Community Consumer Submission 3 (CCS 3) Extract Specifications Version7.6

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Revision History

Date	Version	Author	Description
7/1/2009	1.0	P. Gilding	Original for Fiscal Year (FY) 2010
7/1/2013	7.1	P. Gilding	Update for FY 2014
1/1/2014	7.1 Rev1	P. Gilding	Revision for Mid-Year Release, FY 2015
1/1/2014	7.2	P. Gilding	Consolidated for FY 2015
1/1/2015	7.3	P. Gilding	First update for FY 2016
7/1/2015	7.3.1	P. Gilding	Second update for FY 2016
7/1/2016	7.3.2	P Gilding	First update for FY 2017
7/1/2017	7.3.3	P. Gilding	Update for FY 2018
7/1/2018	7.4	P. Gilding	First Update for FY 2018
10/30/2018	7.4.1	P. Gilding	Second Update for FY 2018
3/4/2019	7.5	S. A. Elmore, PhD	Update for FY 2020 implementation
6/1/2019	7.5.1	S. A. Elmore, PhD	First update for FY 2020
12/20/2019	7.6	S. A. Elmore, PhD	Update for FY 2021 implementation

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Purpose and Scope of CCS 3

Purpose

The Department of Behavioral Health and Developmental Services (Department) developed these CCS 3 Extract Specifications in collaboration with the Data Management Committee (DMC) of the Virginia Association of Community Services Boards (VACSB). The Department, in partnership with community services boards and the behavioral health authority (CSBs), uses the Community Consumer Submission (CCS) to comply with federal and state reporting requirements, including those in the federal substance abuse Treatment Episode Data Set (TEDS) and federal mental health (MH) and substance abuse block grants (MHBG/SABG); to submit data to state funding sources, including the General Assembly and Department of Planning and Budget; and to produce data about the performance of the public mental health, developmental, and substance use disorder (SUD) services system. State and federal policymakers and decision-makers and many others use this CCS data. The CCS provides data for comparisons of and trends in the numbers and characteristics of individuals receiving direct and contracted mental health, developmental, and substance use disorder services from CSBs. Version 7.6 incorporates all revisions made to the Specifications since Version 7, issued in 2009, and shows changes from Version 7.5.1 in red and purple text.

This document provides CCS 3 extract specifications to CSB information technology (IT) staff and vendors for reporting data about individuals and services through the Department's CCS process. The principal audiences for this document are Department and CSB staff and CSB IT vendors involved with collecting, reporting, and using data about individuals receiving services and the direct or contracted services they receive from CSBs. CSB staff and IT vendors responsible for implementing CCS 3 should review and must adhere to these Extract Specifications and the current CCS 3 Business Rules, incorporated by reference into these Specifications and distributed with the current CCS 3 application release. These rules establish acceptable parameters and validation criteria for CCS 3 data elements and describe error-checking routines and operations. CSB IT staff and vendors also should review and must adhere to applicable parts of the current core services taxonomy, such as service and service unit definitions. The extract specifications are incorporated into and made a part of the current community services performance contract by reference.

Core Services Taxonomy 7.2 and the FY 2010 Community Services Performance Contract eliminated requirements for reporting data in Community Automated Reporting System (CARS) reports about the numbers of individuals who received services and units of service they received because this data is now reported through the CCS. Eliminating redundant reporting requirements reduced data errors and improved the completeness and accuracy of CCS data.

Scope

Through CCS 3 Version 7.6, the Department collects 87 required data elements from CSBs about services and individuals in a secure single submission to the Department. CCS software does not require any additional data entry. Instead, CSBs extract data from their local information systems or electronic health records (EHRs) by exporting the data into the CCS application for the creation and transmission of required files.

The CCS is a compilation of demographic, clinical, and descriptive data about individuals with mental illnesses, substance use disorders, developmental disabilities, or co-occurring disorders and data about

the mental health, developmental, substance use disorder, emergency, and ancillary services they receive. In this document, mental illnesses, substance use disorders, and developmental disabilities refer to conditions that individuals experience, while mental health, substance use disorder, and developmental refer respectively to the services that address those conditions. For the CCS to produce valid data, all CSBs must submit complete and accurate data using the same formats and definitions. This document provides definitions of the information needed to produce the standard data files and the extract specifications that are required for CSBs to report individual level data through the CCS. This document also describes the process of submitting CCS files to the Department.

Definitions and Guidance for CCS Reporting

The core services taxonomy is used, per State Board Policy 1021 (SYS) 87-9, to classify, describe, and measure services delivered by all CSBs directly or through contracts with other providers. The taxonomy defines many of the terms used in these Specifications, definitions in the current taxonomy, available at http://www.dbhds.virginia.gov under Office of Management Services

Individual Receiving Services

Section 37.2-100 of the Code of Virginia defines an individual receiving service(s) or individual as a current direct recipient of public or private mental health, developmental, or substance use disorder treatment, rehabilitation, or habilitation services. This definition includes the terms "consumer," "patient," "resident," "recipient," or "client" used in previous statutes, regulations, policies, and other documents. This version of the CCS 3 Extract Specifications uses individual or individual receiving services, unless the context requires the use of consumer (*e.g.*, the Community Consumer Submission). CCS 3 does not collect or report information about individuals receiving substance use disorder prevention or Part C infant and toddler early intervention services; other reporting mechanisms collect this information.

Information about all individuals receiving any direct or contracted CSB services defined in the core services taxonomy, except for substance use disorder prevention services, Mental Health First Aid and suicide prevention services, or infant and toddler early intervention (Part C) services, must be reported in the CCS. Since the CARS no longer reports data about individuals receiving services, there will be no other source for this data except the CCS. CSB information system or EHR extracts that generate data for the Department's CCS 3 extract must include information in Consumer.txt files only about individuals who have an open record or have been admitted to a program area and have received a valid service or have been discharged from a program area with or without receiving a service during the fiscal year (active individuals). CSBs must not include other individuals in Consumer.txt files.

Z-Consumer:

An individual receiving service(s) is identified in the CCS by a hashed social security number (SSN) and a consumer identification number (ConsumerId). However, when a specific individual is not identified as receiving a service, a z-consumer code is used in the Service.txt file. The letter z (lower or upper case) in the first position of the ConsumerId field (data element 7) identifies this z-consumer code. Any value in that field that begins with the letter Z will be considered an unidentified individual, regardless of the characters that follow it. CSBs must not use a z-consumer code to report services

received by groups of individuals; a separate Service.txt record must be submitted for each individual receiving the service. The core-services taxonomy contains more detailed information about service hours reported for z-consumers.

Program Area

The core services taxonomy defines program area as the general classification of service activities for one of the following defined conditions: mental illnesses, developmental disabilities, or substance use disorders. The three program areas in the public services system are mental health, developmental, and substance use disorder services, ProgramAreaId codes 100, 200, and 300. CCS 3 also includes the 400 code as a pseudo ProgramAreaId to identify emergency or ancillary services (services outside of a program area). CSBs must use code 400 only in the Service.txt file, not in the TypeOfCare.txt file. CSBs must not admit or discharge individuals to or from the 400 code.

Service Codes and Units

The core services taxonomy defines services. CCS 3 identifies a service by a program area or pseudo program area code and a core services category or subcategory code (service code) with a corresponding unit of measure. This includes all services received by individuals from the CSB directly and from CSB contractors. All contracted services included in performance contracts and CARS reports must be included in CCS 3 service files. CCS 3 reports actual service delivery; it does not collect, or report estimated units of services. The taxonomy identifies these service codes and defines their corresponding units; refer to it for complete definitions of service units. The units (data element 10) field captures and reports the number of units of services received by individuals. CCS 3 reports the following types of service units in this field: service hours, bed days, day support service hours, and days of service. Appendix F lists valid program area and service codes.

Consumer-Run Services

Consumer-Run Services (730) are not traditional clinical or treatment services, and the nature and context of these programs emphasize individual empowerment and provide support in an informal setting. See the definition for these services in the current taxonomy. No Service.txt records are submitted for this service, and no Consumer.txt records are submitted for individuals who receive only consumer-run services. CSBs providing this service gather and report information about it and the individuals receiving it separately in the CARS management report, rather than in CCS.

Service Hours

A service hour is a continuous period measured in fractions or multiples of an hour during which an individual or a family member, authorized representative, care giver, health care provider, or significant other through in-person or electronic (audio and video or telephonic) contact on behalf of the individual receiving services or a group of individuals participates in or benefits from the receipt of services. This also includes significant electronic contact with individuals receiving services and activities that are reimbursable by third party payers. Service hours measure the amounts of services received by or on behalf of individuals or groups of individuals. Service hours are reported in the CCS Service file only for the following core services:

- Emergency services,
- Motivational treatment services,
- Medication assisted treatment,
- Assertive community treatment,

- Consumer monitoring services,
- Assessment and evaluation services,
- Early intervention services,
- Outpatient services,
- Medical services,
- Peer Support Services
- Family Support Services
- Crisis Intervention Services
- Crisis Stabilization Services
- Intensive outpatient services
- Case management services,
- Individual supported employment,
- Supportive residential services, and
- Mental health or developmental prevention services.

CSBs must not report service hours in the CCS for any other services. CSBs report substance use disorder prevention services and Mental Health First Aid and suicide prevention service hours through the Department's contracted prevention services data system and must not include them in the CCS. CSBs collect service hours for services listed above that are not received by or associated directly with individuals or groups of individuals using the z-consumer ConsumerId code and report them as NC services. For NC services, if the ConsumerId in the Service file does not start with a z or the service is not listed above, an error will occur. Refer to Appendix F for more information.

Service Dates

CCS 3 requires that specific dates be identified for a time period during which services are received by an individual. Because CCS 3 reports services with specific dates, they are not aggregated. Two date fields are available. The first date is the date that the service started (service from date); the second is the date that the service ended (service through date). If a service starts and ends on the same date, then the values of both fields would be the same. Allowing for a separate through date enables reporting services that might be reported more efficiently over a longer period than a single day. The through date is not used to calculate units of service; units of service should be those that are actually received, or those service hours provided for z-consumers, during the time period. CCS 3 does not do any calculations involving from and through dates to calculate the units of service. Tables 1 and 2 show the use of the two fields varies by service code.

Date Provided

The service codes in this reporting category in Tables 1 and 2 are reported for the specific date using the ServiceFromDate field. The value of the ServiceFromDate must also be copied into the ServiceThroughDate field in the extract so that the two fields show that the service starts and ends on the same date. For example, if an individual received three hours of outpatient services on March 1, 2019, the CSB would report a single service record for three hours of outpatient services with a ServiceFromDate of 03012019 and a ServiceThroughDate of 03012019.

Data element 106 (eff. 7/1/18), Service Modality, requires each service hour unit of service (core service codes 100, 310, 312, 313, 318, 320, 335, 350, 390, 460, 581, ~~610,~~ 620, and 720) be identified as face-to-face or non-face-to-face. Thus, for services in Tables 1 and 2 where service units are reported "On that date," CSBs can aggregate multiple service units of the same type of face-to-face service provided on the same day into a single face-to-face service record, but they must send a separate face-to-face service record for each day on which these services are provided. Similarly, CSBs can aggregate multiple service units of the same type of non-face-to-face service provided on the same day

into a single non-face-to-face service record, but they must send a separate non-face-to-face service record for each day on which these services are provided. Alternatively, CSBs can send a separate service record for each face-to-face or non-face-to-face service unit provided on the same day. **CSBs cannot submit service hour service records that aggregate service units for multiple days in a month.**

With the addition of this new Service Modality data element, (Version 7.4) eliminates all of the face-to-face and non-face-to-face codes in data element 64, Service Subtype, for developmental case management services. Now, data element 64 includes only quarterly case management ISP reviews and annual case management ISP meetings as service subtypes for developmental case management services. CSBs must use Not Applicable (code 96) for any developmental case management services that do not involve quarterly case management ISP reviews or annual case management ISP meetings. Refer to data element 64 for additional information.

From/Through Date

The service records in this reporting category in Tables 1 and 2 will have separate values in each date field. The ServiceFromDate field identifies the day the provision or receipt of service begins, and the ServiceThroughDate field identifies the day the provision or receipt of service ends. These fields are inclusive; they include services provided on those days. A day represents a normal 24-hour time period from 12:00 a.m. to 12:00 a.m. (midnight to midnight). CCS 3 Business Rules about service dates include the following requirements.

- For services provided during an admission to a program area, the ServiceFromDate must be a date equal to or greater than the TypeOfCareFromDate, and the ServiceThroughDate must be a date equal to or less than the TypeOfCareThroughDate. If the TypeOfCareThroughDate is blank, the ServiceThroughDate must be a date less than or equal to the end of the current reporting month. In other words, the dates of the service must fall within the dates of the corresponding type of care for the program area.
- The ServiceThroughDate must be a date greater than or equal to the ServiceFromDate, unless it is blank. The ServiceThroughDate can be blank **only** if the CSB is technically unable to provide the ServiceThroughDate.
- Service records cannot span multiple months. If a service extends over multiple months, then a CSB must create a separate service record at the start of each month that the service is provided. The ServiceThroughDate cannot be greater than the last day of the reporting month.

For example, if a CSB began serving an individual in a group home on December 15, 2018, and the individual was still receiving services at the end of the month, the extract for December would have a service record that showed 17 bed days of intensive residential services (service code 521) for the 15th through 31st. The ServiceFromDate would be 12152018; the ServiceThroughDate would be 12312018. If the individual was still receiving services in January, but left the group home on January 14, 2019, there would be a service record in January with a ServiceFromDate of 01012019, a ServiceThroughDate of 01142019, and service units of 14 bed days (the 1st through14th). If this same individual ended his or her intensive residential services on December 22, 2018, then there would be one service record extracted for December showing a ServiceFromDate of 12152018, a ServiceThroughDate of 12222018, and service units of eight bed days (the 15th through 22nd).

Service Date Reporting Categories

The service codes and their corresponding reporting categories are broken out in the following tables in the order in which they are listed in the current core services taxonomy.

Service Code	Table 1: Emergency and Ancillary Services		Reporting Category
	Core Service Name	**Reported Units Provided**	
100	Emergency Services	On that date	Date provided
Ancillary Services			
318	Motivational Treatment Services	On that date	Date provided
390	Consumer Monitoring Services	On that date	Date provided
620	Early Intervention Services	On that date	Date provided
720	Assessment and Evaluation Services	On that date	Date provided
730	Consumer Run services	On that date	Date provided
Service Code	**Table 2: Services Available at Admission to a Program Area**		**Reporting Category**
	Core Service Name	**Reported Units Provided**	
250	Acute Psychiatric or Substance Use Disorder (SUD) Inpatient Services	Over that period of time	From/through date
260	Community-Based SUD Medical Detoxification Inpatient Services	Over that period of time	From/through date
310	Outpatient Services	On that date	Date provided
312	Medical Services	On that date	Date provided
313	Intensive Outpatient Services	On that date	Date provided
320	Case Management Services	On that date	Date provided
335	Medication Assisted Treatment	On that date	Date provided
350	Assertive Community Treatment	On that date	Date provided
410	Day Treatment or Partial Hospitalization	Over that period of time	From/through date
~~420~~	~~Ambulatory Crisis Stabilization Services~~ (retired FY 2021)	~~Over that period of time~~	~~From/through date~~
425	Rehabilitation or Habilitation	Over that period of time	From/through date
430	Sheltered Employment	Over that period of time	From/through date
460	Individual Supported Employment	On that date	Date provided
465	Group supported employment	Over that period of time	From/through date
501	Highly Intensive Residential Services	Over that period of time	From/through date
510	Residential Crisis Stabilization Services	Over that period of time	From/through date
521	Intensive Residential Services	Over that period of time	From/through date
551	Supervised Residential Services	Over that period of time	From/through date
581	Supportive Residential Services	On that date	Date provided
610	MH or Developmental Prevention Services	On that date	Date provided

Type of Care and Episode of Care

Episode of Care Description

The core services taxonomy defines an episode of care as all of the services provided to an individual to address an identified condition or support need over a continuous period of time between an admission and a discharge. An episode of care begins with an admission to a program area, and it ends with the discharge from that program area. An episode of care may consist of a single face-to-face encounter or multiple services provided through one or more programs. CSBs must not admit an individual to emergency or ancillary services; those services are outside of an episode of care. If an individual has received his or her last service but has not yet been discharged from a program area, and he or she returns for services in that program area within 90 days, the individual is not readmitted, since he or she has not been discharged; the individual is merely accepted into that program area for the needed services.

Type of Care Description

In CCS 3, type of care is used to represent a time period between a beginning and an ending point in time or a from date and a through date. A type of care in CCS 3 includes an episode of care, which is just one example of a type of care. A type of care is any time period with the following characteristics.

- It is bounded by a starting point and an ending point, both of which are specific dates.
- It represents a point in time at which to view the status of the individual receiving services.
- It is a marker after which the data input requirements in the CCS change. These markers determine what specific pieces of data are to be reported, as documented in Appendix D, to identify "When is Data Collected"?

The TypeOfCare file in CCS 3 represents a type of care. The TypeOfCare file includes records that represent:

- an episode of care (*i.e.*, an admission to and discharge from a program area),
- a consumer designation code indicating that an individual is participating in a special project, program, or initiative indicated by a 900 code, or
- any other type of care that meets any of the three characteristics above.

Episode of Care and Program Area

In CCS 3, an episode of care in any of the three program areas represents an admission to and discharge from that program area. In CCS 3, there are no admissions to or discharges from a CSB or a particular service, only to or from a program area. Individuals can have an unlimited number of episodes of care, although at any given point in time they must be in only one episode of care for any one program area at any given CSB. A current episode of care is one in which the through date is null. A previous episode of care is one in which the through date is less than or equal to the current date or last day of the extract month. For example, if an individual is receiving treatment for co-occurring mental illnesses and substance use disorders, he or she will have one mental health episode of care and one substance use disorder episode of care and may have any number of previous episodes of care.

Episodes of care in different program areas can overlap; there is no requirement that an episode of care

end in one program area before another episode of care begins in a different program area. However, episodes of care cannot overlap in the same program area; CSBs must not submit TypeOfCare records for more than one episode of care in the same program area at the same time. Admission to a program area admits an individual to any of the services in that program area; there is no separate admission to a service or individual program within that program area.

Type of Care and Consumer Designation Codes (CDCs)

The ~~core~~ services taxonomy establishes consumer designation codes to identify individuals who receive services in specific initiatives or projects. These codes are not service codes per se, like 310 is the core services code for outpatient services; instead, they reflect a particular status of those individuals. The core services taxonomy includes the following consumer designation codes:

905 - Mental Health Mandatory Outpatient Treatment (MOT) Orders,
910 - Discharge Assistance Program (DAP),
915 - Mental Health Child and Adolescent Services Initiative,
916 - Mental Health Services for Children and Adolescents in Juvenile Detention Centers,
918 - Program of Assertive Community Treatment (PACT),
919 - Projects for Assistance in Transition from Homelessness (PATH),
920 - Developmental Disability (DD) Home and Community-Based Waiver Services (HCBS) – Medicaid funded
923 – Developmental Disability Enhanced Case Management Services (DD-ECM)
933 - Substance Use Disorder Medication Assisted Treatment, and
935 - Substance Use Disorder Recovery Support Services.
936 – Project LINK (if applicable to the specific CSB)
937 – Permanent Supportive Housing *(refer to Appendix N for specifics)*

CSBs must use consumer designation code (CDC) 920 only for individuals who have been admitted to the developmental services program area (200) and are receiving services under any of the three Medicaid developmental disability (DD) waivers (Building Independence, Family and Individual Supports, or Community Living) directly from a CSB, from other agencies or individuals contracted by the CSB where the CSB remains the provider for DMAS payment purposes, or from any other provider of Medicaid DD waiver services that is reimbursed directly by DMAS. If it provides DD waiver services to an individual, the CSB must admit the individual to the developmental services program area (200), assign a 920 CDC, and report any DD waiver services it provides to the individual directly or through contracts with other providers of DD waiver services. The CSB reports the DD waiver services in CCS 3 using the core-services taxonomy crosswalk at http://www.dbhds.virginia. gov, under the Offices tab, under Office of Management Services.

These requirements apply to the CSB even if the individual is in a waiver slot assigned to a different CSB. The CSB to which a waiver slot has been assigned and filled must admit the individual in the slot to the developmental services program area (200), assign a 920 CDC, and provide developmental case management services (320) to the individual directly or through a contract with another developmental case management services provider. The CSB must do this whether or not it provides any DD waiver services to the individual directly or through other agencies or individuals contracted by the CSB where the CSB remains the provider for DMAS payment purposes.

The 923 CDC captures data about developmental enhanced case management (ECM) services previously collected using data element 90 in the consumer.txt file. It indicates if an individual who is receiving Medicaid DD Waiver services meets the criteria for receiving ECM services. ECM means the individual receives at least one face-to-face visit monthly with no more than 40 days between visits and at least one such visit every other month is in the individual's place of residence. An individual who meets any of the following criteria must receive ECM services:

- receives services from providers that have conditional or provisional licenses from the Department,
- has more intensive behavioral or medical needs as defined by the Supports Intensity Scale category representing the highest level of risk,*
- has an interruption of services longer than 30 days,
- encounters the crisis system for a serious crisis or for multiple less serious crises within a three-month period,
- has transitioned from a state training center within the previous 12 months, or
- resides in a congregate setting of five or more beds.*

* as identified in Case Management Operational Guidelines and updates issued by the Department.

As of July 1, 2018, rather than using data element 90, CSBs were to use the 923 CDC to report when an individual meets the criteria for ECM or no longer meets those criteria. Whenever an individual meets the ECM criteria, a CSB shall report this in a TypeOfCare record with a 923 CDC and a TypeOfCareFromDate for the start of meeting the criteria. Whenever an individual no longer meets the criteria, a CSB shall report this using a new TypeOfCare record with a 923 CDC and a TypeOfCareThroughDate for the end of meeting the criteria. If a CSB is providing Medicaid DD Waiver services to an individual but not developmental case management services to that individual, the CSB must not submit a TypeOfCare record for ECM since it is not providing case management services to that individual. The CSB that is providing developmental case management services to that individual must submit a TypeOfCare record for ECM if that individual meets the criteria for ECM.

The component services of these projects or initiatives are included in the appropriate core services and numbers of individuals in those initiatives are counted in the CCS in the following manner. When an individual receives services in any of the initiatives listed above, the CSB must enter the consumer designation code for the initiative in a type of care record for the individual. CSBs will accumulate and record units of service for these initiatives in the applicable core services associated with the initiative, such as outpatient, case management, day treatment or partial hospitalization, rehabilitation or habilitation, or various residential services.

A CSB must create a type of care record in the TypeOfCare file for each individual receiving a service in one of these initiatives or projects. The CSB must enter the consumer designation code in the TypeOfCare field. This record must be created when an individual first receives a service in one of these initiatives or projects with a TypeOfCareFromDate when an individual enters into or participates in one of those initiatives or projects, thus starting his or her type of care, and when the individual leaves or stops participating in the initiative or project with a TypeOfCareThroughDate.

Normally the CSB must create a type of care record for a program area episode of care before creating a type of care record for a consumer designation code. In other words, A CSB must admit an individual to a program area before assigning a consumer designation code to the individual. However, this rule

does not apply to the following codes and situations:

- Mental Health Mandatory Outpatient Treatment (MOT) Orders (905) when the CSB only monitors the individual's compliance with the MOT order,
- Discharge Assistance Program (DAP) (910) because the hospital discharge date and related DAP TypeOfCareFromDate may precede the TypeOfCareFromDate for admission to the mental health services program area,
- Mental Health Services for Children and Adolescents in Juvenile Detention Centers (916) when the CSB only provides emergency or ancillary services,
- Projects for Assistance in Transition from Homelessness (PATH) (919) because PATH is included in consumer monitoring services, an ancillary service, and
- Substance Use Disorder Recovery Support Services (935) if the individual only receives emergency or ancillary services.
- Permanent Supportive Housing Services (937) regardless of whether funding for housing comes from DBHDS, or another agency. See Appendix N for additional specifics.

