health benefits in private insurance plans and the requirement for parity on social media. The DBH Ombudsman partners the Department of Insurance, Securities, and Banking in public events to promote parity including participating in a panel on access to equal treatment for mental health and addiction services and appropriate insurance coverage for high school, undergraduate and graduate students, and young adults.

School Based Behavioral Health

66.Please provide an update regarding the type of assessments in place for screening students. How many students were assessed in FY 2022, FY 2023, and FY 2024, to date?

DBH Response:

DBH understands the importance of screening for events or circumstances that may be traumatic to students, and often uses screening tools to guide treatment. School Based Behavioral Health (SBBH) clinicians use a wide range of screeners and assessments to gather information and data regarding student's strengths, weaknesses, and level of functioning. The specific screener or assessment tool is based on the need and the development age of the student. For example, young children who attend Child Development Centers are often assessed using the Ages and Stages Questionnaire. Healthy Futures consultants who provide early childhood mental health consultation services support the centers in administering the screener and help to link the children and families to appropriate services when necessary. Children also are referred to the consultant for child-specific consultation services or to a behavioral health provider in the community.

Young students are also screened if they attend a school participating in the Primary Project. Primary Project is an evidence-based, early intervention and prevention program for young children in pre-Kindergarten/4 through third grade who have been identified with mild adjustment issues in the classroom. Through one-to-one, non-directive play sessions, the

program reduces social, emotional and school adjustment difficulties to improve school-related competencies in task orientation, behavior control, assertiveness, and peer social skills. During SY 23-24 Primary Project services are being offered in 8 DC public and DC charter schools. Four to six weeks after school starts, teachers assess the level of functioning and adjustment of each child in their classroom using the Teacher-Child Rating Scale-Short Form (TCRS-SF). Based on the results of the screening, children with mild adjustments concerns are referred to Primary Project, and children with more significant concerns are referred to a behavioral health clinician in the school. During FY 22 and FY 23 826 and 1,220 students were screened using the TCRS-SF. In FY 24 to date 1,139 students have been screened in the 8 participating schools.

All clinicians complete a diagnostic assessment (DA) for all students participating in treatment services. When completing the DA clinicians gather information (i.e., presenting problem, developmental history, family history, history of abuse, social functioning, and trauma history etc.) from the student and parent/guardian. In addition to the DA, clinicians sometimes complete additional screeners to gather information about a specific topic or concern. For example, clinicians may use a specific screener to assess anxiety, depression, substance use, or attention difficulties. The screener helps to provide additional information which aids in creating a comprehensive and effective treatment plan. In addition, clinicians use screeners for students participating in specific treatment programs (e.g., Bounce Back or Cognitive Behavioral Intervention for Trauma in Schools (CBITS) to assess appropriateness for the program.

67.Please provide an update on DBH's School Behavioral Health Program including a list of all schools that have DBH clinicians, CBO clinicians, or both. Please include:

f. How much clinician time has been spent on Tier 1, Tier 2, and Tier 3 services;
g. How many and what percentage of schools have one or more CBO or DBH clinician currently in place;
h. How many schools have been matched by do not have an active DBH or CBO clinician;
i. How many schools have not been matched with a CBO (Please identify schools without a CBO clinician and provide the reason why one has not been hired);
j. How many schools in each cohort have a School Behavioral Health Coordinator, and what type of position/role do they hold at the school;
k. A list of all of the schools in each cohort; and
l. Any DBH plans to change the type of professionals that can be involved in the provision of Tier 1 and 2 services.

DBH Response:

Please see Attachment 1 of 6 which provides a list of all schools that have a DBH, CBO, or both a DBH and CBO provider.

a. In August 2022, the DBH School-Based Behavioral Health Program transitioned to a new data tracking system. This data tracking system utilizes a QuickBase platform and is called the School Behavioral Health Program (SBHP) Activity Tracker App. The SBHP Activity Tracker

App allows us to track the amount of time clinicians spend on Tier 1 and Tier 2 services. Prior to the current school year (SY2022-2023), we were not able to capture time spent.

Please see Attachment 2 of 6. Time Spent on Tiers of Services.

b. As of January 2024, the current school landscape is 254 schools. Of the 254 schools, 170 schools, comprising 67%, have at least one CBO and/or DBH provider.

c. As of January 2024, 69 schools are partnered with a CBO and/or DBH and have a provider vacancy.

d. As of January 2024, 23 public and public charter schools remain unmatched with a CBO and six schools are seeking new partnerships. Of the not matched schools (23), one of these schools is not participating in the program as the leaders have determined they have sufficient resources to support the behavioral health needs of their students. Additionally, eight of these schools are early childhood schools, and they are currently receiving services through a DBH Clinical Specialist until a partnership can be established. Although CBOs are actively recruiting to fill these positions, they face challenges attributed to a workforce shortage. New initiatives have been implemented to aid in the recruitment and retention of school-based providers.
Please see Attachment 3 of 6. Schools Not Partnered with a CBO or DBH.
Please see Attachment 4 of 6. CBO Matched Schools with Vacancy.

e. As of January 2024, 100% of schools have identified a School Behavioral Health Coordinator (SBHC). While the majority of school staff undertaking this role are school social workers, some are also principals, special education directors, school psychologist, school counselors, Connected Schools manager, Restorative Justice coordinator, Assistant Directors for Climate, Culture & Support, Director of Integrated Services, Chief of Student Support & Engagement, or SSST coordinators.

Please see Attachment 5 of 6. List of SBHC by Cohort.

f. Please reference attachment 6 of 6. Schools by Cohort.

g. DBH is currently exploring the option of a prevention specialist, an unlicensed individual trained to deliver prevention programming and services in schools.

Q67. Attachment 1 of 6. List of Schools with DBH, CBO, or Both Providers
Q67. Attachment 2 of 6. Time Spent on Tiers of Services
Q67. Attachment 3 of 6. Schools Not Partnered with a CBO or DBH
Q67. Attachment 4 of 6. CBO Matched Schools with Vacancy
Q67. Attachment 5 of 6. Schools with a SBHC by Cohort
Q67. Attachment 6 of 6. List of Schools by Cohort

68. Individual School Breakdown: For each school with a DBH or CBO clinician in place during FY 2022, FY 2023, and FY 2024, to date, please provide the following information in an Excel spreadsheet:

a. The number of students who met with a clinician;
b. The number of students who were referred to care;
a. The student to clinician ratio for the school, and the average caseloads of CBO clinicians;
c. The most common diagnoses or concerns;
d. The percentage of each referral source (walk-in, teacher, parent, etc.);
e. The prevention programs and services (Tier 1 or 2) that were offered;
f. The number of students who participated in prevention programs;
g. Name and contact information for their clinician(s) and School Behavioral Health Coordinator;
h. Percentage of clinician's time that was billed to Medicaid, Alliance, or private insurance; and
i. Relevant links for clinician websites, social media pages, or other materials; and
j. Plans to expand the prevention program and barriers to expansion.

DBH Response:

a) the number of students who met with a clinician
b) b) the number of students referred to care.

All Community Based Organization (CBO) and DBH clinicians are required to report daily activity data using the QuickBase platform. Services and supports across all Tiers are captured using the system. This new system has allowed DBH to capture data more effectively and effectively. Because the new data collection process started in August 2022, the FY 22 is not as extensive and DBH does not have the ability to report on all the data points separated out by school.

Please see Attachment 1 of 6 FY23 and FY24 services per school for an excel spreadsheet that describes FY23 and FY24 (to date) data regarding the following areas:

Please see Attachment 2 of 6 for data from DBH clinicians during FY22.

c. The School Behavioral Health Program is designed to supplement rather than replace services available in the school. Each school employs its own providers and resources to support students, families, and staff, in addition to the School Behavioral Health Provider. Although the School Behavioral Health Provider may offer support through Tier-1 prevention and Tier-2 early intervention services to the school community, they are not the sole provider or resource. For specific caseload details by school, please refer to Attachment 1 of 6.
d. In FY22, Adjustment Disorder, Major Depressive Disorder, Attention Deficit Hyperactivity Disorder, and Anxiety were the most common diagnoses. This data is not available for FY23 and FY24, due to the variety of electronic medical records used by external partners.

e. Please see Attachment 3 of 6. percentage of each referral source.

f. SBH providers have conducted 13,860 sessions of Tier-1 and Tier-2 programming, encompassing both evidence-based and clinician-created initiatives. Out of these, 1,200 sessions specifically addressed at least one of the District priorities (Substance use, Suicide, and Violence Prevention). Typical programs offered include, but are not limited to: Anger Management, Anxiety, Ask for Help, Bullying prevention, Conflict Resolution Skills, Coping Skills, Diversity and Inclusion, Empathy, Executive Functioning Skills, Feelings Identification, Grief and Loss, Healthy Relationships/Boundaries, Kimochis, LGBTQ+ Awareness, Love is not Abuse, Mental Health 101, Parent Café, Positive Communication Skills, Restorative Justice, Second Step, Self-esteem, Self-care and Stress Management, Self-regulation Skills, Signs of Suicide, Social Skills, Too Good for Violence, Too Good for Drugs, Trauma, and Zones of Regulation.

g. During the school year 2022-2023 and to date, 475,481 students have participated in at least one Tier-1 prevention or Tier-2 early prevention program. It's important to note that this number does not represent distinct values and may contain duplicates as students have the opportunity to participate in one or more programs.

h. Please see Attachment 4 of 6. SBHP Providers Contact Information. Please see Attachment 5 of 6. SBHC list.

i. This data is not available. DBH is collaborating with DHCF to identify ways we can collect this information in the future

j. Please see Attachment 6 of 6. Relevant links for clinician websites, social media pages, or other materials.

k. Currently, DBH is leading discussions both internally and with the Coordinating Council on School Behavioral Health regarding using unlicensed professionals and possibly paraprofessionals to implement Tier 1 (universal) services. Tier 1 services and supports are available to all students regardless of existing challenges, disabilities, or risk level for behavioral health problems. Interventions are delivered either school-wide, grade-level or classroom-based, including behavioral health promotion activities, programs to reinforce the adoption of social and emotional competencies, and efforts to promote positive school climate and staff well-being. Specific interventions could be implemented by behavioral health undergraduate or graduate level interns, individuals with an Associate Degree, and/or paraprofessionals.

   Some potential barriers to the expansion of the prevention program of service delivery using unlicensed individuals and paraprofessionals would be the lack of experience and knowledge in providing prevention services in schools. It will be essential to carve out sufficient time and funds to train the individuals on specific programming to increase their capacity to be tooled when entering the school. Otherwise, the school community may not accept this

modification of the model. It will also be important to provide supervision to the unlicensed individuals to ensure they have the guidance and support necessary to implement Tier 1 services with fidelity and effectively.

Q68. Attachment 1 of 6. FY24 and FY23 Detail Services per school
Q68. Attachment 2 of 6. Utilization Data for DBH SBHP Clinicians during SY 2021-2022 by School
Q68. Attachment 3 of 6. percentage of each referral source
Q68. Attachment 4 of 6. SBHP Providers Contact Information
Q68. Attachment 5 of 6. SBHC list
Q68. Attachment 6 of 6. Relevant links for clinician websites, social media pages, or other materials.

69.How many of the schools in Cohorts 1, 2, 3, and 4 have started or completed the SBBH School Strengthening Tool and Work Plan. Please describe any obstacles or barriers to completing the School Strengthening Tool and Work Plan and identifying the School Behavioral Health Coordinator. Please describe how these documents can be accessed by members of school communities, families and/or members of the public, whether on the DBH website, MySchoolDC website, or another website.

DBH Response:

As of January 2024, 70% of schools have submitted a School Strengthening Work Plan (SSWP) for School Year 2023-2024 compared to 68% in School Year 2022-2023. Please see the chart below by cohort. School teams use individualized, school-centric data to inform the development of SSWPs tailored to meet the specific needs of the school, students, families, and staff. Feedback from school teams indicates that common barriers to completing the SSWP include being understaffed or being new to the process. While the expectation is that all schools will eventually complete an SSWP, some are choosing to wait until they have an assigned school behavioral health provider.

It is the responsibility of each school to share their SSWP with the broader school community. This dissemination can be accomplished through various channels such as community meetings, Local School Advisory Team (LSAT) meetings, PTA/PTO meetings, among others. This ensures transparency and fosters collaboration within the school community to effectively address the identified needs and priorities outlined in the SSWP.

SY 2023-2024 Completed Workplans by Cohort as of January 2024		**SY 2022-2023 Completed Workplans by Cohort**
Cohort	**Total Number Completed**	
1	37 of 48 schools (77%)	37 of 48 schools (77%)
2	53 of 66 schools (80%)	50 of 66 schools (76%)
3	36 of 46 schools (78%)	33 of 46 schools (72%)
4	49 of 91 schools (54%)	50 of 91 schools (55%)
Extended Expansion	2 of 2 extended expansion (100%)	1 of 2 extended expansion (50%)
Total	177 of 254 schools (70%)	171 of 253 schools (68%)

70.Please provide the following information on the SBBH funding model:

m. Status of the required cost/rate study, the timeline for publication, reason for delay, and how the findings will be shared;
n. Status of program evaluations conducted by Child Trends, the timeline for publication, the reason for delay, and how the findings will be shared;
o. Percentage of total CBO and DBH clinician services, broken down by type of service, which have been able to be billed to Medicaid, private insurance, or other sources in FY 2023 and FY 2024, to date;
p. Plans for re-evaluating the financial model and the data DBH will use to make decisions; and
q. Description of the pilot programs for schools in FY 2023, and FY 2024 to date, related to staffing and hybrid work, as well as any future staffing changes considered.

