

Virginia Department of Behavioral Health and Developmental Services

Community Services | Office of Mental Health Wellness & Recovery Supports

SYSTEM TRANSFORMATION EXCELLENCE AND PERFORMANCE (STEP-VA)

A Scope of Services Manual

August 2026



A life of possibilities for all Virginians

<https://dbhds.virginia.gov/>

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INTRODUCTION

The purpose of this document is to provide a single source outlining the requirements for each of the nine (9) required steps in System Transformation, Excellence, and Performance for Virginia (STEP-VA), creating a consistent set of guidelines to be used by the Department of Behavioral Health and Developmental Services (DBHDS) and the Community Services Boards (CSBs) and Behavioral Health Authorities (BHAs) who have implemented the services.

Throughout this document, the term CSB will be used to describe both CSBs and BHAs, as the STEP-VA requirements are the same for both.

This will be a living document, which DBHDS will update as requirements are modified based on the Code of Virginia, the performance contract, and other governing documents and guidance.

STEP-VA BACKGROUND

STEP-VA, initiated in 2017 by the General Assembly and codified in 2018, is designed to improve the community behavioral health services available to all Virginians. All CSBs in Virginia are statutorily required to provide all STEP-VA services. These services include: Same Day Access, Primary Care Screening, Outpatient Services, Crisis Services, Peer and Family Support Services, Psychiatric Rehabilitation Services, Veterans Services, Case Management, and Care Coordination. These essential services ensure that a continuum of services is available to address the full range of behavioral health needs across the lifespan. Through STEP-VA implementation, DBHDS anticipates fewer admissions to state and private hospitals, decreased emergency room visits, and reduced involvement of individuals with behavioral health disorders in the criminal justice system. The Certified Community Behavioral Health Clinic (CCBHC) model, developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), was used as the foundation for STEP-VA.

CONTACT

STEP-VA Website: [STEP-VA - Virginia Department of Behavioral Health and Developmental Services \(DBHDS\)](#)

For questions or Technical Assistance related to STEP-VA programming, please contact: STEP-VA@dbhds.virginia.gov

Data specific Technical Assistance can be coordinated via request: [BH Performance Measures TA Request](#)

Office hours are available virtually via Microsoft Teams every Tuesday from 1:00pm-1:30pm. Please contact the email address above for more information or to request the link to join.

STEP-VA REQUIRED SERVICES



Service Component	Objective
Same Day Access	Timely access to screening, assessments, and needed behavioral health services.
Primary Care Screening	Consists of two screenings for individuals needing assistance with overcoming barriers to accessing primary health services: 1. Primary care screenings for individuals with SMI and SED, and 2. Antipsychotic metabolic screenings for individuals prescribed antipsychotic medications by the CSB.
Outpatient Services	Access to high quality, evidence-based, trauma-informed, culturally competent, accessible behavioral health outpatient psychotherapy and psychiatry services.
Crisis Services	Provide a comprehensive continuum of services to respond quickly to crisis needs and enable individuals in crisis to remain in the least restrictive environment, preferably the home or community.
Service Members, Veterans, & their Families Services	Ensure active members of the armed forces, veterans, and their families receive high quality, evidence-based, trauma-informed, culturally competent, and accessible behavioral health services.
Peer and Family Support Services	Ensure adequate capacity across settings and stages of recovery, and support ability of peer and family supporters to empower people receiving services to strive towards their goals in the community.
Psychiatric Rehabilitation	Support for individuals with Serious Mental Illness (SMI), Substance Use Disorder (SUD), and Serious Emotional Disturbance (SED), to develop or regain independent living skills.
Targeted Case Management	Ensure behavioral and physical health needs are routinely assessed to link individuals to appropriate services in a coordinated, effective, and efficient manner.
Care Coordination	Organize individual care activities and share information, with the individual's consent as appropriate, among all participants concerned with an individual's care to achieve safer and more effective care.

Code of Virginia

The following code provides guidance on the behavioral health services to be provided by CSBs.

1. [§ 37.2-500. Purpose; community services board; services to be provided](#)
2. [§ 37.2-601. Behavioral health authorities; purpose](#)

Funding

Current information related to funding for STEP-VA can be found in the FY27 State Budget Bill HB30, Item 301 (Grants to Localities), Section II.1-II.16: [Item 301 \(DBDHS/GL\) Financial Assistance for Health Services. HB30 - Chapter.](#)

- Please note DBHDS will complete reporting on the following as required in the budget bill and will reach out to CSBs if any additional information is needed to complete the report:

Section II.16. *DBHDS shall require each CSB or BHA to report annually, by September 1 of each year, on their expenditures on STEP-VA services for the prior fiscal year. The report shall include: (i) the amount expended broken out by service and the amount such funding increased or decreased as compared to the year prior; (ii) the number of individuals served by each service in the fiscal year; and (iii) their expected allocation for the fiscal year in which the report is due. The department shall submit the report by October 1, of each year to the Governor, and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees and provide recommendations as to whether flexibility to allow CSBs to move funding between services should be considered.*

Additional information regarding the use of STEP-VA Ancillary funds can be found in Exhibit G of the Performance Contract, Section 11.12 System Transformation Excellence and Performance (STEP-VA), #6. STEP-VA Ancillary (936) – Restricted (MH SGF BASELINE).

Performance Contract

Many of the core requirements of STEP-VA are outlined in the Performance Contract between the CSBs and DBHDS. Specifically, **Exhibit B** of the performance contract provides behavioral health performance measures related to STEP-VA. **Exhibit G** of the performance contract provides a scope of certain Code mandated and other program services a CSB may be responsible for providing for STEP-VA. Various **Exhibits D** also provide scopes of services and performance measures associated with some of the programs and services that a CSB may be responsible for providing for STEP-VA. Please see individual steps for more information on relevant reference documents for each step. The following codes provide guidance regarding the performance contract between the CSBs and DBHDS.

1. [§ 37.2-508. Performance contract for mental health, developmental, and substance abuse services](#)
2. [§ 37.2-608. Performance contract for mental health, developmental, and substance abuse services](#)

Who is a STEP-VA Client?

A STEP-VA client is an individual who meets at least one of the following:

- Received a **crisis service; or**
- Received an **initial clinical assessment; or**
- Requested/accessed CSB services and was **triaged at first contact AND meets ALL of the following:**
 - Received an **initial clinical assessment (CNA)**
 - Has a **behavioral health disorder**
 - Has a **treatment plan in place**
 - Is receiving **STEP-VA clinical services** (per Performance Contract)
- Exclusion criteria:
 - Medication Management **only**
 - Peer services **without clinical assessment**
 - Peer services **not tied to STEP-VA clinical services**

STEP-VA Core Performance Measures

While each service within STEP-VA has measures associated with that step to assess individuals' outcomes, there are some core performance measures that are utilized across multiple steps to provide more holistic outcome information. These core performance measures are reflected below.

Suicide Screening Measure:

The Columbia Suicide Severity Rating Scale (C-SSRS, Columbia) is the current outcome measure used to screen for risk of suicide in individuals ages six (6) and older that have a new mental health (MH) or substance use disorder (SUD) case opened at a CSB. This screening is conducted during Same Day Access. DBHDS then monitors and extracts data by subpopulation for adults, youth, and the Service Members, Veterans, and Families (SMVF) population. The Columbia may also be used in additional circumstances as clinically indicated.

A training module on the Assessment of Suicidal Risk Using C-SSRS is available here: [Assessment of Suicidal Risk Using C-SSRS](#).

Other training options are available through The Columbia Lighthouse Project website: [FREE Training for Individuals and Systems - The Columbia Lighthouse Project](#).

The World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0): The WHODAS 2.0 assessment tool is the current outcome measure chosen by DBHDS and CSBs to assess the percentage of individuals demonstrating improvement in key outcomes when engaged in the following services: Outpatient Services, Peer and Family Support Services, Service Members, Veterans, and their Families, Psychiatric Rehabilitation, Targeted Case Management, and Care Coordination. The WHODAS 2.0 is consistent with SAMHSA's best practices. Frequently Asked Questions regarding implementation of the WHODAS 2.0 have been provided by DBHDS and can be accessed in Reference Documents under Outpatient Services below.

Please see each individual step for additional information on specific measures related to these services.

SAME DAY ACCESS (SDA)

Full Implementation: July 2020

Objective

Ensure timely access to screening, assessments, and needed behavioral health services.

Scope of Services

SDA serves children, adolescents, and adults seeking behavioral health services. Military status is considered, and appropriate services and referrals are offered/made based on that status. SDA emphasizes engagement of the individual, uses concurrent EHR documentation during the delivery of services, implements techniques to reduce appointment no shows, and uses centralized scheduling.