Extract Files

Each CSB extracts data from its information system or EHR into five separate ASCII comma delimited extract files: Consumer, TypeOfCare, Service, Diagnosis, and Outcomes. Each record in a file must have an Agency Code that will identify the record as belonging to the particular CSB. Appendix C describes the data elements in those files in more detail and with acceptable values.

Consumer File (Consumer.txt)

The Consumer extract file contains a record for each individual that represents a snapshot of the individual receiving services at a point in time. It contains identifying, demographic, and status or descriptive information about the individual.

Extract Schedule and Individual Status Changes

The CCS is a batch system, and CSBs produce and transmit extracts to the Department each month. Because consumer records are extracted monthly, they will contain information about individuals at the time the extract is run. It is possible that an individual's status may have changed more than once during the month, but those changes will not be captured in the extract; only the status that is current when the extract is run will be submitted to the Department. If an individual's status for any Consumer file data element changes during a month, the change must be recorded in the CSB's information system or EHR so it can be extracted for the Consumer file in the monthly CCS extract.

At the Department, the Central Office CCS database will use monthly extract submissions to record changes in an individual's status over time and will maintain a separate record for each individual's change in status, with a different artificial key identifying each consumer record. This will allow the Department to track the history of changes in an individual's status and relate them to specific service

dates. However, this happens in the Department's CCS database and does not affect the local CSB extract process.

Extract Criteria

CSBs must send consumer records to the Department each month for any individuals who within the current fiscal year:

- received an emergency or ancillary service (services available outside of a program area), OR
- were admitted to a program area and received a service, OR
- were discharged from a program area with or without receiving a service.

A Consumer.txt file extract record for an individual must contain all the current values in all of the applicable data elements for that individual at the time of extract.

Type of Care File (TypeOfCare.txt)

Extract Criteria

CSBs must send all type of care records to the Department each month for all individuals who within the current fiscal year or across fiscal years (see the note at the top of the next page):

- were admitted to a program area and were not discharged, OR
- were discharged with or without receiving a service, OR
- received or lost a consumer designation code; for example, began or stopped participating in a PACT (918) or started or ended meeting the criteria for ECM.

CSBs must send TypeOfCare records only for these three circumstances.

The FromDate in a TypeOfCare record containing a consumer designation code must be the date on which an individual first began participating in the specialized initiative or project, and the ThroughDate must be the date on which the individual stopped participating in the specialized initiative or project. If an individual receives a consumer designation code in one fiscal year and continues participating in that specialized project or initiative in the following fiscal year, all of the TypeOfCare records related to that consumer designation code would contain a FromDate but no ThroughDate, until the individual's participation ended. This enables the correct calculation of the days that an individual participated in the specialized project or initiative, and it supports accurate reporting of when the individual began and ended his or her participation in the initiative or project.

Note: If an individual admitted to a program area has not received any service within 100 days since the last service he or she received and has not been discharged, the CSB shall attempt to contact and re-engage him or her. If it cannot contact or re-engage the individual within 30 days from the end of the 100-day period, the CSB shall discharge him or her and report the discharge using a TypeOfCare record with a through date of the date of the last service he or she received.

CSBs must not submit TypeOfCare records containing consumer designation codes with Through Dates for all of the individuals currently participating in specialized projects or initiatives at the end of the current fiscal year and new TypeOfCare records with FromDates on the first day of the next fiscal year for all of the same individuals. This would create erroneous TypeOfCare records.

Service File (Service.txt)

The current core services taxonomy defines all services and service units that are included in CCS 3 extracts, and the Core Services Taxonomy Category and Subcategory Matrix and Appendix F list the unit of service for each service.

Extract Criteria

CSBs must send service records to the Department each month for all services they provided directly or contractually during the current fiscal year. Each service extract must contain records for all services delivered during the fiscal year. For example, the service file for July would include the service records for July; the service file for August would include the service records for July and for August; the service file for September would include the service records for July, for August, and for September; and so on. The service file grows during the year until at the end of the fiscal year it includes all the records for that fiscal year.

The Service Units field reports the services received on the service date or dates; it must not accumulate or total service units at a higher amount than on that date or those dates. For example, it must not represent the total service units for more than one month. In situations where the same service is provided to an individual at multiple times during the same day, CSBs may opt to report these records individually, or CSBs may summarize the units for the day in a single record except for developmental case management services. See the ***Date provided*** section on page 5 for more details.

Diagnosis File (Diagnosis.txt)

The Diagnosis extract file contains one or more records for each individual that represent a snapshot of his or her diagnoses. It contains identifying and diagnostic information about the individual. There may be multiple diagnosis records for an individual, but there must be at least one record. The Diagnosis file will accept DSM-5 mental illness, developmental disability, or substance use disorder codes for historical purposes and ICD-10 mental illness, developmental disability, substance use disorder, and medical codes.

Extract Criteria

CSBs must send diagnosis records to the Department each month for any individuals who within the current fiscal year:

- received an emergency or ancillary service (services available outside of a program area), OR
- were admitted to a program area and received a service, OR
- were discharged from a program area with or without receiving a service.

A Diagnosis.txt file extract record for an individual must contain all the current values in all of the applicable data elements for that individual at the time of extract. Each diagnosis record in the Diagnosis extract file must contain a DiagnosisStartDate (data element 94).

Outcomes File (Outcomes.txt)

The Outcomes extract file contains a record for each outcome measure reported for individuals receiving services. It contains the ConsumerId to link this record to other files such as records in Consumer and Service files for an individual. It also reports data about the date and type of assessment used for the measure and the numeric value of the assessment.

Extract Criteria

CSBs must send Outcomes records to the Department each month for any individuals who received services from them within the current fiscal year whenever CSBs perform assessments on them to gather data for an outcome measure. An Outcomes.txt file extract record for an individual must contain all the current values in all of the applicable data elements for that individual at the time of extract.

Staff Classification (StaffClassification.txt)

The Staff Classification table contains the list of staff classifications for the Peer and Family Support Services; Crisis Intervention and Crisis Stabilization Services (including Emergency Services staff). The Staff Classification is to be linked to the StaffId to identify the current applicable classifications for the person providing Peer or Family Support Services, Crisis Intervention or Crisis Stabilization Services and Emergency Services. This category is for classification, which is different from credentialing or licensing for professional staff.

Extract Criteria

CSBs must send the staff classification to the Department each month for any persons who provided the Peer or Family Support Services; Crisis Intervention or stabilization services (including Emergency Services), for persons who received services from them within the current fiscal year whenever CSBs provide any of these services. A staffclassification.txt table must contain all the applicable labels or data elements for each person providing services.

Submission Procedures and Processes

Timeliness

CSBs must submit all CCS data on a monthly basis. Unless otherwise directed, extract data must be received at the Department no later than the end of the month following the month of the extract. For example, November data is due in the Department no later than December 31. When it will not make a scheduled submission on time, the CSB must notify Chandelle Pullen, Office of Management Services, at Chandelle.Pullen@DBHDS.Virginia.gov, 804-298-3197 (desk) 804.385-3491 (cell), preferably by email, alternate by phone, and provide a revised delivery date. The Department will monitor and report on compliance with the monthly reporting requirements. Semi-monthly disbursements of state and federal funds by the Department to CSBs are contingent on the Department's receipt of monthly CCS submissions.

Protocol for Resubmitting a CCS 3 Extract

The community services performance contract requires each CSB to submit monthly CCS 3 extracts containing consumer, type of care, service, diagnosis, and outcome files that contain records reporting individual consumer characteristic, service, and other data to the Department. Each CSB must submit these extracts to the Department by the end of the month following the month for which the data is being submitted, except for the complete CSB fiscal year extract. Refer to Exhibit E of the performance contract for additional information. If the Department identifies a problem with a monthly CSB extract submission and the Department's Office of Management Services, Chandelle Pullen determines that a resubmission is necessary, the subsequent CSB resubmission is exempt from this protocol. Although CSBs must provide complete and accurate information in their monthly extract submissions, occasionally, it may be necessary for a CSB to resubmit a monthly CCS extract submission in order to correct inaccurate or incomplete service, consumer, type of care, diagnosis, or outcomes records submitted during the month or to replace an incorrectly named or corrupted file.

CSBs cannot resubmit an extract for any month that precedes its most recent submission. If a CSB determines that it needs to resubmit its CCS 3 extract for the current month, it shall follow the steps below to request a resubmission.

1. The designated CCS 3 contact person at the CSB e-mails Chandelle Pullen, Office of Management Services, at Chandelle.Pullen@dbhds.virginia.gov, who is the designated CCS 3 business owner or designee, describing and justifying its request for a resubmission.
2. The CCS 3 business owner, Chandelle Pullen or designee may seek additional information from the CSB to understand the request and its potential impact if the CSB did not make the resubmission.
3. The CCS 3 business owner, Chandelle Pullen or designee will review each request on a case-by-case basis with the Department's I &T staff as soon as possible.
4. The CCS 3 business owner, Chandelle Pullen or designee will communicate its decision and any instructions related to the resubmission, if necessary, to the requesting CSB.
5. If the Department approves the request, the CSB will resubmit its extract for that month to the Department via the sFTP secure server.

Security

Security of the data during transmission from the CSB to the Department is the responsibility of the Department. Authorized CSB users will transmit data to the Department's secure FTP site, which will ensure compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and community services performance contract requirements.

Quality Control Responsibilities

Each CSB is responsible for:

- ensuring that each record in the data submission contains the required key fields, all fields in the record contain valid codes, and no duplicate records are submitted;

- cross-checking data items for consistency across data fields;
- cross-checking data prior to monthly submissions, including improving and reducing warnings to improve data quality; and reduce fatal errors
- responding promptly to CCS error reports by correcting data locally so that the next extract will contain correct, accurate, and complete data or by resubmitting data where appropriate.

The Department is responsible for:

- processing CSB data submissions promptly into the CCS data base;
- checking each record submitted to verify that all CCS key fields are valid;
- creating quality improvement reports that CSBs can run locally on the extract files before they have been submitted and processed and providing monthly data quality reports on data after it has been received and processed by the Department.

CCS Extracts Submitted for a New Fiscal Year

When beginning the cycle of extract submissions for a new fiscal year, a CSB shall drop the following records from its extracts:

- service records prior to July 1 of the new fiscal year,
- type of care records with discharge dates prior to July 1 of the new fiscal year,
- consumer records for individuals discharged from all program areas (mental health, developmental, and substance use disorder) prior to July 1 of the new fiscal year,
- consumer records for individuals with open cases but not admitted to a program area who have not received a service on or after July 1 of the new fiscal year, and
- diagnosis records for individuals whose consumer records have been dropped (preceding two criteria).

Appendix A: Extract Lookup Tables

CCS extract lookup tables used by CSBs and validated by the CCS 3 extract software are listed below. Each begins with a three-character prefix, lkp. The enumeration of each value in each lookup table is not included here for brevity. However, the values in most lookup tables are shown under the data elements that rely on them in Appendix C. If there is any conflict between those values and the values in the lookup tables, the value in the lookup table will take precedence.

CCS 3 Extract Lookup Tables	
Lkp Table Name	**Lookup Table Description**
lkpAgency	Three-character code identifying a CSB
~~lkpCognitive~~	~~Code indicating whether the individual has a cognitive delay~~
lkpDisStatus	Code indicating the status of the individual at the end of a type of care
lkpDrug	Code indicating type of drug used by an individual with a substance use
lkpDrugMethod	Code indicating the method of drug use or usual route of administration
lkpEducation	Code indicating the highest-grade level completed by the individual
lkpEmployment	Code indicating the involvement of the individual in the labor force
lkpEmployDiscuss	Code indicating whether an employment discussion occurred during annual case management ISP meeting or update
lkpEpisodes	Code indicating the number of previous episodes of care in any drug or alcohol program for the individual
lkpFIPS	Federal code indicating the city or county in which the individual lives. NOTE: code homeless as 998 in lkpFIPS (i.e., truly homeless population) beginning FY 2020
lkpFrequency	Code indicating the frequency of use for a substance use disorder
lkpGender	Code indicating the gender of the individual receiving services
lkpGoalMeasure	Code indicating extent to which a goal measure is achieved or implemented.
lkpHispanic	Code indicating the individual's Hispanic origin
lkpHousingMoves	Code indicating the number of times an individual has moved
lkpInsuranceType	Code indicating the individual's current type of insurance coverage
lkpLanguage	Code indicating preferred language used by the individual receiving services
lkpLegal	The individual's legal status in relation to the receipt of services
~~lkpMaritalStatus~~	~~Code indicating the current marital status of the individual.~~
lkpMilitaryStatus	Code indicating the current status of an individual who is serving or has served in a U.S. military branch or who is a dependent family member
lkpOutcomeAction	Code indicating the type of assessment for an outcome measure
lkpOutcomeFreq	Code indicating the frequency of the outcome assessment or action
lkpProgram	Identifier for a program area or pseudo program area
lkpRace	Code indicating the self-identified race of the individual receiving services
lkpReferral	Code indicating person, agency, or organization that referred individual to a
lkpResidence	Code indicating where the individual receiving services lives
lkpService	The three-character-core services taxonomy code for a service
lkpServiceLocation	Code indicating location at which a service was received by the individual
lkpServiceMod	Code indicating face-to-face or non-face-to-face service hour unit of service.
lkpServiceSubtype	Code indicating a specific activity associated with a particular core service
lkpSMISED	Code indicating if the individual has a SMI, SED, or is at-risk of SED
lkpSocial	Code indicating the frequency of the individual's participation in social contacts
lkpStabilityMeasure	Code indicating extent to which a stability measure is maintained.

lkpTypeOfCare	Code indicating the type of care program area or consumer designation
lkpYesNo	Code indicating yes, no, not applicable, unknown, or not collected
lkpYesNoECM	Code indicating yes, no, not applicable, or not collected for data elements 92, 96, and 98
lkpReferralDestination	Code indicating referral of the individual from the CSB (Appendix J)
lkpStaffClassification	Classifications for staff for Peer Support Services, Family-Support Services and Crisis Intervention and Crisis Stabilization Services

Appendix B: CCS 3 Extract File Layouts

Listed below are the file layouts for the five files each CSB produces as part of the initial extract process from the CSB's information system or EHR. As the first or original set of extract files, they are identified as Data Set 1 (DS1). These files are then used as input to subsequent processing, including hashing or transforming sensitive identifying information about individuals receiving services, before transmission of the extracted data to the Department. Full definitions, descriptions, and validations of each of these data elements are contained in Appendix C: CCS 3 Extract Data Element Definitions.

The No. column refers to the data element number. CCS 3 carries the numbers forward from CCS 2 as much as possible. The order of the fields follows the order of CCS 2 as much as possible, with new fields in CCS 3 generally added to the end of the file layout.

Consumer File (Consumer.txt)				
No.	**Field Name**	**Type**	**Length**	**Description**
2	AgencyCode	Text	3	Code identifying a CSB (*e.g.*, 049, 031)
7	ConsumerId	Text	10	Identifier assigned by the CSB to an individual who is or will be receiving services
8	SSN	Text	9	Social security number of the individual; this raw value will be hashed before transmission
16	DateOfBirth	Text	8	MMDDYYYY of the individual's birth date
17	Gender	Text	2	Code indicating the gender of the individual
18	Race	Text	2	Code indicating the race of the individual
19	HispanicOrigin	Text	2	Code indicating Hispanic origin of the individual
13a	SMISEDAtRisk	Text	2	Code indicating if the individual has serious mental illness (SMI), serious emotional disturbance (SED), or is at-risk of SED
~~13b~~	~~CognitiveDelay~~	~~Text~~	~~2~~	~~Code indicating whether the individual is a child who is at least three but less than six years old and has a confirmed cognitive delay within one year of assessment, but does not have an intellectual disability diagnosis~~
~~26~~	~~AxisICode1~~	~~Text~~	~~5~~	~~DSM Axis I diagnosis, code 1~~
~~27~~	~~AxisICode2~~	~~Text~~	~~5~~	~~DSM Axis I diagnosis, code 2~~
~~52~~	~~AxisICode3~~	~~Text~~	~~5~~	~~DSM Axis I diagnosis, code 3~~
~~53~~	~~AxisICode4~~	~~Text~~	~~5~~	~~DSM Axis I diagnosis, code 4~~
~~54~~	~~AxisICode5~~	~~Text~~	~~5~~	~~DSM Axis I diagnosis, code 5~~
~~55~~	~~AxisICode6~~	~~Text~~	~~5~~	~~DSM Axis I diagnosis, code 6~~
~~28~~	~~AxisIIPrimary~~	~~Text~~	~~5~~	~~DSM Axis II primary diagnosis code~~
~~29~~	~~AxisIISecondary~~	~~Text~~	~~5~~	~~DSM Axis II secondary diagnosis code~~
~~30~~	~~AxisIII~~	~~Text~~	~~1~~	~~DSM Axis III diagnosis (Y/N)~~
~~31~~	~~AxisV~~	~~Text~~	~~3~~	~~DSM Axis V diagnosis code~~
14	CityCounty ResidenceCode	Text	3	Federal (FIPS) code indicating the city or county in which the individual lives

Consumer File (Consumer.txt) - *continued*				
No.	**Field Name**	**Type**	**Length**	**Description**
15	ReferralSource	Text	2	Code indicating person, agency, or organization that referred individual to the CSB for evaluation or treatment
23	Type of Residence	Text	2	Code indicating where the individual lives (accidentally omitted for most recent extract) – no changes
22	EmploymentStatus	Text	2	Code indicating the individual's employment status
21	EducationLevel	Text	2	Code indicating the individual's education level
24	LegalStatus	Text	2	Code indicating the individual's legal status
25	NbrPriorEpisodes AnyDrug	Text	2	Code indicating the number of previous episodes in any drug or alcohol program for the individual
44	PregnantStatus	Text	1	Code indicating if the individual is a female with a substance use disorder who is pregnant.
45	FemaleWith Dependent ChildrenStatus	Text	1	Code indicating if the individual is a female with a substance use disorder who is living with dependent children
~~46~~	~~DaysWaitingTo EnterTreatment~~	~~Text~~	~~3~~	~~Code indicating the number of calendar days from the first contact or request for service until the first scheduled appointment in a substance abuse service accepted~~
47	NbrOfArrests	Text	2	Number of arrests in the past 30 days
32	SAPDType	Text	2	SA primary drug: type of drug code
34	SAPDMethUse	Text	2	SA primary drug: method of use code
33	SAPDFreqUse	Text	2	SA primary drug: frequency of use code
35	SAPDAgeUse	Text	2	SA primary drug: age of first use code
36	SASDType	Text	2	SA secondary drug: type of drug code
38	SASDMethUse	Text	2	SA secondary drug: method of use code
37	SASDFreqUse	Text	2	SA secondary drug: frequency of use code
39	SASDAgeUse	Text	2	SA secondary drug: age of first use
40	SATDType	Text	2	SA tertiary drug: type of drug code
42	SATDMethUse	Text	2	SA tertiary drug: method of use code
41	SATDFreqUse	Text	2	SA tertiary drug: frequency of use code
43	SATDAgeUse	Text	2	SA tertiary drug: age of first use
~~49~~	~~AuthRep~~	~~Text~~	~~1~~	~~Code indicating presence of an authorized representative~~
57	MedicaidNbr	Text	12	The individual's Medicaid number in the format prescribed by the DMAS
58	Consumer FirstName	Text	30	The first name of the individual, used to generate a unique consumer ID; the full name is not transmitted to the Department
59	ConsumerLastName	Text	30	The last name of the individual, used to generate a unique consumer ID; same as No. 58
66	MilitaryStatus	Text	2	Current status of an individual serving in or who has served in the military or who is a dependent family member of the individual
67	MilitaryService StartDate	Text	4	The year in which the individual's most recent active or reserve duty began

Consumer File (Consumer.txt) - *continued*				
No.	**Field Name**	**Type**	**Length**	**Description**
68	MilitaryService EndDate	Text	4	The year in which the individual's most recent active or reserve duty ended
~~69~~	~~MaritalStatus~~	~~Text~~	~~2~~	~~The individual's current marital status~~
70	Social Connectedness	Text	2	Measure of frequency of participation in social contacts that support recovery
71	InsuranceType1	Text	2	The type of the individual's current insurance coverage
72	InsuranceType2	Text	2	The type of the individual's current insurance coverage
73	InsuranceType3	Text	2	The type of the individual's current insurance coverage
74	InsuranceType4	Text	2	The type of the individual's current insurance coverage
75	InsuranceType5	Text	2	The type of the individual's current insurance coverage
76	InsuranceType6	Text	2	The type of the individual's current insurance coverage
77	InsuranceType7	Text	2	The type of the individual's current insurance coverage
78	InsuranceType8	Text	2	The type of the individual's current insurance coverage
~~79~~	~~DateNeedforMH ServicesFirstDeter~~	~~Text~~	~~8~~	~~Date on which CSB staff first determined the individual needs MH services~~
~~80~~	~~DateNeedforSUD ServicesFirstDeter~~	~~Text~~	~~8~~	~~Date on which CSB staff first determined the individual needs substance use disorder services~~
81	HealthWellBeing	Text	2	Extent to which the individual remains healthy
82	CommunityInclusion	Text	2	Extent to which outcomes in the individual's ISP are met
83	ChoiceandSelf Determination	Text	2	Extent to which life choices in the individual's ISP have been implemented
84	LivingArrangement	Text	2	Degree to which individual has maintained arrangement
85	DayActivity	Text	2	Degree to which individual has maintained activities
86	SchoolAttendance	Text	2	School attendance during past three months
87	IndependentLiving	Text	1	Living independently or dependently in private residence
88	HousingStability	Text	2	Number of changes in residence during a quarter
89	PreferredLanguage	Text	2	Preferred language used by individual receiving services
~~90~~	~~EnhancedCaseMgmt~~	~~Text~~	~~1~~	~~Identifies individuals who meet ECM criteria~~
91	Employment Discussion	Text	2	Employment discussed at annual case management (CM) ISP meeting
92	EmplymntOutcomes	Text	1	Employment outcomes included in case management ISP
~~93~~	~~Reported Diagnosis~~	~~Text~~	~~7~~	~~ICD-10 diagnosis codes for individuals~~
~~94~~	~~DiagnosticStartDate~~	~~Text~~	~~8~~	~~The date the diagnosis started~~
~~95~~	~~DiagnosticEndDate~~	~~Text~~	~~8~~	~~The date the diagnosis ended~~
96	DiscussionofLast CompletePhysical	Text	1	Case manager asked about the last complete physical examination during annual CM ISP meeting
97	DateofLastComplete PhysicalExamination	Text	8	Date on which the individual received his or her last regularly scheduled complete physical examination
98	DiscussionofLast SchduledDental	Text	1	Case manager asked about the last regularly scheduled dental examination during annual CM ISP meeting
99	DateofLastScheduled DentalExamination	Text	8	Date on which the individual received his or her last regularly scheduled routine preventative dental exam

100	Community Engagement Discussion	Text	1	Case manager discussed community engagement or community coaching opportunities during ISP meeting
101	Community Engagement Goals	Text	1	ISP contains community engagement or community coaching goals
~~109~~	~~MedicareBI~~	~~Text~~	~~11~~	~~The Individual's Medicare Beneficiary Identifier (MBI), if the person has Medicare (not the SSN – use new Medicare number distributed in 2018)~~
111	Gender Identity	Text	2	Identification of consumer gender identity

Data elements 26-31, 52-55, 79, 80, 90, and 93-95 are no longer required in the Consumer.txt file, and CSBs must report them as NULL values. CSBs now report diagnoses in the Diagnosis file using data elements 93-95. Data elements 102-104 and 107 (SDA) in the Outcomes.txt file replace data elements 46, 79, and 80. Data elements 13.b, 49, and 69 are no longer required; CSBs must report them as NULL values. Please see instructions in Appendix E for formatting NULL values.