DBH Response:

a. The goal is to submit the report to the Council in late January. The findings of the report will be shared at the Coordinating Council on School Behavioral Health, in the School Behavioral Health Executive Leadership Meeting, and in the School Behavioral Health Meeting with the DBH and Community Based Organizations' (CBOs) supervisors. The report was delayed due to various challenges including difficulties with obtaining accurate and comprehensive data from all CBOs (two of the CBOs did not submit any data and the data from one was inadequate and could not be used in the rate study) and addressing the complexities of creating recommendations that accurately reflect the implementation nuances that are related to the needs and gap of resources for youth, families, schools, and providers.

b. Child Trends evaluation reports for SY20-21 and SY21-22 have been shared with the members of the Coordinating Council on School Behavioral Health. Child Trends will submit the SY22-23 report to DBH in March 2024. Findings from all three reports have already been shared and discussed during meetings of the Coordinating Council on School Behavioral Health.

c. DBH and the Community Based Organizations (CBOs) who are providing the services through the school based behavioral health expansion initiatives have contracts with the Managed Care Organizations (MCOs) and the clinicians are billing for treatment services. Some CBOs have been successful with contracting with private insurances; however, barriers continue to exist. Based on the location of the services, some private insurers have refused to panel clinicians. Currently, clinicians bill for treatment services for all Medicaid clients and those with no insurance. Prevention and early intervention services are not reimbursable in the current State Medicaid plan. The cost of these services is supported with funding from the DBH local budget allocation. Unfortunately, DBH has not been able to pull accurate billing data to inform the percentage of total clinician services, broken down by type. Not all clinicians had individual NPI numbers and therefore accurate data could not be pulled. DBH will continue to collaborate with DHCF to understand the landscape of Medicaid billing for treatment services within the school setting and problem solve and identify strategies to begin pulling accurate billing data for treatment services.

d. The findings and recommendations from the cost study will help to inform any necessary shifts or revisions to the funding structure within the School Based Behavioral Health Program. DBH will incorporate these findings to determine the future financial model in collaboration with the Department of Health Care Finance and the provider community. DBH will continue to seek feedback from CBO partners, Coordinating Council members, and fiscal services to explore possible revisions to the funding model and process for funding distribution.

e. Due to the large number of vacancies and significant workforce challenges within the School Behavioral Health Program, the Department of Behavioral Health (DBH) is exploring flexibility with the implementation of prevention, early intervention, and treatment services. Members of the Coordinating Council and workgroups explored alternative options to implementing services and DBH proposed a few options to pilot. During SY23-24, DBH is implementing three pilots as described below.

Pilot 1: Schools receive funding to hire a full-time licensed clinician
Pilot 1 is for DC public charter schools that: 1) have not been partnered with a CBO through the SBHP, 2) have been partnered with a CBO but had a clinician vacancy for 12 months or more (as of 9/30/2023), or 3) have had a CBO partner disruption. The pilot will provide schools with funds directly to hire licensed clinicians. These clinicians will be 12-month employees. Schools will be required to meet all SBHP requirements included in the Scope of Services including the following items: 1) provide clinical supervision (1.5 hours individual weekly and 2 hours monthly group supervision) 2) submit data and adhere to reporting requirements 3) participate in the Community of Practice and 4) develop a School-centric Assessment and School Strengthening Work Plan. This pilot is underway and award letters to schools/LEAs will be distributed in January 2024.

Pilot 2: Hybrid Telework Model
Pilot 2 is for DC public or charter schools that focus on adult-learner or high school populations that are matched with a CBO but do not have a clinician. These schools typically provide support to students on various schedules and settings. CBO clinicians will provide services through a hybrid model (i.e., in-person services three days a week and telemedicine two days a week). Clinicians will also be required to receive clinical supervision, submit data and adhere to the reporting requirements, participate in the CoP, and develop the School-centric Assessment and School Strengthening Work Plan. Currently three LEAs are participating in this pilot.

Pilot 3: Prevention Specialist provides Tier 1 services and a licensed clinician provides Tier 2 and Tier 3 services
For CBOs who are partnered with a school but have a vacancy, they would have the option to hire a staff member to provide only Tier 1 prevention services. The CBO would hire a professional who has knowledge and experience working with youth and families but does not necessarily have a license in social work or a related field. The individual providing Tier 1 services would implement Tier 1 services outlined in the School Strengthening Workplan. Tier 2 and Tier 3 services would be provided by a licensed behavioral health provider hired by the CBO. The prevention specialist and the licensed clinician would continue to actively participate on the School Behavioral Health Team and be embedded in the school. This pilot option is under development, and it is anticipated to be rolled out in FY24 Quarter 3.

71.Please provide the following information on the Community of Practice for school-based behavioral health:

a. Changes to the current organization structure and plans for the future;
b. List of planned events, training, regular meetings, or other convenings with brief summaries of the purpose of each event, target audience, and planned number of participants in FY 2022, FY 2023, and FY 2024, to date;
c. Plans for assessing the effectiveness and utilization rate for the community of practice; and
d. Level of funding for the community of practice each year since FY2019 (the first year of the program), and an explanation of whether/how funding has kept up with the expansion of the program to include all public schools.

DBH Response:

a. The following structural adjustments were made to the DC Community of Practice (DC CoP) based on emerging needs of community members:

- Monthly CoP meetings continue to alternate between mornings and afternoons (e.g., September 3:00 - 5:00 pm; October 9:00 - 11:00 am) to accommodate different schedules of the CoP members. Also, the December CoP meeting was the first in-person meeting since the pandemic.
- SY 2022-2023 Annual Survey findings will inform future meeting planning.

- The Skill-building Chat was dissolved in July 2023. The function of the Skill-building Chat (applying the learning from the DC CoP meeting) was transferred to Practice Groups (PG).
- New facilitators were recruited to support the Family and Youth Engagement PG and the Positive School Climate/Social and Emotional Learning Implementation PG.
- The Crisis Response and Intervention PG merged with the Trauma informed Practices in Schools PG.
- Pilots were developed with school teams to implement strategies promoting youth and family engagement in school behavioral health. The FYE PG leaders partnered with Friendship Chamberlain Elementary School's school behavioral health (SBH) team to include families and youth in the design and implementation of school behavioral health services.
- Parenting T0k was launched in October 2023 to provide space for parents to learn new skills and discuss parenting challenges. Parenting T0k conversations, co-facilitated by a parent and clinician, aim to foster understanding, reduce stigma, and provide resources for supporting various aspects of children's mental well-being.

The CoP plans for the future in collaboration with all DC partners to achieve shared goals include:

1. Develop meaningful, continued, and growing participation in CoP learning spaces to apply school behavioral health (SBH) practices at Tiers 1, 2, and 3, and
2. Build workforce capacity to engage school-based teams to implement high-quality SBH practices at Tiers 1, 2, and 3.

Objectives for SY 2023-2024 include:

1. Continue to increase the number of new members attending DC CoP events.
2. Continue to increase the number of school teams that attend DC CoP events regularly.
3. Continue to increase access to resources developed/ shared through the CoP.
4. Improve communication around services available and how to access them, especially for caregivers and youth.
5. Continue customizing the CoP resources for different groups including families, youth, and school leaders.
6. Continue to promote use and application of evidence-based and best practices in schools.
7. Learn more about and address the reason(s) potential community members do not attend CoP learning events.
8. Develop a plan for reporting the CoP impact.
9. Continue to provide foundational trainings (i.e., MTSS, grief & loss) to new and existing CoP members.
10. Continue providing Social Work and Psychology CEUs for the CoP meetings & add Professional Counseling CEUs.

b. The attachment provides FY 2022, FY 2023, and FY 2024 to date information on planned events, training, regular meetings, or other convenings with brief summaries of the purpose of each event, target audience, and planned number of participants.

c. The evaluation vendor Child Trends notes that the CoP has engaged hundreds of school mental health providers (i.e., social workers, psychologists, and counselors), school behavioral health coordinators (SBHCs), DBH and CBO clinicians, and a smaller, but equally important, group of educators, principals, caregivers, and other community members. Given the importance of promoting cross-sector collaboration to improve behavioral health outcomes for students, it is essential to further explore and address the limited number of CoP participants who have a high frequency of return participation in CoP sessions.

Three examples of continuous quality improvement strategies implemented by the CoP vendor are:

Engagement with Child Trends: The DC CoP meets regularly with the evaluation vendor, Child Trends, to discuss evaluation-related topics and align efforts. Data collected by the DC CoP are regularly shared with the Child Trends team.

Meeting Registration: Since meeting registration numbers are high (up to 100+ registrants), the registration form was identified as the best mechanism to collect information required by the DC CoP for evaluation of utilization. Data on engagement and application of new knowledge and skills are synthesized and summarized to examine aggregate results or patterns over time, for example, meeting feedback summaries and attendance charts and graphs. The data is used to inform outreach efforts; target communication and resource dissemination; work with partners to improve participation; and track implementation of evidence-based practices at Tier 1, 2, or 3 following each monthly meeting. Information such as Tier 1, 2, and 3 applications are regularly shared with Child Trends.

Meeting Feedback Forms: Meeting feedback forms are used to assess participant satisfaction; changes in knowledge, awareness, and understanding of meeting content; and attainment of meeting goals/objectives. The meeting feedback form includes a standard set of questions in order to monitor changes over time and are regularly reviewed and used to inform DC CoP planning.

With respect to plans for evaluating the DC CoP, DBH will continue the plan that has been in place for the past several years:

1. Child Trends will continue to survey SBHC, clinicians, staff, families and students to learn more about the effectiveness of the DC CoP
2. Child Trends will continue to request that the DC CoP collect information through their pre-registration survey and evaluation survey on whether participants have applied skills/knowledge gained through participation in the DC CoP in their work.

DBH believes that the combination of data from SBHCs, clinicians, school staff, families and students (which will capture both participants and non-participants of the DC CoP) is likely the most efficient way to understand the role of the DC CoP in building the capacity of school teams to address the behavioral health needs of students, families, and staff and to measure the effectiveness of the Community of Practice.

d. The level of funding for the community of practice each year since FY 2019 is as follows:

Community of Practice Funding	Amount
Base Year	$780,750
Option Year 1	$675,550.00 (reflects a $123,000 modification decrease and negotiated removal of service line items)
Option Year 2	$844,227.00
Option Year 3	$807,308 (includes a $123,000.00 modification increase for additional service line item)
Option Year 4	$700,286.00

Resources of the CoP were available to all DC public and public charter schools each fiscal year. See Attachment 1 of 1. CoP Planned Events and Planned Participants

72.Please describe the relationship between DBH, DCPS, and OSSE in relation to the School-Based Behavioral Health program. Please include the following information:

a. The status of active MOUs and any other relevant interagency agreements;
b. How frequently DBH met with agency staff at these agencies regarding SBBH in FY 2023 and FY 2024, to date;
c. The number and descriptions of positions at OSSE and/or DCPS which support SBBH implementation; and
d. Current initiatives for outreach to and within LEAs, school staff, families, and associated groups like PTOs, for the purpose of supporting the SBBH implementation, including website communication.

DBH Response:

DBH, OSSE, and DCPS have a strong and long-standing relationship. The agencies have consistently engaged in a collaborative partnership to support the development and implementation of the School Behavioral Health Program and the workforce pipeline. The DBH Clinical Support Manager, the OSSE School Behavioral Health Outreach Specialist, and the DCPS Expansion Outreach Director have regularly scheduled meetings during each month. The DBH School Behavioral Health Branch Chief regularly met with the DCPS Expansion Outreach Director in support of the active Memorandum of Agreement which formalizes the partnership that places DBH-hired clinicians in assigned school placements within DCPS. The DBH Program Coordinator for the School Behavioral Health Internship Program co-facilitates with the

OSSE Mental Health Coordinator the monthly meetings of the Workforce Development committee.

a. DBH is currently finalizing the modification 4 of the MOU for the DBH funded FTE at OSSE. DBH is currently finalizing the FY24 MOU for the DBH funded FTE at DCPS.

b. In FY 2023 and in FY 2024 to date, DBH has met weekly with DCPS and bi-weekly with OSSE. There are additional meetings between DBH, DCPS, and OSSE that occurred monthly and as needed.

c. DBH funds a full-time position at DCPS and a full-time position at OSSE that support the School Behavioral Health implementation.