Throughout FY26, multiple discussions in STEP-VA Program Workgroup, I-SERV Pilot Workgroup, and other various collaborative groups led to an evolving view of SDA workflows. In order to ensure effective implementation of I-SERV, updates to SDA workflows had to be explored. Future FY Performance Contracts will include updated processes, workflows, and language to reflect these efforts from FY26 and FY27. The information within this manual and I-SERV FAQs may serve as an interim supplemental guide to effective implementation of I-SERV within the SDA process.

CSBs have the flexibility to utilize two formats of SDA: 1) Individuals may receive a same-day MH and SUD risk screening and triage at first contact, then complete the Comprehensive Needs Assessment (CNA) the same day; or 2) Individuals may receive a same-day MH and SUD risk screening and triage at first contact, then complete the CNA at a later date. It is possible both formats may be utilized at a CSB, depending on the needs of the individual, the community, and the CSB.

1. Same day screening (first contact) and CNA:
 - a. An individual may walk into or contact a CSB to request MH or SUD services and receive a MH and SUD risk screening and triage at the time the individual first contacts the CSB/BHA for services. The screening and triage may be completed in person, by telephone, or via telehealth. Appointments are not necessary for the initial screening.
 - b. The individual will then receive a comprehensive clinical behavioral health assessment from a licensed or license-eligible clinician on the same day.
2. Same day screening (first contact) and CNA at a later date:
 - a. An individual may walk into or contact a CSB to request MH or SUD services and receive a MH and SUD risk screening and triage at the time the individual first contacts the CSB/BHA for services. The screening and triage may be completed in person, by telephone, or via telehealth. Appointments are not necessary for the initial screening.
 - b. The individual may receive the CNA from a licensed or license-eligible clinician at a later date, depending on results from the risk screening and triage:
 - i. Individuals in an active crisis will be routed to Emergency Services or other appropriate crisis services and resources immediately.

- ii. Individuals determined to be at high risk will be seen for a full CNA within 24 hours. A safety plan will be included at identification of high risk level.
- iii. Individuals determined to be at low or moderate risk will be seen for a full CNA within 10 business days of the first contact/request for services.

At the time of first contact, the preliminary triage and risk assessment will include collection of the following components, at minimum:

1. Demographics: Name, SSN, DOB, Address, Phone number, Military status
2. Risk of harm to self and others (*Recommendation: Question(s) may be pulled from ASQ, Columbia/C-SSRS, or other normed & validated risk screening*)
3. Priority Populations: Sex, Pregnancy status, Substance use (including route of use)
4. Date of call/Date of service
5. Presenting/requested service need
6. *Recommendation: Basic insurance information may also be collected at first contact*

Determining “first contact”:

1. First contact represents the first time that a person, guardian, or family member contacts the CSB to obtain services for the individual in a six-month period.
2. At the time an individual makes a request for services, they are directed to SDA or given an appointment, a preliminary screening including a risk assessment is conducted, and basic data about the individual is collected.
3. It may be in person, by phone, or by audiovisual means.
4. In the absence of guidance related to specific circumstances, it is recommended to defer to the clinical judgment of the CSB.

The CNA must include the following components:

1. Contain all elements outlined in [12VAC35-105-650. Assessment policy](#) of the Virginia Administrative Code.
2. Must be completed by a Licensed or License-Eligible Mental Health Professional (LMHP or LMHP-E).
3. Identify which services will best meet the needs identified and describe how the appropriate criteria are met for the receiving service(s).

Based on the results of the CNA, if the individual is determined to need CSB services, the individual will receive an appointment for face-to-face or other direct services in the program offered by the CSB that best meets the individuals’ needs within 30 calendar days, or sooner if indicated by clinical circumstances. This serves as the program admission.

The time from the point of first contact to the time of completion of the CNA is calculated through the use of the I-SERV measure. Frequently Asked Questions regarding the I-SERV measure have been provided by DBHDS and can be accessed in the Reference Documents section below.

Considerations for Children's Services:

1. Offering hours that are convenient for families after the school day, which may include evening or weekend hours.
2. Offering telehealth assessment times for a parent or caregiver who may have difficulty getting to a clinic during the workday.
3. For CSBs that have a strong presence in schools, leveraging that relationship to connect with youth and children for services (ex: having a space where a clinician could conduct an assessment in a school building for ease of access).
4. Using a trauma-informed screening approach.
5. The youth voice is considered in addition to the caregiver voice.
6. Evidence-based practices for children
 - a. Required: Motivational Interviewing
 - b. Suggested: Screening, Brief Intervention, and Referral to Treatment (SBIRT) where appropriate

Performance Measures

Name	Brief Description	Numerator & Denominator	Reporting	Goal	Technical Specifications
I-SERV (Time to Services)	Percentage of new consumers with initial Comprehensive Needs Assessment provided within 10 business days of first contact, as well as mean number of days from first contact.	Numerator: New consumers (not seen in the past 6 months) 12 years or older that received an initial evaluation within 10 business days of their first contact. Denominator: New consumers (not seen in the past 6 months) 12 years or older that received an initial evaluation.	Submit EHR data through Enterprise Data Warehouse (EDW).	CSBs and DBHDS will work together to establish benchmark by the end of SFY27.	Attachment 1: Data utilized for I-SERV
Appointment Kept	Percentage of new consumers with initial comprehensive needs assessment who keep and attend a follow up appointment within 30 calendar days.	Numerator: All individuals that received an initial comprehensive needs assessment during the reporting period and were in need of follow-up services and received a valid service within 30 calendar days of the assessment. Denominator: All individuals that received an initial comprehensive needs assessment during the reporting period and	Submit EHR data through EDW.	70%	Attachment 1: Data utilized for 30 Day Appointment Kept

		were in need of follow-up services.			
Suicide Screening (C-SSRS, Columbia)	Percentage of individuals ages six and older that receive Columbia Suicide Severity Rating Scale (C-SSRS) screening within 30 days before or 5 days after a new MH or SUD case has been opened.	Numerator: number of individuals (ages six and older) who received the Columbia Suicide Severity Rating Scale screening within 30 days before or 5 days after the case opening. Denominator: Individuals ages six and older that have a new MH or SUD case opened at a CSB.	Submit EHR data through EDW.	86%	Attachment 1: Data utilized for Columbia Screening

Reference Documents

Virginia Code:

1. [12VAC35-105-645. Initial contacts, screening, and admission.](#)
2. [12VAC35-105-650. Assessment policy.](#)

Performance Contract:

1. Exhibit B: Section V, Performance Measures, CSB Core Performance Measures
 - a. Suicide Screening Measure (including Benchmark)
 - b. Same Day Access Measures, I-SERV Definition
 - c. Same Day Access Measures, Appointment Kept (including Benchmark)
2. Exhibit G: Section 11.12, System Transformation, Excellence, and Performance (STEP-VA)
 - a. #4. Same Day Access (SDA), Scope of Services and Deliverables

Other:

1. See Attachment 2 for I-SERV FAQs (Updated 7.6.26)

PRIMARY CARE SCREENING

Full Implementation: July 2021

Objective

Consists of two screenings for individuals needing assistance with overcoming barriers to accessing primary health services: 1. Primary care screenings for individuals with SMI and SED, and 2. Antipsychotic metabolic screenings for individuals prescribed antipsychotic medications by the CSB.

Scope of Services

Individuals with SMI or SED, populations primarily served by the CSBs, are known to be at higher risk for poor physical health outcomes, largely due to unidentified chronic conditions. Therefore, it is important for behavioral health staff to provide related care coordination to ensure access to needed physical health care. There are two required screenings associated with this step.

Primary Care Screening

Any child diagnosed with SED, or any adult diagnosed with SMI and engaged in MH Targeted Case Management and Psychiatry Services will be provided or referred for a primary care screening on an annual basis to gather the following medical data points: Height, Weight, and BMI. The screening may be completed by the CSB directly or the individual may be referred to a primary care provider to have the screening completed.

- If the screening is done by a primary care provider, the CSB is responsible for the screening results to be entered in the individual's CSB EHR. The CSB will actively support this connection and coordinate care with physical health care providers for all service recipients.
- If an individual does not have a primary care provider, they should be referred, particularly should their screening measures fall outside of normal ranges.

Antipsychotic Metabolic Screening

Any individual receiving STEP-VA services, over the age of 3 years old, being prescribed an antipsychotic medication by a CSB prescriber will receive a metabolic screening within 1 year of identification and comply with recommended metabolic screening schedule (at least annually). Individuals will be screened and monitored for metabolic syndrome following the American Diabetes Association criteria, including for the following: Glucose, Hemoglobin A1c, Lipid Profile.

- The CSB must report the screening completion and monitoring completion in the regular submissions of EHR data to DBHDS.