Type of Care File (TypeOfCare.txt)

No.	Field Name	Type	Length	Description
2	AgencyCode	Text	3	Code identifying a CSB (*e.g.*, 049, 031)
7	ConsumerId	Text	10	Identifier assigned by the CSB to an individual who is or will be receiving services; the local consumer Id, not the statewide Id (hashed SSN)
3	TypeOfCare	Text	3	Code indicating the program area (100, 200, or 300) or consumer designation code (*e.g.*, 910, `, or 923)
12	DischargeStatus	Text	2	Code indicating treatment status of an individual at the end of the type of care, that is at discharge from a program area.
61	TypeOfCareFromDate	Text	8	MMDDYYYY of the starting date of the type of care
60	TypeOfCareThroughDate	Text	8	MMDDYYYY of the ending date of the type of care
108	TransactionID	Text	12	A number that uniquely identifies each type of care record

Service File (Service.txt)				
No.	**Field Name**	**Type**	**Length**	**Description**
2	AgencyCode	Text	3	Code identifying a CSB (*e.g.*, 049, 031)
7	ConsumerId	Text	10	Identifier assigned by the CSB to an individual who is or will be receiving services
3	ProgramAreaId	Text	3	Code indicating if the individual received this service in a service area (100, 200, or 300 for MH, DV, SA) or as emergency or ancillary services (400)
5	ServiceCode	Text	3	Core services taxonomy service code for this service
48	ServiceFromDate	Text	8	MMDDYYYY indicating the start date of the service
10	Units	Text	8	Units of service as specified in the current core services taxonomy: service hours, day support hours, days of service, and bed days; reported with two decimal places.(*e.g.*, 1.25, 1.00, etc.)
~~56~~	~~ConsumerServiceHours~~	~~Text~~	~~8~~	~~No longer collected; reported as a NULL value~~
62	ServiceThroughDate	Text	8	MMDDYYYY indicating the end date of a service If the service started and ended on the same day, this value must be the same as the service from date
63	StaffId	Text	10	The CSB local staff identification number ~~(optional)~~
64	ServiceSubtype	Text	2	A specific activity associated with a particular core service category or subcategory
65	ServiceLocation	Text	2	The location at which the service was received by or provided to an individual
106	Service Modality	Text	2	This identifies how a service unit is delivered (*i.e.*, face- to-face or non-face-to-face)
108	TransactionID	Text	12	A number that uniquely identifies each service record

Data element 56 is no longer required in CCS 3; CSBs must report it as a NULL value. Please see instructions in Appendix E for formatting NULL values.

Diagnosis File (Diagnosis.txt)				
No.	**Field Name**	**Type**	**Length**	**Description**
2	AgencyCode	Text	3	Code identifying a CSB (*e.g.*, 049, 031)
7	ConsumerId	Text	10	Identifier assigned by the CSB to an individual who is or will be receiving services
93	ReportedDiagnosisCode	Text	7	Valid DSM-4 or ICD-10 diagnosis code
94	DiagnosisStartDate	Text	8	Date the diagnosis started
95	DiagnosisEndDate	Text	8	Date the diagnosis ended
108	TransactionID	Text	12	A number that uniquely identifies each diagnosis record

Outcomes File (Outcomes.txt)				
No.	**Field Name**	**Type**	**Length**	**Description**
2	AgencyCode	Text	3	Code identifying a CSB (*e.g.*, 049, 031)
7	ConsumerId	Text	10	Identifier assigned by the CSB to an individual who is or will be receiving services
102	Date of Assessment	Text	8	MMDDYYYY indicating the date on which the assessment used for an outcome measure occurred
103	Assessment Action	Text	2	Describes the type of assessment or action related to the assessment (*e.g.*, follow-up)
104	Assessment Value	Text	5	Displays the numeric value of the assessment
105	Assessment Frequency	Text	2	Displays how often the assessment or action was performed
107	Related Date	Text	8	A date related to an outcome measure
108	TransactionID	Text	12	A number that uniquely identifies each outcomes record

Staff Classification File (StaffClassification.txt)				
No.	Field Name	Type	Length	Description
2	AgencyCode	Text	3	Code identifying a CSB (e.g., 049, 031)
63	StaffId	Text	10	The CSB local staff identification number
110	StaffClassification	Text	2	The DBHDS staff classification
112	ClassificationStartDate	Text	8	Date the classification started
113	ClassificationEndDate	Text	8	Date the classification ended
108	TransactionID	Text	12	A number that uniquely identifies each Staff Classification record with service

Appendix C: CCS 3 Extract Data Element Definitions

This appendix contains definitions and validations of current CCS 3 data elements. Definitions list lookup table names and valid values. Some lookup tables, like ICD10 diagnostic codes, are too big to reproduce here. If there is any conflict between this document and values in the lookup tables, values in the lookup tables take precedence. Each definition contains a line for the purpose(s) of the data element, *e.g.*, meeting federal block grant (FBG), mental health block grant (MHBG), substance abuse block grant (SABG), treatment episode data set (TEDS), or DBHDS Annual Report requirements. CCS 3 Business Rules, incorporated by reference in these specifications, contain additional information needed to collect and report data elements accurately. Some definitions include *italicized explanations* that are not part of the definitions or code values themselves. This table lists current CCS 3 data elements alphabetically with their data element numbers for convenient reference.

Alphabetical Cross Reference of Data Elements							
No.	**Data Element**	**No.**	**Data Element**	**No.**	**Data Element**	**No.**	**Data Element**
2	Agency Code	82	Community Inclusion Measure	94	Diagnosis Start Date	111	Gender Identity
103	Assessment Action	58	Consumer First Name	12	Discharge Status	81	Health Well Being Measure
105	Assessment Frequency	7	Consumer Id	96	Discussion of Last Complete Physical Examination	19	Hispanic Origin
104	Assessment Value	59	Consumer Last Name	98	Discussion of Last Scheduled Dental Examination	88	Housing Stability
83	Choice & Self-Determination	97	Date Last Complete Physical Examination	21	Education Level	87	Independent Living Status
14	City County Residence Code	99	Date Last Scheduled Dental Examination	91	Employment Discussion	71	Insurance Type 1
113	Classification End Date	102	Date of Assessment	92	Employment Outcomes	72	Insurance Type 2
112	Classification Start Date	16	Date of Birth	22	Employment Status	73	Insurance Type 3
100	Community Engagement or Coaching Discussion	85	Day Activity Measure	45	Female With Dependent Children Status	74	Insurance Type 4
101	Community Engagement or Coaching Goals	95	Diagnosis End Date	17	Gender	75	Insurance Type 5

Alphabetical Cross Reference of Data Elements							
No.	**Data Element**	**No.**	**Data Element**	**No.**	**Data Element**	**No.**	**Data Element**
76	Insurance Type 6	44	Pregnant Status	38	SASD Meth Use	62	Service Through Date
77	Insurance Type 7	3	Program Area Id	36	SASD Type	13a	SMI SED At Risk
78	Insurance Type 8	18	Race	43	SATD Age Use	70	Social Connectedness
24	Legal Status	15	Referral Source	41	SATD Freq Use	8	SSN
84	Living Arrangement Measure	107	Related Date	42	SATD Meth Use	110	Staff Classification
57	Medicaid Nbr	93	Reported Diagnosis Code	40	SATD Type	63	Staff Id
68	Military Service End Date	35	SAPD Age Use	86	School Attendance Status	108	Transaction ID
67	Military Service Start Date	33	SAPD Freq Use	5	Service Code	61	Type Of Care From Date
66	Military Status	34	SAPD Meth Use	48	Service From Date	60	Type Of Care Through
47	Nbr Of Arrests	32	SAPD Type	65	Service Location	23	Type Of Residence
25	Nbr Prior Episodes Any Drug	39	SASD Age Use	106	Service Modality	10	Units
89	Preferred Language	37	SASD Freq Use	64	Service Subtype		

No.	Data Element Name and Definition	Data Type	Max Length
2	**Agency Code:** The number provided by the Department that identifies the CSB providing services to the individual and supplying individual and service data through the CCS.	Text	3
Must match one of the values in the lookup table, lkpAgency. The table uses leading zeros for two-digit CSB numbers to make the field length three characters.			
Purposes: Identify the CSB reporting CCS 3 data and meet federal block grant (FBG: MHBG and SABG) and TEDS reporting requirements.			
3	**Program Area Id:** Indicates in the Service file the program area in which an individual is receiving services. The three program areas are mental health, developmental, and substance use disorder services. ProgramAreaId 400 is a pseudo program area for emergency or ancillary services. The Type of Care file uses data element 3 in the **TypeOfCare** field to capture program area (100, 200, or 300).	Text	3
Must match one of the values in the lookup table, lkpProgram. Valid codes are: 100 Mental Health Services Program Area 200 Developmental Services Program Area 300 Substance Use Disorder Services Program Area 400 Emergency or Ancillary Services			
	Program Area Id also identifies consumer designation (900) codes (CDC) in the Type of Care file.	Text	3
When used in the Type of Care file for a CDC, data element 3 must match one of the values in the lookup table, lkpTypeOfCare.			
Purposes: Identify the program area in the service and type of care records and meet FBG, TEDS, and DOJ Settlement Agreement reporting requirements, and report outcome measures adopted by the Department and the VACSB.			
5	**Service Code:** Identifies each core service in which the individual receives services. The current core services taxonomy defines core-services, and the Core-Services Category and Subcategory Matrix indicates the type of service unit collected and reported for each service and lists each service code.	Text	3
Must match one of the values in the lookup table, lkpService. CSBs must not submit Service.txt records in CCS 3 for consumer-run, substance use disorder prevention, Mental Health First Aid or suicide prevention, or infant and toddler intervention (Part C) services.			
Purposes: Identify the program area in the service and type of care records and meet FBG and TEDS reporting requirements.			

No.	Data Element Name and Definition	Data Type	Max Length
7	**Consumer Id:** A number or a combination of numerical and alphabetical characters used to identify the individual receiving services uniquely within the CSB; it is the local consumer Id, rather than the statewide Id.	Text	10
Each CSB assigns and maintains these numbers, which can be up to 10 alphanumeric characters. If an individual return to the same CSB after discharge from a previous type of care, the CSB should use his or her same ConsumerId again.			
Purposes: Identify the unique individual whose data is being reported in the consumer, type of care, service, diagnosis, and outcomes records; link services to the individual receiving them; and report unduplicated individuals receiving services in the DBHDS Annual Report.			
8	**SSN:** The social security number of the individual receiving services from the CSB. CCS 3 hashes the SSN for HIPAA privacy purposes before transmission to the Department.	Text	9
The SSN must contain only numbers; it must not contain any separations, dashes, or other special characters.			
Purposes: Identify unique individuals, report unduplicated individuals, and construct unique identifier algorithm for One Source. *Must remain hashed for DBHDS compliance with SABG requirements.*			
10	**Units:** Amount of service received by the individual in the time period from the ServiceFromDate field to the ServiceThroughDate field. Reported with two decimal places (*e.g.*, 1.25 or 1.00)	Text (decimal)	8
These units are the numeric measurement of the service received by the individual. Units of measure for this field are service hours, day support hours, days of service, and bed days, as defined in the current core services taxonomy. Units of prevention are collected here for mental health and developmental prevention services using the unidentified z-consumer Id. Valid services and units in each program area and emergency and ancillary services are listed in the valid services table in Appendix F.			
Purposes: Report amounts of services in the Annual Report, calculate unit costs, and meet FBG and TEDS reporting requirements.			

No.	Data Element Name and Definition	Data Type	Max Length
12	**Discharge Status:** Status of an individual at the end of a type of care when he or she is discharged from a program area; this field is captured in a type of care record. The coding of this data element must reflect an individual's status at the end of an episode of care when the CSB discharges the individual from a program area, not when the individual moves among core services within a program area.	Text	2

Must match one of the values in the lookup table, lkpDisStatus. Valid codes are:

01 Retired: ~~Assessment and evaluation services are ancillary services; this code is not available for use by the CSB and is hiddent in the extract software.~~ Individuals for whom CSBs use this value previously should be reported at 07.

02 Treatment Completed: Individual discharged from a program area having made significant progress toward completing current ISP goals.

03 Treatment Incomplete at Discharge: Individual discharged from a program area without significant progress toward completing treatment goals at discharge or after the CSB lost contact with the individual for 90 days. In the later situation, the TypeOfCareThroughDate is the date of the last face-to-face service or service-related contact.

04 Individual Died: Individual's death is documented in his or her clinical record.

05 Breaking Program Rules: Individual discharged from a program area for breaking program rules.

~~06 Retired: This code is not available for use by CSBs and is hidden in the extract software. Archival data will be combined with 03 Treatment Incomplete at Discharge~~.

07 Other: Includes individuals who moved or left treatment due to illness, hospitalization, transfer to a state training center or certified nursing facility (DD), or for any other reason not captured by a value in the lookup table.

08 Individual Incarcerated: Individual discharged due to incarceration in a prison, local or regional jail or juvenile detention center, or other place of secure confinement. This does not include involuntary admission to a state or local psychiatric hospital or unit; in this situation, the individual should continue as an open case at the CSB.

96 Not Applicable

97 Unknown (Asked but not answered)

98 Not Collected (Not asked)

Purposes: Identify outcomes and meet FBG and TEDS reporting requirements.

No.	Data Element Name and Definition	Data Type	Max Length
13a	**SMI SED At Risk:** Code indicating if the individual has serious mental illness (SMI), serious emotional disturbance (SED), or is at-risk of SED, **as defined in the current core services taxonomy.**	Text	2
Must match one of the values in the lookup table, lkpSMISED. Valid codes are: 01 None 11 Serious Mental Illness (SMI) – *Age range of SMI: 18 years of age or older* 12 Serious Emotional Disturbance (SED) Ages- *Age range of SED Birth through 17 years* 13 At-risk of SED-*Age range of "At-risk" : "At-risk of SED ages Birth through 7 years* **96 Not Applicable** 97 **Unknown (Asked but not answered)** **98 Not Collected (Not asked)**			
Purposes: Describe levels of MI disability for individuals receiving services in DBHDS Annual Report and meet MHBG reporting requirements.			
14	**City County Residence Code:** Federal (FIPS) code indicating the city or county in which the individual lives.	Text	3
Must match one of the values in the lookup table, lkpFIPS.			
Purpose: TEDS and BG reporting			

No.	Data Element Name and Definition	Data Type	Max Length
15	**Referral Source:** The person, agency, or organization that referred the individual **TO** the CSB for evaluation, treatment and/or other services *Admitted or enrolled in program area, 100,200,300.*	Text	2

Must match one of the values in the lookup table, lkpReferral Valid codes are:

01 Self
02 Family or Friend
06 Developmental Disabilities (DD) Provider (Waiver) – DBHDS Licensed
07 School System or Educational Authority
08 Employer or Employee Assistance Program (EAP)
09 ASAP or DUI Program
10 Police or Sheriff
11 Local Correctional Facility
12 State Correctional Facility
13 Local Community Probation and Pre-Trial Services
16 Other Community Referral
17 Private Hospital
21 State Hospital*
22 State Training Center (ICF/IID certified)- *SEVTC or CVTC*
24 Court
27 Other Virginia CSB/BHA
30 Department of Social Services ~~(Not TANF)~~
31 Department of Juvenile Justice (DJJ)
32 Family Assessment and Planning Team/CSA office
33 Residential Substance Abuse Treatment Facility
34 Part C Provider *(NOTE: 29 are CSB operated & 11 external partner programs)*
35 Nursing Facility (certified) (*includes Hiram Davis Medical Center (HDMC)*
36 other BH healthcare provider
37 Alcohol or another SA Provider
38 Primary Health Care Provider – *All regardless of who provider or operator is (i.e., private and CSB).*
39 Specialty Provider/Clinician External *(i.e., neurologist, neurobehavioral psychologist, rheumatologist, dentist, PT, OT, SLP, etc.) not associated with the CSB)*
40 Psychiatric Residential Treatment Facility (PRTF) (i.e., *Alice C. Tyler Village, Barry Robinson Center, Bridges Treatment Center, Commonwealth Center for Children and Adolescents, Cumberland Hospital, FairWinds – Horseshoe, Grafton Integrated Health, Hallmark Youthcare- Richmond, Harbor Point Center for BH, Hughes Center, Jackson Field BH, Kempsville Center for BH, Liberty Point BH, North Spring BH, Newport News BH, Phoenix House Counseling, Phoenix House Program, Popular Springs Hospital, Riverside BH, Timber Ridge School, UMFS of VA-Centreville, UMFS – Richmond, Youth for Tomorrow; Southstone Behavorial Health)*
41 State Probation and Parole
42 Federal Probation
43 97 Unknown (Asked but not answered) 98 Not Collected (Not asked)
*Code referrals from Virginia Center for Behavioral Rehabilitation as State Hospital (code 21).

Note: 96 is not a valid code for this data element

Purposes: Meet TEDS, MHBG reporting requirements and respond to inquiries about linkages with other agencies, and STEP-VA

No.	Data Element Name and Definition	Data Type	Max Length
16	**Date of Birth:** The date of birth of the individual receiving services.	Text	8
MMDDYYYY with no spaces, slashes, or special characters. Use two digits for month and day, *e.g.*, February is 02; February 1 is 0201.			
Purposes: Meet FBG, TEDS and STEP – VA reporting requirements and construct unique identifier algorithm for One Source.			
17	**Gender:** The gender of the individual receiving services as identified ~~by the individual~~.as identified on their birth certificate. Staff should ask: *What gender/sex were you assigned at birth on your original birth certificate?*	Text	2
Must match one of the values in the lookup table, lkpGender. Valid codes are: 01 Female 02 Male 97 Unknown (Asked but not answered) 98 Not Collected (Not asked)			
Purposes: meet FBG, TEDS reporting requirements, and construct unique identifier algorithm.			
18	**Race:** The race of the individual receiving services as identified by the individual.	Text	2
Must match one of the values in the lookup table, lkpRace. Valid codes are: 01 Alaska Native 02 American Indian 03 Asian or Pacific Islander 04 Black or African American 05 White 06 Other 13 Asian 23 Native Hawaiian or Other Pacific Islander 31 American Indian or Alaska Native and White** 32 Asian and White** 33 Black or African American and White** 34 American Indian or Alaska Native and Black or African American** 35 Other Multi-Race** 97 Unknown (Asked but not answered) 98 Not Collected (Not asked) **Note: 96 is not a valid code for this data element.** Individuals can self-identify one of these races, used by the federal Office of Management and Budget in the 2000 census: American Indian (02) or Alaska Native (01), Asian (13), Black or African American (04), Native Hawaiian or Other Pacific Islander (23), White (05), or Other (06). Alternately, individuals can choose one of the new multi-race codes, designated with the ** in the table. CCS 2 used code 03 for historical purposes; CSBs must not use this code in CCS 3 for new individuals receiving services.			
Purposes: meet FBG, TEDS reporting requirement, and respond to other inquiries.			

No.	Data Element Name and Definition	Data Type	Max Length
19	**Hispanic Origin** The Hispanic origin of the individual receiving services as identified by the individual using codes provided by the federal government	Text	2

Must match one of the values in the lookup table, lkpHispanic;

01 Puerto Rican
02 Mexican
03 Cuban
04 Other Hispanic
05 Not of Hispanic Origin
06 Hispanic – Specific origin not identified
97 Unknown (Asked but not answered)
98 Not Collected (not asked)

Purposes: Meet FBG and TEDS reporting requirements and respond to other inquiries.

No.	Data Element Name and Definition	Data Type	Max Length
21	**Education Level:** The level of education of the individual receiving services, specifies the highest secondary school, vocational school, or college year completed or attained. There is no separate code for special education. Individuals who are in special education or have graduated from special education should have the highest school grade completed entered.	Text	8

Must match one of the values in the lookup table, lkpEducation. *Italicized language* below further defines the codes. Valid codes are:

01 No Years of Schooling (also use for a child under 3 or 3-4 years old who is not in pre-school)

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

Code an individual who has completed a GED as Grade 12.

23 Nursery, Pre-School, Head Start
24 Kindergarten
25 Special Education *(see note below)*
26 Vocational Only
27 College Undergraduate Freshman
28 College Undergraduate Sophomore
29 College Undergraduate Junior
30 College Undergraduate Senior
31 Graduate or Professional Program
97 Unknown (Asked but not answered)
98 Not Collected (Not asked)

Note: 96 is not a valid code for this data element.

Note: *Use Code 25 only for individuals who are in a self-contained, in a special education program without an equivalent school grade level; with mainstreaming, this code should be used rarely*

Purposes: Meet FBG and TEDS reporting requirements and respond to other inquiries.

No.	Data Element Name and Definition	Data Type	Max Length
22	**Employment Status:** Code indicating the employment status of the individual receiving services; *e.g.*, employed, unemployed, in an employment program, or not in the labor force; CSBs must collect this at admission to and discharge from a program area and **update it annually**.	Text	2
Must match one of the values in the lookup table, lkpEmployment. *Italicized language* further defines the codes. Select the one code below that most accurately describes the individual's employment status when it is collected. Valid codes are:			
Must match one of the values in lkpEmployment. *Italicized language* further defines the codes. Valid codes are: *01* Employed Full Time: Employed 35 hours a week or more; includes Armed Forces *This does not include an individual receiving supported or sheltered employment; the correct code for this individual is 12 or 13.* *02* Employed Part Time: Employed less than 35 hours a week *This does not include an individual receiving supported or sheltered employment; the correct code for this individual is 12 or 13.* 03 Unemployed but Seeking Employment *06* Not in Labor Force: Homemaker *The individual is not in the labor force only because he or she is a homemaker and has no other valid employment status.* *07* Not in Labor Force: Student or Job Training Program *Job training program does not include supported or sheltered employment, but it does include prevocational or day support services.* 08 Not in Labor Force: Retired *09* Not in Labor Force: Disabled *The individual is not in the labor force only because of his or her physical disability, mental illness, developmental disability, or substance use disorder.* 10 Not in Labor Force: Resident or Inmate of Institution *The individual is not in the labor force only because he or she lives in a state or local hospital, training center, nursing home, local or regional jail or state correctional facility, or other institution.* 11 Not in Labor Force-Other: Unemployed and not Seeking Employment *The individual is unemployed and does not want a job or employment, or another value (e.g., 07 student) is not appropriate due to his or her age (e.g., four years old).* 12 Employment Program: Supported Employment *The individual receives individual or group supported employment services, defined in the core services taxonomy or works in a supported employment setting.* 13 Not in Labor Force: Sheltered Employment *The individual receives sheltered employment services, defined in the core services taxonomy, or works in a sheltered employment setting.* *97* Unknown (Asked but not answered) *The individual or his or her authorized representative did not provide an employment status.* *98* Not Collected (Not asked) *This value must not be used for individuals admitted to a program area; its use is only appropriate for individuals for whom a case is opened to receive Emergency or Ancillary Services.* **Note: 96 is not a valid code for this data element.** The code selected should be the most meaningful description of the individual's employment status when this data is collected		

No.	Data Element Name and Definition *(Element 22 Continued)*	Data Type	Max Length
For example, if the individual at admission is unemployed but wants a job and needs supported employment, the correct value is 03 rather than 12. After the individual is admitted to a program area and is receiving supported employment, the correct value at the annual update is 12.			
Purposes: meet FBG, TEDS reporting requirements, and construct unique identifier algorithm ~~for One Source.~~			
23	**Type Of Residence:** Code indicating where the individual receiving services lives.	Text	2
Must match one of the values in the lookup table, lkpResidence. Valid codes are:			
01 Private - Household **(**BG 07) 02 Shelter (BG 01) *03* Boarding Home *(non-licensed 3 persons of less)* *04* Foster Home or Family Sponsor Home *or Foster Care* *(02-BG: individual resides in a foster home. A foster home is a home that is licensed by a county or state department to provide foster care to children, adolescents, and/or adults. This includes therapeutic foster care facilities. Therapeutic foster care is a service that provides treatment for troubled children within private homes of trained families.* 05 Licensed Assisted Living Facility (~~CSB or~~ non-CSB operated) BG = 05) *06* Community Residential Service = *Waiver provider (BG03)* 07 Residential Treatment or Alcohol or Drug Rehabilitation (Other Residential Setting) 08 Nursing Home or Physical Rehabilitation Facility (BG =05) *09* Hospital *(BG= 05)-state hospital, psychiatric hospital* 10 Local Jail or Correctional Facility (BG 06) *Individual resides in a jail and/or correctional facility with care provided on a 24 hour, 7 days a week basis. This includes a jail, correctional facility, detention centers, and prison.*	11 State Correctional Facility (BG 06) 12 Other Institutional Setting (ICF/IID, IMD, 13 Homeless ~~or homeless shelter~~) ***(01 BG)***– *person has no fixed address; includes homeless,~~ shelters~~* NOTE: *Shelter = 02)* 14 Juvenile Detention Center 15 Veterans Health Administration (VHA) 16 Adult Transition Home 17 other residential status (BG =08) 97 Unknown (Asked but not answered) 98 Not Collected (Not asked) **Note: 96 is not a valid code for this data element.** (BG = Block Grant)		
Purposes: Meet FBG and TEDS reporting requirements, provide DBHDS Annual Report data, and respond to other inquiries (*e.g.*, VHCD).			