DCPS employs an Expansion Outreach Director. The FTE shall:

- Undertake outreach for the purpose of identifying suitable CBOs that will partner with schools to provide multi-tiered prevention, early intervention, and treatment services in Cohort expansion schools.
- Establish formal relationships with CBOs through an application and vetting process, as well as the development and full execution of Memorandums of Agreement (MOA).
- Monitor each CBO's compliance with the MOA, specifically, adherence to required assurances, background checks, data collection and submission, and maintenance of active agreements.
- Communicate and report on expansion efforts, both internally and externally, with specific focus on partnership sustainability, process and outcomes, in collaboration with the DBH Evaluation vendor.
- Promote DCPS participation in the District Expansion School-based Behavioral Health Community of Practice and application support at the school level.
- Actively ensure communication alignment across schools, CBOs and other District agencies about expansion.
- Support school leaders in leveraging the expertise and appropriate services of the CBOs to meet the needs of students and their families.

OSSE employs a School Behavioral Health Outreach Specialist. The FTE shall:

- Assist with implementation of the Comprehensive School Behavioral Health System's expansion.
- Support all D.C. Public Charter Schools.
- Maintain regular communication and collaboration with the evaluation team and Community of Practice to prevent duplication of services.
- Provide operational support with school-CBO matching process and activities;
- Support collection and coordination of data from schools and CBOs, to include school-centric assessment and School Strengthening Work Plan logistics; and
- Deepen engagement and support with school leaders to:
    - Build program knowledge and buy-in;

- Leverage the expertise and appropriate services of the CBOs to meet the needs of the students and their families;
- Integrate mental health service delivery with other school-wide initiatives (school climate, restorative justice, etc.); and
- Consult on use of available OSSE data to inform data driven decision-making.

d. DBH agency leaders continue to actively engage and participate with the education sector and the parent sector organizations (e.g., PAVE) during information and outreach events. During the events DBH staff share resources, speak with parents about school behavioral health services as well as share resources that are available for the school community including students, teachers and administers.

Along with other community partners and District agency leaders, the DC Community of Practice (DC CoP) members come together monthly to learn from each other, solve problems of practice and to support the implementation of best practices in school behavioral health to promote healthy development and well-being for all students and their families. CoP members also join Practice Groups and Work Groups led by volunteers representing different roles. Practitioners, educators and family members engage in shared work through the DC CoP. The DBH website links to DC CoP website communication and resources of the DC CoP via https://dbh.dc.gov/service/dc-community-practice.

Additionally, DBH continues to provide consultation on the Total Family Care Adult Peer Support Specialist pilot development for building parents and schools partnerships in promoting and supporting student emotional well-being in school and academic achievement. The pilot will focus on delivering technical assistance to school teams that want to advance comprehensive school behavioral health services (e.g., youth and family engagement in school behavioral health).

73. What is the projected implementation date for the Peer Educator Pilot Program funded in the FY 2024 Budget.
    a. When will grantee(s) be selected? If they have already been selected, please identify them?
    b. Please provided the finalized scope of work, including all programmatic and reporting requirements.

DBH Response:

The Request for Application will be posted by the end of January, the applications will be reviewed by a review committee, and the vendor will be selected by the end of February 2024. The grantee will be selected by the end of February 2024 and services will begin in late February or the first week in March 2024.

b. DBH is currently finalizing the Scope of Work. It will be completed by the end of January 2024, and the Request for Application will be posted in early February 2024.

Adult Substance Abuse Services

74.Please provide the following information on DBH's work to promote access to a continuum of quality substance abuse prevention, treatment, and recovery support services for FY 2023 and FY 2024, to date:

c. List of providers and number of consumers served by DBH's outpatient methadone maintenance treatment programs and clinics; and
d. Number of prescriptions per month reported to the Prescription Drug Monitoring Program.

DBH Response:

In partnership with its grantees and community partners, DBH continues to lead the effort to promote and enhance access to the full continuum of quality substance use prevention, treatment, and recovery support services in the District. We utilize the following pathways / strategies to achieve these goals:

Web based Resources
A key component of our strategy to increase access to community services is through promotion of the DBH sponsored web site. This site provides information on accessing harm reduction, prevention, treatment, and recovery support services. Prevention information and resources about the DC Prevention Centers can be accessed via https://dbh.dc.gov/prevention; information about accessing treatment through the DBH Assessment and Referral Center and DBH-certified treatment provider network can be found at https://dbh.dc.gov/page/substance-use-disorderservices; youth specific treatment information is available at https://dbh.dc.gov/youthsudservices;and recovery resources are available at https://dbh.dc.gov/recoveryresources.

DBH also partners with DC Health through its MyRecoveryDC, https://myrecoverydc.org/initiative to provide updated, ward level information and resources, as well as access to individuals with lived experience for support. DBH also participates in the Network of Care, another web-based resource which provides information about local behavioral health resources. Lastly, through social media and other web-based platforms, DBH pushes daily messages about accessing services and supports, as well as highlighting the important work of community providers and partners.

Social Marketing
In FY22, DBH launched the "Hope" Campaign ("This Time It is Different"), which targets individuals who need to be engaged or re-engaged in treatment by promoting the District's treatment, recovery services and supports. This campaign continues to run and is visible across the city on billboards, at bus stops and on buses. As part of this campaign, by texting "Ready" to 888- 811, an individual receives a list of treatment providers who are open and available at the

time of the text. In addition, all DBH promotional materials list the number for the Access Helpline (24/7 Hotline, discussed below) staffed by behavioral clinicians who can address emergent issues at the time of the call or refer the individual to community providers for on-going care.

Outreach and Community Engagement
DBH's Public Engagement Director continues to coordinate outreach efforts and community engagement, leveraging both DBH resources as well teams across community organization. The Public Engagement Director coordinates outreach efforts and builds relationships with other governmental partners and community stakeholders to address the needs of the community. The outreach teams continue to provide support, training, distribute educational materials at community and pop-up events, and conduct community outreach in specified neighborhoods with the highest needs, engaging our most vulnerable citizens.

In the Winter of 2024, through the State Opioid Response (SOR) grant, DBH plans to launch-an Opioid Ambassador's training, which provides community stakeholders an in-depth overview of DBH's services and supports to enable them to spread the word throughout their communities regarding how those in need can best access services and supports.

Access HelpLine
Through the above pathways, we emphasize to community partners and those seeking care that our Access HelpLine at 1(888)7WE-HELP or 1-888-793-4357 is the most expedient and efficient means to connect to a DBH or certified, community behavioral health provider. This 24-hour, seven-day-a-week telephone hot line, staffed by licensed and trained behavioral health professionals, serves as our Crisis and Triage hub: providing crisis management, counseling, information regarding community services, as well as routine care in the community. The AccessHelpLine also receives calls from the "988" National Suicide Prevention Life Line emanating from the District to support individuals and friends or loved ones of individuals struggling with suicidal thoughts, contemplating self-harm, in emotional distress and seeking confidential support.

List of providers and number of consumers served by DBH's outpatient methadone maintenance treatment programs and clinics

In Fiscal Year 2023, the three community-based Opioid Treatment Programs (OTPs) listed below served 1,218 individuals. In addition, OTPs are also located at the DC Jail and the Veterans Administration: Complete claims data for the first quarter in FY 2024 is unavailable. All substance use treatment providers began using their own electronic health record (EHR) instead of DATAWITS in FY 2024. This has caused some delays in billing (e.g., one OTP reported that its EHR needed to be reconfigured to allow for the submission of both the therapeutic guidance claim and the dosing claim).

Outpatient Methadone Provider	Location	Number of Consumers Served in FY2023
Behavioral Health Group (BHG)	1320 Good Hope Road, SE Washington, DC 20020	395
Baymark (Formerly Foundation for Contemporary Mental Health - Partners in Drug Abuse Rehabilitation and Counseling [PIDARC])	2112 F Street, NW Suite 137 Washington, DC 20037	601
United Planning Organization (UPO)	1900 Massachusetts Ave, SE Bldg 13 Washington, DC 20003	222

Number of prescriptions, per month, reported to the Prescription Drug Monitoring Program

DC Health manages the Prescription Drug Monitoring Program (PDMP). As a result, the requested data are not available to DBH at this time. The methadone clinics do not report prescriptions to the PDMP.

75.For the Safe Syringe Program, please provide the following information for FY 2023 and FY 2024, to date:

e. Number of syringes distributed, per vendor per month, for the Safe Syringe Exchange program;
f. Targeted geographic areas for each vendor;
g. How does DBH track syringe distribution to avoid abandoned syringes; and
h. The number of sharps collected by each vendor.

DBH Response

a. DBH began oversight of the syringe services programs (SSPs) in January 2023. Prior to that date, DC Health had oversight of this program. See *FY23 Oversight Question 75, Attachment 1 of 2. Syringe Services Program Syringes* for the number of syringes distributed, per vendor per month for FY 2023 (starting in January) and FY 2024 (October and November) for the Safe Syringe Exchange program.

b. DBH's three mobile SSPs partners serve the entire District. In addition, they are assigned specific geographic areas by DBH for naloxone distribution through Text-to-Live; syringe cleanups; and to respond to community concerns. See *FY23 Oversight Question 75, Attachment 2 of 2. SSP Map* for a map of where each vendor is assigned. When issues arise in an area that is not in anyone's regular catchment area, DBH assigns an SSP to address the issue on a case-by-case basis.

c. DBH does not have the capability to track syringe distribution during routine outreach and engagements in order to avoid abandoned syringes. The SSPs promptly follow up and report back to DBH, however, when they are called to respond to community concerns about abandoned syringes.

d. See FY 23 *Oversight Question 75, Attachment 1 of 2. Syringe Services Program Syringes* for the number of sharps collected by each vendor for FY 2023 (starting in January) and FY 2024 (October and November).

76.Please provide the following information for LIVE.LONG.DC 3.0 for FY 2023 and FY 2024, to date:

i. Timeline for publication of LIVE.LONG.DC 3.0;
j. The number of DBH staff dedicated to opioid prevention and response, including grades and titles;
k. An updated list and map of locations (including ward) where the public can get Naloxone;
l. The number of Naloxone that was distributed in FY 2022, FY 2023, and FY 2024, to date. If possible, provide a list of the locations and the number of Naloxone that was distributed at each location;
m. The number of Naloxone trainings conducted in FY 2022, FY 2023, and FY 2024, to date; and
n. A spreadsheet listing the faith-based institutions receiving grants on opioid prevention and treatment, including grant amount and description of services;

DBH Response:

a. LIVE.LONG.DC 3.0 is undergoing final review with an expectation of public release in late January or early February 2024.

b. There are 24 DBH staff positions 100% dedicated to opioid prevention and response through the State Opioid Response (SOR) grant. Other DBH staff work on opioid prevention and response and collaborate with the SOR team as appropriate, but are not dedicated to the SOR team full time. See *FY23 Oversight Question 76, Attachment 1 of 3. Opioid Prevention and Response Staff* for the number of staff including grades and titles.

c. See Naloxone Public Locations for an updated list and map of locations (including ward) where the public can get naloxone.

d. There were 65,124 naloxone kits distributed in FY 2022; 86,136 in FY 2023; and 12,348 to date in FY 2024 (October–November) . See *FY23 Oversight Question 76, Attachment 2 of 3 Naloxone Distribution FY 2022–FY 2024* for a list of the locations and the number of naloxone kits that were distributed at each location (data from October 2021–November 2023).

e. There were 125 naloxone trainings in FY 2022; 157 in FY 2023; and 36 to date in FY 2024 (October–November). In addition to instructor-led trainings, there is an online module available on-demand where people can access free naloxone training at any time on the DBH Learning Institute.

In FY22, a total of 2,897 individuals were trained either through community trainings or the online module. In FY23, 4,880 individuals were trained. In October-November of FY24, 1,045 individuals took naloxone training.

f. See *FY23 Oversight Question 76. Attachment 3 of 3. Faith-Based Grantees* for a list of the faith-based institutions receiving grants on opioid prevention and treatment, including grant amount and description of services.

77.How many calls the Access Helpline received related to opioid addiction in FY 2022, FY 2023, in FY 2024, to date. Please provide the following information for the Assessment and Referral Center (ARC) in FY 2023 and FY 2024, to date:

a. Number of clinicians and other staff conducting assessments;
b. Number of assessments conducted; and
c. List of places where consumers were referred, including number referred to each center, description of services, and length of type between referral, intake, and first appointment.

DBH Response:

How many calls the Access Helpline received related to opioid addiction in FY 2022, FY 2023, in FY 2024, to date.

Calls related to opioid addition typically are received by the DBH-operated Assessment and Referral Center (the ARC) or our provider network as Access Helpline the mental health helpline and access along with community based providers. The ARC historically has conducted substance use disorder intake and referral. Beginning in FY20, all substance use disorder providers were required to provide intake, assessment and referral to the appropriate level of care. DBH now contracts with 29 community-based SUD treatment and recovery providers located across the District, of whom 12 are also certified to provide mental health treatment.