Considerations for Children's Services:

1. Ensure that children and adolescents receive age-appropriate screening and preventative interventions.
2. Support families in problem-solving barriers to accessing a primary care provider (i.e. planning around transportation, clinic hours, insurance type)

Performance Measures

Name	Brief Description	Numerator & Denominator	Reporting	Goal	Technical Specifications
Primary Care Screening	Percentage of adults with an SMI diagnosis and children with SED, engaged in Mental Health Targeted Case Management and Psychiatry services, who receive an annual primary care screening to include: - Height - Weight - BMI	Numerator: # of individuals with SMI/SED who received Mental Health Case Management and Psychiatry Services and have undergone a primary care screening within the one year. Denominator: # of individuals with SMI/SED who received Mental Health Case Management and Psychiatry Services.	Submit EHR data through EDW.	CSBs and DBHDS will work together to establish benchmark by the end of SFY27	Attachment 1: Data utilized for Primary Care Screening
Antipsychotic Metabolic Screening	Percentage of individuals, receiving STEP-VA services, over the age of 3 years old, receiving antipsychotic medications prescribed by a CSB, who have undergone metabolic screenings within 1 year of identification, and comply with recommended metabolic screening schedule (at least annually).	Numerator: # of individuals who received antipsychotic medications and have undergone metabolic screenings within the one year. Denominator: # of individuals who received antipsychotic medications.	Submit EHR data through EDW.	CSBs and DBHDS will work together to establish benchmark by the end of SFY27	Attachment 1: Data utilized for Antipsychotic Metabolic Screening and Guidance for Reporting Antipsychotic Medication

Reference Documents

Performance Contract:

1. Exhibit B: Section VI, Additional Expectations and Elements Being Monitored
 - a. Outpatient Primary Care Screening and Monitoring
 - i. Primary Care Screening: Measures, Benchmark, Outcomes, & Monitoring
 - ii. Antipsychotic Metabolic Screening: Measures, Benchmark, Outcomes, & Monitoring
2. Exhibit G: Section 11.12, System Transformation, Excellence, and Performance (STEP-VA)
 - a. #3. Primary Care Screening and Monitoring, Scope of Services and Deliverables

OUTPATIENT SERVICES

Full Implementation: July 2022

Objective

Provide high quality, evidence-based, trauma-informed, culturally competent, accessible behavioral health psychotherapy and psychiatry services.

Scope of Services

Outpatient services are foundational for a behavioral health system. Outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychiatry, psychological testing and assessment, laboratory, and ancillary services. These should be provided in a manner that is high quality, evidence-based, trauma-informed, culturally competent, and accessible. These services are to include individual, family, and group psychotherapy and must include outpatient services for children, adolescents, and families that are developmentally appropriate and trauma responsive. Services may be provided directly by the CSB, through regional collaborations where appropriate and effective, or contractual/referral arrangements. In the event that specialized services outside the expertise of the CSB are required for the purposes of outpatient treatment, the CSB will ensure access through referral or other formal arrangements with local community providers, through the use of telehealth/telemedicine services, or through provision of supervision and training of CSB clinicians. Practice approaches will consider such issues as the individual's stage of life and cognitive issues. Below are the requirements of CSBs in the provision of outpatient services:

- Offer evidence-based and best practices as part of programming and implementation of outpatient services to the adults, children, and families in the community.
- Increase capacity and community access to children's outpatient services.
- Individuals will receive services with a high-quality CSB outpatient provider or a referral to a non-CSB outpatient behavioral health service within 30 business days of the completed CNA, if clinically indicated.
- Establish expertise in the treatment of trauma related conditions.
- Provide a minimum for outpatient providers of 8 hours of trauma focused training in treatment modalities to serve adults, children/adolescents, and their families within the first year of employment, and 4 hours in each subsequent year or until 40 hours of trauma-focused training can be demonstrated.
- Provide training data regarding required trauma training yearly in August when completing federal Block Grant reporting (Evidence Based Practice Survey) sent by DBHDS.

Each CSB is required to provide, at a minimum, the following Evidence-Based Practices (EBP) for psychotherapy:

- Cognitive Behavioral Therapy (CBT)
- Motivational Interviewing (MI)

Each CSB is required to provide, at a minimum, the following EBPs for psychiatry:

- Medication Management

- Long-Acting Injectable Psychotropic Medications

Each CSB is required to provide at least one EBP from the list below which meets the needs identified by the Community Needs Assessment in the community served by the CSB:

- Acceptance and Commitment Therapy
- Collaborative Assessment and Management of Suicidality (CAMS)
- Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
- Dialectical Behavior Therapy (DBT)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Functional Family Therapy (FFT)
- Hi-Fidelity Wraparound (HFW)
- Integrated Treatment for Co-Occurring Disorders
- Living in Balance
- Medication Assisted Treatment (MAT)
- Moral Reconation Therapy
- Motivational Enhancement Therapy
- Multi-Systemic Therapy (MST)
- Parent Child Interaction Therapy (PCIT)
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Seeking Safety
- Solution Focused Brief Therapy
- Trauma Focused CBT (TF-CBT)
- Effective but underutilized medications for SUD treatment

Additionally, CSBs who provide Regional STEP-VA services for Outpatient Services have requirements specified in the Exhibit D that accompanies the funding allocated. This includes, but is not limited to:

- Ensuring the regional program includes trauma-focused training, including evidence-based practices and trauma informed care.
- Developing MOUs outlining regional partnerships.
- Offer evidence-based and best practices as part of programming and implementation, and provide training on evidence-based practices.
- Identify outpatient trainings and evidence-based practices needed in the region for children, families, and adults.
- Regional training infrastructure of at least 1.5 FTE for training coordination and training duties for STEP-VA services.
- *See Exhibit D noted in Reference Documents for more information.*

Considerations for Children's Services:

1. Early assessment and identification of childhood emotional disturbances, and engagement of the child and family in the development of a plan of care designed to minimize the symptoms of adverse effects of illness, maximize wellness, assist the child in developing a

resilient and hopeful approach to school, family, and community, and maintain the child in their natural environment.

2. Children and adolescents are treated using a family/caregiver-driven, youth-guided, and developmentally appropriate approach that comprehensively addresses family/caregiver, school, medical, mental health, substance use, psychosocial, and environmental issues.
3. Services for children and their families may be offered in the home and community and should not be limited to office-based contact.

Performance Measures

Name	Brief Description	Numerator & Denominator	Reporting	Goal	Technical Specifications
WHODAS 2.0	Percentage of individuals receiving STEP-VA services assessed using the WHODAS 2.0 who demonstrate improvement in their WHODAS 2.0 score over a 6-month period.	Numerator: # of individuals engaged in STEP-VA services with improved WHODAS 2.0 scores over a 6-month period. Denominator: Total # of individuals engaged in STEP-VA services using WHODAS 2.0.	Submit EHR data through EDW.	CSBs and DBHDS will work together to establish benchmark by the end of SFY27	Attachment 1: Data utilized for WHODAS 2.0
Availability of specified EBPs	CSBs provide specified EBPs through attestation and/or quality reviews.	N/A	EBP annual survey is completed by CSB and collected by VCU CEP-VA yearly; Data sent to DBHDS to analyze.	All minimum required EBPs for psychotherapy and psychiatry are provided by CSB, as well as one additional EBP from the provided list which meets the needs identified by the locality's community needs assessment.	N/A
Minimum and Full Trauma Training Requirement	Percentage of CSB outpatient provider staff that have received the required 8 hours of trauma-focused training within the first year of employment and 4 hours in each subsequent year or until 40 hours of trauma-focused training can be demonstrated.	Numerator: # of CSB outpatient provider staff receiving 8 hours of trauma focused training within the first year of employment and 4 hours in each subsequent year until 40 hours of trauma focused training can be demonstrated. Denominator: # of CSB outpatient provider staff.	EBP annual survey is completed by CSB and collected by VCU CEP-VA yearly; Data sent to DBHDS to analyze.	95% for minimum trauma training 95% for full trauma training	N/A

Reference Documents

Performance Contract:

1. Exhibit B: Section V, Performance Measures, CSB Core Performance Measures
 - a. WHODAS 2.0 Measure & Benchmark
2. Exhibit B: Section VI, Additional Expectations and Elements Being Monitored
 - a. Outpatient Services: Measures, Benchmark, & Monitoring
3. Exhibit D (D1047): FY26-27 Performance Measures for the Regional STEP-VA Services for Peer and Family Supports (PFS), Outpatient Services, & Service Members, Veterans, and their Families (SMVF)
4. Exhibit G: Section 11.12, System Transformation, Excellence, and Performance (STEP-VA)
 - a. #2. Outpatient Services, Scope of Services and Deliverables

Other:

1. See Attachment 3 for WHODAS 2.0 FAQs (Updated 8.31.26)

CRISIS SERVICES

Full Implementation: July 2022

Objective

Provide a comprehensive continuum of services that respond quickly to crisis needs and enable individuals in crisis to remain in the least restrictive environment, preferably the home or community.