No.	Data Element Name and Definition	Data Type	Max Length
24	**Legal Status:** The legal status of the individual receiving services identifies the type of civil or forensic court order or criminal status related to the individual's admission to a CSB program area or a state facility or to the opening of a record for emergency or ancillary services	Text	2

Must match one of the values in the lookup table, lkpLegal. Valid codes are:

01 Voluntary: An individual is admitted voluntarily for community (including local inpatient) services or state facility services.

02 Involuntary Civil: An adult is admitted involuntarily, as decided at a non-criminal hearing, for purposes of an NGRI or competency examination or evaluation or for treatment under a Mandatory Outpatient Treatment (MOT) order or an inpatient civil commitment order; this does not include court-ordered psychological evaluations or other assessments for custody cases.

04 Involuntary Juvenile Court: A juvenile is admitted involuntarily, as decided at a non-criminal hearing, for the purposes of an NGRI or competency examination or evaluation or for treatment under an inpatient civil commitment order or remains in the community and is court- ordered to treatment in the community; custody remains with the parent or guardian. This does not include court-ordered psychological evaluations or other assessments for custody cases.

06 Involuntary Criminal: An individual who is incarcerated with pending criminal charges or convictions is admitted involuntarily for evaluation or treatment.

07 Involuntary Criminal Incompetent: An individual who is incarcerated with pending criminal charges is deemed incompetent to stand trial and is admitted involuntarily for competency restoration.

08 Involuntary Criminal NGRI: An individual who has been adjudicated not guilty by reason of insanity (NGRI) is admitted involuntarily for treatment.

09 Involuntary Criminal Sex Offender: An individual who is incarcerated under criminal sex offender charges is admitted involuntarily for evaluation or treatment.

10 Involuntary Criminal Transfer: An individual who is incarcerated with pending criminal charges is transferred to a state hospital from a correctional facility for evaluation or treatment.

11 Treatment Ordered Conditional Release: An individual who has been adjudicated NGRI and released conditionally under a court order.

12 Treatment Ordered Diversion: An individual who has been court-ordered to treatment as a term or condition of diversion from the criminal justice system.

13 Treatment Ordered Probation: An individual who has been court-ordered to treatment as a term or condition of probation.

14 Treatment Ordered Parole: An individual who has been court-ordered to treatment as a term or condition of parole.

97 Unknown (Asked but not answered)

98 Not Collected (Not asked)

Note: An individual who is ordered to the CSB for a psychological evaluation or other assessment in connection with a custody case would be recorded as 01 (Voluntary). **Note: 96 is not a valid code for this data element.**

Purposes: Meet FBG and TEDS reporting requirements and respond to other inquiries.

No.	Data Element Name and Definition	Data Type	Max length
25	**Nbr Prior Episodes Any Drug:** The number of previous episodes of care in which the individual has received any substance use disorder services, regardless of the setting (*e.g.*, hospital, community, another state). This number reflects complete episodes of care since the individual first entered the system.	Text	2
Must match one of the values in the lookup table, lkpEpisodes. Valid codes are: 00 No prior episodes 01 One prior episode 02 Two prior episodes 03 Three prior episodes 04 Four prior episodes 05 Five or more prior episodes 96 Not Applicable 97 Unknown (Asked but not answered) 98 Not Collected (Not asked)			
Purposes: Meet TEDS (federal SABG) reporting requirements and respond to other inquiries.			
32	**SAPD Type:** The primary substance use disorder problem (drug of abuse) of the individual receiving services.	Text	2
Must match one of the values in the lookup table, lkpDrug. Valid codes are: 01 None 02 Alcohol 03 Cocaine or Crack 04 Marijuana or Hashish: Including THC and other cannabis sativa preparations 05 Heroin 06 Non-prescription Methadone 07 Other Opiates/Synthetics: Including codeine, Dilaudid, morphine, Demerol, opium, and any other drug with morphine-like effects 08 PCP - Phencyclidine 09 Other Hallucinogens: Including LSD, DMT, STP mescaline, psilocybin, or peyote 10 Methamphetamines 11 Other Amphetamines: Including Benzadrine, Dexedrine, Preludin, Ritalin, and any other "…amines" and related drugs 12 Other Stimulants 13 Benzodiazepine: Including Diazepam, Flurazepam, Chlordiazepoxide, Clorazepate, Lorazepam, Alprazolam, Oxazepam, Temazepam, Prazepam, or Triazolam, 14 Other Tranquilizers 15 Barbiturates: Including Phenobarbital, Seconal, or Nembutal 16 Other Sedatives or Hypnotics: Including chloralhydrate, Placidyl, Doriden, or mempromate 17 Inhalants: Including ether, glue, chloroform, nitrous oxide, gasoline, or paint thinner 18 Over the Counter: *e.g.*, aspirin, cough syrup, , over-the-counter diet aids, and any other legally obtained, non-prescription medication. 20 Other 96 Not Applicable 97 Unknown (Asked but not answered) 98 Not Collected (Not asked)			

No.	Data Element Name and Definition	Data Type	Max Length
	Purposes: Meet SABG and TEDS reporting requirements and respond to other inquiries.		
33	**SAPD Freq Use:** The individual's frequency of use of the primary drug of abuse.	Text	2
	Must match one of the values in the lookup table, lkpFrequency. *Italicized language* below further defines the codes. Valid codes are: 01 No use in the past month - *an individual has not used any drug in past month or an individual who is not currently a user is seeking service to avoid a relapse* 02 One to three times in the past month 03 One to two times per week 04 Three to six times per week 05 Daily 96 Not Applicable 97 Unknown (Asked but not answered) 98 Not Collected (Not asked)		
	Purposes: Meet SABG and TEDS reporting requirements and respond to other inquiries.		
34	**SAPD Meth Use:** The individual's method of use or usual route of administration for the primary drug of abuse.	Text	2
	Must match one of the values in the lookup table, lkpDrugMethod. Valid codes are: 01 Oral 02 Smoking 03 Inhalation 04 Injection (IV or Intramuscular) 05 Other 96 Not Applicable 97 Unknown (Asked but not answered) 98 Not Collected (Not asked)		
	Purposes: Meet FBG and TEDS reporting requirements and respond to other inquiries.		
35	**SAPD Age Use:** The age at which the individual receiving services first used the primary drug of abuse or, for alcohol, the age of the individual's first intoxication.	Text	2
	There is no lookup table for this field. The age must not be older than the individual's age. Valid codes are: 00 Newborn 01-95 Actual Age of First Use 96 Not Applicable 97 Unknown 98 Not Collected		
	Purposes: Meet SABG and TEDS reporting requirements and respond to other inquiries.		

No.	Data Element Name and Definition	Data Type	Max Length
36	**SASD Type:** The secondary substance use disorder problem (drug of abuse) of the individual receiving services.	Text	2
Valid codes are the same as the type of the individual's primary drug of abuse.			
37	**SASD Freq Use:** The individual's frequency of use of the secondary drug of abuse.	Text	2
Valid codes are the same as the frequency of use for the individual's primary drug of abuse.			
38	**SASD Meth Use:** The individual's method of use or usual route of administration for the secondary drug of abuse.	Text	2
Valid codes are the same as the method of use for the individual's primary drug of use.			
39	**SASD Age Use:** The age at which the individual receiving services first used the secondary drug of abuse, or for alcohol, the age of the individual's first intoxication.	Text	2
Valid codes are the same as the age at first use for the individual's primary drug of abuse.			
40	**SATD Type:** The tertiary substance use disorder problem (drug of abuse) of the individual receiving services.	Text	2
Valid codes are the same as for the type of the individual's primary drug of abuse.			
41	**SATD Freq Use:** The individual's frequency of use of the tertiary drug of abuse.	Text	2
Valid codes are the same as the frequency of use for the individual's primary drug of abuse.			
42	**SATD Meth Use:** The individual's method of use or usual route of administration for the tertiary drug of abuse.	Text	2
Valid codes are the same as the method of use for the individual's primary drug of use.			
43	**SATD Age Use:** The age at which the individual receiving services first used the tertiary drug of abuse or, for alcohol, the age of the individual's first intoxication.	Text	2
Valid codes are the same as the age at first use for the individual's primary drug of abuse.			

No.	Data Element Name and Definition	Data Type	Max Length
44	**Pregnant Status:** Indicates if the individual is a female with a substance use disorder who is pregnant	Text	1
Must match one of the values in the lookup table, lkpYesNo. Gender must be 01 (Female) to enter a 'Y' status. Valid codes are: Y Yes N No U Unknown (Asked but not answered) X Not Collected (Not asked) A Not Applicable			
Purposes: Meet FBG and Post-Partum Women (PPW) reporting requirements and respond to other inquiries.			
45	**Female With Dependent Children Status:** Indicates if the individual *identifies as* ~~is~~ a female with a substance use disorder who is living with dependent children (ages birth through 17)	Text	1
Must match one of the values in the lookup table, lkpYesNo. Gender must be 01 (Female) to enter a 'Y' status. Valid codes are: Y Yes N No A Not Applicable U Unknown (Asked but not answered) X Not Collected (Not asked)			
Purposes: Meet FBG reporting requirements and respond to other inquiries.			

No.	Data Element Name and Definition	Data Type	Max Length
47	**Nbr Of Arrests: N**umber of arrests of the individual in the past 30 days preceding admission to the mental health (100) or substance use disorder services (300) with the CSB and at discharge to program area CSBs must collect and report this at intake admission to and at discharge from a program area (100,300)~~ and annually at the individualized service plan review~~.	Text	2

Any formal arrest should be counted, regardless of whether incarceration or conviction resulted or regardless of the status of the arrest proceedings on the date of admission. *If in treatment less than 30-days, use number of arrests during period of treatment for the discharge data (BG instructions V 2.7)*

Valid codes are:
If value is zero (no arrests within 30 days preceding admission), use "00"

00-31 Number of arrests
~~96 Not Applicable~~ (retire 96 as of FY 2021) **NOT A Valid Code beginning FY 2021**
97 Unknown (Asked but not answered)
98 Not Collected (Not asked)

Purposes: Meet FBGs, and TEDS reporting requirements and respond to other inquiries.

No.	Data Element Name and Definition	Data Type	Max. Length
48	**Service From Date:** MMDDYYYY indicating the date on which the service occurred or on which the service began within the reporting month for those services spanning more than one day.	Text	8
	Must be a valid date within the current fiscal year, which starts on July 1 of one year and ends on June 30 of the following year.		
	Purpose: Meet FBG and TEDS reporting requirements.		
57	**Medicaid Nbr:** The Medicaid number of the individual receiving services in the format specified by the Department of Medical Assistance Services (DMAS), only 12 numeric characters.	Text	12
Reported for individuals enrolled in Medicaid at their admission to a program area. If an individual is enrolled in Medicaid at one point, but then loses his or her Medicaid eligibility, the value in this field should continue to show the Medicaid number. If the individual's Medicaid number changes, then the new number must be transmitted. If a CSB includes formatting characters (*e.g.*, hyphens, pound signs) in its Medicaid number, the CSB must strip them out before exporting the number to the CCS 3 extract. Do not enter Medicaid HMO, Managed Care, Commonwealth Coordinated Care (Medicare Medicaid Dual Eligible) Project, ~~or Medicaid Governor's Access Plan (GAP~~) [NOTE: *GAP ended 3/31/19, do not include GAP after 3/31/19]* numbers in this field; reflect these coverages in the InsuranceType data elements (71-78). **Enter only actual Medicaid numbers in data element 57. Enter only the Medicaid number not the billing number for any managed care Medicaid service, do not pull from insurance field to this element, as they may not be the same.**			
Purposes: Collect data for the DBHDS Annual Report and respond to other inquiries.			
58	**Consumer First Name:** The first name of the individual receiving services, used to extract characters for input to a probabilistic matching algorithm run by the Department to generate a unique consumer Id. The full first name is not transmitted to the Department.	Text	30
Any valid alphanumeric character.			
Purpose: Construct unique identifier algorithm for OneSource.			

No.	Data Element Name and Definition	Data Type	Max. Length
59	**Consumer Last Name:** The last name of the individual receiving services, used to extract characters for input to a probabilistic matching algorithm run by the Department to generate a unique consumer Id. The full last name is not transmitted to Department.	Text	30
Any valid alphanumeric character. Last names with hyphens should put the individual's legal last name before the hyphen.			
Purpose: Construct unique identifier algorithm for One Source.			
60	**Type Of Care Through Date:** MMDDYYYY indicating the ending date of a type of care.	Text	8
Must be a valid date and must be the same date as the TypeOfCareFromDate or later. Must not be a date in the future (*e.g.*, past the date of the extract file at the latest).			
Purpose: Meet FBG and TEDS reporting requirements.			
61	**Type Of Care From Date:** MMDDYYYY indicating the starting date of a type of care.	Text	8
Must be a valid date. Must not be before a previous TypeOfCareThroughDate in the same program area.			
Purpose: Meet FBG and TEDS reporting requirements.			
62	**Service Through Date:** MMDDYYYY indicating the ending date of a service. If the service through date is the same as the ServiceFromDate; i.e. the service started and ended on the same day, this value should be the same as the service from date.	Text	8
Must be a valid date and must be the same day as the ServiceFromDate or later. Must not be a date in the future (*e.g.*, past the date of the extract file at the latest).			
Purpose: Meet FBG and TEDS reporting requirements.			

No.	Data Element Name and Definition	Data Type	Max. Length
63	**Staff Id:** Indicates the local staff identification number.	Text	10
This is ~~an **optional**~~ **a mandatory data element** supplied by CSBs ~~on a **voluntary basis**. If it omits this field, the CSB must represent it with two consecutive commas for formatting NULL values in the extract file (refer to Appendix E).~~			
Purpose: Provide information for quality improvement and management. STEP-VA; Peer and Family Support Services; Workforce Development, program analysis.			

No.	Data Element Name and Definition	Data Type	Max Length
64	**Service Subtype:** A specific activity associated with a particular core service category or subcategory for which a Service.txt file is submitted. **Pad with 0 (zero) = required = FATAL ERROR as of July 1, 2020** **For services that do not have a valid service subtype code as 96.**	Text	3

Must match one of the values in the lookup table, lkpServiceSubtype. Valid codes are:

01 RETIRED ~~Crisis Intervention~~: ~~Clinical intervention in response to an acute crisis episode; includes counseling, short term crisis counseling, triage, or disposition determination; this includes all emergency services not included in subtypes 02 through 06 below~~ SEE#24 below for new Crisis Intervention definition and code

02 Crisis Intervention Provided Under an ECO: Clinical intervention and evaluation provided by a certified preadmission screening evaluator in response to an emergency custody order (ECO) issued by a magistrate

03 Crisis Intervention Provided Under Law Enforcement Custody (a paperless ECO): Clinical intervention and evaluation provided by a certified preadmission screening evaluator to an individual under custody of a law enforcement officer without a magistrate-issued ECO

04 Independent Examination: An examination provided by a independent examiner who satisfies the requirements in and who conducts the examination in accordance with § 37.2-815 of the Code of Virginia in preparation for a civil commitment hearing

05 Commitment Hearing: Attendance of a certified preadmission screening evaluator at a civil commitment or recommitment hearing conducted pursuant to § 37.2-817 of the Code of Virginia

06 MOT Review Hearing: Attendance at a review hearing conducted pursuant to §§ 37.2-817.1 through 37.2-817.4 of the Code of Virginia for a person under a mandatory outpatient treatment (MOT) order

13 Case Management Services for Quarterly Case Management ISP Review: Services provided by a case manager for a quarterly case management ISP review in a case management service licensed by the Department –required for DD services only

14 Case Management Services for Annual Case Management ISP Meeting: Services provided by a case manager for an annual case management ISP meeting in a case management service licensed by the Department –required for DD services only

(continued next page)

15 **Peer Support Community Based Services** (See Appendix M*): ONLY Peer driven, peer led services provided by representatives of local communities of recovery.*

16 **Family Community Based Services** (See Appendix M) *ONLY Family driven, family led services provided by representatives of local communities of recovery.*

17 **Peer Support Employment:** *Peer support services focused on assisting the individual in preparing to work, finding and keeping a job, and thriving in a work environment.*

18 **Family Support Employment***: Family support services focused on assisting the individual in preparing to work, finding and keeping a job, and thriving in a work environment.*

19 **Peer Housing Support***: Peer support services focused on assisting the individual with meaningful choice of housing and related community based housing support services.*

20 **Family Housing Support***: Family support services focused on assisting the individual with meaningful choice of housing and related community-based housing support services.*

(note to DMC partners… the original 21 has been deleted as not needed)

21 **Intensive Care Coordination/High Fidelity Wraparound *High Fidelity Wraparound (HFW)* (code Family Provided services under 22***) is a team-based, collaborative planning process for developing and implementing individualized care plans for children with behavioral health challenges and their families. HFW is an evidence-based process driven by 10 principles, four phases and a theory of change. Intensive Care Coordination is the service by which this planning process is delivered. When a Family/Youth Support Partner is involved in HFW they partner with the Intensive Care Coordinator through all phases of HFW and through their lived experience ensure that the family and youth's voice, strengths, needs and culture drive the process. ***ICC/HFW is ONLY for children under age 18.***

22 **Preadmission Screening Evaluation:** *An evaluation provided by a certified preadmission screening clinician to determine if individual meets the criteria for a TDO or involuntary commitment but is not subject to an ECO.*

(continued next page)

124 Crisis Intervention Services/Mobile: *See Appendix L for additional information*
125 Crisis Intervention Services/Day Program Intermittent: *See Appendix L for additional information*
126 Crisis Stabilization Services/Mobile: *See Appendix L for additional information:*
127 Crisis Stabilization Services/ Crisis Day Program (intermittent): *See Appendix L for additional information:*
128 Crisis Stabilization Services/Crisis 23 hour: *Applies to all program areas. See Appendix L for additional information:*
129 Crisis Stabilization: Residential Therapeutic Homes s/a Crisis Stabilization Unit: *See Appendix L for additional information:*

224 Crisis Intervention Services/Mobile: *See Appendix L for additional information*
225 Crisis Intervention Services/Day Program Intermittent: *See Appendix L for additional information*
226 Crisis Stabilization Services/Mobile: *See Appendix L for additional information:*
227 Crisis Stabilization Services/ Crisis Day Program (intermittent): *See Appendix L for additional information:*
228 Crisis Stabilization Services/Crisis 23 hour: *Applies to all program areas. See Appendix L for additional information:*
229 Crisis Stabilization: Residential Therapeutic Homes

324 Crisis Intervention Services/Mobile: *See Appendix L for additional information*
325 Crisis Intervention Services/Day Program Intermittent: *See Appendix L for additional information*
326 Crisis Stabilization Services/Mobile: *See Appendix L for additional information:*
327 Crisis Stabilization Services/ Crisis Day Program (intermittent): *See Appendix L for additional information:*
328 Crisis Stabilization Services/Crisis 23 hour: *Applies to all program areas. See Appendix L for additional information:*
329 Crisis Stabilization: Residential Therapeutic Homes
96 Not Applicable

Unknown (97) and Not Collected (98) are not valid codes for this data element.

CSBs must use codes 13 and 14 for developmental case management services that involve quarterly case management ISP reviews or annual case management ISP meetings, but CSBs also may use these codes for mental health or substance use disorder case management services that involve quarterly case management ISP reviews or annual case management ISP meetings. If they do not use codes 13 and 14 for mental health or substance use disorder case management services, CSBs must use Not Applicable (96).

No.	Data Element Name and Definition	Data Type	Max Length
65	**Service Location:** The location in which the service for which a Service.txt file is submitted was received by or provided to an individual. CSBs must report service location in the Service file for every service in all program areas (100, 200, and 300) and for emergency services or ancillary services (400). CSBs must collect service location at every service encounter.	Text	2

Must match one of the values in the lookup table, lkpServiceLocation. Valid codes are:

01 Consumer Residence: where the individual lives, his or her primary residence; however, if he or she lives in a CSB or CSB-contracted Residential facility, then enter 15. *Include PROJECT LINK effective 7/1/2019 and forward for those CSBs providing PROJECT LINKservices.*

02 CSB Program Site: the location in which a CSB or its contractor provides services *includes Day Support Program, Psychosocial Day program.* if this is where the individual lives, enter 15

03 Court: includes general district and juvenile and domestic relations courts, court services units and probation and parole offices 04 Local or Regional Jail: a facility serving adults primarily; not a Department of Corrections facility

05 Local or Regional Juvenile Detention Center: a facility serving juveniles under the age of 18 who have been committed to the facility; not a Learning Center operated by the state

06 Law Enforcement Facility: a location in the community that houses law enforcement officers; includes police stations and sheriffs' offices

07 Non-State Medical Hospital: a medical hospital licensed by but not operated by the state; includes hospitals and UVA and MCV hospitals

08 Non-State Psychiatric Hospital or Psychiatric Unit in a Non-State Medical Hospital: a psychiatric hospital or unit licensed by but not operated by the state; includes UVA and MCV, *VHA and MTF facilities (same definitions as in 15 Referral Source)*

09 State Hospital or Training Center: a facility operated by the Department of Behavioral Health and Developmental Services and defined in § 37.2-100 of the Code of Virginia

10 Educational Facility: includes public or private schools, community colleges, colleges, and universities*(i.e., homeschooling, TTAC,)*

11 Assisted Living Facility: a facility licensed by the Department of Social Services that provides housing and care for individuals in need of assistance with daily living activities

12 Nursing Home: a facility ~~licensed~~ certified by the Department of Health that provides services to individuals who require continuing nursing assistance and assistance with activities of daily living [*note: include Virginia Veterans Care Centers (i.e., Sitter Barefoot- Richmond; Salem VA VA NF – Salem, Va); excludes HDMC and SWMHI geriatric unit – code HDMC & SWMHI under 09]*

(continued on next page)

No.	Data Element Name and Definition *(Element #65 continued)*	Data Type	Max Length
	13 Shelter: a community-based facility that provides temporary housing or living space for a brief period of time to individuals who are homeless or in need of temporary sheltering; generally, does not provide any around-the-clock behavioral health or medical care and may or may not provide basic living amenities, but may provide space for meals, personal hygiene, and overnight accommodations 14 Other Community Setting (any location that is used for the provision of services other than those identified in preceding codes) *includes Adult Transition homes (Crisis)* 15 CSB or CSB-Contracted Residential Facility: this does not include CSB-controlled inpatient beds 16 Congregate Residential Facilities: Provider-controlled setting where multiple individuals live together and receive care in the community. 17 Peer Run Centers (i.e., Peer Respite, Wellness Recovery Center): A service site in which a majority of persons who oversee the program's operation and are in positions under direction that have lived experience 18 Non-hospital residential treatment facility- (i.e., Children & youth Jackson Field, UMFS, Grafton) : a facility other than a hospital, that provides psychiatric services and is a 24 hour supervised, clinically and medically necessary out of home active treatment program designed to provide necessary support and address mental health, behavioral, substance abuse, cognitive, and training needs of an individual under 21 years of age in order to prevent or minimize the need for more intensive inpatient treatment. Not Applicable (96), Unknown (97), and Not Collected (98) are not valid codes for this data element		
	Purposes: Meet DOJ Settlement Agreement and grant reporting requirements. Purposes: Track services to a high visibility population and respond to requests from the General Assembly, Dept. of Veteran Services and other reporting requirements.		