Assessment and Referral Center (ARC): Number of clinicians and other staff conducting assessments

During FY 2023 and FY 2024, the ARC had three registered nurses (RN), two independently licensed clinical social workers (LICSW) and two certified addiction counselors (CAC) conducting assessments.

Assessment and Referral Center (ARC): Number of assessments conducted

In FY 2023, the ARC conducted 1550 assessments. In FY 2024 to date, the ARC has conducted 342 assessments.

Assessment and Referral Center (ARC): List of places where consumers were referred, including number referred to each center

See Attachment 1 of 1. *List of Places Consumers Were Referred by the ARC in FY22 and FY23* for the requested data. Also, please reference *Attachment to Question 79* which describes the full range of Substance Use Services and referral process available through DBH certified network. Unfortunately, data regarding the length of time between referral, intake and first appointment for services is not currently available.

78.Please provide the following information for the DBH Peer Specialist Certification Program FY 2022, FY 2023, and FY 2024, to date:

a. Number of peers trained and certified;
b. Duration of the program and any significant enhancements or modifications introduced; and
c. Number of certified peer specialists working in the District, including roles and activities.

DBH Response:

DBH has a total of 154 active certified peers. The DBH Certified Peer Certification Program resumed in person training in FY22 after a pause due to the COVID pandemic. One training class was held and 10 peers were certified. In FY 23, DBH held three training classes. A total of 22 peers were certified through the training class and another eight were certified through waiver testing for a total of 30 certified peers. DBH will hold three peer specialist Peer training classes in in FY 24, starting in February. Waiver testing also will be an option.

a. DBH certified a total of 10 peers in FY 22 and 30 peers in FY 23. Training for FY 24 will begin in February 2024.

b. The DBH Certified Peer Training program consists of six weeks of classes and 80 hours of practicum assignments. The training curriculum was modified to align with the national standards for peer specialists. In 2023 Bi-lingual Spanish-English speaking staff joined the training team. This new team member added to the diversity of the current team and affords more additional support to Spanish speaking program participants who speak English as a second language.
c. In FY 22, 102 peers reported that they were meaningfully employed. In FY 23, DBH held a peer job fair to connect certified peer with providers. In FY 23, 100 peers reported they were meaningfully employed. 14 of the 100 peers who provided information about employment work in DC Government agencies including DBH, the MLK Public Library, and Fire and EMS. In FY 23, four Peer Operated Centers worked with DBH to provide peer support in four shelters serving people facing homelessness that have high incidents of opioid use and overdoses identified by the Department of Human Services. Peers also work in community-based hospitals and the certified provider network.

79.Please provide the following information regarding substance abuse services that are offered to adults in FY 2023 and FY 2024, to date:

a. The total number (via spreadsheet) of adults who received substance abuse services, broken down by age, home ward, ward where services took place, format (in-person/virtual/hybrid), and the types of services provided;
b. Please provide (via spreadsheet) a list of all agencies and organizations that provide substance abuse services to adults, including location, Ward, how many adults served, the format of their services (virtual/in-person/hybrid), what services they provided, and contact information (staff contact, email address, phone number, and website); and
c. Plans in FY 2024 to expand the types of substance abuse services offered to adults.

DBH Response:

DBH certifies a network of community-based providers to render a variety of substance use disorder (SUD) treatment services, which are based on the following levels of care established by the American Society of Addiction Medicine (ASAM): Level 1 Outpatient, Level 2.1 Intensive Outpatient Program, Level 2.5 Day Treatment, Level 3.1 Clinically Managed Low-Intensity, Level 3.3 Clinically Managed High-Intensity, Level 3.5 Clinically Managed High Intensity Adult or Medium Intensity Youth, Level 3.7 Medically Monitored Intensive Inpatient Withdrawal Management.

DBH also provides a range of prevention and recovery services. Many adults with a substance use disorder (SUD) also have a co-occurring mental health disorder. DBH supports integrated care with screening, diagnosis and treatment for both mental and substance use disorders to treat the whole person for the best health outcomes. SUD providers are located across the District and listed at: https://dbh.dc.gov/page/substanceuse-disorder-services.

a. The total number (via spreadsheet) of adults who received substance abuse services, broken down by age, home ward, ward where services took place, format (in-person/virtual/hybrid), and the types of services provided

b. Please provide (via spreadsheet) a list of all agencies and organizations that provide substance abuse services to adults, including location, Ward, how many adults served, the format of their services (virtual/in-person/hybrid), what services they provided, and contact information (staff contact, email address, phone number, and website);

See Attachment 1 of 1, List of Providers and Clients served - MH and SUD services in FY23 and FY24YTD.

c. Plans in FY 2024 to expand the types of substance abuse services offered to adults

In October 2023, in partnership with a contracted vendor, Community Bridges Inc., DBH opened the District's first Stabilization Center (DCSC). The DCSC provides individuals under the influence of alcohol or drugs with person-centered care and a recovery-oriented alternative to law enforcement response or transfer to an emergency department. The DCSC includes onsite services to screen and assess medical and behavioral health status, as well as addressing immediate personal needs (i.e., food, bathrooms, shower, and laundry), and transportation services. The DCSC also provides consumers with referrals to an appropriate ASAM level of care within the community and offers care management and coordination directly or through community partners. The Stabilization Center is open 24/7 and serves individuals 18 years and older.

During the coming year, DBH plans to fund the establishment of a community-based level 3.5 SUD treatment facility for youth, which will include services for transitional age youth, in a clinically managed, medium intensity, residential setting using Federal Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant funds. Via the SUPTRS funds, DBH will be awarding grants to adult substance use treatment providers to initiate Eye Movement and Desensitization Reprocessing (EMDR) therapy. The grants will pay for training and hiring of clinicians to provide EMDR to consumers in treatment.

To support the substance use needs of clients in nursing homes, out State Opioid Response Grant (SOR) funded a consultant to conduct SUD training and technical assistance in at least 19 skilled nursing/long-term care facilities with the goal of encouraging these facilities to provide medication for opioid use disorder (MOUD) and other related treatment in their facilities. This work is continuing this year.

DBH also awarded SOR grants in April 2023 to community providers to establish new recovery residences for individuals with stimulant use disorder/opioid use disorder (STUD/OUD). Through the grant, individuals with OUD/STUD received intensive care management while living in a safe and monitored recovery residence. Intensive care management includes an assessment of an individual's functional life skills (e.g., personal living skills, social skills, vocational skills and service procurement skills) in order to establish a long term plan for ongoing recovery. Individuals will not be immediately asked to leave the setting if they return to using. Rather, staff will work with the resident to get them back on their recovery path.

Through six funded SOR Expanding Access and Retention in Care for Opioid and/or Stimulant Use Disorder Treatment grantees, DBH implemented strategies to reduce barriers to accessing treatment for prospective patients with STUD/OUD, re-engage such clients who have unexpectedly or prematurely discontinued their treatment, support current patients to promote retention, and provide whole-person care. By addressing clients' connection to care, this grant initiative seeks to further reduce behavioral health disparities within underserved communities and improve access to behavioral health care services.

DBH recently requested carryover funds from the grant year that ended September 29, 2023, from SAMHSA. Many initiatives continued to be negatively impacted by the COVID-19 pandemic, which slowed down services as well as exacerbated the workforce shortages. Some

larger initiatives needed more time for planning and start up. In DBH's carryover request, recommendations were made to fund or expand MOUs with DOH, DOC and the Mayor's Office of LGBTQIA+ Affairs as well as funding for prevention, harm reduction, treatment, recovery services, and workforce development initiatives. These include grants for ward community mini-grants, expansion of social marketing campaigns, vans for syringe services program outreach, wellness activities at OTPs, training and education on treatment options, care management expansion for youth, increase OUD/STUD screening for pregnant and parenting women, faith-based grants with a focus on recovery, increased recovery housing, in-person opioid response team following an overdose, and harm reduction training. DBH will be notified in early Spring 2024 of SAMHSA's approval of the carryover request.

80. Please provide the following information on the Stabilization Center since it opened in October 2023:

a. The total number of individuals served, disaggregated by race, age, gender, ward of residence, and housing status;
b. Percentage of individuals served who have come to the Center more than 1, 5, and 10 times;
c. Types of services provided; and
d. Numbers of referrals made to other agency programs and organizations, broken down by program/service.

DBH Response:

The Total number of Individuals served, Disaggregated by Race, Age, Gender, Ward of residence, and Housing Status

The District of Columbia Stabilization Center (DCSC) is a critical enhancement to our substance use disorder continuum of care. Through a competitive procurement process managed by the Office of Contracting and Procurement, Community Bridges, Inc., was selected to operate the Stabilization Center.

From the launch of the Stabilization Center on October 31, 2023, through January 5.2024, the Center served 654 individuals**.** A description of the individuals who have received services at the Center and the number transported by FEMS by location is displayed on the charts below.

Demographics of the Population Seved by the DC Stabilization Center October 31, 2023 – January 5, 2024 N=654		
Gender	Number	Percentage
Males	510	78%
Females	144	22%
Age Range	Number	Percentage

18-19 years	8	1%
20-29 years	84	13%
30-39 years	142	22%
40-49 years	164	25%
50-59 years	122	17%
60-69 years	109	20%
70-and older	23	3%
Unknown	2	<1%
Race/Ethnicity	Number	Percentage
African American	454	69%
White	116	18%
Other/Not Specified	84	13%

Since the Stabilization Center opened just over two months ago, DBH continues to work to refine our processes to reliably report on the ward of residence and housing status given the challenge with getting this information during intake. It is not possible at this time to provide the ward residence. In the interim, zip code information is available Fire and EMS on the originating locations of individuals who they transport to the Stabilization Center but this might not be where the individual resides and zip codes cross multiple wards. Also, Fire and EMS transports represents 68% of the total admissions to the Stabilization Center so zip codes are not available for 32% of those admitted to the Stabilization Center. Below are the six zip codes with the highest number of calls for Fire and EMS that result in transport to the Stabilization Center. These zip codes represent 86% of all transports.

Top 6 Zip codes of FEMS Transports to the DC Stabilization Center October 31, 2023 – January 5, 2024 N=445 (68%)			
Zip Code	Ward	Number of Transports	Percentage
20001	Wards 1 and 5	74	17%
20011	Wards 1, 3 and 5	56	13%

20009	Wards 1 and 2	44	7 %
20002 20010	Wards 1, 5, and 6 Wards 1 and 5	111 47	25% 11%
20019	Ward 7	50	11%
All other zip codes		63	14%
		445	

Reference: DC Fire and Emergency Medical Services Transport Data

e. Percentage of Individuals served who have come to the Center more than 1, 5, and 10 times;

To date, of the 654 individuals admitted to the Stabilization Center, 236 or 36% have been admitted more than once as shown on the chart below. It is common and anticipated that individuals will come to the Center multiple times as they go through the stages of change to make the decision to move into recovery (Prochaska and DiClemente, 1983).

Number of Multiple Admissions to the Stabilization Center October 31, 2023-January 5, 2024 236 of 654 (36%)	
Number of Admissions	Number of Individuals with Multiple Admissions
2-5 admissions	149
6-10 admissions	50
11-17 admissions	37

Types of Services Provided

The Stabilization Center is a voluntary service that provides a supportive environment for individuals who are intoxicated as a result of their consumption of alcohol, opioids or other drugs to stabilize. The Center is open 24 hours per day, 7 days per week and serves adults over 18

years of age regardless of their ability to pay or insurance coverage. Admission to this low barrier, person-centered, recovery focused service is based solely on the patient's clinical needs.

The unit consists of 16 observation / treatment beds for stays of up to 23 hours. In addition, there are 6 longer stay beds (up to 72 hours) for individuals with co-occurring or complex medical needs who require a longer period of observation to determine their appropriate level of care and disposition. The majority of individuals are transported by FEMS however, they can be brought to the facility by a community provider, MPD, a family member, friend or can simply walk into the Center.

Services include:

- Medical Screening and Clearance / Stabilization / Support Services
- Addressing the Consumers' immediate personal care needs
- Comprehensive diagnostic assessment for mental health, substance use disorders, and co-occurring conditions
- Medication Assisted Treatment (MAT)
- Referrals to appropriate ASAM level of treatment in the community
- Peer Counseling and Recovery Coaching appropriate to consumer's needs and readiness to change
- Harm Reduction services and supports
- Care management and coordination post discharge
- Navigation, linkages and referrals to housing, transportation, social services, and other supports
- Diverting individuals under the influence of substances who are medically cleared from emergency rooms to a low barrier service where they can stabilize.

Numbers of Referrals made to other Agency Programs and Organizations, by Program and Service

Since the Stabilization Center opened, 129 (20%) of the individuals admitted have accepted a referral or warm hand off to a community provider for ongoing care. Everyone receives peer counseling prior to discharge, as well as a Naloxone kit and information regarding community treatment and social services. We are continuing to refine our data collection system to track service delivery outcomes.