Scope of Services

Crisis Services includes four core elements:

1. Regional Crisis Call Centers (RCCCs) provide access to trained crisis workers 24 hours a day, seven days a week. Staff are equipped to respond to all contacts—whether by phone, chat, or text—using crisis intervention skills to triage, assess needs, and coordinate connections to appropriate supports based on the caller’s needs and preferences. RCCCs also work in close partnership with regional hubs to ensure individuals can access the full continuum of crisis services, while advancing statewide initiatives and priorities such as 911 diversion.
2. Regional Mobile Crisis Response (MCR): Mobile Crisis Response is a 24/7 service that provides rapid, in-person help to people experiencing a behavioral health crisis where they are in their community. A licensed clinician conducts an assessment to understand both the person’s history and the immediate reason for the crisis. The goal is to reduce risk, prevent harm, and create a quick, individualized plan to keep the person safe. MCR aims to stabilize people in the community whenever possible, offering early intervention and support to avoid unnecessary hospitalizations.
3. Regional Community Based Stabilization: Crisis stabilization provides short-term care in a non-hospital, community-based setting for individuals who need support and observation. These programs are designed to stabilize individuals in the community, reduce acute symptoms, and support both the individual and their natural support system. Services include short-term observation and intensive stabilization for those needing more care than can be provided by mobile crisis response. Crisis stabilization also helps identify and mobilize available resources, including personal support networks, while offering care at lower costs and without the overhead of hospital-based acute care.
4. Essential principles and practices: These must include a recovery orientation, trauma-informed care, significant use of peer staff, a commitment to Zero Suicide/Suicide Safer Care, strong commitments to safety for consumers and staff, and collaboration with law enforcement.

Key Strategies:

1. **Psychiatry Services:** This strategy works to extend the reach of very limited child psychiatry resources. Regions were asked to provide pediatric psychiatry in one or more of the following three venues:
 - a. Face to face office visits with youth
 - b. Tele-psychiatry services to youth in remote sites, and
 - c. Youth psychiatry consultations to other providers, such as pediatricians, primary care providers, and others.

Medical Services are defined as 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 prescriber.

2. **Mobile Crisis Services:** Mobile crisis services provide direct care and treatment to non-hospitalized individuals, including children and adults. The goals are to avoid unnecessary hospitalization, rehospitalization, or disruption of living situation; assure safety and security; and stabilize individuals in crisis. Mobile crisis services may be provided in an individual's home, school, or in a community-based program.
3. **Crisis Stabilization Units:** Based on service gaps identified in their proposals, each region has different needs and resources for residential crisis stabilization services. All residential crisis stabilization services are short-term and focused on maintaining family/natural support contact and returning individuals to their homes.
4. **Background:** Historically, CSB services had been oriented toward behavioral health crisis response because, by statute, only emergency services and preadmission screenings had to be provided regardless of funding or other considerations. As a result, CSB's did not consistently provide a full continuum of services to prevent or recover from a crisis. Ideally, public behavioral health services will support Virginians before, during, and after a behavioral health crisis occurs, and provide needed services in the least restrictive environment for individuals experiencing crisis.

Key points:

- The Crisis Services step is integrated into a larger Crisis System Transformation that includes projects such as:
 - REACH program
 - DOJ investments in crisis call center
 - DMAS Behavioral Health Enhancement rates for multiple crisis services
 - Marcus Alert
 - Pediatric Psychiatry and Children's Crisis Response
 - SAMHSA Crisis Now Model
- Many of the Crisis transformation projects are regional.

Considerations for Children's Services:

Crisis behavioral health services are provided to a child under the age of 18, and their family/caregiver, who is experiencing a psychiatric or substance use (behavioral health) crisis.

Performance Measures

Name	Brief Description	Numerator & Denominator	Reporting	Goal	Technical Specifications
MCR Call Arrival Time	The percentage calls responded to within 1 hour (urban) or 2 hours (rural) from the time of dispatch.	Numerator: The # of calls responded to within 1 hour (urban) or 2 hours (rural) from the time of dispatch. Denominator: The total # of calls (to 988, transfers from 911, regional MH hotlines, REACH hotline, CSB hubs) that result in an in-person mobile crisis response.	Mobile Crisis Response providers submit data through the VA Crisis Data Platform. This is transferred to EDW.	Baseline est. FY25 = 80.9%	N/A
MCR Community Outcome	The percentage mobile crisis responses that are resolved in the community.	Numerator: # of mobile crisis responses that have a disposition of retain setting, retain setting with support, or alternate community setting. Denominator: Total # of in-person mobile crisis responses.	Mobile Crisis Response providers submit data through the VA Crisis Data Platform. This is transferred to EDW.	Baseline est. FY25 = 55.5%	N/A

Reference Documents

Virginia Code:

1. [12VAC35-105-700. Written policies and procedures for crisis or emergency interventions: required elements.](#)
2. [12VAC35-105-710. Documenting crisis intervention and emergency services.](#)

Performance Contract:

1. Exhibit D (D3103): FY26 Performance Measures for Regional Crisis Call Center, Regional Training and Coordination, Regional Children and Adult Mobile Crisis Response, and Regional Community-Based Stabilization Services
2. Regional Crisis Hubs have requirements specified in the Exhibit D that accompanies the funding allocated.

Other:

1. For questions or additional information regarding Crisis Services, please contact:
Bill Howard – william.howard@dbhds.virginia.gov

SERVICE MEMBERS, VETERANS, AND THEIR FAMILIES (SMVF)

Full Implementation: July 2023

Objective

Ensure active members of the armed forces, veterans, and their families receive high quality, evidence-based, trauma-informed, culturally competent, and accessible behavioral health care services.

Scope of Services

SMVF provides mental health, substance use, and supportive services in the most efficient and effective manner possible. Services shall be high quality, evidence-based, trauma-informed, culturally competent, and accessible. Per the Code of VA, this should include mental health services for members of the armed forces located 50 miles or more from a military treatment facility, and veterans located 40 miles or more from a Veterans Health Administration medical facility. Services may be provided directly by the CSB, through regional collaborations where appropriate and effective, or contractual/referral arrangements. Below are the expectations of the CSBs in the provision of services to the SMVF population:

- All CSBs shall ensure they have clinician(s) who specialize in treatment for post-traumatic stress disorder and other forms of trauma including from military and/or combat service including military sexual trauma and substance use disorders.
- CSBs shall ensure behavioral health services including but not limited to MH, SUD, Co-Occurring and Youth/Adolescents. Clinical services for this population shall align with federal clinical guidelines from Veterans Affairs and Department of Defense which can be found at <https://www.healthquality.va.gov>.
- CSBs shall identify and refer SMVF individuals seeking services to internal providers that have been trained in military cultural competency (MCC); collaborate with and provide resource information pertaining to Military Treatment Facilities (MTFs), Veterans Health Administration (VHA) facilities, and Virginia Department of Veterans Services

Additionally, CSBs who provide Regional STEP-VA services for SMVF have requirements specified in the Exhibit D that accompanies the funding allocated. This includes, but is not limited to:

- Ensure the program is implemented as a regional program and is not specific to the physical location of the program.
- Participating CSBs in the region develop a Memorandum of Understanding (MOU) outlining the mission, vision, and goals of the regional partnerships
- Offer evidence-based and best practices as part of programming
- Support at least 1.0 FTE Regional Navigator
- Support the implementation, enhancement, and goals of Lock and Talk
- Support for regional training and capacity building in service to SMVF
- *See Exhibit D noted in Reference Documents for more information.*

Considerations for Children's Services:

1. **Understanding Military Lifestyle:** Frequent moves can disrupt stability, friendships and educational continuity, while a parent's deployment can cause emotional stress associated with a parent's deployment and the potential for anxiety or behavioral issues.
2. **Emotional and Psychological Support:** Awareness of potential trauma related to combat experiences of parents or other family members is essential.
3. **Social Connections:** Encouraging participation in peer support groups can help children foster friendships with others who understand their experiences.
4. **Communication and Involvement:** Helping families establish routines for communication during deployments can maintain connections. Providing resources and workshops for parents can support them in helping their children through transitions and deployments.
5. **Cultural Competence:** Understanding the unique values and traditions of military families and recognizing diversity in their experiences can enhance support services. Each military family may have different needs based on their service branch, deployment history, and personal circumstances.
6. **Transition Planning:** Offering support for transitions, such as moving to a new location or adjusting to a parent's return from deployment, as well as resources for children when a parent transitions from military to civilian life, can help ease these changes.