No.	Data Element Name and Definition	Data Type	Max Length
66	**Military Status:** The current status of **an individual** ~~who is seeking or~~ **receiving services** who is serving or has served in a branch of the U.S. military or who is a dependent family member of the individual. **CSBs must collect and report military status at admission to and discharge from a program area (100,200, 300, 400), annually, or when it changes and report it in the Consumer file.** *Please add a flag somewhere in your process for the CM/SC to ask:* *Please inquire about military connection by asking: "Have you served in the United States military or are you the spouse or dependent child of an individual who served in the United States military?" (dependent code 06) NOTE: reworded at suggestion of CSB for better clarity.*	Text	2
Must match one of the values in the lookup table, lkpMilitaryStatus. Valid codes are: Armed Forces on Active Duty: An individual who is serving on active duty in the U.S. Army, Navy, Marine Corps, Air Force, or Coast Guard or the U.S. Public Health Service or the U.S. Merchant Marine and could include mobilized members of the Reserve or Guard 02 Armed Forces Reserve: An individual who is serving in a duty status in a unit of the U.S. Army Reserve, Naval Reserve, Marine Corps Reserve, Air Force Reserve, or Coast Guard Reserve, but currently is not mobilized 03 National Guard: An individual who is serving in a duty status in a unit of the National Guard, but currently is not mobilized 04 Armed Forces or National Guard Retired: An individual who is retired, having served on active duty as a member of the U.S. Army, Army Reserve, Navy, Naval Reserve, Marine Corps, Marine Corps Reserve, Air Force, Air Force Reserve, Coast Guard, Coast Guard Reserve, or National Guard or the U.S. Public Health Service or Merchant Marine 05 Armed Forces or National Guard Discharged: An individual who has been discharged (any type of discharge) from military service in the U.S. Army, Army Reserve, Navy, Naval Reserve, Marine Corps, Marine Corps Reserve, Air Force, Air Force Reserve, Coast Guard, Coast Guard Reserve, or National Guard or the U.S. Public Health Service or Merchant Marine. 06 Armed Forces or National Guard **Dependent** Family Member: An individual who is the spouse or the dependent child of an individual who is serving on active duty in, is retired from, or has been discharged from the U.S. Army, Army Reserve, Navy, Naval Reserve, Marine Corps, Marine Corps Reserve, Air Force, Air Force Reserve, Coast Guard, Coast Guard Reserve, or National Guard or the U.S. Public Health Service or Merchant Marine 96 Not Applicable (No military status) 97 Unknown (Asked but not answered) 98 Not Collected (Not asked)		
Purposes: MHBG, increase validity of numbers and accuracy in reporting Veteran and Military Service Connections. Track services to a high visibility population and respond to requests from the General Assembly and Dept. of Veteran Services.			

No.	Data Element Name and Definition	Data Type	Max Length
67	**Military Service Start Date:** The year in which the individual's most recent active or reserve duty in the U.S. Army, Army Reserve, Navy, Naval Reserve, Marine Corps, Marine Corps Reserve, Air Force, Air Force Reserve, Coast Guard, Coast Guard Reserve, or National Guard or the U.S. Public Health Service or Merchant Marine began. CSBs must collect and report military service start date at admission to and discharge from a program area, annually, or when it changes and report it in the Consumer file.	Text	4
Enter the year or null. The format for the year is YYYY. *Enter null if code 06 is used for data element 66.*			
Purposes: Track services to a high visibility population and respond to requests from the General Assembly and Dept. of Veteran Services.			
68	**Military Service End Date:** If retired or discharged, the year in which the individual's most recent active or reserve duty in the U.S. Army, Army Reserve, Navy, Naval Reserve, Marine Corps, Marine Corps Reserve, Air Force, Air Force Reserve, Coast Guard, Coast Guard Reserve, or National Guard or the U.S. Public Health Service or Merchant Marine ended. CSBs must collect military service end date at admission to and discharge from a program area, annually, or when it changes and report it in the Consumer file.	Text	4
Enter the year or null. The format for the year is YYYY. *Enter null if code 06 is used for data element 66.*			
Purposes: Track services to a high visibility population and respond to requests from the General Assembly and Dept. of Veteran Services.			
70	**Social Connectedness:** The degree to which the individual receiving mental health or substance use disorder services is connected to his environment through types of social contacts that support recovery. This is measured by how often the individual has participated in any of the following activities in the past 30 days: participation in a non-professional, peer-operated organization that is devoted to helping individuals reach or maintain recovery such as Alcoholics Anonymous, Narcotics Anonymous, Secular Organization for Sobriety, Double Trouble in Recovery, or Women for Sobriety; participation in any religious or faith-affiliated recovery self-help groups; or participation in organizations that support recovery other than the organizations described above, including consumer-run mental health programs and Oxford Houses. CSBs must collect social connectedness at admission to and discharge from a program area and **update it annually** at the annual review of the ISP for individuals who have been receiving services in the program area for one year from the date of admission.	Text	2

(continued next page)

No.	Data Element Name and Definition *(Element # 70 Continued)*	Data Type	Max Length	
Must match one of the values in the lookup table, lkpSocialConnectedness. *Italicized language* further defines the codes. Valid codes are: 01 No Participation in the Past Month 02 Participation One to Three Times in the Past Month 03 Participation One to Two Times per Week 04 Participation Three to Six Times per Week 05 Participation Daily *96* Not Applicable - *For admission to or discharge from the developmental services program area or for opening a record for emergency or ancillary services* 97 Unknown (Asked but not answered) 98 Not Collected (Not asked)				
Purpose: Meet federal SABG NOMS reporting requirements. Project LINK				

No.	Data Element Name and Definition	Data Type	Max Length
71	**Insurance Type 1:** The type of health insurance currently covering the individual receiving services. CSBs must collect this when a record is opened on the individual for emergency or ancillary services or an individual is admitted to a program area and **update it whenever it changes**. *(04 & 06 are health care benefits, an option for eligible Veterans)*	Text	2

Must match one of the values in the lookup table, lkpInsuranceType. *Italicized language* below further defines the codes. Valid codes are:

01 Private Insurance - *includes Blue Cross/Blue Shield/Anthem, non-Medicaid or Medicare HMOs, self-paying employer-offered insurance, or other private insurance*

02 Medicare - *individual is enrolled in Medicare*

03 Medicaid - *individual is enrolled in Medicaid (for individuals in the three Developmental Disability (DD) Waivers, enter 03 for data element 71 and 10 for data element 72)*

04 Veterans Administration – *Health care benefits*

05 Private Pay - *any payment made directly by the individual or a responsible family member or any payment by non-insurance sources, e.g., courts, social services, jails, or schools*

06 Tricare *(formerly known as CHAMPUS) – health care program for uniformed service members, military retirees and their families (dependents).*

07 FAMIS

08 Uninsured - *if the individual is not covered by any health insurance but private payments are received, enter 08 for data element 71 and 05 for data element 72*

09 Other

10 Medicaid Managed Care - ~~*includes Commonwealth Coordinated Care Plus (CCC+)**~~ *members in regular Medicaid, (enter 10 for data element 71 and 03 for data element 72)*

11 Medicare Medicaid Dual Eligible - *includes CCC+ dual eligible members (enter 11 for data element 71, 02 for data element 72, and 03 for data element 73*

12 ~~*GAP*~~ *Retired FY 2021*

96* Not Applicable - *use this to fill in fields when the individual receiving services has no other insurance coverage after those indicated in previous InsuranceType data elements (e.g., 71 and 72); for example, if the individual is uninsured and 08 has been entered for data element 71, use 96 for data elements 72 through 78

97 Unknown (Asked but not answered)

98 Not Collected (Not asked)

~~**CCC+ includes individuals who are: age 65 and older, in nursing facilities, in the Technology Assisted or EDCD Waivers, in the three DD Waivers but only for their acute and primary care services (actual DD Waiver services and case management, support coordination, and transportation services are carved out of CCC+), in Medallion 3 ABD populations, and effective 01/01/2018 receiving mental health rehabilitation (State Plan Option) services under a CCC+ MCO.*~~

Purposes: Meet federal MHBG reporting requirements and respond to data requests (*e.g.*, for Medicaid expansion).

No.	Data Element Name and Definition	Data Type	Max Length
73	**Insurance Type 3:** See data element 71 for definition. See data element 71 for valid codes.	Text	2
74	**Insurance Type 4:** See data element 71 for definition. See data element 71 for valid codes.	Text	2
75	**Insurance Type 5:** See data element 71 for definition. See data element 71 for valid codes.	Text	2
76	**Insurance Type 6:** See data element 71 for definition. See data element 71 for valid codes.	Text	2
77	**Insurance Type 7:** See data element 71 for definition. See data element 71 for valid codes.	Text	2
78	**Insurance Type 8:** See data element 71 for definition. See data element 71 for valid codes.	Text	2
81	**Health Well Being Measure:** Identifies the extent to which the individual remains healthy as evidenced by the absence of unplanned hospital admissions; CSBs must collect and report this quarterly **only for individuals receiving Medicaid Developmental Disability (DD) Waiver services**. For other individuals, use code 96.	Text	2

Must match one of the values in the lookup table, lkpGoalMeasure. *Italicized language* below further defines the codes. Valid codes are:

01 Measure Met - *No unplanned hospital admissions occurred during the quarter.*

02 Measure Partially Met - *Unplanned admission(s) occurred or a hospitalization continued, and the individual's case management ISP was reviewed and updated as needed during the quarter.*

03 Measure Not Met - *Unplanned admission(s) occurred and the case management ISP was not reviewed and updated as needed during the quarter.*

04 Measure Not in ISP - ***Do not use.***

96 Not Applicable - *Use for all other individuals receiving services.*

97 Unknown (Asked but not answered)

98 Not Collected (Not asked)

Purpose: Meet DOJ Settlement Agreement reporting requirements for the eight domains.

No.	Data Element Name and Definition	Data Type	Max Length
82	**Community Inclusion Measure**: Identifies the extent to which desired community inclusion outcomes in the individual's ISP have been achieved as determined by the individual, the authorized representative if the individual cannot determine this, and the case manager during the quarterly case management ISP review; CSBs must collect 82 and report this quarterly **only for individuals receiving Medicaid DD Waiver services.** This includes opportunities as part of day support, employment, or residential services for education, employment, volunteer, and community inclusion or engagement activities that involve opportunities to develop relationships and interact with people other than paid program staff. This measure includes individuals who receive Medicaid DD Wavier Community Engagement/Community Coaching services, but it also includes individuals who participate in	Text	3

Must match one of the values in the lookup table, lkpGoalMeasure. *Italicized language* below further defines the codes. Valid codes are:

01 Measure Met - Community inclusion and engagement activities that involve opportunities to develop relationships and interact with people other than paid program staff were included in the individual's ISP and occurred at the frequency desired by the individual.
02 Measure Partially Met - Community inclusion and engagement activities that involve opportunities to develop relationships and interact with people other than paid program staff were included in the individual's ISP but did not occur at the frequency desired by the individual.
03 Measure Not Met - Community inclusion and engagement activities that involve opportunities to develop relationships and interact with people other than paid program staff were not included in the individual's ISP.
04 Measure Not in ISP - **Do not use.**
96 Not Applicable - Use for all other individuals receiving services.
97 Unknown (Asked but not answered)
98 Not Collected (Not asked)

Purpose: Meet DOJ Settlement Agreement reporting requirements for the eight domains.

No.	Data Element Name and Definition	Data Type	Max Length
83	**Choice and Self-Determination Measure:** Identifies the extent to which the individual's desired life choices (*e.g.*, healthcare, home, people to live with, daily schedule, clothing to wear, living area decoration, church to attend, social and recreational activities to participate in) have been included in the individual's ISP and have been implemented as determined by the individual, the authorized representative if the individual cannot determine this, and the case manager during the quarterly case management ISP review; CSBs must collect and report this quarterly **only for individuals receiving Medicaid DD Waiver services**. For other individuals, use code 96.	Text	2

Must match one of the values in the lookup table, lkpGoalMeasure. *Italicized language* below further defines the codes. Valid codes are:
(*The individual*)

01 Measure Met - *Played a major role in making most or all of the decisions that affected him or her such as choosing a physician, dentist, or roommate; meal menus; visitors; daily activities; or what to wear.*

02 Measure Partially Met - *Had some input into making the decisions that affected her or him but did not play a major role in making those decisions.*

03 Measure Not Met - *Rarely or never had input into making the decisions that affected him or her.*

04 Measure Not in ISP - ***Do not use.***

96 Not Applicable - *Use for all other individuals receiving services.*

97 Unknown (Asked but not answered)

98 Not Collected (Not asked)

Purpose: Meet DOJ Settlement Agreement reporting requirements for the eight domains.

No.	Data Element Name and Definition	Data Type	Max Length
84	**Living Arrangement Measure:** Identifies the degree to which an individual has maintained his or her chosen living arrangement, including moving from one home of choice to another, as determined by the individual, the authorized representative if the individual cannot determine this, and the case manager during the quarterly case management individual support plan (ISP) review; CSBs must collect and report this quarterly **only for individuals receiving Medicaid DD Waiver services**. For other individuals, use code 96.	Text	2

Must match one of the values in the lookup table, lkpStabilityMeasure. *Italicized language* below further defines the codes. Valid codes are: (*The individual*)

01 Measure Met Maintained - *Maintained his or her chosen living arrangement.*
02 Measure Met Different - *Moved to a different living arrangement of his or her choice.*
03 Measure Not Met Maintained - *Maintained a current living arrangement not of his or her choice.*
04 Measure Not Met Different - *Moved to a different living arrangement not of his or her choice.*
05 Measure Not in ISP - ***Do not use.***
96 Not Applicable - *Use for all other individuals receiving services.*
97 Unknown (Asked but not answered)
98 Not Collected (Not asked)

Purpose: Meet DOJ Settlement Agreement reporting requirements for the eight domains.

No.	Data Element Name and Definition	Data Type	Max Length
96	**Discussion of Last Completed Physical Examination:** The case manager asked about the last completed physical examination during discussion with the individual and the authorized representative, if one has been appointed or designated, at his or her most recent annual case management individual support plan (ISP) meeting. CBSs must collect and report this annually **for individual receiving Medicaid DD Waiver Services**.	Text	1
Must match on of the values in the lookup table, lkpYesNoECM. *Italicized language* below further defines the codes. Valid codes are: Y Yes – *Asked the individual about the physical examination.* N No – *Did not ask the individual about the physical examination* A Not Applicable – *Use only for any individual who is not receiving Medicaid DD Waiver services.* X Not Collected - *Use only for any who is receiving Medicaid DD Waiver services but whose annual ISP meetingdid not occur during the reporting period.*			
Purpose: Meet DOJ Settlement Agreement reporting requirements for the eight domains.			
97	**Date of Last Complete Physical Examination:** The date on which an individual received his or her last regularly scheduled complete wellness and preventative physical examination by a medical doctor, physician assistant, or nurse practitioner. This is not a date on which the individual was seen only in response to an illness, medical condition, or injury. The case manager must collect and report this **for individuals of any age receiving DD Waiver services** and **for adults with SMI receiving MH case management services** whenever the date changes. If the exact date is not available or known, an estimated complete date (MMDDYYYY) is acceptable.	Text	8
MMDDYYYY with no spaces, slashes, or special characters. Use two digits for the month and day, *e.g.*, February is 02 and February 1 is 0201. Must be a valid calendar date and must not be a date in the future (*e.g.*, after the date of the extract file). For all other individuals not receiving DD Waiver services or with SMI receiving MH case management services, this field should be null, unless the CSB chooses to complete this data element for those other individuals.			
Purpose: Meet DOJ Settlement Agreement eight domains reporting requirements and report Department, VACSB outcome measures			

No.	Data Element Name and Definition	Data Type	Max Length
98	**Discussion of Last Scheduled Dental Examination:** The case manager asked about the last regularly scheduled routine preventative dental examination during discussion with the individual and the authorized representative, if one has been appointed or designated, at his or her most recent annual case management ISP meeting. CSBs must collect and report this annually **for individuals receiving Medicaid DD Waiver services.**	Text	1
Must match one of the values in the lookup table, lkpYesNoECM. *Italicized language* below further defines the codes. Valid codes are: Y Yes - *Asked the individual about the dental examination.* N No - *Did not ask the individual about the dental examination.* A Not Applicable - *Use only for any individual who is not* Receiving Medicaid DD Waiver Services. X Not Collected - *Use only for any individual who is receiving Medicaid DD Waiver services but whose annual ISP meeting did not occur during the reporting period.*			
Purpose: Meet DOJ Settlement Agreement eight domains reporting requirements.			
99	**Date of Last Scheduled Dental Examination:** The date on which an individual received his or her last regularly scheduled routine preventative dental examination by a dentist. This is not a date on which the individual was seen only for a routine tooth cleaning without an examination by a dentist or for a dental emergency. The case manager must collect and report this date whenever it changes **for individuals of any age receiving Medicaid DD Waiver services.** If the exact date is not available or known, an estimated complete date (MMDDYYYY) is acceptable.	Text	8
MMDDYYYY with no spaces, slashes, or special characters. Use two digits for the month and day, *e.g.*, February is 02 and February 1 is 0201. Must be a valid calendar date and must not be a date in the future (*e.g.*, after the date of the extract file). For all other individuals not receiving Medicaid DD Waiver services, this field should be null, unless the CSB chooses to complete this data element for those other individuals			
Purpose: Meet DOJ Settlement Agreement eight domains reporting requirements.			

No.	Data Element Name and Definition	Data Type	Max Length
100	**Community Engagement/Community Coaching Services Discussion:** Identifies an individual receiving case management services from the CSB whose case manager discussed Medicaid DD Waiver Community Engagement/Community Coaching services with him or her during his or her most recent annual case management individualized services and supports plan (ISP) meeting. Community engagement or community coaching supports and fosters the ability of an individual to acquire, retain, or improve skills necessary to build positive social behavior, interpersonal competence, greater independence, employability, and personal choice necessary to access typical activities and functions of community life such as those chosen by the general population; it does not include community opportunities with more than three individuals with disabilities. CSBs must collect and report this **only for individuals receiving Medicaid DD Waiver services**. For other individuals, use code A.	Text	1

Must match one of the values in the lookup table, lkpYesNo. *Italicized language* below further defines the codes. Valid codes are:

Y Yes - *Discussion occurred about Medicaid DD Waiver Community Engagement/ Community Coaching services*

N No - *Discussion about Medicaid DD Waiver Community Engagement/ Community Coaching services did not occur during the annual case management ISP meeting.*

A Not Applicable - *Use only for any individual who is not receiving Medicaid DD Waiver services.*

U Unknown (Asked but not answered)

V Not Collected (Not asked) - *Use for any individual who is receiving Medicaid DD Waiver services but whose annual ISP meeting did not occur during the reporting period.*

Purpose: Meet DOJ Settlement Agreement eight domains reporting requirements and report Department, VACSB outcome measures

No.	Data Element Name and Definition	Data Type	Max Length
101	**Community Engagement Community Coaching Services Goals:** Identifies an individual receiving case management services from the CSB whose case management individualized services and supports plan (ISP), developed or updated at the annual ISP meeting, contained Medicaid DD Waiver Community Engagement/or Community Coaching services goals. CSBs must collect and report this **only for individuals receiving Medicaid DD Waiver services**. For others, use code A.	Text	1
Must match one of the values in the lookup table, lkpYesNo. *Italicized language* below further defines the codes. Valid codes are: Y Yes - *ISP contains Medicaid DD Waiver Community Engagement/~~or~~ Community Coaching services goals.* N No - *ISP does not contain Medicaid DD Waiver Community Engagement/ Community Coaching services goals.* A Not Applicable - *Use only for any individual who is not receiving Medicaid DD Waiver services.*			
Purpose: Meet DOJ Settlement Agreement reporting requirements for the eight domains.			

No.	Data Element Name and Definition	Data Type	Max Length
102	**Date of Assessment:** MMDDYYYY indicating the date on which the assessment used for the outcome occurred.	Text	8
Must be a valid date within the current fiscal year, which starts on July 1 of one year and ends on June 30 of the following year.			
Purpose: Report outcome measures adopted by the Department and the VACSB, including Same Day Access (SDA), and STEP- VA			

No.	Data Element Name and Definition	Data Type	Max Length
103	**Assessment Action:** The type of assessment or action related to the assessment for the outcome measure. Applies to 100 and 300 program areas.	Text	2

Must match one of the values in the lookup table, lkpOutcomeAction. *Italicized language* below further defines the codes. Valid codes are:

01 Columbia Suicide Severity Rating Scale, Screener Version (6 Item Initial Screener Version) see Appendix H
02 Body Mass Index (BMI) Assessment
03 BMI Follow Up Documented
04 Patient Health Questionnaire – 9 (PHQ-9) - *optional*
05 Same Day Access (SDA) Assessment - *an individual receives a clinical behavioral health assessment, not just a screening, from a licensed or license-eligible clinician when he or she requests mental health or substance use disorder services. This does not include other assessments such as psychological or competency evaluations. When data element 103 is coded 05, code data element 104 as 01 if the assessment determined the individual needed services or 02 if it did not; in either case, code data element 105 as 96*
06 First Available Appointment Offered - *Based on the SDA assessment, if applicable, an individual is offered an appointment in a mental health or substance use disorder service offered at the CSB that best meets his or her needs. When data element 103 is coded 06, code data element 104 as 00 and element 105 as 96 and enter the date in data element 107*
07 Primary Care Screening *a yearly primary care screening to include, at minimum, height, weight, blood pressure, and BMI.*
08 Anti-psychotic medications prescribed by CSB practitioner *(for age 3 and up)*
09 Metabolic Syndrome Screening – *Annual– Glucose,- hemoglobin- lipid profiles*

~~10 Referral to primary care physician *(Use 01=Yes; 02 No; 05 = individual/parent/legal guardian refused), for all other physicians other than primary care physicians use code 13; Referral Destinations lkpReferralDestination use 13*~~

11 *Individual Attended PCP Appointment follow referral outside normal range (05 Individual/legal guardian refused)*
12 DLA -20 *enter AVERAGE* composite score
13 Referral Destination -*use lkpRreferralDestination in Appendix J*
(continued on next page)

14. Tuberculosis at Risk Screening for any **admission to 300 program area only**

Questions for staff to ask for TB at risk screening:
Have you had any of the following symptoms which are unexplained:
a) cough for more than 2-3 weeks;
b) fevers;
c) night sweats;
d) weight loss; or
e) Hemoptysis or coughing up blood?

If yes, refer to Local Public Health Department for further screening (mark referral destination 13 with 22 as noted in Appendix J)

There is no expectation that a nurse provides this screening. The CSB is welcome to use the form found here: http://www.vdh.virginia.gov/content/uploads/sites/112/2019/02/VA-TB-Risk-Assessment-and-User-Guide-2019-1.pdf

Other codes can be added for new outcome assessments or actions.

Not Applicable (96), Unknown (97), and Not Collected (98) are not valid codes for this data element. If there is no outcome assessment or action, there would be no outcome record reported

Purpose: Report outcome measures adopted by the Department and the VACSB, including SDA, STEP-VA and FBG reporting requirements

No.	Data Element Name and Definition	Data Type	Max Length
104	**Assessment Value:** The numeric value of the assessment.	Text	5

Must be consistent with a value in the applicable outcome assessment (*e.g.*, BMI or PHQ-9); use leading zeros to complete the field.
00 None
01 Yes
02 No
00 – 27 PHQ-9 Score - *the two-character numeric PHQ-9 score - optional*

000.0-999.9 – BMI Assessment Score - *the ~~three~~ four-character numeric BMI score including the decimal point*
Not Applicable (96),
Unknown (97), and
Not Collected (98) are not valid codes for this data element. See data element 103.

If field 103 is:	Then field 104 must be one of the following values
01 Columbia Suicide Severity Rating Scale, Screener Version (6 Item Initial Screener Version) see Appendix H	00 ~~None~~ =completed ~~01 Yes~~ ~~02 No~~
04: Patient Health Questionnaire - 9 (PHQ-9) (optional)	00 – 27 PHQ-9 Score - *the two-character numeric PHQ-9 score - optional*
07 Primary Care Screening Done	02 No 03 Yes, screening values not within normal 04 Yes, screening values within normal 05 No, legal guardian or individual refused
08 Antipsychotic Medication Use	01 Yes 02 No
09 Metabolic Syndrome Screening	02 No 03 Yes, screening values not within normal ranges 04 Yes, screening values within normal ranges; 05 No, individual/legal guardian refused

11 Individual Attended PCP Appointment	01 Yes 02 No 05 No, individual/legal guardian refused
12 DLA -20 Average Composite Score *(technical note only pad with zeros)*	1.0-7.0
13 Referral Destination	Use value from Data Element lkpReferralDestination (see Appendix J)
14 Tuberculosis (300 program area only)	01 Screening completed/referred to public health dept. (use *lkpReferralDestination;* Mark Referral Destination 13 with 22) 02 Screening completed/not referred 03 Previous positive result to TB

Purpose: Report BG outcome measures adopted by the Department, the VACSB. STEP-VA.