81. Please provide the following information for the second Stabilization Center:

    a. Planned location;
    b. Project status and timeline. The justification in the approved FY2024 CIP states that the project is "a Mayoral priority [and]...will need to be opened in FY24." Is the project on track to meet that goal?

c. Outreach efforts to residents, community-based organizations and businesses, particularly those residing near the proposed Stabilization Centers, regarding the selection site process;
d. Lessons learned from the build-out and operation of the first stabilization and sobering center that will inform the second; and
e. Any plans for a third center, including location.

DBH Response:

The proposed location of the second Stabilization Center is 1338 Park Rd, NW Washington DC 20010

Project status and timeline. The justification in the approved FY2024 CIP states that the project is "a Mayoral priority [and]...will need to be opened in FY24." Is the project on track to meet that goal?

The chosen prospective site, which was first built as a fire house in Columbia Heights in 1900, is currently on the Historical Register as of 2007. This site requires an extensive environmental study, due to the age of the building, as well as clean up necessary to abate lead and asbestos currently in the building. The Department of General Services (DGS) has received the capital funds allocated in the FY24 budget to develop and release a Request for Proposal (RFP) for architectural services, engineering, and design / build work to complete the buildout, following the environmental cleanup. The RFP to select the contractor for the build out will be released in January 2024 and the selection of the vendor is expected in April. Due to the extensive renovations and restoration work necessary at the selected site, the second stabilization center is currently not expected to open until the second quarter of 2025.

Outreach efforts to residents, community-based organizations and businesses, particularly those residing near the proposed Stabilization Centers, regarding the selection site process

DBH anticipates that we will partner with the Ward One representative on the Council who supports the Stabilization Center in this area in outreach efforts.

Lessons learned from the build-out and operation of the first stabilization and sobering center that will inform the second

Due to the implementation and launch of the first Stabilization Center, we have learned a number of lessons which will inform the second Center. Securing the appropriate vendor very early in the process is critical to a successful launch. This lead time is necessary to ensure the vendor achieves DBH provider certification early as well as the ability to bill Medicaid to provide the financial foundation necessary for the long term financial sustainability of the program.

Building successful partnerships between the vendor and behavioral health providers across the service continuum as well as housing operators are critical to ensure "throughput" for consumers once discharged from the Center on their road to recovery. The first Center has yielded lessons

and insights which will be incorporated into the second Center, yielding great fruit to maximize the therapeutic impact on our consumers given their short tenure within the program.

Any plans for a third center, including location

DBH continues to evaluate the need for additional stabilization centers.

82.Please provide an update on DBH's plans to work with SAMHSA to create a pilot SUD unit at a long-term care/skilled nursing facility to allow for treatment of individuals transitionally unable to receive SUD treatment in these settings.

a. What is the timeline to implement the Substance Abuse and Behavioral Health Targeted Outreach Pilot Act of 2023 required by the FY 2024 Budget? Has the RFP been released? If so, please provide a copy to the Committee;
b. Has the grantee(s) been selected? If so, please provide the required activities and reporting requirements under the grant.

DBH Response:

Please provide an update on DBH's plans to work with SAMHSA to create a pilot SUD unit at a long-term care/skilled nursing facility to allow for treatment of individuals transitionally unable to receive SUD treatment in these settings.

DBH previously planned to submit a grant application to SAMHSA targeting older African American males in nursing homes (who currently represent the majority of the District's residents experiencing fatal overdoses), but were unable to do so during the last grant cycle. DBH plans to do so in the next SAMHSA grant cycle seeking funding for a pilot SUD unit at long-term care/skilled nursing facility (with appropriate training for their staff) to enable effective SUD / OUD treatment for this segment of the nursing home population who historically have not had access to such services.

What is the timeline to implement the Substance Abuse and Behavioral Health Targeted Outreach Pilot Act of 2023 required by the FY 2024 Budget? Has the RFP been released? If so, please provide a copy to the Committee; Has the grantee(s) been selected? If so, please provide the required activities and reporting requirements under the grant.

DBH released a Request for Application (RFA) No. RMO OTOP113023 on December 1, 2023. Selections were made by the review committee and the funding recommendation was approved by the DBH Director on January 3, 2024. Award letters with terms and conditions were then released on January 3, 2024, as follows:

Targeted Outreach Projects	
Applicant	**Location of Services**

District Bridges Application: requested $750,000*	-Columbia Heights Civic Plaza -Mount Pleasant Street, NW and Kenyon Street NW -Georgia Ave (NH Ave and Kennedy St NW)
Us Helping Us Application Requested $199,999.99*	1100-1300 blocks of Mt. Olivet Road NE
Family Medical and Counseling Services Application Requested $200,000*	3800-400 blocks of Minnesota Ave., NE
HIPS Application Requested $199,977.05*	600 Block of T Street NW

*Application amounts requested are based upon the budget submitted by the applicant.

Required Activities

Services to be provided under Competitions #1 and #2 include the following:

1. Focus on specific geographic area within participating Ward or Wards as defined by the grantor;
2. Conduct ongoing outreach and engagement;
3. Conduct mental health and substance use screenings;
4. Provide referrals and navigation assistance as needed and as accepted on a voluntary basis;
5. Provide support navigating the District's Coordinated Entry Process (assessment and housing placement) for unhoused individuals and assists in accessing recovery housing or other transitional housing supports as indicated;
6. Provides support for benefits, eligibility, and enrollment with all public benefits such as maintaining Medicaid eligibility, applying for disability benefits such as SSI or SSDI where indicated, and transportation services needed to access primary and behavioral health care;
7. Integrate peer supports where possible to promote hope the development of an alliance with formal government programs where interactions may historically have been strained and trust cannot be assumed; and
8. Collaborate with other District outreach and mobile teams such as DHS outreach providers and the Community Response Team.
9. Have within the team staff who are certified as Officer-Agents with the ability to initiate involuntary psychiatric evaluation via FD12 for an individual experiencing an acute psychiatric crisis and deemed likely to injure self or others.

Data Collection and Reporting

Each month by the 10th of the month the grantee shall submit a report for the preceding month to include:

1. The number of individuals or groups the grantee engaged through outreach efforts;
2. The number of individuals the grantee connected to substance use disorder treatment programs, primary healthcare, mental health services, housing assistance, employment support, or other services;
3. The number of overdose reversals or interventions performed by the grantee using naloxone or other overdose reversal medications;

4. The amount of harm reduction supplies distributed by the grantee, including clean needles, syringes, naloxone kits, condoms, or other materials that reduce the risks associated with drug use; and
5. The number of educational sessions, workshops or prevention activities delivered by the grantee to target populations.
6. Additionally, the grantee shall provide a listing of all staff working under the contract and any additional staff members who are working as part of a team to provide services to clients, and their individual caseloads, or a description of caseloads for the team;
7. Report unusual incidents electronically using the Department's unusual incident report database upon the occurrence of the incident to the designated DBH point of contact for the grant within 24 hours; and
8. Emergency response reporting following DBH guidance.

Data Collection and Tracking

The grantee shall submit to DBH a final report no later than 30 days after expiration of the Grant Agreement. The final report shall summarize all data collection, data analysis, findings, and recommendations aggregating what has been provided in monthly reports. DBH shall provide a template for this report.

1. Grantees should also ensure accurate reporting of any FD12's initiated; # of times services and supports from CRT or the DBH-MPD Co-Response (CoR) team are requested; # of times individuals known to the targeted outreach team are transported to the DC Stabilization Center or to any other facility to initiate treatment for a behavioral health condition.
2. Grantees should also be able to track internally referrals and enrollments in crisis residential beds, the ARC, residential SUD treatment, ACT services or a CSA; to the greatest extent possible grantees should be able to track and report when a participant starts or restarts Medication for Opioid Use Disorder (MOUD).
3. Grantees shall track the # of participants assisted through the District's coordinated entry process and/or actually connected to temporary or permanent housing.

83.Please provide a step-by-step process of the authorization and reimbursement of SUD and mental health residential treatment programs. Please including:

a. Specific roles and responsibilities of Comagine Health;
b. Average length of time for authorization; and
c. Whether there is a maximum number of stays, and guidelines for determining maximum.

DBH Response:

The District provides comprehensive SUD services, including assessment and referral services, to individuals enrolled in the Medicaid program through the Adult Substance Abuse Rehabilitation Services (ASARS) State Plan Amendment and the Section 1115 Behavioral Health Transformation Demonstration Waiver. In October 2020, DBH published a final rulemaking that updated the section of the District of Columbia Municipal Regulations on Certification Standards for Substance Use Disorder Treatment and Recovery Providers (Title 22,

Subtitle A, Chapter 63), which decentralized SUD assessment and referral services. All DBH certified SUD providers are required to provide assessment and referral services, as necessary.

When a client seeks SUD residential treatment from a certified provider, that provider must complete the required *Co-Triage* (level of care assessment) tool to determine the appropriate level of care for the individual's particular clinical presentation, and if appropriate, identify and refer the individual to an appropriate treatment provider. Within 48 hours of an individual presenting at the provider's treatment facility, the accepting provider is expected to perform the *Continuum Assessment* which determines the clinical medical necessity criteria for the requested level of care, and submits the initial clinical documentation to DC Health Care Finance (DHCF's)contracted Quality Improvement Organization (QIO), Comagine Health.

Upon admission, as part of the request for authorization for care, the provider is expected to complete a *Continuum Assessmen,* which should include the following clinical documentation:

a. Documentation of an active moderate to severe Substance Use and/or Addictive Disorder per the DSM-V;
b. An individualized, comprehensive biopsychosocial assessment of the client's Substance Use and/or Addictive Disorder;
c. An evaluation by a Qualified Provider (QP) confirming medical necessity for the requested services;
d. A medical history detailing the individual's medical conditions, and
e. For level 3.3 SUD care ONLY, description of cognitive deficits of moderate to severe intensity.

Additional information may be needed in order to determine the appropriateness of the level of care requested, such as a comprehensive urine toxicology screen results, pregnancy test results for women, and glucose levels to validate medical clearance. Failure to submit all the required documentation may lead to potential denial of payment for that service. The QIO may also request additional clinical information from the Provider to support their request for authorization for the care.

The Provider, upon receipt of prior authorization, shall perform all required Room & Board authorization requests, clinical documentation, and procedural activities required by DBH. DBH remains responsible for covering SUD Residential Treatment Room & Board, as well as ensuring that the client receives the highest quality and most appropriate care possible to address his clinical needs.

Once the QIO (Comagine) receives the authorization request, the QIO is then required to conduct clinical medical necessity reviews and communicate the authorization decisions to Providers within three (3) business days. The QIO includes the authorized time span and date(s) of concurrent review, as applicable. When clinical medical necessity criteria are met, and services are authorized, the QIO shares the authorization decision with the SUD residential treatment provider. The QIO conducts continuing stay reviews periodically during the client's treatment at the SUD residential facility to ensure the continued necessity for higher levels of care and that the client is not more appropriately served at a lower intensity level. When medical necessity

criteria are not met, the QIO communicates the denial of authorization to the Provider and provides options / recommendations for treatment in an approved level of care, as well as communicating the provider's appeal rights.

In order for the Provider to safely discharge the individual, DBH covers Room & Board for a period of up to 24 hours after the adverse benefit determination is issued to allow the provider to transition the client to a different level of care since Medicaid does not cover SUD Residential Treatment Room & Board. Failure to discharge the individual and coordinate alternate services may result in non-payment to the SUD residential treatment provider for any services rendered beyond the authorized period and recommended discharge date.

Specific roles and responsibilities of Comagine Health;

a. Comagine Health, DHCF's contracted Quality Improvement Organization (QIO), conducts substance use/residential treatment facility reviews for prior authorization and continued stay requests for substance use residential treatment facilities. These reviews are conducted either prior to or after a client's admission to a SUD Residential Treatment Facility to determine, for payment purposes, the clinical appropriateness and medical necessity for acute, more restrictive, higher levels of residential care, per ASAM (American Society of Addiction Medicine) medical appropriateness criteria. Comagine Health is required to provide a prompt approval or denial decision for each admission to the provider, the clinical reasons for the denial of authorization, and recommendations for alternate treatment modalities in the event of an authorization denial.

Average length of time for authorization

b. Per their contract with DHCF, Comagine Health is required to complete initial and concurrent reviews within three (3) business days. Currently, their initial reviews are completed within 3 days in 100% of cases, and concurrent reviews are completed within 3 days at a 98.5% rate. These timeliness numbers exceed the performance measures outlined in Comagine Health's contract with DHCF - as they are required to review both initial and concurrent reviews within 3 days 98% of the time.

Whether there is a maximum number of stays, and guidelines for determining maximum

c. As stated above, the Comagine conducts medical necessity reviews per ASAM medical necessity criteria and communicate the authorization decisions to Providers within three (3) business days. Comagine includes the authorization period and date(s) for concurrent reviews. When medical necessity criteria are met, and services are authorized, Comagine shares authorization information with the Provider. They also conduct continued stay reviews while the client is in treatment at the SUD residential facility to ensure that the client is not more appropriately and safely treated at a different level of care.

d. When medical necessity criteria are not met, Comagine communicates the denial of authorization to the Provider and provides options for treatment at a different level of care

and informs the provider of their appeal rights and the process to file an appeal. There are no "maximum number" of days that Comagine will authorize for care at a residential treatment facility. All authorization decisions are based on clinical documentation reflecting the client's needs as presented by the provider, according to ASAM medical necessity / appropriateness criteria for the level of care in question.