Performance Measures

Name	Brief Description	Numerator & Denominator	Reporting	Goal	Technical Specifications
Identifying SMVF members	At admission, health records in all program areas will contain a valid entry for the Military Service demographic variable.	N/A	Submit EHR data through EDW.	90%	N/A
WHODAS 2.0	See Outpatient Services	See Outpatient Services	Submit EHR data through EDW.	CSBs and DBHDS will work together to establish benchmark by the end of SFY27.	See Outpatient Services
Military Cultural Competency Training	Percentage of CSB direct services staff that receive military cultural competency training within 90 days of hire and	Numerator: CSB direct services staff who receive military cultural competency training within 90 days of hire and every 3 years of employment thereafter.	EBP annual survey is completed by CSB and collected by VCU CEP-VA yearly; Data	95%	N/A

	every 3 years of employment thereafter.	Denominator: CSB staff delivering direct services to the SMVF population.	sent to DBHDS to analyze.		
Suicide Screening Measure (C-SSRS, Columbia)	Percentage of SMVF identified individuals ages six and older that receive Columbia Suicide Severity Rating Scale screening within 30 days before or 5 days after a new MH or SUD case has been opened.	See SDA	Submit EHR data through EDW. DBHDS has the ability to pull data from the Columbia Suicide Screening responses and trends for this subgroup.	86%	See SDA

Reference Documents

Performance Contract:

1. Exhibit B: Section V, Performance Measures, CSB Core Performance Measures
 - a. Suicide Screening Measure (including Benchmark)
 - b. WHODAS 2.0 Measure (including Benchmark)
2. Exhibit B: Section VI, Additional Expectations and Elements Being Monitored
 - a. Service Members, Veterans, and Families (SMVF)
 - i. Training Measures (including Benchmark)
 - ii. Identifying SMVF Members (including Benchmark)
 - iii. Columbia Suicide Screening for the SMVF subgroup
3. Exhibit D (D1047): FY26-27 Performance Measures for the Regional STEP-VA Services for Peer and Family Supports (PFS), Outpatient Services, & Service Members, Veterans and their Families (SMVF)
4. Exhibit G: Section 11.12, System Transformation, Excellence, and Performance (STEP-VA)
 - a. #5 Service Members, Veterans, and Families (SMVF)

Other:

1. Memorandum of Understanding for The Department of Behavioral Health & Developmental Services and The Department of Veterans Services

PEER AND FAMILY SUPPORT SERVICES

Full Implementation: July 2023

Objective

Ensure adequate capacity across settings and stages of recovery, and support the ability of Peer and Family Supporters to empower people receiving services to strive towards their goals in the community.

Scope of Services

Peer and family support services (PFS) are person-centered, strength-based, and recovery-oriented services, assisting individuals in achieving positive coping mechanisms for the stressors and barriers encountered during their path to wellness and recovery. These services encompass various aspects of wellness, including emotional, financial, social, spiritual, occupational, physical, intellectual, and environmental well-being. The services should be high quality, evidence-based, trauma-informed, culturally competent, accessible, and recovery and resilience-oriented. Peer and family support services may be offered in various settings. STEP-VA funded Peer and Family support staff should minimally provide services in at least one of the following programs: crisis services, psychiatric rehabilitation services, outpatient services, and substance use disorder services. Services are delivered by trained Peer Supporters with lived experience. These services promote hope, teach coping skills, foster connections to natural supports, and help individuals develop personalized recovery strategies.

Additionally, CSBs who provide Regional STEP-VA services for Peer and Family Support Services have requirements specified in the Exhibit D that accompanies the funding allocated. This includes, but is not limited to:

- Increasing the capacity of Family Support Partner role through workforce development initiatives
- Supporting regional training and capacity building in service to Peer and Family Supporters
- Ensuring the program is implemented as a regional program and is not specific to the physical location of the program
- Development and review of MOUs outlining the mission, vision, and goals of the regional partnerships
- *See Exhibit D noted in Reference Documents for more information.*

Considerations for Children's Services:

1. Family Support Partner Services: Family Support Partner (FSP) services are strengths-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 individuals, with a behavioral health, developmental, substance use, or co-occurring challenge. The services provided to the parent/caregiver must be directed toward the benefit of the individual in need of services. Services are expected to improve outcomes for the individual and increase the individuals' and families' 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.

FSP services are rendered by a parent/caregiver of a minor or adult child with a similar mental health, developmental, substance use or co-occurring challenge with experience navigating developmental, substance use, or behavioral health care services.

2. Youth Peer Support: Individuals who have lived experience with one or more systems (i.e. Mental Health, Juvenile Justice, Foster Care, etc.), who assist, empower, and support youth and young adults as they navigate and improve youth-serving systems. Essentially, they are individuals with lived system-navigation experience who deliver one-on-one peer support to youth and young adults. They provide guidance and support by listening and identifying strengths, areas of need, supports, and resources.

They also assist the young person in establishing goals and formulating the next steps to successfully transition to adulthood based on the individual's definition of success. Youth support is specifically designed to meet the needs of youth in ways that acknowledge youth culture, elevate youth voice, and keep a youth-led lens the entire way through.

Performance Measures

Name	Brief Description	Numerator & Denominator	Reporting	Goal	Technical Specifications
WHODAS 2.0	See Outpatient Services	See Outpatient Services	Submit EHR data through EDW.	CSBs and DBHDS will work together to establish benchmark by the end of SFY27.	See Outpatient Services
Peer FTEs (STEP-VA funded)	Total number of Peer Support Services FTE offering peer support services in mental health and/or substance use treatment settings funded by STEP-VA allocations.	N/A	To be collected via CSB self-report on the STEP-VA 6-month check-in survey.	Year 1 will allow for monitoring and benchmarking.	N/A
Peer FTEs (Total)	Total number of Peer Support Services FTE offering peer support services in CSB from all funding sources.	N/A	To be collected via CSB self-report on the STEP-VA 6-month check-in survey.	Year 1 will allow for monitoring and benchmarking.	N/A
Peer Training (Orientation)	Percentage of peer supervisory staff and direct service staff who complete the required DBHDS orientation	Numerator: The # of peer supervisory and direct service staff who completed DBHDS	EBP annual survey is completed by CSB and collected by VCU CEP-VA yearly;	80%	N/A

	training on the role of the PRS/FSP.	orientation training on the role of PRS/FSP. Denominator: The # of CSB peer supervisory and direct service staff.	Data sent to DBHDS to analyze.		
Peer Training (Triennial)	Percentage of peer supervisory staff and direct service staff who complete the required DBHDS triennial training on the role of PRS/FSP.	Numerator: The # of peer supervisory and direct service staff who completed DBHDS triennial training on the role of PRS/FSP. Denominator: The # of CSB peer supervisory and direct service staff.	EBP annual survey is completed by CSB and collected by VCU CEP-VA yearly; Data sent to DBHDS to analyze.	80%	N/A
Programs into which STEP-VA funded Peer/Family Support is embedded	Percentage of STEP-VA funded Peer and Family Support staff who minimally provide services in at least one of the following programs: Crisis Services, Psychiatric Rehabilitation Services, Outpatient Services, and Substance Use Disorder Services.	Numerator: The # of STEP-VA funded Peer/Family Support staff who minimally provide services in at least one of the following programs: Crisis Services, Psychiatric Rehabilitation Services, Outpatient Services, and Substance Use Disorder Services. Denominator: The # of STEP-VA funded Peer/Family Support staff	CSB shall attest to this through the six-month STEP-VA survey.	90%	N/A
Peer Certification and Registration	Percentage of Peer/Family Support staff who obtain certification within 15 months of hire (from the Virginia Certification Board) and complete registration within 18 months of hire (from the Board of Counseling).	N/A	CSBs will submit to DBHDS, via sFTP (details to follow), an Excel or .csv file containing the following for all peers employed by the agency: First name, certification date, registration date, hire date, termination date, and EHR staff ID. Submit by 9/30/25 and annually thereafter.	90%	N/A
Peer Engagement	Percentage of individuals engaging in billable peer services across the CSB.	Numerator: The # of individuals that engaged in CSB billable peer services.	Data will be collected via the EDW beginning on	Year 1 will allow for monitoring and benchmarking.	N/A

		Denominator: The total # of individuals enrolled to CSB programs that offer peer support services.	July 1, 2026. A baseline will be determined by October 1, 2026.		
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Reference Documents

Performance Contract:

1. Exhibit B: Section V, Performance Measures, CSB Core Performance Measures
 - a. WHODAS 2.0 Measure (including Benchmark)
2. Exhibit B: Section VI, Additional Expectations and Elements Being Monitored
 - a. Peer and Family Support Services
 - i. Peer FTEs (STEP-VA Funded): Measure & Benchmark
 - ii. Peer FTEs (Total): Measure & Benchmark
 - iii. Peer Certification and Registration: Measure & Benchmark
3. Exhibit D (D1047): Performance Measures for the Regional STEP-VA Services for Peer and Family Supports (PFS), Outpatient Services, & Service Members, Veterans, and their Families (SMVF)
4. Exhibit D (D3216): FY26 Performance Measures for the STEP-VA Peer/Family Support
 - a. D3216 Amendment 2: Amended and Restated FY26 Performance Measures for the STEP-VA Peer/Family Support
 - b. D3216 Amendment 3: Amending FY26 Performance Measures for the STEP-VA Peer/Family Support

PSYCHIATRIC REHABILITATION SERVICES (PRS)

Full Implementation: July 2024

Objective

Support individuals with SMI, SUD, and SED in developing, regaining, or increasing their functioning and independent living skills. Assist individuals with SMI, SUD, and SED develop the skills and access resources to succeed in the living, working, learning, and social environments of their choice.