No.	Data Element Name and Definition	Data Type	Max Length
105	**Assessment Frequency:** The frequency of the outcome assessment or action. (optional field)	Text	2

Must match one of the values in the lookup table, lkpOutcomeFreq. Valid codes are:

01 Initial	04 Annual
02 Monthly	05 Discharge
03 Quarterly	06 Other
	~~07 Admission to Program Area~~
	96 Not Applicable - *Use when frequency is not applicable.*
	Unknown (97), and Not Collected (98) are not valid codes for this data element.

Purpose: Report outcome measures adopted by the Department and the VACSB, STEP-VA; DLA -20

No.	Data Element Name and Definition	Data Type	Max Length
106	**Service Modality:** This identifies how a service with a service hour unit of service (~~core~~ service codes 100, 310, 312, 313, 318, 320, 335, 350, ~~360, 380,~~ 390, ~~395~~, 460, 581, ~~591~~,~~610,~~ 620, and 720) is delivered: face-to-face or non-face-to-face. CSBs must report service modality for all services with a service hour unit of service	Text	2
	Must match one of the values in the lookup table lkpServiceMod. Valid codes are: *01* Face-to-Face Service - *staff deliver the service to the individual face-to-face.* *02* Non-Face-to-Face Service - *staff provide the service for the individual but not face-to-face with her or him. For 610 Prevention Services, do not report substance use disorder prevention or Mental Health First Aid or suicide prevention service hours in CCS 3; CSBs report these service units in the Department's separate prevention data system. CSBs must report all mental health and develop mental prevention service hours as 02 since they are reported using the z-consumer function (see page 22 of Core Services Taxonomy 7.3).* 96 Not Applicable - *use for any core service with a service unit of a bed day, day of service, or day support hour.* **Unknown (97) and Not Collected (98) are not valid codes for this data element.**		
	Purpose: Report outcome measures adopted by the Department and the VACSB, including SDA.		
107	**Related Date: only used for Same Day Assessment (SDA)** A date related to an outcome measure. MMDDYYYY indicating the date on which an event related to an outcome occurred. *Currently, CSBs should use this data element only when data element 103 is coded 06 for First Available Appointment Offered – this date must be completed even if offered and attended are the same day. Otherwise, leave this field blank (NULL).*	Text	8
	Must be a valid date.		
	Purpose: Report outcome measures adopted by the Department and the VACSB, including SDA.		
108	**Transaction ID:** A number that uniquely identifies each record in each service, type of care, diagnosis, or outcomes file in each CCS submission; this is not a data element for Consumer records	Text	12
	Must be all numeric characters; use leading zeros to complete the field.		
	Purpose: Used to track records from individual CSBs in the Department's OneSource data warehouse for data quality purposes.		

No.	Data Element Name and Definition	Data Type	Max Length
110	**Staff classification –** The classification correlating to StaffID, and related to peer support services, family -support services and Crisis or STEP-VA programs for the purposes of CCS 3	Text	2

Identify as appropriate for Type of Service, per lkpStaffClassification – related to CSB – Staff ID (63) (See Appendix M for additional information related to Peer/Family Support Services and Appendix L related to Crisis services)

01 **Peer Supporter** - Person with personal lived experience with mental health and/or substance use challenges.

02 **Family Supporter** - Person with personal lived experience with a family member with mental health and/or substance use disorders.

03 **Peer Supporter-Trained**: Person with personal Lived Experience. Successful completion of 72 hours (60 classroom hours) of training required by DBHDS or International Certification & Reciprocity Consortium (IC&RC) credential. Person is NOT registered.

04 **Family Supporter-Trained**: Person with personal Lived Experience. Successful completion of 72 hours (60 classroom hours) of training required by DBHDS or IC&RC credential. Person is NOT registered

05 **Peer Supporter –E** (eligible) Person has at least one year of recovery for persons having lived experience with mental illness or substance use disorder conditions (12VAC 35-250-40.2); Successful completion of 72 hours (60 classroom hours) of training required by DBHDS or IC&RC credential. Person will be working on the educational component (500 hours) towards certification. Person is registered with DHP/BOC.

06 **Family Supporter – E** (eligible): 1. A parent of a minor or adult child with a mental illness or substance use disorder or co-occurring mental illness and substance use disorder similar to the individual receiving peer-support services; or 2. An adult with personal experience with a family member with a mental illness or substance use disorder or co-occurring mental illness and substance use disorder similar to the individual receiving peer support services. Person who has successfully completed the DBHDS 72-hour PRS Training course or has an IC&RC credential from another state. Person will be working on the peer support experience component (500 hours) towards certification. Person is registered with DHP/BOC

07 **Peer Recovery Specialist**: A person who has obtained all of the above requirements, education and experience which professionally qualifies to provide collaborative services to assist individuals in achieving sustained recovery from the effects of mental illness, addiction, or both (12VAC35-250). Person is required to be certified by Virginia.

08 **Family Support Partner**: Person with personal Lived Experience as defined by (12 VAC.35-250-20) Successful completion 72 hours training required by DBHDS or IC&RC credential. Person will be working on the educational component (500 hours) towards certification. Person is required to be Family Support Partner – Certified by Virginia.

09 **Peer Recovery Specialist – R (Registered):** Certified Peer Recovery Specialist (as defined in 12VAC35-250) who has registered with the Virginia Board of Counseling. In addition, person is required to be registered by Department of Health Professions – Board of Counseling.

(DHP/BOC)

10 **Family Support Specialist – R (registered):** Certified Family Support Partner (as defined in 12VAC35-250) who has registered with the Virginia Board of Counseling. Person is required to be Family Support Partner – Certified by Virginia.

11 **Certified Pre-screener**

12 **Medical/Nursing**- *physician, registered or licensed practical nurse, nurse practitioner, DO, psychiatrist*

13 **LMHP type** *–includes all DHP, DHP licensed eligible, includes a LMHP who responds to a crisis call in the community with the primary intent of de-escalating the crisis*

14 **QMHP** (*Includes all QMHP levels) includes a QMHP who responds to a crisis call in the community with the primary intent of de-escalating the crisis*

96 not applicable

Purpose: Report outcome measures adopted by the Department and the VACSB, including SDA.

111	Gender Identity: *What is your gender identity?* Capture utilization of services for underserved populations and how the person identifies their gender, lkpGenderIdentity	Text	2

01 Female
02 Male
03 Female-to-male (FTM)/Transgender Male/Trans Man
04 Male-to-Female (MTF)/Transgender Female/Trans Woman
05 Undefined
06 Additional Gender Category/ Other
07 Decline to answer

(NOTE: Federal language do not change);
97 Unknown (Asked but not answered);
98 Not collected (not asked)

Purpose: Report BG requirements.

No.	Data Element Name and Definition	Data Type	Max Length
112	**Classification Start Date** -optional	Text	8
	Intentionally left blank		
	Purpose: Report outcome measures adopted by the Department and the VACSB, for Peer and Family -Support-Services and Crisis		

No.	Data Element Name and Definition	Data Type	Max Length
113	**Classification End Date** - optional	Text	8
	Intentionally left blank		
Purpose: Report outcome measures adopted by the Department and the VACSB, for Peer and Family Support-Services and Crisis			

Discontinued Elements Table

The preceding table displays data elements in numerical sequence. However, some data element numbers are missing in that sequential listing because the associated data elements have been discontinued. The following table lists discontinued CCS 2 and CCS 3 data elements.

No.	Data Element	No.	Data Element	No.	Data Element
1	Transaction Activity Code	29	Axis II Secondary	55	Axis I Code 6
4	CSB Admission Date	30	Axis III	56	Consumer Service Hours
6	Service Enrollment Date	31	Axis V	69	Marital Status
9	Service Release Date	46	Days Waiting to Enter Treatment	79	Date Need for MH Services
11	CSB Discharge Date	49	Authorized Representative	80	Date Need for SUD Services
13.b	Cognitive Delay	50	Medicaid Status	90	ECM Case Management
20	Co-Dependent	51	Date of Last Direct SA Service	109	Medicare BI
26	Axis I Code 1	52	Axis I Code 3		
27	Axis I Code 2	53	Axis I Code 4		
28	Axis II Primary	54	Axis I Code 5		

Appendix D: Data Collection Matrix

When is Data Collected?

In CCS 3, data elements are collected at different steps of the individual's involvement with the CSB. There are two major steps from the standpoint of data extracts:

- Case Opening, and
- Type of Care event, for example, at admission to or at discharge from a program area.

Many data elements also must be **updated whenever they change or at least annually**.

Case Opening

This step occurs when a CSB determines that it can serve an individual, and it opens a case for the individual. This step requires submission of some of the data elements in the Consumer File table and all of the data elements in the Services file table (Appendix B), but it does not require submission of the event itself in a TypeOfCare file. CSBs must collect the data elements listed in the following table at case opening, although other elements may be collected. A CSB opens a case when it provides emergency or ancillary services (motivational treatment, consumer monitoring, assessment and evaluation, or early intervention services); then the CSB must collect these data elements.

CCS 3 Data Elements Collected at Case Opening			
No.	**Data Element**	**No.**	**Data Element**
2	AgencyCode	62	ServiceThroughDate
3	ProgramAreaId, use only 400 to indicate the service is an emergency or ancillary service	64	Service Subtype
		65	Service Location
5	ServiceCode	66	Military Service
7	ConsumerId (CSB identifier)	67	Military Start Date
8	SSN	68	Military End Date
10	Units	71	InsuranceType1
14	CityCountyResidenceCode	72	InsuranceType2
15	Referral Source	73	InsuranceType3
16	DateOfBirth	74	InsuranceType4
17	Gender	75	InsuranceType5
18	Race	76	InsuranceType6
19	HispanicOrigin	77	InsuranceType7
24	LegalStatus	78	InsuranceType8
44	PregnantStatus	93	ReportedDiagnosisCode
48	ServiceFromDate	94	DiagnosisStartDate
58	ConsumerFirstName	106	Service Modality
59	ConsumerLastName	108	Transaction ID
	Intentially left blank	~~109~~	~~Medicare Beneficiary Identifier Number~~

Admission to or Discharge from a Program Area (Type of Care event)

When an individual is admitted to or discharged from a program area, a CSB must continue to report and update when necessary the data elements from the case opening step, and it must collect and report the following additional *italicized* data elements.

CCS 3 Data Elements Collected at Admission To or Discharge From a Program Area			
No.	**Data Element**	**No.**	**Data Element**
2	AgencyCode	71	InsuranceType1
3	ProgramAreaId (100, 200, or 300)	72	InsuranceType2
5	ServiceCode	73	InsuranceType3
7	ConsumerId (CSB identifier)	74	InsuranceType4
8	SSN	75	InsuranceType5
10	Units	76	InsuranceType6
12	*DischargeStatus*	77	InsuranceType7
13a	*SMISEDAtRisk*	78	InsuranceType8
14	CityCountyResidenceCode	*81*	*HealthWellBeingMeasure*
15	*ReferralSource*	*82*	*CommunityInclusionMeasure*
16	DateOfBirth	*83*	*ChoiceandSelf-DeterminationMeasure*
17	Gender	*84*	*LivingArrangementMeasure*
18	Race	*85*	*DayActivityMeasure*
19	HispanicOrigin	*86*	*SchoolAttendanceStatus*
21	*EducationLevel*	*87*	*IndependentLivingStatus*
22	*EmploymentStatus*	*88*	*HousingStability*
23	*TypeOfResidence*	*89*	*PreferredLanguage*
24	LegalStatus	*91*	*EmploymentDiscussion*
25	*NbrPriorEpisodesAnyDrug*	*92*	*EmploymentOutcomes*
32-43	*SA Primary, Secondary, and Tertiary Drug*	93	ReportedDiagnosisCode
44	PregnantStatus	94	DiagnosisStartDate
45	*FemaleWithDependentChildrenStatus*	*95*	*DiagnosisEndDate*
47	*NbrOfArrests*	*96*	*DiscussionofLastCompletePhysical*
48	ServiceFromDate	*97*	*DateofLastCompletePhysicalExam*
57	*MedicaidNbr*	*98*	*DiscussionofLastScheduledDental*
58	ConsumerFirstName	*99*	*DateofLastScheduledDentalExam*
59	ConsumerLastName	*100*	*Community Engagement Discussion*
60	*TypeOfCareThroughDate*	*101*	*Community Engagement Goals*
61	*TypeOfCareFromDate*	*102*	*Date of Assessment*
62	ServiceThroughDate	*103*	*Assessment Action*
63	*StaffId (~~optional~~)*	*104*	*Assessment Value*
64	ServiceSubtype	*105*	*Assessment Frequency*

65	ServiceLocation	*106*	*Service Modality*
66	*MilitaryStatus*	*107*	*Related Date*
67	*MilitaryStatusStartDate*	*108*	*Transaction ID*
68	*MiltaryStatusEndDate*	*110*	*Staff Classification*
70	*SocialConnectedness*	*111*	*Gender Identity*
112	*Classification Start Date*	*113*	*Classification End Date*

Data Element and Program Area Cross-Reference Table

Different data elements apply to and are collected for different program areas, as shown in the following table. Data elements that are collected for emergency or ancillary services are listed in the **CCS 3 Data Elements Collected at Case Opening** table on page 62.

Data Element and Program Area Cross-Reference Table				
Element No.	**Data Element**	**Mental Health**	**Substance Use Disorder**	**Develop-mental**
2	AgencyCode	Y	Y	Y
3	ProgramAreaId	Y	Y	Y
5	ServiceCode	Y	Y	Y
7	ConsumerId (CSB identifier)	Y	Y	Y
8	SSN	Y	Y	Y
10	Units	Y	Y	Y
12	DischargeStatus	Y	Y	Y
13a	SMISEDAtRisk	Y	Y	N
14	CityCountyResidenceCode	Y	Y	Y
15	ReferralSource	Y	Y	Y
16	DateOfBirth	Y	Y	Y
17	Gender	Y	Y	Y
18	Race	Y	Y	Y
19	HispanicOrigin	Y	Y	Y
21	EducationLevel	Y	Y	Y
22	EmploymentStatus	Y	Y	Y
23	TypeOfResidence	Y	Y	Y
24	LegalStatus	Y	Y	Y
25	NbrPriorEpisodesAnyDrug	Y	Y	N
32-43	SA Primary, Secondary, and Tertiary Drug	Y	Y	N
44	PregnantStatus	Y	Y	N
45	FemaleWithDependentChildrenStatus	N	Y	N
47	NbrOfArrests	Y	Y	N
48	ServiceFromDate	Y	Y	Y
57	MedicaidNbr	Y	Y	Y
58	ConsumerFirstName	Y	Y	Y
59	ConsumerLastName	Y	Y	Y
60	TypeOfCareThroughDate	Y	Y	Y
61	TypeOfCareFromDate	Y	Y	Y
62	ServiceThroughDate	Y	Y	Y
63	StaffId ~~(optional)~~	Y	Y	Y
64	ServiceSubtype	Y	Y	Y
65	ServiceLocation	Y	Y	Y
66	MilitaryStatus	Y	Y	Y
67	MilitaryServiceStartDate	Y	Y	Y
68	MilitaryServiceEndDate	Y	Y	Y
70	SocialConnectedness	Y	Y	N
71	InsuranceType1	Y	Y	Y

Data Element and Program Area Cross-Reference Table				
Element No.	**Data Element**	**Mental Health**	**Substance Use Disorder**	**Develop-mental**
72	InsuranceType2	Y	Y	Y
73	InsuranceType3	Y	Y	Y
74	InsuranceType4	Y	Y	Y
75	InsuranceType5	Y	Y	Y
76	InsuranceType6	Y	Y	Y
77	InsuranceType7	Y	Y	Y
78	InsuranceType8	Y	Y	Y
81	HealthWellBeingMeasure	N	N	Y
82	CommunityInclusionMeasure	N	N	Y
83	ChoiceandSelf-DeterminationMeasure	N	N	Y
84	LivingArrangementMeasure	N	N	Y
85	DayActivityMeasure	N	N	Y
86	SchoolAttendanceStatus	Y	N	N
87	IndependentLivingStatus	Y	N	N
88	HousingStability	Y	Y	N
89	PreferredLanguage	Y	Y	Y
91	EmploymentDiscussion	Y*	Y*	Y
92	EmploymentGoals	Y*	Y*	Y
93	ReportedDiagnosisCode	Y	Y	Y
94	DiagnosisStartDate	Y	Y	Y
95	DiagnosisEndDate	Y	Y	Y
96	DiscussionofLastCompletePhysicalExam	N	N	Y
97	DateofLastCompletePhysicalExamination	Y	N	Y
98	DiscussionofLastScheduledDentalExam	N	N	Y
99	DateofLastScheduledDentalExamination	N	N	Y
100	Community Engagement Services Discussion	N	N	Y
101	Community Engagement Services Goals	N	N	Y
102	Date of Assessment	Y	Y	N
103	Assessment Action	Y	Y	N
104	Assessment Value	Y	Y	N
105	Assessment Frequency	Y	Y	N
106	Service Modality	Y	Y	Y
107	Related Date	Y	Y	N
108	Transaction ID	Y	Y	Y
110	Staff Classifications (related to STEP-Va)	Y	Y	Y
111	Gender Identity	Y	Y	Y
112	Classification Start Date	Y	Y	Y
113	Classification End Date	Y	Y	Y

* Collecting these data elements is optional per the definitions of data elements 91 and 92.

Appendix E: Business Rules

Business rules enforce the policies and procedures specified by an organization for its processes. The complete set of current CCS Business Rules is incorporated by reference into these Extract Specifications, and they are contained in the current release of the CCS 3 application. These rules establish acceptable parameters and validation criteria for CCS 3 data elements and describe error-checking routines and operations. CSB staff and IT vendors responsible for implementing CCS 3 should review and must adhere to these business rules.

The following are general business rules for the CCS 3 database not discussed elsewhere in this document. Validation checks are basic business rules, and some of the general validations of CCS 3 data are described below.

Extract Record Values

General

CSBs must validate all field values in CCS 3 extract files before they submit their extracts to the Department. Invalid data fields will produce fatal errors that will cause a record in a file to be rejected.

Dates

All dates must be valid and must be entered in the format MMDDYYYY with no slashes, spaces, or special characters. Leading zeroes must be supplied for single digit days and months, *e.g.*, February 1 is 0201. Century values must be greater than or equal to 1900. There must not be a month value greater than 12, and there must not be a day value greater than 31.

CCS 3 Unknown Value Codes

The CCS 3 Extract Specifications, in an attempt to improve the data quality of extracts, clarifies the meaning of certain field codes for situations when the value of a field is not clear. In these specifications, they are called unknown values. In the past, CCS used codes 96, 97, and 98 to indicate Not Applicable, Unknown, and Not Collected, as well as allowing blanks or missing values. These codes were introduced in earlier versions of the CCS, but their use is standardized in CCS 3. These distinctions may seem subtle, but they are important for reporting clearly and unambiguously. There are four categories into which unknown values can be placed: Blanks, Not Applicable, Unknown, or Not Collected.

Blanks (NULL)

There are certain fields for which there is no extract value. The value would be applicable and could be known if collected; however, clinical circumstances dictate that a value cannot always be supplied. An example is social security number (SSN); some individuals may not have an SSN.

These fields can be left blank (NULL) on the initial extract; i.e., they can be left out. These fields must not be filled with spaces. In the extract file, they will be indicated by two consecutive commas. For example, if there were three fields in a row, but the value for the second field was blank (NULL), then the extract would look like this: value1, value3.

Note that if a blank value is to be used at the end of an extract file, there must be a comma representing that blank, shown as: ,, at the end of the file. Omitting the comma will cause the extract to ignore the value completely, meaning the blank will not be recorded.

Not Applicable (96)

There are certain fields where a value is nonsensical or not applicable; for example, FemaleWithDependentChildrenStatus does not make sense for a male. Also, a male cannot be pregnant. Thus, the CSB would enter a value of *not applicable*. The values of *not applicable* depend on the size of the field in which it is being used, as shown in the following table.

Single byte field	'A' for not applicable	Four byte field	'9996'
Two byte field	'96'	Five or more bytes	'99996'
Three byte field	'996'		

There are some fields in CCS 3 where the value is built into or provided by the known code, so that the 96 code does not apply. For example, an individual has to have a type of residence of some sort (data element 23), and there are codes built into the lkpResidence table to identify the possible types. Thus, if the individual is homeless or lives in a homeless shelter, then code 13 indicates that. However, the values of 97 and 98, Unknown and Not Collected, may still apply. Another example is education level (data element 21); there is a code in lkpEducation to indicate that the individual never attended school (01), so the code for *not applicable* is not needed.

Unknown (97: Asked but not answered)

A value may be applicable in a certain situation, but the value may not be known. Staff attempted to collect the information, but it could not be obtained. In the preceding example, if the individual were female, then she could have a dependent child, or she could be pregnant. Thus, *not applicable* would not be appropriate for this situation. However, if staff asked for this information, but the individual did not provide it or it was otherwise not available, then *unknown* would be the appropriate value. The values of *unknown* depend on the size of the field in which it is being used, as shown in the following table.

Single byte field	'U' for not applicable	Four byte field	'9997'
Two byte field	'97'	Five or more bytes	'99997'
Three byte field	'997'		

Not Collected (98: Not asked)

There are other situations where the most accurate description of a value indicates that it was not collected; i.e., there was no attempt to collect the information. This is different from the *unknown* code. Not collected indicates that the value would be applicable, and could be known, but its value was not obtained at the time of the extract. Note that this is different from a blank value, which is an acceptable value on some fields. However, if there is a code in the lookup table for Not Collected, then that value should be used instead of a blank.

The values of *not collected* depend on the size of the field in which it is being used:

Single byte field	'X' for not collected	Four byte field	'9998'
Two byte field	'98'	Five or more bytes	'99998'
Three byte field	'998'		

Appendix F: FY 2020 Valid CCS 3 Services Table for Data Element 10

This table displays the ProgramAreaId, ServiceCode, core service name, and unit of service for each service that CSBs can report as a valid service in CCS 3. Services with any other combination of ProgramAreaId and ServiceCode must not be included in a CSB's CCS 3 extract submission. CSBs report services in the Service file with units of service shown in data element 10. Service files must include a ConsumerId in data element 7.

When service hours are not received by or associated directly with specific individuals or groups of individuals, then the ConsumerId field must contain a z-consumer (unidentified individual receiving services) code. A Service file with a z-consumer code is also known as an NC Service file, NC indicating the absence of an identified consumer. Service hours can be reported in a Service file with a Z-consumer code (an NC Service file) for any core-service for which the unit of service is a service hour. Services with service units other than service hours must not be reported in NC Service files.
Page 5 of these specifications and the core services taxonomy explain NC service hours in more detail.

Substance use disorder prevention services and Mental Health First Aid, and suicide prevention services are not included in this table because this service data is reported separately through the prevention data system planned and implemented by the Department in collaboration with the VACSB Data Management Committee. Infant and Toddler Intervention Services are not included because this service data is provided separately through iTOTS or its successor data system.