In-Patient Care

84.Please provide the following information for Saint Elizabeths Hospital in FY 2022, FY 2023, and FY 2024, to date:

a. Types of services and interventions offered;
b. Number of adult admissions;
c. Number of adult walk-ins;
d. Number of FTEs (broken down by type and certification/license);
e. Number of open work orders; and
f. Major facility upgrades and renovations (including plans for FY 2024).

DBH Response:

a. Types of services and interventions offered

Saint Elizabeths Hospital (SEH), an IMD (Institution for Mental Diseases) is the only public psychiatric hospital in the District that is dedicated to providing recovery-based and trauma-informed residential treatment to District residents with severe mental illnesses and substance use disorders. SEH is also a State-of-the art teaching hospital. The hospital is licensed for 292 inpatient adult beds.

b. Number of adult admissions

FY 2022 inpatient admissions = 189

- FY 2023 inpatient admissions = 316
- FY 2024 inpatient admissions (1st Qtr.) = 93, annualized = 372

Note: The hospital reduced inpatient admissions in FY 2022 and 2023 in response to the Covid-19 pandemic emergency. In FY 2024 the census is increasing back to the pre-pandemic levels.

c. Number of adult walk-ins;
SEH does not admit walk-ins.

d. Number of FTEs (broken down by type and certification/license);

- FY 24 Budget FTEs = 816.8
- Licensed Staff – RNs = 200
- Licensed Staff – MDs = 70
- Licensed Staff – Other (Psychologists, Social Workers, Pharmacists.) = 71

e. Number of open work orders;

- FY 2022 Work Orders = 3,958; open at year-end = 33
- FY 2023 Work Orders = 3,741; open at year-end = 33
- FY 2024 (YTD 12/15/23) Total Work Orders = 827; open = 15

f. Major facility upgrades and renovations (including plans for FY 2024).

1. Floor Replacement in patient care areas (FY 2023). 98% completed. $1.1M
2. HVAC Modernization – independent HVAC to medication rooms (FY 2023) – Completed - $491K
3. Upgrade Unit 2TR Nursing Station for staff safety (FY 2023) – Completed. - $100K
4. Install backdoor alarms on Nursing Units to enhance security – Completed.- $122K
5. Replace Boilers/Water heaters – Main Hospital, Kitchen (FY 2023, 2024) - 90% completed. - $800K
6. Thermal Docking Stations/Dinex System (FY 2023, 2024) – Expect 90% completion by mid-Feb. 2024 and full completion by June 2024. - $1.8M
7. Video Surveillance (Camera) Security System (Phase-1) - FY 2023, 2024 – 90% completed. Expect full completion by end of Jan. 2024.-- $0.2M
8. Video Surveillance (Camera) Security System (Phase-2) - FY 2024 - Expect full completion by end of FY 2024 - $3.3M

85. Please provide an update on the work of DBH, OSSE, and the Psychiatric Residential Facility (PRTF) Interagency Collaboration Committee regarding youth placed in PRTFs, with and without Individualized Education Plans (IEPs). How is the educational component of these placements financially supported? Please provide relevant documents (MOAs or MOUs) related to this subject.

DBH Response:

The Interagency Collaboration Committee continues to operate and work on concerns relevant to the DC Family and Child Behavioral Health System of Care (SOC). It is anticipated that in FY 24 the Committee will identify specific challenges (for youth and families) within the system and present those challenges with recommendations to the agencies' senior leadership for decisions and practice change.

This Committee is comprised of DBH and all referring government agencies (CFSA, DYRS, CSS, DCPS, and OSSE), the Managed Care Organizations, DC Department of Disability Services, and the Department of Health Care Finance. The Committee is committed to both practice and policy change.

One issue that has been resolved with OSSE has been the issue of payment for youth that had been operationally defined as "parental" or "unilateral placements" (a parent makes a PRTF placement without coming through the PRTF Review Committee or the MCO). Any referral made outside of a direct OSSE or HSCSN placement comes through the DBH PRTF Review

Committee. The PRTF Branch now has regular communication with OSSE and HSCSN regarding admission to PRTFs outside the PRTF Review Committee.

OSSE currently has MOUs with CFSA and DYRS to pay for the educational component of "committed" youth enrolled with their agencies who require placement in a PRTF and are reviewed and approved for placement by the PRTF Review Committee. However, there is no policy or MOA in effect that governs shared information with DBH. This lack of a MOA between DBH and OSSE limits DBH's ability to secure community resources for students discharged from a PRTF and address payment for educational services provided to students that receive regular education or are not system involved. The DBH PRTF Branch is collaborating with staff within the DBH General Counsel's Office to draft a MOA between DBH, OSSE and DCPS. This document will allow all agencies to share information more easily and outline the responsibilities of each agency.

Currently, when a student with general education requires PRTF for behavioral and emotional needs, the referring agency will have to negotiate with the PRTF to waive the educational fee or pay for educational services using their local dollars.

86. In FY 2023 and FY 2024, to date, how many children were discharged from inpatient psychiatric hospitalization or psychiatric residential treatment facilities and received in-home and community-based mental health services?
    a. Please include CBI, intensive care coordination, and intensive case management services—within 30 days, 60 days, or 90 or more days of their discharge.

DBH Response:

In FY23, 311 youth were discharged from a community hospital inpatient psychiatric hospitalization and received in-home and community-based mental health services. Of the youth discharged, 12 youth received CBI within 30 days, four youth received CBI within 60 days, two youth received CBI within 61 days, and 53 youth were engaged in CBI within 90 days or more. In FY24 YTD, 244 youth were discharged from a community hospital inpatient psychiatric hospitalization. Of the youth discharged in FY24 YTD, nine youth received CBI within 30 days, three youth received CBI within 60 days, zero youth received CBI within 90 days, and 31 youth engaged in CBI within 90 or more days. In addition to CBI, additional Mental Health Rehabilitative Services (MHRS) are available to youth based on recommendations of the discharge plan from the hospital. Additional services include medicine management, therapy, community support, substance use services and/or group. Data shows of the youth discharged from inpatient treatment in FY23, 293 youth were involved in additional services within 90 days or more. In FY24 YTD, 232 youth were involved in additional services after 90 days.

In FY23,15 youth were discharged from a Psychiatric Residential Treatment Facility (PRTF). Out of the 15 youth discharged, 5 youth received CBI within 90 or more days. In FY24 YTD, 2 youth were discharged from PRTF and zero youth received CBI. The other youth discharged from a PRTF received community support, therapy, medication management, High Fidelity Wraparound, and Assertive Community Treatment (ACT).

Violence Prevention and Response, Department of Corrections & Behavioral Court Diversion

87. Please provide the following information regarding DBH's role in the District's city-wide violence prevention and response strategy:
    a. The name(s) of DBH staff who lead DBH's violence prevention and response work within the agency;
    b. The number of DBH staff, including titles, grade, and percentage of time spent on violence prevention and response;
    c. How DBH works with hospital-based violence interruption programs, such as those at MedStar Washington Hospital Center, Children's National Hospital, and the Howard University Center of Excellence; and
    d. DBH's budget and spending (in Microsoft Excel) in FY 2022, FY 2023, and FY 2024, to date, on violence prevention and response programming and resources.

DBH Response:

DBH's violence prevention and response work is led by Dr. Richard Bebout, Chief of Crisis Services. The Access Help Line (AHL), the Community Response Team (CRT), the Comprehensive Psychiatric Emergency Program (CPEP), and the Disaster Services programs all operate under Dr. Bebout's oversight. The Crisis Services teams frequently participate in responding to individuals, communities, and both governmental and non-governmental organizations experiencing traumatic events. Much of DBH's work is related to trauma-recovery. In addition, the school-based behavioral health program prevention curriculum includes improving emotional self-regulation, problem-solving and interpersonal skills which promotes healthy decision making and mental wellness that support violence prevention. While we know that more than half of the clinician time is spent on prevention and early intervention. We do not track the percentage of time per individual.

DBH participates in cross agency and District wide violence prevention and response. Last fall, DBH participated in a day long tabletop exercise with a cross-section of agencies in the victim services arena. Convened by the City Administrator and the Office of Gun Violence Prevention, CJCC director Kristy Love facilitated the day which was designed to promote greater awareness and cross-talk between agencies and across clusters, to begin to inventory programs and "assets" already in place to support victims of gun violence and other trauma, and to discuss strategies for filling gaps and improving coordination.

Most recently, Dr. Bebout was assigned as DBH point-of-contact for the THRIVE initiative kicked off this month by DMPSJ Appiah and MPD Chief Pamela Smith. THRIVE is a 2024 homicide reduction partnership plan focused on three high risk PSAs and communities in Wards 5, 7 and 8. This work builds on multi-year cross-agency, cross-sector work that created task forces to address unique and shifting challenges in targeted areas such as U Street NW, H Street NE, and Minnesota Avenue, NE. CRT participates regularly in such task force efforts. CRT also responds frequently to support requests following homicides. CRT receives requests from and communicates regularly with ward-based teams from Mayor's Office of Community

Relations and Services (MOCRS) in the wake of homicide or other traumatic events and responds to many requests come directly from community partners familiar with CRT.

88.Please provide the following information for the Behavioral Court Diversion program in FY 2023 and FY 2024, to date:

a. A description of which youth are eligible to participate in the program;
b. The process or protocol of selecting or referring youth to the program;
c. The number of youth who participated, including the type of status offense they were alleged to have committed, the referral source (i.e., judge, probation officer, prosecutor, etc.) and the outcomes for youth in the program;
d. The number of youth who received CBI services through the Juvenile Behavioral Diversion Program;
e. The number of youth who received CBI services through the Family Court Social Services Division;
f. The average and median wait time for a first appointment with a psychiatrist after referral from the Juvenile Behavioral Diversion Program and the Family Court Social Services Division;
g. The recidivism rate of the youth participants and an explanation of how recidivism rates are measured;
h. All costs associated with the program; and
i. The program's capacity and any expansion plan or barriers to expansion.

DBH Response:

The Juvenile Behavioral Diversion Program (JBDP) is a voluntary, mental health-based solution or specialty court that provides intensive case management and mental health services to youth in the juvenile justice system with significant mental health concerns. The JBDP has operated within the DC Superior Court Juvenile Division since January 2011. This program connects and engages juveniles and their caregivers/families in appropriate community-based mental health services and supports and provides for a period of engagement during which time the court monitors both the implementation of mental health services and the youth and families' participation in those services. Court-involved juvenile status offenders are given the option of voluntarily participating in mental health services rather than being prosecuted. If successful, participants can have their cases dismissed or shortened lengths of probation sentences.

The goals of the program are to: (1) increase the number of youth able to remain in the community with improved functioning in the home, school and community with appropriate mental health services and supports, (2) reduce the likelihood of the youth's further contact with the criminal justice system as a youth and later as an adult, and (3) to reduce crime in the community and protect public safety. This program is intended for children and youth who are often served within multiple systems who are at risk of re-offending without linkage to mental health services and other important supports. Participants are required to attend regular court status hearings to monitor progress and to participate in mental health services and other specified court conditions. Youth generally participate in the program from three months to one

year, depending on the pace of their overall progress towards individualized goals, as determined by the "team," i.e., all individuals assisting in the youth's service plan (e.g., the youth/family/service providers/probation officer/defense counsel/Education Attorney/AAG and JBDP Judge).

a. The Juvenile Behavioral Diversion Program (JBDP) serves juvenile offenders who are 18 years of age or younger at the time of the instant offense. All court-involved youth receive mental health screening at the time of initial intake, following arrest. Youth are administered the Connor's Comprehensive Behavior Rating Scale (CBRS) which measures social, emotional, behavioral and academic problems in children and adolescents ages 8 to 18 years. Additionally, youth are administered the Sex Trafficking Assessment Review (STAR) to determine a child or adolescent's risk of sexual exploitation in the community. These screenings are used to initially identify youth who may be appropriate for either the JBDP or Here Opportunities Prepare You for Excellence (HOPE) Court for youth at-risk or involved in the commercial and sexual exploitation of children (CSEC).

Determining eligibility for the JBDP is a two-step process. The Office of the Attorney General (OAG) reserves the right to permit or deny a youth to participate in the program on a case-by-case basis as an initial step in determining a youth's overall eligibility for the program. The OAG makes its determination of "legal eligibility" based on a variety of factors including prior and current contacts with the court, nature and circumstances surrounding the offense, mental health needs, and other relevant social factors. The second step in determining eligibility is a referral to the "Suitability Committee" of the JBDP. There, the Committee determines if the youth meets basic, clinical criteria, i.e. (1) the presence of a primary mental health diagnosis and/or substance use disorder and (2) that the youth is able to participate in community-based services at the time of entry into the program. The Committee then takes into consideration multiple, additional factors that may impact a youth's ability to fully participate in the program, utilizing a biopsychosocial model of assessment, to determine final, clinical "suitability."