Scope of Services

Psychiatric Rehabilitation Services are evidence-based, collaborative, person directed, and individualized. These services promote recovery, full community integration, and improved quality of life for persons who have been diagnosed with behavioral health diagnoses. These services should be delivered in a person-centered, recovery-oriented, trauma-informed, culturally competent, and equitable manner. PRS focuses on skill and resource development related to independent living and increasing the individual's ability to manage their challenges to more fully participate in community opportunities related to functional, social, educational, and vocational goals.

PRS can be implemented in various models, settings, and by most mental health disciplines, aiming to help individuals become successful and satisfied in their chosen environments. Models like Assertive Community Treatment (ACT), Clubhouse, or Individual Placement and Support (IPS) for Supported Employment, can implement PRS within their structures. Additionally, settings like hospitals, psychosocial rehabilitation centers, day programs, drop-in centers, and community mental health centers can conduct PRS.

Allowable services under this step include:

- MH/SUD Intensive Outpatient Program (IOP)
- Assertive Community Treatment
- MHSUD Supported Employment
- MHSUD Supervised Residential
- MHSUD Supervised Intensive Residential
- MHSUD Supervised Highly Intensive Residential
- Intensive In-home Services
- Therapeutic Day Treatment (TDT)
- Coordinated Specialty Care
- Mental Health Skill Building
- Psychosocial Rehabilitation Services
- Clubhouse Model/Fountain House
- Permanent Supportive Housing
- High Fidelity Wraparound
- Parent Child Interaction Therapy
- MHSUD peer support

- MHSUD group peer support
- Illness Management and Recovery
- Social Skills Training
- Cognitive Behavioral Therapy for Psychosis
- Supported Employment (SE): DBHDS will continue to collaborate with the CSBs to implement SE, to ensure consistency with [SAMHSA's Best Practices](#).

Considerations for Children's Services:

1. Children's practices that engage caregivers or other family members as clinically indicated to mitigate any family system antecedents to behavioral or mental health symptoms

Performance Measures

Name	Brief Description	Numerator & Denominator	Reporting	Goal	Technical Specifications
WHODAS 2.0	See Outpatient Services	See Outpatient Services	Submit EHR data through EDW.	CSBs and DBHDS will work together to establish benchmark by the end of SFY27	See Outpatient Services
Psychiatric Rehab Services offered	List of psychiatric rehab services offered at each CSB	N/A	CSB shall attest to this through the six-month STEP-VA survey.	Each CSB will offer at least one of the approved psychiatric rehabilitation services	N/A

Reference Documents

Performance Contract:

1. Exhibit B: Section V, Performance Measures, CSB Core Performance Measures
 - a. WHODAS 2.0 Measure & Benchmark
2. Exhibit D (D3087): Performance Measures for the STEP-VA Services for Case Management, Care Coordination, and Psychiatric Rehabilitation

Other:

1. Anthony, W. A., & Farkas, M. D. (2009). Primer on the psychiatric rehabilitation process. Boston: Boston University Center for Psychiatric Rehabilitation. <https://cpr.bu.edu/wp-content/uploads/2011/11/Primer-on-the-Psychiatric-Rehabilitation-Process.pdf>
2. Substance Abuse and Mental Health Services Administration. (2009). *Supported Employment: Getting Started with Evidence-Based Practices*. https://library.samhsa.gov/sites/default/files/d7/priv/gettingstarted-se_0.pdf
3. Substance Abuse and Mental Health Services Administration. (2025). *Individual Placement and Support (IPS) Supported Employment Model* (PEP25-01-002). <https://library.samhsa.gov/product/individual-placement-and-support-ips-supported-employment-model/pep25-01-002>

TARGETED CASE MANAGEMENT (TCM)

Full Implementation: July 2024

Objective

Ensure behavioral and physical health needs are routinely assessed to link appropriate services in a coordinated, effective, and efficient manner to support the needs of individuals and families and promote wellness and integration into all aspects of life.

Scope of Services

The CSB is responsible for ensuring the provision of high-quality Targeted Case Management (TCM) services in the community for adults, children, and their families. CSBs should offer evidence-based and best practices as part of their programming and implementation of these services. The CSB should also maximize billing and collection of funds from other sources including Medicaid, Medicare, and other fees to increase funds available for TCM. TCM should be designed and implemented in accordance with requirements in DBHDS's Licensing Regulations ([12VAC30-50-420](#)).

TCM services can include:

- Assessment and planning services, to include developing an individual service plan (ISP)
- Linking individuals to services and supports identified in the ISP
- Assisting in locating, developing, or obtaining needed services and resources
- Coordinating services with other agencies and providers
- Enhancing community integration by contacting other entities to arrange community access and involvement
- Making collateral contacts with the individual's significant others
- Follow up and monitoring to assess ongoing progress and service delivery
- Education and counseling that guides the client and develops a supportive relationship that promotes the service plan
- Increasing health literacy and empowering self-advocacy
- Ensuring that individuals receive a primary care screening annually (see Primary Care)

Considerations for Children's Services:

1. Family Dynamics: Understanding family dynamics involves assessing the role and capability of caregivers and parents to ensure they can provide the necessary support. It is also important to understand the child's family structure, including siblings, extended family, fictive kin, and living arrangements. Additionally, respecting and integrating the child's cultural background into the individual service plan is essential for effective support.

2. **Educational Needs:** Consider the child’s educational needs. This includes evaluating their school performance, identifying any special education needs, and ensuring necessary accommodations are in place. Promoting involvement in extracurricular activities can also support social skills and personal interests, contributing to their overall development.
3. **Support Services:** Identify available local resources such as counseling, healthcare, and after-school programs that can assist the child and their family.
4. **Safety and Stability:** A stable environment helps the child feel secure and supported. Work to ensure the child is in a safe living situation free from abuse and neglect. Stability of placement is also crucial, especially in foster care situations, to provide consistent and reliable support.
5. **Collaboration and Communication:** Work collaboratively with parents, educators, healthcare providers, and other stakeholders to ensure all aspects of the child’s care are addressed. Maintain open lines of communication with all parties involved in the child’s care to promote transparency and coordination.
6. **Empowerment and Advocacy:** Including the child’s input in decision-making, to the extent appropriate for their age, empowers them and ensures their voice is heard. Supporting the family in navigating systems and accessing necessary services is also crucial. Advocacy helps families understand their rights and obtain the support they need.
7. **Transition Planning:** Prepare the child for transitions, such as moving to a new school or, for older adolescents, preparing for adulthood. This includes developing the skills and planning for continued support as the child ages out of services or moves into new phases of life. Transition planning ensures that the child is equipped to handle changes and continue their development.

Performance Measures

Name	Brief Description	Numerator & Denominator	Reporting	Goal	Technical Specifications
WHODAS 2.0	See Outpatient Services	See Outpatient Services	Submit EHR data through EDW.	CSBs and DBHDS will work together to establish benchmark by the end of SFY27	See Outpatient Services

Reference Documents

Virginia Code:

Note: This is a working document and is not intended as a final draft (Rev. 8/31/26)

1. [12VAC30-50-420. Case management services for seriously mentally ill adults and emotionally disturbed children.](#)

Performance Contract:

1. Exhibit B: Section V, Performance Measures, CSB Core Performance Measures
 - a. WHODAS 2.0 Measure & Benchmark
2. Exhibit D (D3087): Performance Measures for the STEP-VA Services for Targeted Case Management, Care Coordination, and Psychiatric Rehabilitation

CARE COORDINATION

Full Implementation: July 2024

Objective

Organize individual care activities and share information, with the individual's consent as appropriate, among all participants concerned with an individual's care to achieve safer and more effective care. Ensure the individual's needs and preferences are known and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care.

Scope of Services

Care coordination involves person-centered, holistic care planning that connects resources across the continuum of care for all individuals served by the CSBs. It promotes team-based care among all participants and is not a distinct service. Care coordination is essential to all healthcare services, including, but not limited to, case management, hospital liaison, and discharge planning services.

Care coordination can be embedded into other services as deemed appropriate by CSBs. It is separate from case management, in that it is a collaborative activity that helps ensure all parties involved in someone's care are informed and that the individual's needs are effectively communicated across their support team. Care coordination is an activity that can occur within case management as well as within other services. Care coordination must be provided to all individuals served by CSBs, regardless of whether they receive targeted case management. It ensures all care team members receive relevant information and updates for a complete, safe, and non-duplicative plan of care. If staff are hired exclusively for care coordination, their tasks should not be duplicated by other services like targeted case management.