Program Area Id	Service Code	Core Service Name	Unit of Service	Service File	NC Service File
Emergency and Ancillary Services (Case Opening)					
400	100	Emergency Services	Service Hour	●	●
400	318	Motivational Treatment Services	Service Hour	●	●
400	390	Consumer Monitoring Services	Service Hour	●	●
400	720	Assessment and Evaluation Services	Service Hour	●	●
400	620	Early Intervention Services	Service Hour	●	●
400	730	Consumer-Run Services	NA	NA	NA
Services Available at Admission to a Program Area					
Inpatient Services					
100	250	Acute Psychiatric Inpatient Services	Bed Day	●	
300	250	Acute Substance Use Disorder Inpatient Services	Bed Day	●	
300	260	Community-Based Substance Use Disorder Medical Detoxification Inpatient Services	Bed Day	●	
Outpatient Services					
100	310	Outpatient Services	Service Hour	●	●
200	310	Outpatient Services	Service Hour	●	●
300	310	Outpatient Services	Service Hour	●	●
100	312	Medical Services	Service Hour	●	●
200	312	Medical Services	Service Hour	●	●

Program Area Id	Service Code	Core Service Name	Unit of Service	Service File	NC Service File
300	312	Medical Services	Service Hour	●	●
300	313	Intensive Outpatient Services	Service Hour	●	●
300	335	Medication Assisted Treatment Services	Service Hour	●	●
100	350	Assertive Community Treatment	Service Hour	●	●
Case Management Services					
100	320	Case Management Services	Service Hour	●	●
200	320	Case Management Services	Service Hour	●	●
300	320	Case Management Services	Service Hour	●	●
Day Support (DS) Services					
100	410	Day Treatment or Partial Hospitalization	DS Hours	●	
300	410	Day Treatment or Partial Hospitalization	DS Hours	●	
~~100~~	~~420~~	~~Ambulatory Crisis Stabilization Services~~ retired FY 2021	~~Service Hours~~	●	
~~200~~	~~420~~	~~Ambulatory Crisis Stabilization Services~~ retured FY 2021	~~Service Hours~~	●	
~~300~~	~~420~~	~~Ambulatory Crisis Stabilization Services~~ retired FY 2021	~~Service Hours~~	●	
100	425	Rehabilitation	DS Hours	●	
200	425	Habilitation	DS Hours	●	
300	425	Rehabilitation	DS Hours	●	

Program Area Id	Service Code	Core-Service Name	Unit of Service	Service File	NC Service File
Employment Services					
100	430	Sheltered Employment	Days of Serv	●	
200	430	Sheltered Employment	Days of Serv	●	
300	430	Sheltered Employment	Days of Serv	●	
100	460	Individual Supported Employment	Service Hour	●	●
200	460	Individual Supported Employment	Service Hour	●	●
300	460	Individual Supported Employment	Service Hour	●	●
100	465	Group Supported Employment	Days of Serv	●	
200	465	Group Supported Employment	Days of Serv	●	
300	465	Group Supported Employment	Days of Serv	●	
Residential Services					
100	501	Highly Intensive Residential Services NOTE: MH residential	Bed Day	●	
200	501	Highly Intensive Residential Services NOTE: ICF/IID	Bed Day	●	
300	501	Highly Intensive Residential Services note: SA Medical managed withdrawal services	Bed Day	●	
100	510	Residential Crisis Stabilization Services	Bed Day	●	
200	510	Residential Crisis Stabilization Services	Bed Day	●	
300	510	Residential Crisis Stabilization Services	Bed Day	●	
100	521	Intensive Residential Services	Bed Day	●	
200	521	Intensive Residential Services	Bed Day	●	
300	521	Intensive Residential Services	Bed Day	●	
100	551	Supervised Residential Services	Bed Day	●	
200	551	Supervised Residential Services	Bed Day	●	
300	551	Supervised Residential Services	Bed Day	●	
100	581	Supportive Residential Services	Service Hour	●	●
200	581	Supportive Residential Services	Service Hour	●	●
300	581	Supportive Residential Services	Service Hour	●	●
Prevention Services					
100	610	Mental Health Prevention Services	Service Hour	●	●
200	610	Developmental Prevention Services	Service Hour	●	●

Appendix G: Taxonomy Definitions of Outpatient and Medical Services

This appendix contains the revised-Core Services Taxonomy 7.3 definition of the Outpatient Services subcategory (310), which deletes language about medical and medication services, and the definition for the new Outpatient Services subcategory of Medical Services (312). This change was implemented initially on 07-01-2017 for FY 2018.

a. **Outpatient Services** provide clinical treatment services, generally in sessions of less than three consecutive hours, to individuals and groups.

   i. ***Outpatient Services*** (310) are generally provided to individuals on an hourly schedule, on an individual, group, or family basis, and usually in a clinic or similar facility or in another location, including a jail or juvenile detention center. Outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory, and other ancillary services.

c. ***Medical Services*** (312) include the provision of psychiatric evaluations and psychiatric, medical, psychiatric nursing, and medical nursing services by licensed psychiatrists, physicians, psychiatric nurse practitioners, other nurse practitioners, and nurses and the cost of medications purchased by the CSB and provided to individuals. Medication services include prescribing and dispensing medications, medication management, and pharmacy services. Medication only visits are provided to individuals who receive only medication monitoring on a periodic (monthly or quarterly) basis from a psychiatrist, other physician, psychiatric nurse, or physician's assistant. These visits are included in medical services. The Department has identified a minimum set of information for licensing purposes that would be needed to constitute an individualized services plan (ISP) for individuals receiving only medication visits.

Appendix H: Outcome Measure Definitions and Implementation Guidance Adult

Suicide Risk Assessment:

Percentage of adults who are **18 years old or older**, are receiving MH or SUD outpatient **or** case management services or MH medical services and have a new or recurrent diagnosis of major depressive disorder (MDD) who received a suicide risk assessment, completed during the visit in which the diagnosis was identified.

Implementation Guidance

- The date on which the MDD diagnosis is identified is the date on which it is entered in the CSB's electronic health record (EHR). Do not record an earlier date on which non-CSB staff may have made a diagnosis as the start date. The start date for the diagnosis is the date on which it was entered in the EHR. For an episode to be considered recurrent, there must be an interval of at least two months between separate episodes in which criteria are not met for a major depressive episode.
- MDD is identified with any of the codes in F32 (single episode) or F33 (recurrent episodes) in the ICD-10.

  The *Columbia Suicide Severity Rating Scale*™, Screener Version - Recent (six questions) Version is used. There is no assessment score; only completion of the assessment is reported, and The CSBs report an assessment value of 00 means completed Reference: http:///cssrs.columbia.edu/training/training-options/
- The CCS 3 operational definition for this measure includes the following elements.
  - The individual is at least 18 years of age when the MDD diagnosis is made.
  - The adult must receive a MH (program area code 100) outpatient (core service code 310), medical (code 312), or case management (code 320) service; a SUD (program area code 300) outpatient (core service code 310), medical (code 312), intensive outpatient (code 313), or case management (code 320) service; or an ancillary (program area code 400) assessment and evaluation (core service code 720) service if the assessment is performed here rather than in outpatient or case management services. CSBs can aggregate multiple service units of each of these types of services provided on the same day, but CSBs must send a separate service record for each day on which each of these types of services were provided in the Service.txt file in its monthly CCS 3 extract. Alternatively, CSBs can send a separate service record for each service unit provided in a day in the Service.txt file in its monthly CCS 3 extract. See the ***Date Provided*** section on page 5 for additional guidance.
  - During the service contact when the MDD diagnosis is made, the adult receives the diagnosis, it is recorded in the EHR, and the CSB includes the F32 or F33 diagnosis code in the diagnosis record with the same date as the from date in the service record. The diagnosis start date in the diagnosis record identifies when the diagnosis was made, and the same date is entered in the outcomes record included in the Outcomes.txt file submitted in the monthly CCS 3 extract. CSBs must include a start date for each diagnosis record reported in the Diagnosis.txt file in its monthly CCS 3 extract.
- Training on the use of the Columbia Scale is available from the Columbia Lighthouse project at http://cssrs.columbia.edu/trainig/training-options/.
- This outcome measure must be implemented on July 1, 2017. CSBs should implement it for all new adults beginning on that date and for all adults currently receiving MH or SUD outpatient or MH or SUD case management services, MH medical services, or assessment and evaluation services

whenever a MDD diagnosis is made.

[Reference: NFQ or CQM 0104; CMS ID 161; NQS Domain: Clinical Process/Effectiveness]

1. **Child Suicide Risk Assessment:** Percentage of children who are **7 through 17 years** old, are receiving MH or SUD outpatient or case management services or MH medical services, and have a new or recurrent diagnosis of major depressive disorder (MDD) who received a suicide risk assessment completed during the visit in which the diagnosis was identified.

Implementation Guidance

- The date on which the MDD diagnosis is identified is the date on which it is entered in the CSB's electronic health record (EHR). Do not record an earlier date on which non-CSB staff may have made a diagnosis as the start date. The start date for the diagnosis is the date on which it was entered in the EHR. For an episode to be considered recurrent, there must be an interval of at least two months between separate episodes in which criteria are not met for a major depressive episode.
- MDD is identified with any of the codes in F32 (single episode) or F33 (recurrent episodes) in the ICD-10.
- The *Columbia Suicide Severity Rating Scale* ™, Screener Version - Recent (six questions) is used. There is no assessment score; only completion of the assessment is reported, and CSBs report an assessment value of 00 indicates the Columbia was completed.

- The CCS 3 operational definition for this measure includes the following elements.
  - The individual is at least seven years old and less than 18 years of age when the MDD diagnosis is made.
  - The child must receive a MH (program area code 100) outpatient (core service code 310), medical (code 312), or case management (code 320) service; a SUD (program area code 300) outpatient (core service code 310), medical (code 312), intensive outpatient (code 313), or case management (code 320) service; or an ancillary (program area code 400) assessment and evaluation (core service code 720) service if the assessment is performed here rather than in outpatient or case management services. CSBs can aggregate multiple service units of each of these types of services provided on the same day, but CSBs must send a separate service record for each day on which each of these types of services were provided in the Service.txt file in its monthly CCS 3 extract. Alternatively, CSBs can send a separate service record for each service unit provided in a day in the Service.txt file in its monthly CCS 3 extract. See the ***Date Provided*** section on page 5 for additional guidance.
  - During the service contact when the MDD diagnosis is made, the child receives the diagnosis, it is recorded in the EHR, and the CSB includes the F32 or F33 diagnosis code in the diagnosis record with the same date as the from date in the service record. The diagnosis start date in the diagnosis record identifies when the diagnosis was made, and the same date is entered in the outcomes record included in the Outcomes.txt file submitted in the monthly CCS 3 extract. CSBs must include a start date for each diagnosis record reported in the Diagnosis.txt file in its monthly CCS 3 extract.
- Training on the use of the Columbia Scale is available from the Columbia Lighthouse project at http://cssrs.columbia.edu/trainig/training-options/.
- This outcome measure must be implemented on July 1, 2017. CSBs should ensure that it is implemented for all new children beginning on that date and for all children currently receiving MH or SUD outpatient or MH or SUD case management services, MH medical services, or assessment and evaluation services whenever a MDD diagnosis is made.

[Reference: NFQ or CQM 1365; CMS ID 177; NQS Domain: Patient Safety]

2. **Complete Physical Examination:** Percentage of adults who are **18 years old or older**, are identified as having a serious mental illness (SMI) and are receiving MH case management services who received a complete physical examination in the last 12 months.

Implementation Guidance

- The date of the complete physical examination reported in data element 97 of CCS 3 will be used for this measure. This measure is defined below.

  Date of Last Complete Physical Examination: The date on which an individual received his or her last regularly scheduled complete wellness and preventative physical examination by a medical doctor or nurse practitioner. This is not a date on which the individual was seen only in response to an illness, medical condition, or injury. This must be collected and reported by the case manager whenever the date changes for individuals of any age receiving Medicaid Developmental Disability waiver services; and for adults with serious mental illness receiving mental health case management services. If the exact date is not available or known, an estimated complete date (MM/DD/YYYY) is acceptable.

- This measure uses existing CCS 3 data from the Consumer.txt file; therefore, it will not be reported in the Outcomes.txt file.
  - The CCS 3 operational definition for this measure includes the following elements.
    - The individual is at least 18 years of age and has a SMI (CCS 3 data element 13.a).
    - The adults must receive a MH (program area code 100) case management (core service code 320) service. CSBs can aggregate multiple service units of case management services provided on the same day, but CSBs must send a separate service record for each day on which case management services were provided in the Service.txt file in its monthly CCS 3 extract. Alternatively, CSBs can send a separate service record for each case management service unit provided in a day in the Service.txt file in its monthly CCS 3 extract. See the ***Date Provided*** section on page 5 for additional guidance.

3. **Body Mass Index (BMI):** Percentage of adults who are **18 years old** or older, are receiving CSB MH: medical services, had a BMI documented during the current encounter or during the previous six months, and had a BMI outside of normal parameters who have a follow-up plan documented during the encounter or during the previous six months of the current encounter. Calculate this measure for all adults receiving medical services over the six-month period.

Implementation Guidance

- This measure contains three rates:
  - **BMI Calculated:** Percentage of adults who are 18 years old or older and received MH services who had their BMI calculated;
  - **BMI Outside Normal Range:** Percentage of adults are 18 years old or older, received MH medical services, and had their BMI calculated whose BMI was outside of the normal range (this is not reported by CSBs; it is calculated by the Department); and
  - **BMI Follow-up Plan:** Percentage of adults who are 18 years old or older, received MH medical services, had their BMI calculated, and whose BMI was outside of the normal range who had a follow-up plan documented.

- MH (program area code 100) medical (core service code 312) services is a core-service subcategory of outpatient services. The definition is included in Appendix G.

- The CCS 3 operational definition for this measure includes the following elements.
  - The individual is at least 18
  - The adult must receive a MH (program area code 100) medical (core service code 312) service. CSBs can aggregate multiple service units of medical services provided on the same day, but CSBs must send a separate service record for each day on which medical services were provided in the Service.txt file in its monthly CCS 3 extract. Alternatively, CSBs can send a separate service record for each medical service unit provided in a day in the Service.txt file in its monthly CCS 3 extract. See the ***Date Provided*** section on page 5 for additional guidance.
- CSBs report the initial BMI assessment in data element 103 with a value of 02 and the BMI assessment score in data element 104 with the calculated three-character numeric BMI score including decimal point. The range of scores includes ≤ 18.5 underweight, 18.5 - 24.9 normal, 25.0-29.9 overweight, ≥ 30 obese, but report any score from 00.0 through 99.9.
- CSBs report the BMI follow up plan documented in data element 103 with a value of 03 and with an assessment value in data element 104 of yes (01) or not eligible (02) as defined on page 46 of the Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual. Page 45 of the manual describes documentation of the follow-up plan.
- A follow-up plan for a BMI out of normal parameters may include:
  - Documentation of education;
  - Referral, for example to a registered dietician, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professions, or surgeon;
  - Pharmacological interventions;
  - Dietary supplements;
  - Exercise counseling; or
  - Nutrition counseling.
- CSBs must implement this measure on July 1, 2017 for 18 years and older and begin reporting BMI calculations then as they are performed. However, given the six-month follow-up, the Department will not be able to begin analyzing the entire measure until the second half of FY 2018.

  [Reference: NFQ or CQM 0421; CMS ID 069; NQS Domain: Population/Public Health]

5. **Major Depression or Dysthymia Remission at 12 Months:** Original measure 5 is deferred.

6. **SUD Services Initiation, Engagement, and Retention**: Percentage of adults and children who are 13 years old or older with a new episode of SUD services as a result of a new SUD diagnosis who received the following. This measure contains three rates:

   - **Initiation of SUD Services:** Percentage of these adults and children who initiated any SUD services within 14 days of the new SUD diagnosis;
   - **Engagement in SUD Services:** Percentage of these adults and children initiated any SUD services within 14 days of the new SUD diagnosis who received two or more additional SUD services within 30 days of the first service; and
   - **Retention in SUD Services:** Percentage of these adults and children who initiated any SUD

services within 14 days of the new SUD diagnosis and received two or more additional SUD services within 30 days of the first service who received at least two SUD services every 30 days for 90 days following initiation of treatment with the first service.

Implementation Guidance

- The measure tracks initiation, engagement, and retention of individuals in SUD services over a 150-day period. It identifies individuals in the month that begins 150 days before the end of the measurement month who have open SUD TypeOfCare (TOC) records and who received a new SUD diagnosis in that month. It then tracks this cohort of individuals over the following 120 days to identify those individuals who initiated any SUD services, were engaged in those services, and were retained in them.
- This measure uses existing CCS 3 data from the Consumer.txt, Service.txt, and Type of Care.txt files; therefore, it will not be reported in the Outcomes.txt file.
- A new episode of SUD services means admission to the SUD services program area.
- The CCS 3 operational definition for this measure includes the following elements.
  - The individual is at least 13 years of age when the SUD diagnosis is made.
  - The SUD diagnosis is identified within the range of F10 - F19 codes in the ICD-10. CSBs must include a start date for each diagnosis record in the Diagnosis.txt file in its monthly CCS 3 extract.
  - The individual must have an open (TOC) record for the SUD services program area (program area code 300) with a through date that is ≥ the start date (150 days prior to the last day of the measurement month) or is null and a from date that is ≤ the last day of the measurement month.
  - The individual must receive a valid SUD service: a local inpatient (core service codes 250 or 260), outpatient (codes 310, 312, 313, or 335), case management (code 320), day support (codes 410, 420, or 425), employment (codes 430, 460, or 465), or residential (codes 501, 510, 521, 551, or 581) service

    CSBs can aggregate multiple service units of each of type of service in Table 2 on page 7 for which reported service units are provided "on that date" on the same day, but CSBs must send a separate service record for each day on which each of these types of services were provided in its monthly CCS 3 extract. Alternatively, CSBs can send a separate service record for each service unit provided in a day in the Service.txt file in its monthly CCS 3 extract. See the ***Date Provided*** section on page 5 for additional guidance.

    CSBs can aggregate multiple service units of each of type of service in Table 2 on page 7 for which reported service units are provided "over that period of time" for the reporting month in its monthly CCS 3 extract. However, it would be preferable to aggregate these service units for no more than one week; this would enable the second and third rates above to be calculated more precisely.
- To calculate the first rate, identify individuals with open SUD TOC records with a service record for a valid SUD service with a service record from date between the diagnosis start date and the diagnosis start date plus 14 days.
- To calculate the second rate, for the individuals identified in the first rate, identify those who received two or more additional valid SUD services within 30 days of the service from date identified in the first rate.
- To calculate the third rate,-for individuals identified in the first rate, identify those who received at

least two SUD services every 30 days for the 90 days following the service from date identified in the first rate.

[Reference: NFQ or CQM 0004; CMS ID 137; NQS Domain: Clinical Process/Effectiveness]

This measure uses the following existing CCS 3 data elements:

Element	Field Name	Purpose
2	Agency Code	Identifies the CSB (*e.g.*, 049, 031)
3	Program Area Id	Identifies the SUD program area
5	Service Code	Identifies SUD local inpatient, outpatient, case management, day support, employment, or residential core service categories or subcategories
7	Consumer Id	Identifies an individual receiving service(s)
10	Units	Identifies SUD service units received
16	Date of Birth	Produces the age of the individual (13 and older)
48	Service From Date	Identifies the date of service for the 14-day, 30-day, and 90-day intervals
61	Type of Care From Date	Identifies individuals with open SUD TypeOfCare records
60	Type of Care Through Date	Identifies individuals with open SUD TypeOfCare records
93	Diagnosis	The current ICD-10 SUD diagnosis of the individual
94	Diagnosis Start Date	The date the SUD diagnosis started

Appendix I: CCS 3 User Acceptance Testing (UAT) Process

This UAT Process is contained in Appendix D of the FY 2019 and FY 2020 CSB Administrative Requirements, which is incorporated into the FY 2019 and FY 2020 Community Services Performance Contract. The Process is included in these extract specifications for ease of reference. UAT measures the quality and usability of an application. Several factors make UAT necessary for any software development or modification project, especially for complex applications like CCS 3 or the Waiver Management System (WaMS) that interface with many IT vendor-supplied data files and are used by many different end users in different ways.

1. UAT reduces the cost of developing the application. Fixing issues before the application is released is always less expensive in terms of costs and time.
2. Ensuring the application works as expected. By the time an application has reached the UAT process, the code should work as required. Unpredictability is one of the least desirable outcomes of using any application.

In the UAT process, end users test the business functionality of the application to determine if it can support day-to-day business practices and user scenarios and to ensure the application is correct and sufficient for business usage. The CSBs and Department will use the following UAT process for major new releases of CCS 3, WaMS, or other applications that involve the addition of new data elements or reporting requirements or other functions that would require significant work by CSB IT staff and vendors. All days in the timeframe are calendar days. Major changes in complex systems such as CCS or WaMS shall occur only once per year at the start of the fiscal year and in accordance with the testing process below. Critical and unexpected changes in WaMS may occur outside of this annual process, but the Department will use the UAT process to implement them.

Department and CSB User Acceptance Testing Process	
Time Frame	**Action**
D Day	Date data must be received by the Department (e.g., 8/31 for CCS 3 monthly submissions and 7/1 for WaMS).
D - 15	The Department issues the final version of the new release to CSBs for their use.
D - 20	UAT is completed and application release is completed.
D - 35	UAT CSBs receive the beta version of the new release and UAT begins.
D - 50	CSBs begin collecting new data elements that will be in the new release. Not all releases will involve new data elements, so for some releases, this date would not be applicable.
D - 140	The Department issues the final revised specifications that will apply to the new release. The revised specifications will be accompanied by agreed upon requirements specifications outlining all of the other changes in the new release. CSBs use the revised specifications to modify internal business practices and work with their IT vendors to modify their EHRs and extracts.
Unknown	The time prior to D-150 in which the Department and CSBs develop and negotiate the proposed application changes. The time needed for this step is unknown and will vary for each new release depending on the content of the release.

Shorter processes that modify this UAT process will be used for minor releases of CCS 3 or other applications that involve small modifications of the application and do not involve collecting new data elements. For example, bug fixes or correcting vendor or CSB names or adding values in existing look up tables may start at D-35.

Appendix J: Look up table for Referral Destination

Referral Destination - for lkpReferralDestination table: The person, agency, or organization the CSB made a referral for the individual for evaluation, treatment and/or other services (i.e. refers to external CSB partners) * ~~*with exception of primary care services*~~. *This is not a fatal error*	Text	2

Children/youth: (BH, SUD, DD):

01 School System or Educational Authority

02 Part C Provider *(NOTE: 29 are CB operated & 11 external partner programs)*

03 Psychiatric Residential Treatment Facility (PRTF) (i.e., *Alice C. Tyler Village, Barry Robinson Center, Bridges Treatment Center, Commonwealth Center for Children and Adolescents, Cumberland Hospital, FairWinds – Horseshoe, Grafton Integrated Health, Hallmark Youthcare- Richmond, Harbor Point Center for BH, Hughes Center, Jackson Field BH, Kempsville Center for BH, Liberty Point BH, North Spring BH, Newport News BH, Phoenix House Counseling, Phoenix House Program, Popular Springs Hospital, Riverside BH, Timber Ridge School, UMFS of VA-Centreville, UMFS – Richmond, Youth for Tomorrow)*

04 Family Assessment and Planning Team/CSA office

BH:

05 Other Behavioral Health Provider, including Health Dept. 06 School System or Educational Authority

07 Private MH/SUD Outpatient Practitioner

08 State Operated Hospital*

ALL: Any Ages

09 Developmental Disabilities (DD)Services Care Provider (Waiver) 10 Intermediate Care Facilities for Intellectual Disabilities (ICF/IID) – *includes SEVTC, CVTC*

11 Private Hospital

12 Other Virginia CSB/BHA

13 Department for Aging and Rehabilitative Services(DARS)

14 Department of Social Services – *for ALF or referral for NF assessment*

15 State Probation and Parole, Court system/criminal justice system

16 Specialty Provider/Clinician External (i.e., neurologist, neurobehavioral psychologist, rheumatologist, dentist, PT, OT, SLP, etc.) not associated with the CSB

17 Residential Substance Abuse Treatment Facility

18 Nursing Facility (*Includes Hiram Davis)*

Veterans/Dependent Family as applicable:

19 Federal Veterans Health Administration (VHA) *Federal Veterans Health Administration (VHA) facilities including Veterans Affairs (VA) Medical Centers (Ex.: Community- Based Outpatient Clinics (Ex: Chesapeake Community-Based Outpatient Clinic), Community Living Centers (place where nursing home level of care, skilled nursing, and medical care are available), and/or Domiciliary (homeless services) programs.*

20 Virginia Department of Veterans Services (DVS) *Includes all DVS programs and services (including but not limited to Virginia Veteran and Family Support program, education and benefits assistance etc.) Veteran Care Centers (Ex: Sitter Barfoot Veterans Care Center(Richmond) or Virginia Veterans Care Center (Salem),*

21 Military Treatment Facility (MTF) *Includes military health care facilities and programs that provide health care and/or behavioral health services to military service members and/or their dependents. Includes military hospitals and clinics found on military bases/posts or in Federal Government contract facilities (Ex: Naval Medical Center Portsmouth and Kenner Army Health Clinic on Fort Lee).*

22 Public Health Department (based on TB screening – Element # 103, action 14)

23 Primary Care Physician

*State Operated Hospital: includes Central, Western and Eastern State Hospitals; Northern, Southern, Southwestern Virginia Mental Health Institutes; Va. Center for Behavioral Rehabilitation, Piedmont Geriatric Center and Catawba Hospital

Note: 96, 97, 98 are not valid codes for this data element.