The Suitability Committee transitioned to meeting virtually via Microsoft Teams in April 2020 due to the pandemic. The transition was smooth and has not hindered the Committee's work in any way or caused disruption to the workflow. Meetings continue to be held in a virtual forum with no plan to shift to in-person for the foreseeable future.

b. A juvenile offender can be referred to the JBDP by the initial hearing judge, the juvenile calendar judge, the Assistant Attorney General (AAG), the youth's defense attorney or a Court Social Services Probation Officer. Once a juvenile is deemed legally eligible, a referral is made to the Suitability Committee whereupon clinical eligibility is determined. The Suitability Committee, co- chaired by a DBH and a Court Social Services Division (CSSD) representative, is otherwise comprised of members from CSSD, the Child Guidance Clinic (CGC), and the DBH "preferred providers," i.e., those Community Services Agencies (CSAs) that are affiliated with the JBDP. These CSAs provide services to the majority of the youth in the program and collectively offer the range of services most highly utilized by program participants, including trauma-focused services. Following the clinical review, the Committee establishes recommendations for individualized services for each youth that are both comprehensive and

holistic. These recommendations are forwarded to all court officials involved in the youth's case, regardless of their outcome of eligibility for the program. The Committee's recommendations can be implemented outside of the JBDP, should a youth decline to enter the program or voluntarily op-out later. All youth enrolled in JBDP receive mental health services through the DBH provider network (or outside DBH's network, as needed) and are supervised by specialized probation officers (trained in the mental health System of Care of DC) of Court Social Services Division (CSSD).

c. The number of youth who participated in the JBDP program in CY23 is 56. The number of youth participating in JBDP thus far in CY24 is 29. There are currently 12 cases pending entry, i.e., cases found legally eligible and clinically suitable but are in various stages of legal preparedness for entry to the program. Though referrals can be prompted by multiple court or community sources, i.e., judges, probation officers, defense attorneys, etc., it is the OAG that ultimately becomes the main referral source, as all referrals must first be found legally eligible by the OAG. Once legal eligibility is established, a referral is sent by OAG to the Child Guidance Clinic of CSSD, where the clinical referral packet is compiled for review for the Suitability Committee.

Below is a chart that details enrollment and case resolutions (Graduated/Terminated ("Certified Back")/Charge Dismissed) for youth since the program's inception in CY2011.

JBDP Enrollment Stats
CY2011-2023

Enrollment Year	Graduated	Terminated	Charge Dismissed	Active	Pending	Transfer to HOPE	Total Enrolled
2011	30	24	--	0	0	--	54
2012	37	25	--	0	0	--	62
2013	26	13	3	0	0	--	42
2014	35	16	3	0	0	--	54
2015	30	9	4	0	0	--	43
2016	45	13	2	0	0	1	61
2017	40	32	15	0	0	8	95
2018	26	19	11	0	0	0	56
2019	23	15	7	0	0	1	46

2020	**15**	**8**	**7**	**0**	**0**	**0**	**30**
2021	**20**	**11**	**0**	**2**		**0**	**33**
2022	**15**	**13**	**4**	**2**	**0**		**34**
2023	**5**	**6**	**0**	**25**			**36**
Totals	347	204	56	**29**	0		**646**

The chart below details the types of offenses committed by youth in CY23.

Type of Offenses	**Number of Offenses Of all youth enrolled in CY 23**
Unlawful Entry and Assault (Threats- Mis. & Felony, Simple Assault, Assault on Police, Disorderly Conduct), Panhandling	36
Theft (Shoplifting, Receiving Stolen Property, Theft I & II), conspiracy	9
Robbery – UUV-Unlawful Entry Motor Vehicle, Burglary-No Permit	15
Destruction of Property/Fare Evasion/Disorderly Conduct	5
Runaway	1
Truancy	0
Sex Abuse	0
Possession of Weapon/Ammunition	35
Robbery while armed/Assault with Weapon/Carjacking/Unlawful Discharge of Weapon	22
Possession of Controlled Substance	0
Credit Card Fraud	1
Total Offenses	**124***

*Youth are often charged with multiple offenses. This list includes pre- and post-adjudicated charges

d. Of the 56 youth that were involved in JBDP in CY23, 21 youth are receiving or have received Community-Based Intervention (CBI) services, i.e., CBI I (Multisystemic Therapy (MST), CBI II and III, and CBI IV (Functional Family Therapy (FFT)) for a total percentage of 38%. This data point indicates that a very high percentage of youth participants of the JBDP meet criteria for the most intensive, community-based services that DBH offers, further indicating that JBDP youth participants are among the highest at-risk youth (and families) served by DBH through this one program. Although CBI was not provided to all youth involved in JBDP, participants received services from an array that are offered through the Mental Health and Rehabilitation System (MHRS) through DBH, e.g., community support, individual and family-based therapies, evidence-based practices (Trauma-Focused CBT, Trauma Systems Therapy, High Fidelity Wraparound, Transition to Independence Process (TIP) and Transition Age Youth (TAY) services), and substance use services. Each youth enters the program with a preliminary, individualized plan for services and treatment created by the Suitability Committee following a

comprehensive review of the case. The plan is then implemented once the youth enters the program and is adjusted per the needs of the youth and family as they progress through the program. Recommendations for services while in JBDP are based on clinical determinants, services already in place, willingness to engage in intensive services and service criteria.

e. DBH does not have access to the universe of youth involved with Family Court Social Services Division. Therefore, we are unable to provide the number of youth receiving CBI services through Court Social Services Division.

f. The average and median wait time for a first appointment with a psychiatrist is within a two-week period from the time of referral for medication management, per the protocols established with preferred providers of the program. However, advocacy is made on a case-by-case basis by the DBH Program Coordinator to assist program participants in securing earlier appointments with the youth's Core Service Agency (CSA) or through DBH's Howard Road, in the event of an urgent need.

g. Court Social Services' Child Guidance Clinic (CGC) is responsible for collecting and analyzing the majority of the JBDP data. Recidivism is defined as "a plea or found involved" in a crime up to one year after completion of the program. The data collected to date for the CY2022 cohort indicates a recidivism rate of 24%, far below the national average of 43% to 50%. Recidivism rates are calculated one-year post-graduation. Since youth enter and exit the JBDP on a rolling basis, data cannot be analyzed until the entire cohort for the year has reached one-year post-graduation. Therefore, the rate of recidivism for the CY2023 cohort is not yet available as not all participants have reached the one-year post-graduation mark.

Below is the recidivism data for the JBDP since the program's inception in calendar year 2011.

Calendar Year	Total Number of Youth Enrolled	Total Youth w/ Reconvictions within 12 months of exiting JBDP	Recidivism Rates
2022*	34	8	24%
2021*	33	15	45%
2020	25	7	28%
2019	47	10	21%
2018	56	17	30%
2017	95	19	20%
2016	61	9	14.5%
2015	33	6	18%
2014	54	12	22%
2013	42	6	14%
2012	62	19	30%

*excludes info for youth who exited the program < 12 months; 2019 to 2021 calculated per youth vs. per reconviction

h. The cost to the Department is the salary for one FTE social worker at the current rate of $133,558.00.

i. The program capacity is 100 youth per year. There is no plan for expansion at this time as the program has not consistently reached capacity in its years of operation. However, there is currently an initiative from the OAG to increase its referral numbers over the next year and beyond to bring the program's enrollment numbers to its capacity. As the primary determiner of referrals to the program, OAG is mainly responsible for the flow and number of referrals to the program. While the Suitability Committee has the ability to rule out referrals that do not meet clinical eligibility, the vast majority of cases that are reviewed are found "*suitable*." Youth who are referred to the program, having been found to meet both legal and clinical eligibility, still have the right of refusal to enter the program and may opt for an alternative offer of case resolution for a variety of differing reasons, e.g. they don't want to participate in mental health services, they don't want the increased structure and oversight of the JBDP, they don't want to attend more frequent court hearings or perhaps they have been offered another less intensive option.

89.Please provide an update on the DBH services to consumers under the custody of the Department of Corrections, including services provided in the READY Center.

DBH Response:

DBH supports individuals with behavioral health needs in the custody of the Department of Corrections (DOC). The Forensic Services Division links individuals to behavioral health services, track the contact of returning citizens with DBH community-based providers monthly, and report ongoing performance data to relevant partners including DOC. DBH staff link on average 80 individuals to behavioral health services per month.

To further assist individuals in custody, Forensic Services staff provide DOC and Unity, its contracted healthcare provider in the DC Jail, with individual pertinent mental health information. Forensic Services staff cross-reference electronic medical records to identify whether new admittees have received mental health services locally and, if so, their diagnosis, treatment provider, and when last seen. These efforts expedite the identification of individuals who need help and promote the continuity of care and services while incarcerated.

DBH works closely with Unity Health Care's discharge planning team at DOC to maximize follow-up in the community after individuals with known behavioral health challenges are released. Funding was identified through a technology transfer grant from the National Association of State Mental Health Program Directors to incentivize high-need individuals to

keep mental health appointments upon release from DOC custody. Additionally, a DBH liaison at DC Superior Court works with DOC representatives daily to link incarcerated residents who are suddenly released from the courthouse to the community.

Unity consistently is proactive about arranging immediate community follow-up for MAT participants, has expanded its distribution of naloxone upon release, and now has the ability to provide greater prescription coverage for MAT upon release so individuals have up to a week to be connected or re-connected to a provider in the community.

The State Opioid Response (SOR) grant supports two substance use disorder (SUD) treatment units in DC Jail: one for women and one for men. There is daily therapeutic programming including the use of the Trauma Addiction, Mental Health, and Recovery (TAMAR) model. In FY23, there were 57 individuals who were served on the women's unit and 156 individuals on the men's unit. The women's unit is now undergoing renovations and DOC plans to reopen it in the next few weeks.

In addition to residents on the units, other individuals in the jail can receive medication for opioid use disorder (MOUD). In September 2023, 255 individuals received buprenorphine, 60 received methadone, and 2 received naltrexone. There were 56 individuals who received naloxone upon release from the jail in September. This September snapshot represents approximately the average number of individuals receiving MOUD and naloxone in the DC Jail on a regular basis.

SOR also supports the peer workforce development program, which in FY 2022 moved from under its College and Career Readiness division to DOC READY Center. Due to the change in management, the program began implementation in February 2023. There were 56 new participants in the program in FY 2023.

DBH Crisis Calls

90.Please provide the following information for the Community Response Team in FY 2022, FY 2023 and FY 2024, to date:

d. Number of calls from 911 diverted to DBH;
e. Types and percentages of services billed to insurance or Medicaid;.
f. Number of Helpline/Mental Health Hotline FTEs;
g. Number of Community Response Team FTEs (indicate whether staff are full or part-time);
h. Number of vacancies on the Community Response Team;
i. Helpline/Mental Health Hotline budget and spending;
j. Community Response Team budget and spending;
k. Number of calls received and responded to;
l. The locations where the team was dispatched, by ward;
m. Breakdown of how many calls related to children and youth or adults; and
n. Top 5 types of crises addressed.

DBH Response:

Community Response Team (CRT)			
	FY22	FY23	FY24 YTD
# of calls diverted from 911	470	644	212
AHL Budget	$3.5M	$2.4M	$3.0M
AHL Spending	$1.8M	$1.7M	$.6M
CRT Budget	$11.3M	$12.3M	$10.6M
CRT Spending	$5.9M	$8.3M	$2.7M
# Referrals to CRT	5,829	7,058	1,645
#Referrals—Children/Youth	21	556	205
#Referrals—Adults	5,808	6,502	1,440

DBH received 470 calls from 911 in FY22, 644 in FY23, and 212 in Q1 of FY24. DBH and OUC, together with partners from MPD and FEMS, received a second year of intensive technical assistance from the Harvard Kennedy School's Government Performance Lab GPL). With the support of the GPL, the cross-agency workgroup reached consensus to increase from 1 to 6 the number of eligible call-types and reduced from 9 to 3 the number of exclusionary criteria. These changes were informed by a national scan of alternative 911 response programs that collected data that demonstrated scale and impact, addressed racial equity, and proved safe for individuals in crisis, community members, and responders. The implementation of the new inclusion and exclusion criteria is being phased in and integrated into the standardized triage questions used by OUC call-takers.

During FY24, OUC will fully implement "PowerPhone," a technology platform that uses algorithms to instruct call-takers where to send each call. Though the year-over-year data show incremental increases, the PowerPhone implementation, coupled with the expansion of eligible call types, is projected to yield as much as a ten-fold increase in the number of 911 calls being diverted to DBH.

While the majority of diverted 911 calls are resolved by AHL call-takers by providing telephone support alone or followed by linkage/referral, between one-quarter and one-third of 911 calls diverted to DBH result in the deployment of a mobile crisis team from CRT. AHL currently has 21 of its 31 FTEs filled and 10 positions in recruitment. CRT currently has 47 staff on board with all 18 vacancies in recruitment. The vacancy rate reflects the overall behavioral health workforce shortages reported nationally as well as the unique challenges presented by operating 24/7 in-person with very high-need individuals throughout the community, not in an office or virtual environment.