CSBs coordinate care based on a person and family-centered plan, consistent with best practices. This includes access to physical and behavioral health services, social services, housing, educational systems, and employment opportunities to facilitate wellness and recovery. Care coordination strives for seamless transitions of care, considering the individual's choice, and integrates care by organizing activities, information, and needs and preferences across all appropriate care settings.

When individuals are served by MCO care coordinators, care coordination provided by the CSB is collaborative, and not duplicative. It focuses on improving communication between healthcare and other service providers and improving individual engagement and satisfaction with care.

Care Coordination includes partnerships or formal contracts with community partners/agencies such as:

- FQHCs and other health clinics
- Veterans Organizations (e.g., the Department of Veterans Affairs medical centers, outpatient clinics, drop-in centers)
- Facilities providing inpatient care, ambulatory/detox, step-down services, and residential programs

- Agencies providing community supports to youth and families (e.g., school systems, child welfare agencies, other social and human service agencies)
- Agencies assisting individuals with acquiring benefits (e.g., Medicaid).

Considerations for Children's Services:

1. Family-centered care is important for the person served, particularly for children and youth. It is grounded in the philosophy that:
 - a. Support is most effective when you understand each family's goals, values and expectations.
 - b. All families have strengths, and we learn and grow when we build on them.
 - c. Family wellbeing is elevated by the quality of informal and formal support and services.
2. The youth and young adult populations also have specific barriers to accessing and staying engaged in care. Those may include but are not limited to stigma, parental denial or lack of awareness, lack of parental support, peer influence, transportation, costs of services, or mistrust of institutions.

Performance Measures

Name	Brief Description	Numerator & Denominator	Reporting	Goal	Technical Specifications
WHODAS 2.0	See Outpatient Services	See Outpatient Services	Submit EHR data through EDW.	CSBs and DBHDS will work together to establish benchmark by the end of SFY27	See Outpatient Services

Reference Documents

Performance Contract:

1. Exhibit B: Section V, Performance Measures, CSB Core Performance Measures
 - a. WHODAS 2.0 Measure & Benchmark
2. Exhibit D (D3087): Performance Measures for the STEP-VA Services for Targeted Case Management, Care Coordination, and Psychiatric Rehabilitation

Data Utilized for I-SERV:

Updated 6/25/2026

6-Month Lookback Period	First Eleven Months of MY	Last 30 Days of MY
	Measurement Year (MY): 12-month reporting period	
Denominator Lookback Period: First eleven months of the MY plus a six-month lookback period to identify new episodes of care.		
	Numerator Measurement Period: Measurement Year (MY)	

#	Criteria	Table	Fields	Value	Notes
1	All New Individuals with a preliminary triage at first contact	PR-1 – Procedure Segment Fields PV1 - Patient Visit Segment Fields	Procedure Code Service Date Admit Date	V0009 MMDDYYYY as Date of First Contact Admit Date >= Date of First Contact - 6 months and Admit Date < Date of First Contact	Must be a new individual defined as someone who has not been served at the CSB in the past 6 months. No PV1 at the CSB site in the past 6 months Individual must have no PV1 Admit Date within the 6 months prior to the Date of First Contact
2	All New Individuals aged 12 and older	PID – Patient Identification Fields	Date of Birth	Service Date - Date of Birth >= 12 years	
3	All New Individuals with a Comprehensive Needs Assessment (CNA)	PR-1- Procedure Segment Fields	Procedure Code Service Date	90791 MMDDYYYY as Assessment Date	
4	All New Individuals with a Comprehensive Needs Assessment (CNA) ages 12 and up	PID – Patient Identification Fields	Date of Birth	Assessment Date - Date of Birth >= 12 years	
5	All New Individuals with a Comprehensive Needs Assessment			Assessment Date – Date of First Contact <= 10 business days	Mean number of days will be the total number of days between First

	(CNA) within 10 business days				Contact and Assessment Date for all members of the denominator population divided by the number of individuals in the denominator population
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Calculation of Measure:

- Criteria (1-5) / Criteria (1-4)
- Mean = Total business days between First Contact and CNA / Number of individuals in Denominator

Updated: 7/1/26

Calculation of Measure: Criteria (1-5) / Criteria (1-4)

Updated 7/1/2026

If multiple admissions occur within the allowable lookback window, the same Columbia assessment may satisfy more than one admission.

			PR-1 Service Date	Min(Service Date) – Admission Date <= 60 days	
4	Received Columbia Suicide Screening	ZAA-Custom Segment Fields	Columbia Suicide Severity Rating Scale Assessment Value Columbia Suicide Severity Rating Scale Assessment Date	03 Low 04 Medium 05 High MMDDYYYY >= PV1 Admission Date -30, and <= PV1 Admission Date+5	ZAA.42:03, 04, 05 30 days before admission date to 5 days after admission date

Calculation of Measure: Criteria (1-4) / Criteria (1-3)

Data Utilized for Primary Care Screening Measure:

Updated 6/25/2026

#	Criteria	Table	Fields	Value	Notes
1	MH Targeted Case Management Services AND Psychiatric Services	ZAA-Custom Segment Fields PR-1-Procedures Segment Fields	Client Transaction Type Procedure Code Service Date Associated Diagnosis	SVA: STEP-VA H0023 or T1016, AND 90792, or 99202-99205, or 99212-99215 MMDDYYYY within the measurement period as Service Date Mental Health	ZAA.22: SVA Lookback to capture those who received CM and Psychiatric Services for at least 12 months. Based on primary DX-as MH. Cross walk provided here: https://hcup-us.ahrq.gov/toolssoftware/ccs10/ccs10.jsp
2	SMI/SED	ZAA-Custom Segment Fields	SMI SED	01A Serious Mental Illness (SMI) 02A Serious Emotional Disturbance (SED)	ZAA.20: 01A, 02A
3	Primary Care Screen within 12 months of relevant service	ZAA-Custom Segment Fields	Primary Care Screening Assessment Value Primary Care Screening Assessment Date	03 Yes, screening values not within normal 04 Yes, screening values within normal MMDDYYYY-Min(Service Date) <= 12 months	ZAA.42: 03, 04 ZAA.41: Primary Care assessment date.

Calculation of Measure: Criteria (1-3) / Criteria (1-2)

Data Utilized for Metabolic Screening Measure:

Updated 6/25/2026

#	Criteria	Table	Fields	Value	Notes
1	Service within the measurement period	PR-1- Procedure Code Fields	Procedure Code Service Date	90792, 99202-99205, 99211-99215 MMDDYYYY within the measurement year	Individuals with admission dates and no corresponding discharge dates.
2	Antipsychotic Prescribed	ZAA-Custom Segment Fields	Anti-psychotic medications prescribed by CSB psychiatric practitioner (for age 3 and up) Assessment Value Anti-psychotic medications prescribed Date	01 Yes MMDDYYYYwithin measurement year	ZAA.44:01 ZAA.43
3	Age> 3	PID – Patient Identification Fields	Date of Birth	Service Date - Date of Birth >= 3 years	
4	Metabolic Screening	ZAA-Custom Segment Fields	Metabolic Syndrome Screening – Annual– Glucose,- hemoglobin-lipid profiles Assessment Value Metabolic Syndrome Screening - Annual- Glucose, - hemoglobin-lipid profiles Assessment Date	03Yes, screening values not within normal ranges 04Yes, screening values within normal ranges; 06Yes, referred for screening, results Pending MMDDYYYYwithin 12 months	ZAA.46:03, 04, 06 ZAA.45:Metabolic screening assessment date (annual)

Calculation of Measure: Criteria (1-4) / Criteria (1-3)

Data Utilized for WHODAS 2.0 Improvement:

Updated 7/1/2026

Definitions:

- **Initial WHODAS Screening:** Initial WHODAS Screening is the first WHODAS screening, and related six domain-level composite scores, that is available for the client during the reporting period. This WHODAS Screening, and related six scores, are retained by DBHDS as the “Initial WHODAS screening”. This score is reported through in fields ZAA.59 and ZAA.60.1-ZAA.60.6
- **Follow-up WHODAS Screening:** The Follow-Up WHODAS Screening is the most recent WHODAS screening, and related six domain-level composite scores, that is available for the client during the reporting period. This WHODAS Screening, and related six scores, are retained by DBHDS as the “Follow-Up WHODAS screening”. This score is reported through in fields ZAA.59 and ZAA.60.1-ZAA.60.6

#	Criteria	Table	Fields	Value	Notes
1	Standalone STEPVA service within the measurement period	ZAA-Custom Segment Fields PR-1-Procedures Segment Fields	Client Transaction Type Procedure Codes Service Date	SVA: STEP-VA OR ACT, MAT, or CSC 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90853, 99406, 99407, H0004, H0004, H0005, H2015, 96160, 96161, H0048, H0039, H2017, H2033, 96146, 96136, G0396, G0397, G2011, G8431, G8510, G9007, H0002, H0049, H1000, H2000, H0006, T1016, 96160, 96161, H0023, H0040, H0015 MMDDYYYY within the measurement period	ZAA.22: SVA, ACT, MAT, or CSC Active enrollments in 6-month measurement period Measurement Period: 6 months
2	Age 7 or Older	PID – Patient Identification Fields	Date of Birth	Service Date - Date of Birth >= 7 years	Service date is PR1.5 related to row 1
3	Initial WHODAS Screening	ZAA-Custom Segment Fields	WHODAS New Six Domain-Level Composite Scores Assessment Date	MMDDYYYY within the measurement period	Minimum ZAA.59 within measurement period This Screening will be used as initial screening date.