Appendix K: Values for Elements 102, 103 and 104

The following guidance is provided by DBHDS, at the request of the VACSB Quality and Outcomes Committee (Q & O) and the Data Management Committee (DMC), to give guidance and parameters for the CSBs and their E.H.R.s for the data collection extract consistency. The following charts are provided in addition to the information in Extract 7.6 for Elements 102, 103 and 104.

Element 102: Enter Date of Assessment for Ages 3 and up for the following elements in 104: 07 Primary Care Screening *Yearly;* 08 Anti-psychotic medication prescribed by CSB Practitioner; 09 Metabolic Syndrome Screening: Annual Glucose, hemoglobin- lipid profiles; 10-Referral to primary care physician (Code: 01 = yes; and 02 – No, 05 = individual/parent/legal guardian refused) for all other physicians other than primary care physicians use code 13, Referral Destination.

Element 103: Assessment Action: The type of assessment or action related to the assessment for the outcome measure. LkpOutcomeAction.

Element 104: Assessment Value: use leading zeros to complete the field to text of 5 – precede field code with 000. The following is excerpted from the 7.6 CCS 3 Extract

If field 103 is:	Then field 104 must be one of the values before
04: Patient Health Questionnaire - 9 (PHQ-9)	00 – 27 PHQ-9 Score - *the two-character numeric PHQ-9 score - optional*
07 Primary Care Screening Done	02 No 03Yes, screening values not within normal ranges 04Yes, screening values within normal ranges; 05 No, legal guardian or individual refused
08 Antipsychotic Medication Use	01 Yes 02 No
09 Metabolic Syndrome Screening	02 No 03 Yes, screening values not within normal ranges 04 Yes, screening values within normal ranges; 05 No, individual/legal guardian refused
~~10 Referred to Primary Care Physician (PCP)~~	~~01 Yes~~ ~~02 No~~ ~~05 No, individual/legal guardian refused~~

11 Individual Attended PCP Appointment	01 Yes 02 No 05 No, individual/legal guardian refused
12 DLA -20 Average Composite Score *(technical note only pad with zeros)*	1.0-7.0
13 Referral Destination	Use value from Data Element lkpReferralDestination (see Appendix J)

CCS 3 EXTRACT 7.6: Elements # 102, 103, 104 and Parameters

Population	102 Date of Assessment	103 Assessment Action	104- Assessment Values	enter	Parameters
Adults: Ages 18 & up (reference Appendix J) **Child Suicide Risk Assessment ages 7-17** 100 & 300 services	Enter date	01 Columbia Suicide Severity Rating Scale, Screener Version	00 ~~None~~ completed ~~01~~ ~~Yes~~ ~~02~~ ~~No~~		
Ages 18 years of age **and older with SMI OR rev OR receiving MH case management** services (reference Appendix H)	Enter date	02 Body Mass Index (BMI) Assessment	00.0-99.9 - BMI Assessment Score - *the three-character numeric BMI score including the decimal point;*		
Reference Appendices G & J; **at least 18 years of age;** 100/312	Enter date	03 BMI Follow Up Documented	00 None 01 Yes 02 No		
	Enter date	04 Patient Health Questionnaire - 9	00 - 27 PHQ-9 Score - *the two-character numeric PHQ-9 score*		
Element 103: an individual receives a clinical behavioral health assessment, not just a screening, from a licensed or license-eligible clinician when he or she requests mental health or substance use disorder services.	Enter date	05 Same Day Access *When data element 103 is coded 05, code data element 104 as 01 if the assessment determined the individual needed services or 02 if they did not; in either case code date element 105 as 96.*	00 None 01 Yes 02 No		

Population	102 Date of Assessment	103 Assessment Action	104- Assessment Values	enter	
Element 103: Based on the SDA assessment, if applicable, an individual is offered an appointment in a mental health or substance use disorder service offered at the CSB that best meets his or her needs.		*06* First Available Appointment Offered *When data element 103 is coded 06, code data element 104 as 00 and element 105 as 96 and enter the date offered in element 107.*	00 None 01 Yes 02 No		
100 services; SMI (320) or SED OR targeted Case Management *NOTE: per Taxonomy At risk of SED= Birth through 7* *SED = Birth through 17* *SMI =Ages 18 and up = SMI*	Annual Date – enter date	07 Primary Care Screening	If annual primary screening has been done: 01 No 02 Yes, screening values not within a normal range 03 Yes, screening values within normal range 04 No Legal Guardian refused **Parameters**	HT Inches Wt. = Pounds BP = systolic/diastolic BMI = Calculated by formula – Ht, Wt. age see col. To right	**Height: Weight – AGE:** https://www.cdc.gov/growthcharts/background.htm clinical growth charts and BMI for age – 2000 CDC Reference: Diabetes.org – ADA clinical practice guidelines book 2019; **Blood Pressure: Children ages 3 and up**: https://www.nhlbi.nih.gov/files/docs/bp_child_pocket.pdf

Blood Pressure: Adults:

Blood Pressure Levels

Normal Blood Pressure	Less than 120/80 mmHg
At Risk for High Blood Pressure (Prehypertension)	Between 120/80 mmHg and 139/89 mmHg
High Blood Pressure (Hypertension)	More than 140/90 mmHg

Reference: CDC.gov: https://www.cdc.gov/bloodpressure/measure.htm

BMI:

Children: BMI calculator: (NOTE: HT = inches)

https://www.cdc.gov/healthyweight/bmi/calculator.html

					Adult BMI: If your BMI is less than 18.5, it falls within the underweight range. • If your BMI is 18.5 to <25, it falls within the normal. • If your BMI is 25.0 to <30, it falls within the overweight range. • If your BMI is 30.0 or higher, it falls within the obese range. Reference: Centers for Disease Control (CDC)
Population	**102 Date of Assessment**	**103 Assessment Action**	**104- Assessment Values**	**enter**	**Parameters**
Ages 3 & up; 100/312 & **300/312**	Enter date of answer	08 Antipsychotic Medication ***prescribed by CSB Practitioner***	01 Yes 02 No		

Population	102 Date of Assessment	103 Assessment Action	104- Assessment Values		enter	Parameters
Ages 3 & up; 100/312& 300/312 services and on antipsychotic medication	Annual Date – enter date	09 **Metabolic Syndrome Screening: Annual fasting Glucose, hemoglobin A1c , lipid profiles**	02	No	Fasting Glucose	**FASTING GLUCOSE:** >/= 100 is abnormal • pre-diabetes (fasting plasma glucose 100–125 mg/dl) • diabetes (fasting plasma glucose ≥126 mg/dl) Reference: Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes. Diabetes Care 2004 Feb; 27(2): 596-601. **HEMOGLOBIN:** **A1C results** **Diagnosis* A1C Level** **Normal Below 5.7 percent** **Prediabetes 5.7 to 6.4 percent** **Diabetes 6.5 percent or above** ***Any test used to diagnose diabetes requires confirmation with a second measurement, unless there are clear symptoms of diabetes.** **Reference: NIDDK**
			03	Yes, screening values not within normal range		
			04	Yes, screening values within normal range		
			05	No, individual/legal guardian refused		
					Hemo-globin A1C	

				Fasting Lipid panel	**LIPID PANEL:** **Desirable Cholesterol Levels[2]** **HDL ("good" cholesterol)** — 60 mg/dL or higher **LDL ("bad" cholesterol)** — Less than 100 mg/dL **Total Cholesterol** — Less than 200 mg/dL **Triglycerides** — Less than 150 mg/Dl Reference: CDC https://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_cholesterol.htm

Population	102 Date of Assessment	103 Assessment Action	104- Assessment Values	enter	Parameters
			BMI ages 3-18 BMI > 18	See URL See URL	https://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html#HowIsBMICalculated https://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html#HowIsBMICalculated Other references: • American Diabetes Association, • American Psychiatric Association, • American Association of Clinical Endocrinologists, and • North American Association for the Study of Obesity.
~~**Ages 3 & up; 100/312 & 300/312 services and on antipsychotic medication; and values not WNL for 09**~~	~~Enter date~~	~~10 Referral to primary care physician:~~	~~01 Yes~~ ~~02 No~~ ~~05 Individual/ parent/legal guardian refused~~		
Ages 3 & up; 100/312 & 300/312 services and on antipsychotic medication; and values not within normal limits for 09	Enter date	11 Individual attended PCP Appointment for f/up after outside of normal range	01 Yes 02 No 05 Individual/ parent/legal guardian refused		

Population	102 Date of Assessment	103 Assessment Action	104- Assessment Values	enter	Parameters
Age 6 and up	Enter dates Annual, quarterly and at discharge	12 DLA-20 Enter **average composite score from DLA -20**	1.0-7.0		
ALL ages	Enter date referral given to individual	13 Referral Destination other than PCP external to CSB **See lkpReferralDestination in Appendix J**	**See lkpReferralDestination in Appendix J**		See LkpReferralDestination table in Appendix J of the CCS3 Extract 7.5 or CCS 3.5.2

Appendix L: STEP-VA Crisis (new FY 2021)

This refers back to service subtype… element # 64

This section may change after the general assembly section 2020, if so, the definitions will be update in an Extract addendum

Service Descriptions

CRISIS INTERVENTION DEFINITION (Initial Service Response up to 72 Hours)
Brief focused assessment that reviews precipitating events leading to the crisis, history of crisis, mental status exam and disposition. Crisis intervention includes the mobilization of resources to defuse the crisis, restore safety, implement interventions that minimize the potential for psychological trauma, prevent further deterioration of functioning, link to other supports and services and to avert hospitalization. Services are delivered in the community, home, school, or desired secured environment and are face-to-face with the individuals and/or family providing appropriate crisis intervention strategies, even if the time spent during the up to 72 hours is not continuous. The person in crisis must be present for all or some of the services.
Crisis intervention services shall be available 24 hours a day, seven days a week, wherever the need presents
 	
COMMUNITY BASED MOBILE CRISIS STABILIZATION (Crisis Avoidance- post "up to" 72-hour intervention) (360)
Crisis stabilization services are community based mobile service for the development, monitoring, coordinating and implementing of an individualized crisis prevention plan, to ensure the stabilization of the crisis post the initial service delivered through crisis intervention. Crisis stabilization services shall be available 24 hours a day, seven days a week, wherever the need presents, including, but not limited to, the individual's home, other living arrangement or other location in the community. Crisis stabilization services shall not be rendered in an acute care hospital setting or residential treatment facility, although an initial referral to a mobile response agency may be made prior to the individual's discharge from the facility. Crisis stabilizations service can be provided intermittently dependent on the individual or support systems need up to 45 days post the initial crisis intervention.
Crisis stabilization services include:
• Effectively responding to or preventing identified precursors or triggers that risk a person's ability to remain in the community and cycle in out of crisis;
• Assisting a person and/or their support system with identifying signs of psychiatric and personal crises;
• Practicing de-escalation strategies;
• Developing a crisis prevention plan;
  ○ Assessing and developing a step by step plan to utilize before a crisis
  ○ Developing a step by step plan to stabilize future crisis situations utilizing trauma informed and least restrictive treatment philosophies
• Seeking other supports to restore stability;
• And, where appropriate developing strategies to take medication appropriately

The individualized crisis prevention plan shall include a transition/discharge plan that links the individual to clinical and behavioral services, formal and informal community supports, and linkages with appropriate system partners after the crisis stabilization services are finished as appropriate. Crisis stabilization services function to provide a short-term linkage and referral between persons in crisis and the appropriate/additional behavioral health and/or IDD services and supports, while reducing the rate of hospitalization, incarceration, out of home placement and unnecessary emergency room visits. This service includes post crisis follow-up to ensure linkage with recommended services.
It is expected that 90% of calls during any time frame are responded to in the community within 1 hour from the mobile team being dispatched.

23-HOUR CRISIS STABILIZATION

23- Hour Crisis Stabilization provides short-term, 24/7, facility-based, walk-in psychiatric/substance related crisis evaluation and brief intervention services to support an individual who is experiencing an abrupt and substantial change in behavior noted by severe impairment of functioning typically associated with a precipitating situation or a marked increase in personal distress. These services also include screening and referral for appropriate outpatient services and community resources.
Interventions are provided by licensed and unlicensed behavioral health professionals, with supervision of the facility provided by a licensed professional and designed to prevent out of community treatment or hospitalization.
Interventions used to deescalate a crisis situation may include assessment of crisis; active listening and empathic responses to help relieve emotional distress; effective verbal and behavioral responses to warning signs of crisis related behavior; assistance to, and involvement/ participation of the individual (to the extent he/she is capable) in active problem solving, planning, and interventions; referral to appropriate levels of care for adults experiencing crisis situations which may include a crisis stabilization unit or other services deemed necessary to effectively manage the crisis; to mobilize natural support systems; and to arrange transportation when needed to access appropriate levels of care.

CRISIS STABILIZATION UNIT (CSU)

This is a residential alternative to or diversion from inpatient hospitalization, offering psychiatric stabilization and/or withdrawal management services, when appropriate. Crisis Stabilization can serve as a stepdown from a psychiatric admission, if the person meets admission criteria. Services may include:

a. Psychiatric, diagnostic, and medical assessments;
b. Crisis assessment, support and intervention;
c. Medication administration, management and monitoring;
d. Psychiatric/Behavioral Health Treatment;
e. Nursing Assessment and Care;
f. Psychosocial and psychoeducational individual and group support;
g. Brief individual, group and/or family counseling; and
h. Linkage to other services as needed. Additional language if

DETOX CSU:

The program provides medically monitored residential services for the purpose of providing psychiatric stabilization and substance withdrawal management services on a short-term basis. Additional Services may include:
i. Medically Monitored Residential Substance Withdrawal Management (at ASAM Level 3.7-WM);

Provider Qualifications
CRISIS HOTLINE • An LMHP, LMHP-S, LMHP-R, LMHP-RP, or a Certified Pre-Screener • A registered Peer Supporter or Family Support Specialist-solely for the follow up and linkage not crisis de-escalation. (non-billable) CRISIS INTERVENTION (preference 2-person team; preference licensed responder in person or tele) • An LMHP, LMHP-S, LMHP-R, LMHP-RP, or a Certified Pre-Screener shall conduct a brief focused assessment. A QMHP, QMHP-A, or QMHP-C may conduct assessment under the real time (in person or tele-assessment) supervision of an above-mentioned licensed practitioner. • Crisis intervention shall be provided only by an LMHP, LMHP-S, LMHP-R, LMHP-RP, a Certified Pre-Screener, QMHP, QMHP-A, or QMHP-C. • A registered Peer Supporter or Family Support Specialist (one member of a two-person team accompanying either a licensed professional or QMHP) • QMHP/LMHP must have completed the required training identified to be a crisis intervention provider (TBD) CRISIS STABILIZATION • Crisis stabilization shall be provided by an LMHP, LMHP-S, LMHP-R, LMHP-RP, a Certified Pre-Screener, QMHP, QMHP-A, or QMHP-C. • The Crisis education and prevention plan will be developed by only an LMHP, LMHP-S, LMHP-R, LMHP-RP, Certified Pre-Screener, QMHP, QMHP-A, or QMHP-C; CEPPs developed by a QMHP level practitioner must be signed off on by a licensed practitioner as noted above within 72 hours. • A registered Peer Supporter or Family Support Specialist (one member of a two-person team accompanying either a licensed professional or QMHP) • QMHP/LMHP must have completed the required training identified to be a crisis stabilization provider (TBD) 23 HOUR CRISIS STABILIZATION • 23 hour employs a Psychiatrist or Psychiatric Nurse Practitioner (ability to practice independently) for at least 20 hours per week; Psychiatrist or Psychiatric Nurse Practitioner available for consult/emergency 24/7. • 23-hour crisis stabilization shall be supervised 24/7 by an LMHP, LMHP-S, LMHP-R, LMHP-RP • Nurse on staff 24/7 • Services can be delivered by QMHP, QMHP-A, or QMHP-C and/or A registered Peer Supporter or Family Support Specialist with in their scope of practice. • Residential Aide level staff can also provide supervision and support under the supervision of an LMHP of QMHP

CRISIS STABILIZATION UNIT

- CSU employs a Psychiatrist or Psychiatric Nurse Practitioner (ability to practice independently) for at least 20 hours per week. ; Psychiatrist or Psychiatric Nurse Practitioner available for consult 24/7.
- CSU employs nursing staff 24/7
- CSU supervised by an LMHP, LMHP-S, LMHP-R, LMHP-RP
- Services can be delivered by QMHP, QMHP-A, or QMHP-C and/or A registered Peer Supporter or Family Support Specialist with in their scope of practice.
- Residential level staff can also provide supervision and support under the supervision of an LMHP of QMHP

Appendix M: Peer and Family Support Services (NEW FY 2021)

Title	Definition	Allowable Scope	Billable?	Credential
Peer Supporter	Person with personal lived experience with mental health and/or substance use challenges.	DBHDS Practice Guidelines	No	None
Family Supporter	Person with personal lived experience with a family member with mental health and/or Substance use disorders.	DBHDS Practice Guidelines	No	None
Peer Supporter – Trained	Person with personal Lived Experience. Successful completion of 72 hours (60 classroom hours) of training required by DBHDS or International Certification & Reciprocity Consortium (IC&RC) credential. Person is NOT registered.	DBHDS Practice Guidelines	No	None
Family Supporter – Trained	Person with personal Lived Experience. Successful completion of 72 hours (60 classroom hours) of training required by DBHDS or IC&RC credential. Person is NOT registered	DBHDS Practice Guidelines	No	None
Peer Supporter – eligible	Person have at least one year of recovery for persons having lived experience with mental illness or substance use disorder conditions (12VAC35-250-40.2); Successful completion of 72 hours (60 classroom hours) of training required by DBHDS or IC&RC credential. Person will be working on the educational component (500 hours) towards certification. Person is registered with DHP/BOC.	As defined in the DBHDS Peer Recovery Specialist Practice Guidelines	Yes	PS-E
Family Supporter – eligible	A parent of a minor or adult child with a mental illness or substance use disorder or co-occurring mental illness and substance use disorder similar to the individual receiving peer support services; or An adult with personal experience with a family member with a mental illness or substance use disorder or co-occurring mental illness and substance use disorder similar to the individual receiving peer services;	As defined in the DBHDS Peer Recovery Specialist Practice Guidelines	Yes	FS-E

	Person who has successfully completed the DBHDS 72-hour PRS Training course or has an IC&RC credential from another state; Person will be working on the peer support experience component (500 hours) towards certification. Person is registered with DHP/BOC.			
Peer Recovery Specialist	A person who has obtained all of the above requirements, education and experience which professionally qualifies to provide collaborative services to assist individuals in achieving sustained recovery from the effects of mental illness, addiction, or both (12VAC35-250).. Person is required to be Certified by Virginia.	As defined in the DBHDS Peer Recovery Specialist Practice Guidelines	Yes	CPRS - R
Family Support Partner	Person with personal Lived Experience as defined by (12.35-250-20) Successful completion 72 hours training required by DBHDS or IC&RC credential. Person will be working on the educational component (500 hours) towards certification. Person is required to be Family Support Partner – Certified by Virginia.	As defined in the DBHDS Peer Recovery Specialist Practice Guidelines	Yes	CFSP - R
Peer Recovery Specialist – Registered	Certified Peer Recovery Specialist (as defined in 12VAC35-250) who has registered with the Virginia Board of Counseling. In addition, the person is required to be registered by Department of Health Professions – Board of Counseling. (DHP/BOC)	As defined in the DBHDS Peer Recovery Specialist Practice Guidelines	Yes	PRS –R
Family Support Specialist – Registered	Certified Family Support Partner (as defined in 12VAC35-250) who has registered with the Virginia Board of Counseling. Person is required to be Family Support Partner – Certified by Virginia. In addition, the person is required to be registered by Department of Health Professions – Board of Counseling.	As defined in the DBHDS Peer Recovery Specialist Practice Guidelines	Yes	FSP-R

Peer Support- Peer Support Services are person-centered, strength-based, and recovery oriented. Services provided assist individuals in achieving positive coping mechanisms for the stressors and barriers encountered during their path to wellness and recovery. Peer Support services provide support for an individual's self-guided recovery towards wellness, to include but are not limited to:

- Emotional
- Financial
- Social
- Spiritual
- Occupational
- Physical
- Intellectual
- Environmental

Peer Support services are delivered by Peer Supporters with lived experience with mental health and/or substance use disorders and recovery from these challenges. Additionally, Peer Supporters are trained to offer support and assistance to individuals in developing and maintaining a path to recovery, resiliency, and wellness. Services include targeted self-disclosure by the Peer Supporter of lived experience in a manner that promotes hope and teaches individuals about paths to recovery and overcoming barriers. Services seek to foster connections to natural supports, community resources; and assist individuals in identifying existing strengths, skills and how to apply them. Services assist the individual to develop goals and plans for recovery, resiliency and wellness through the maintenance of mutuality, trust building and education. Services are person-centered, providing the opportunity for self-reflection and the development of personalized solutions and recovery strategies.

Family Support Services Definition - Family Support Partner services are strength-based, individualized, person-centered, and growth oriented supports provided to the parent/caregiver of a youth or young adult under the age of 21, hereafter to be referred to as individual, with a behavioral health or developmental or substance use challenge or co-occurring mental health, substance use or developmental challenge that is the focus of the support. The services provided to the parent/caregiver must be directed exclusively toward the benefit of the individual in need of services. Services are expected to improve outcomes for individual and increase the individual's and family's confidence and capacity to manage their own services and supports while promoting wellness and healthy relationships. Family Support Partners may provide education, modeling, active listening, and the disclosure of personal experiences. Through this process parents/caregivers are empowered to use their voice to express their needs, strengths and preferences related to care. Family Support Partner services are rendered by a parent/caregiver of a minor or adult child with a similar mental health or developmental or substance use challenge or co-occurring mental health, substance use or developmental challenge with experience navigating developmental, substance use or behavioral health care services.

Appendix N: Permanent Supportive Housing (NEW FY 2021)

Permanent supportive housing (PSH) includes any person in PSH regardless of the funding source (i.e., DBHDS, DSS).

Definition

Supported housing is defined as services to assist individuals in finding and maintaining appropriate housing arrangements. This activity is premised upon the idea that certain clients are able to live independently in the community only if they have support staff for monitoring and/or assisting with residential responsibilities. These staff assist clients in selecting, obtaining, and maintaining safe, decent, affordable housing while maintaining a link to other essential services provided within the community. The objective of supported housing is to help obtain and maintain an independent living situation. Supported Housing is a specific program model in which a consumer lives in a house, apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance, but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities. Criteria identified for supported housing programs include housing choice, functional separation of housing from service provision, affordability, integration (with persons who do not have mental illness), and right to tenure, service choice, service individualization and service availability. (BG definition)

Minimum Requirements for Reporting Supported Housing

- Target population: Targeted to persons who would not have a viable housing arrangement without this service.
- Staff assigned: Specific staff are assigned to provide supported housing services.
- Housing is integrated: That is, Supported Housing is provided for living situations in settings that are also available to persons who do not have mental illnesses.
- Consumer has the right to tenure: The ownership or lease documents are in the name of the consumer.
- Affordability: Supported housing assures that housing is affordable (consumers pay no more than 30-40% on rent and utilities) through adequate rent subsidies, etc.