Crisis Services became Medicaid billable first through the 1115 Waiver and later through the inclusion of these services in the Medicaid State Plan Amendment (SPA). CRT can bill two codes—one for *Mobile Crisis Intervention* (S9484 U1) which is billed as an hourly rate, and one for *Behavioral Health Outreach* (H0023) which is billed on a per-service basis. CRT generated about $1.5 million in claims revenue in FY22 and nearly $1.8 million in FY23 though collection numbers are not yet final due to the claims adjudication process. CRT also performs many duties that are not Medicaid billable.

Reported growth in demand is also substantiated by comparing year-over-year referral volume. In FY 22, CRT received 21 referrals for children and youth and 5808 referrals for adults compared 556 referrals for children and youth and 6502 referrals for adults in FY 23. In the first quarter of FY24, CRT received 205 referrals for children and youth and 1440 referrals for adults. The increase to CRT for crises involving children and youth reflects CRT's assuming overnight and weekend responsibility for ChAMPS referrals beginning in Q2 of FY23. Even examining the adult referrals alone, CRT experienced a 12% increase in FY23 compared to FY22. The total increase in calls for service from FY 22 to FY 23 is 21%.

Community Response Team Referrals			
	FY 22	FY 23	FY 24 Q1
Children/youth	21	556	205
Adults	5,808	6,502	1,440

CRT is working with the iCAMS team to improve forms so that data can be captured more completely and reliably while minimizing the burden on mobile responders entering documentation in the field. The existing coding system includes too many distinct crisis types, too many text fields, and too few sortable data fields with streamlined drop-down menus. This leads to incomplete data capture and unacceptable interrater reliability. CRT reports informal consensus that the following categories represent the five most common types of crisis calls addressed, in order:

(1) Symptomatic (Without Suicidal or Homicidal Ideation);
(2) Self-Neglect/Extreme Inability to Care for Self;
(3) Suicidal Ideation (With or Without a Specific Plan);
(4) Homicidal Ideation (With or Without an Identified Target) or Current Threat of Violence;
(5) Hoarding

91.Please provide a detailed narrative on the training requirements for Community Response Team members in handling crises involving children and youth. Please include the types of assessments employed with youth in crisis, the team's approach to collaborating with the child's family during such events, the average duration of deployment for crises involving children or youth, and the number of times in FY 2023, and FY 2024, to date when the Community Response Team called MPD to a crisis involving children or youth.

DBH Response

To prepare to share in the administration of the ChAMPS youth mobile crisis program when the contract was restructured early in 2023, CRT team members completed CFSA mandated reporter training, suicide assessment training for children and youth, and supervisory staff (team leads and team supervisors participated in on-site training with ChAMPS staff at Anchor Mental

Health/Catholic Charities. CRT staff also participated in ride-alongs with Anchor staff responding to youth mobile crisis calls. Staff received additional training in the use of the Columbia Suicide Severity Risk Scale (C-SSRS) which is normed for both youth and adults. CRT staff also ask additional violence/lethality and safety questions that are built into the CRT intervention form in iCAMS.

As part of continuous quality improvement efforts in the child/adolescent mobile crisis arena, CRT identified the need for more child and youth directed training to enhance responses to this population and improve outcomes. In Q2 of FY24, CRT plans to implement program-wide communication and de-escalation training to be utilized with all cases with a specific emphasis on child/youth/families. Additionally, the DBH Crisis Division is creating a new position to strength child/youth crisis and trauma support services. The incumbent will coordinate community trauma response across all divisions internal to DBH including the Child and Family Services (CAFS) division and school-based behavioral health (SBBH) and externally with ChAMPS to identify trainings that will support CRT's efforts to provide the most appropriate and effective care to the children and youth ages 5-17.

Although intervention form captures start and stop times for direct, in-person or collateral interactions, we currently are not able to capture and report total time required per deployment including travel time. We expect to report on this metric reliably in the future with further integration of the AHL Customer Relationship Management technology and planned implementation of geo-tracking software. As noted elsewhere, CRT is working with the iCAMS team to update forms to hard-code this information in required fields if and when MPD assistance is requested. For youth mobile crisis calls, CRT generally only requests MPD assistance if FD12 transport support is needed.

92.Please provide an update on DBH's implementation of the National Suicide Hotline Designation Act of 2020, which created a new 9-8-8 universal telephone number for the purpose of suicide prevention and mental health crisis response. Please include for FY 2023 and FY 2024, to date:

a. DBH cost for 9-8-8 implementation;
b. Number of FTEs for 9-8-8 and number of vacancies (please indicate which staff are contractors);
c. Number of calls received through 9-8-8, by month;
d. How 988 is operating with/within the Access Helpline;
e. The average response time for calls, including the longest and shortest wait times that occurred to date, as well as the average;
f. Data that the implementation of 988 has replaced calls for mental health-related issues to 911;
g. Protocol for service, follow-up, or referral;
h. Description and number of each call type;
i. List of languages in which 988 services are provided; and
j. Please summarize the findings of any review or evaluation of these services and attach any relevant reports.

DBH Response:

While DBH has been awarded grant funding to support the 988 implementation and expects to begin implementing those federal supplemental grants in FY2024, to date no costs or spending can be tied directly to the 9-8-8 implementation. To date 988 has not had dedicated call-takers within AHL per se, rather all center staff have responded to all call types of calls regardless of how they enter the queue. AHL has a total of 31 FTEs budgeted of which 21 are currently filled with 10 vacant positions in active recruitment.

In FY23, DBH received a total of 9,758 calls through the 988 Suicide & Crisis Lifeline. In the first quarter of FY24, we received 2685. (Comparing Q1 for FY24 against FY23 call volume we note an additional 19% increase in Lifeline calls year-over-year.) Monthly totals appear in the table below:

Oct. 2022	680	Oct. 2023	955
Nov. 2022	785	Nov. 2023	839
Dec. 2022	796	Dec. 2023	891
Jan. 2023	814		
Feb. 2023	734	Total YTD =	2685
Mar. 2023	833		
Apr. 2023	793		
May 2023	827		
June 2023	804		
Jul 2023	884		
Aug 2023	831		
Sept. 2023	988		
Total =	9769		

Call types cannot be broken out reliably. Historically, one of the challenges has been getting call-takers trained to manually enter call data into unsophisticated repository that was labor intensive and overly reliant on text fields. A further challenge stemmed from the fact that non-suicidal calls may be placed through the 988 Suicide & Crisis Lifeline and calls involving genuine suicidal crises could arrive through multiple pathways and were not restricted to the Lifeline. However, full implementation of the new *SalesForce* based Customer Relationship

Management (CRM) system in FY24 will support much more granular reporting and interrater reliability.

Vibrant Emotional Health, SAMHSA's national 988 Lifeline administrator, provides monthly reports on each center's performance. AHL's average answer speed for 988 calls in FY23 ranged from 5 seconds in February to a high of 46 seconds in April with an average of 23 seconds. It is important to note that AHL is one of roughly 200 affiliated Lifeline call centers nationwide. Calls that are not answered during the prescribed time-period (maximum allowable limit is 2 minutes) are automatically rerouted to another center in the network.

DBH's call center, known as the Access Helpline (AHL), has served continuously as the District's sole National Suicide Prevention Lifeline affiliate for many years and maintains its accreditation through the American Association of Suicidology. The activation of the 9-8-8 three-digit call code and rebranding of the 9-8-8 Suicide & Crisis Lifeline on July 16, 2022, were expected to increase call volume. By comparing the April through June in 2023 to the same three-month period before the 988 launch in 2022, DBH observed a 30% increase in calls to the Lifeline, consistent with national projections.

National evaluators are working to estimate that number but there is no one-to-one correlation and it would be difficult to do this locally. Clearly, the public desires an alternative to 911 for low-risk mental health related calls and 988 will increasingly become a viable alternative over time. Quantifying this is complicated by the fact that 988 calls are currently routed based on the area code of the phone the caller uses rather than being geo-routed in the same manner as 311 and 911 calls. The Federal Communications Commission, SAMHSA, and many states are seeking a resolution that will allow for a more vigorous public information campaign to promote 988 as an alternative to 911 and not limited to suicide-related concerns.

As reported elsewhere (see Q93), DBH is working to migrate certain administrative functions out of AHL to allow staff to focus more narrowly on crisis calls in part because of the continued growth in demand that is projected as the 3-digit dial code becomes more fully socialized. Some AHL functions shifted effective October 1, 2023, and others are expected to move beginning April 1, 2024. Heretofore, all call-takers have been trained to respond to all call types and incoming pathways, including crisis and warm-line calls, 911 diversion calls, 988 Lifeline calls, and others. Moving forward, AHL will begin to preferentially route certain call types to specific call-takers who will specialize, for example, in responding to 988 and 911 calls diverted as part of the shift away from an automatic law enforcement response to behavioral health crisis. Although we expect all call-takers will still need to be trained to respond to the full range of call types, specialization will be needed to respond to different sub-populations (e.g., LGBTQ youth) and modalities (e.g., chat and text).

While we are unable to report the exact number of encounters or the specific languages supported by AHL for 988 callers, Lifeline callers have access to interpreter services described in response to Q48.

Attached please find a year-end report prepared for SAMHSA by Vibrant Emotional Health that details our center's performance. Despite having achieved and sustained in-state answer rates at or above the national standard of 80% in 2022 and 90% effective July 2023, AHL experienced a drop after OCTO implemented a new automated call distribution (ACD) telephone technology. AHL concurrently implemented workflow changes and co-located some call-takers at OUC, the District's 911 call center, all of which contributed to the drop in performance. DBH worked for several months with OCTO, SAMHSA, Vibrant, and a nationally known call-center consulting group to contractor to troubleshoot the issues impacting our answer rate. We returned to acceptable levels of performance early in FY24 and continue to monitor performance closely. Our "in-state" answer rate for December was 82% (731 of 891 calls) as reported by Vibrant.

The average answer rate for the past 4 weeks based on data from OCTO is 91%. We are working with OCTO and SAMHSA to identify factors contributing to discrepancies between the national data reported and the local queue performance data we receive from OCTO. It is important to remember that the 988 Suicide & Crisis Lifeline is a network of 200 call centers and calls that are not answered in a timely fashion are automatically rerouted so that no one's call goes unanswered.

93.Please provide the following information on the transition of the AccessHelpline to the Managed Care Organizations:

o. Timeline of this transition;
p. Changes to key functions of the AccessHelpline;
q. Changes to staffing levels;
r. The strategies and mechanisms in place to ensure a seamless and efficient transition for individuals seeking behavioral health support;
s. Anticipated changes in service accessibility, responsiveness, or outreach strategies, considering the shift to MCOs; and
t. Description of training or preparation initiatives for Access Helpline staff to adapt to the changing landscape.

DBH Response:

The functions DBH's Access Helpline (AHL) has historically performed fall into two broad categories—(1) crisis call center functions, and (2) resource brokering and linkage. DBH and AHL will retain all crisis line functions for individuals experiencing behavioral health crises, to include serving as the District's sole 988 Suicide & Crisis Lifeline affiliate. In fact, AHL is working to innovate and add new services, such as text and chat as well as follow-up services. We continue to recruit to fill all budgeted FTEs to perform the crisis line functions and to meet the future growth in demand that is projected as we educate the public about 988 both locally and nationally.

It is important to note that DBH saw a 30% increase in Lifeline calls in the first year after the 3-digit call code went live on July 16, 2022, without a full-scale public information campaign. We are working to adopt new technology such as geolocation capability to guide the deployment of mobile crisis teams and to track available resources in real-time.

In contrast to AHL's crisis call center responsibilities, provider enrollment functions and the management of pre-authorizations and continuing authorizations for specialty services will shift to the MCOs effective April 1, 2024. DBH and DHCF are meeting at least bi-weekly with the MCOs to ensure a seamless transition for individuals already enrolled in care as well as those seeking behavioral health support for the first time. DBH is providing the MCO's with the tools and criteria needed to determine eligibility for specialized services so that authorization decisions based on medical necessity will continue unchanged, at least for the first 18 months following the switchover.

We recognize that individual, provider, and stakeholder behavior will not change overnight, and AHL staff will work closely with care coordinators at each of the MCOs to support their members in accessing needed services. Staff are currently working to refine at-a-glance guides containing key phone numbers and essential workflows to enable AHL call takers to effectively assist callers to navigate in the new system of care. Existing DBH outreach and care coordination efforts will continue uninterrupted. Ultimately, the integration of all behavioral health services into the managed Medicaid plans is expected to improve system performance on many key performance indicators and lead to better outcomes for individuals with complex behavioral health and primary care needs by promoting whole-person care and aligning outcomes with financial incentives through pay-for-value mechanisms and robust data tracking. Training for AHL staff to operate in the new Medicaid Managed Care environment will be finalized by February 15, 2024, and joint meetings will be held with the care coordination teams at each of the managed care plans.