					The corresponding WHODAS score will be referred to as InitialScore
4	Followup WHODAS Screening	ZAA-Custom Segment Fields	WHODAS New Six Domain-Level Composite Score Assessment Date	MMDDYYYY >= InitialScreening date + 150 days	ZAA.59 The corresponding WHODAS score will be referred to as Follow-Up Score The most recent WHODAS score will be captured in this measure, and the individual will only be counted once if they have more than two WHODAS in the measurement period.
5	Improvement in WHODAS	ZAA-Custom Segment Fields	WHODAS New Six Domain-Level Composite Score Assessment Value	Domain 1 Domain 2 Domain 3 Domain 4 Domain 5 Domain 6 Follow-Up WHODAS Score <= Initial WHODAS Score	ZAA.60.1 ZAA.60.2 ZAA.60.3 ZAA.60.4 ZAA.60.5 ZAA.60.6

Calculation of Measure: Criteria (1-5) / Criteria (1-4)

Note: This specification document is the final document for the FY27 implementation

DBHDS WHODAS Scoring Methodology:

CSBs shall submit summed domain-level scores for the six WHODAS 2.0 domains through ZAA.60.1-ZAA.60.6.

DBHDS will use the submitted WHODAS domain-level composite scores for statewide reporting and performance measurement. No additional score normalization or standardization will be applied for FY27.

Guidance for Reporting Antipsychotic Medication (Y/N) Field

Field Name: Anti-psychotic medications prescribed by CSB practitioner Segment:

ZAA - Custom Segment

Purpose:

This field captures whether a client currently has an active antipsychotic prescription from the CSB. It supports consistent data reporting and statewide analysis.

Reporting Instructions:

- **Report “01” (Yes):** If the client has an active antipsychotic prescription from the CSB, regardless of whether the medication was newly prescribed or refilled during the current visit.
- **Leave Blank:** If there is no change in antipsychotic prescribing status since the last report. It is acceptable to leave this field blank between prescribing events.
- **Report “02” (No):** When the CSB is no longer prescribing an antipsychotic for the client (e.g., the medication has been formally discontinued).

Key Notes:

- The field is **optional** during visits where there is no prescribing activity or change in status.
- Indicate “01” (Yes) when an antipsychotic is prescribed or is actively managed by the CSB.
- If a client is no longer prescribed an antipsychotic, explicitly report “02” (No) to reflect the discontinuation.
- Do **not** report “02” (No) solely because no medication was prescribed during a specific visit if the prescription remains active.

Examples:

- A client receives a 90-day prescription for an antipsychotic. At subsequent check-ins where no prescription is changed or discontinued, the field can be left **blank**, or the field can be reported as “01”.
- When the prescription is formally discontinued, send an explicit “02” to reflect the change.
- If there is no change in antipsychotic prescribing status since the last report you may report “01” or “02” as appropriate or leave this field blank.

For questions, please contact ORE@dbhds.virginia.gov

Frequently Asked Questions (FAQs)

I-SERV

What is I-SERV?

I-SERV measures the time from **First Contact** to **Initial Evaluation (CNA)** for new consumers accessing services through Same Day Access (SDA).

I-SERV is a performance measure utilized in Certified Community Behavioral Health Clinics (CCBHCs). DBHDS has adapted this measure for utilization in STEP-VA's SDA step for the purposes of more consistently and accurately evaluating consumers' timely access to services across the 40 CSBs as well as to better align with CCBHC requirements and expectations.

Note (updated 6/2/26): DBHDS is currently adapting only Submeasure 1 (Time to Initial Evaluation) of the CCBHC I-SERV measure at this time. CCBHC I-SERV Submeasures 2 and 3, discussed in CCBHC manual referenced in the Resources section of this document, are not being implemented for STEP-VA at this time.

1. What is the I-SERV performance measure definition?

The percentage of new consumers with an initial comprehensive needs assessment (CNA) provided within 10 business days of first contact as well as the mean number of days from the first contact.

Numerator: New consumers (not seen in the past 6 months) 12 years or older that received an initial evaluation within 10 business days from their first contact.

Denominator: New consumers (not seen in the past 6 months) 12 years or older that received an initial evaluation.

*Note 1: I-SERV requires **two separate and distinct** data points to calculate the measure, including **date of first contact** and **date of CNA**. Methodology for collecting date of first contact is described further in this document.*

*Note 2: (updated 3/12/26) If a crisis interaction occurs within the 6-month lookback period, individuals will not be included in the measure. This subpopulation will be revisited in regards to this measure in future fiscal years if further refinement is needed. For additional technical specifications on this measure, please see **Attachment 2** at the end of this document.*

2. How is first contact determined?

In order to operationalize the I-SERV measure, first contact requires defining from both a programmatic and data perspective. CCBHC guidelines (see link under Resources section below) were utilized to identify general guidelines as to what does and does not constitute a first contact.

3. What constitutes a first contact?

First contact represents the first time that a person, guardian, or family member contacts the CSB to obtain services for the person in a 6-month period.

At the time an individual makes a request for services:

- They are directed to SDA or are given an appointment
- A preliminary screening, including a risk assessment, is conducted
- Basic data about the individual is collected

This may be in person, by phone, or by audiovisual means.

Note (updated 6/2/26): This is not an exhaustive list. The CSB may exercise clinical judgment in circumstances that do not fall within the guidelines above to determine whether or not an interaction constitutes a first contact.

4. What does not constitute a first contact?

- Referrals from primary care physicians or other providers
- Referrals from higher levels of care or another setting (i.e. hospital or jail)
- If an individual calls to simply ask when same day access hours are
- If during the encounter, the call taker or staff person providing assistance determines the person does not need evaluation or other behavioral health services

Note (updated 6/2/26): This is not an exhaustive list. The CSB may exercise clinical judgment in circumstances that do not fall within the guidelines above to determine whether or not an interaction constitutes a first contact.

5. What information should be collected at first contact?

Based on CCBHC guidelines and STEP-VA Program Workgroup discussions, the following should be collected at first contact:

- Demographics: Name, DOB, SSN, Address, Phone Number, Military Status
 - Risk of harm to self and others (*Recommendation: Consider pulling question(s) from ASQ, Columbia, or other normed/validated risk screening*)
 - Priority population: Sex, Pregnancy, Substance use (including route of use)
 - Date of call/Date of service
 - Presenting/requested service need(s)
 - *Recommendation:* Basic insurance information
-

6. How are the date of first contact and the date of CNA determined and documented for data collection purposes?

Date of First Contact:

V-code V0009 was established specifically for the purpose of tracking the date of first contact element of the I-SERV measure. To utilize this v-code, it should be associated with a preliminary triage screening within the CSB's EHR. The preliminary triage screening should consist of the information identified in #6 above. The v-code service date will be utilized as the date of first contact for the purposes of I-SERV.

Date of CNA:

(updated 6/2/26) DBHDS will utilize the CPT Code 90791 to determine the date that the CNA was conducted.

For additional technical specifications on these data elements, please see **Attachment 2** at the end of this document. For additional information on CPT Code 90791, please see **Attachment 3** at the end of this document.

Note: The first contact and CNA may occur on the same date or they may occur on different dates. Please see #8 for more information on these processes.

7. What if first contact and CNA occur on the same day? On different days?

Many individuals across CSBs may have a first contact and a CNA on the same day if your CSB's SDA process allows. However, many individuals may also have a first contact and

CNA on different days, either due to demand for SDA services, client needs/preferences, CSB workflows, or a variety of other circumstances. Regardless of which method of SDA your CSB utilizes, it will be necessary to create a **programmatic and data workflow to capture the first contact** (including v-code and required first contact elements described in #6 above) as a **separate and distinct event** from the CNA. This will allow for accurate collection of both I-SERV measure elements (date of first contact and date of CNA), as well as allow for flexibility in cases where an individual may need to complete the CNA at a later date.

8. What if the client doesn't complete the CNA?

Individuals who complete a first contact but do not complete a CNA are **excluded** from the I-SERV measure. DBHDS will remove these cases from the data pool.

9. What if a client returns for a CNA after a long gap from first contact?

If an individual completes a first contact, then returns within the 6-month look back period to complete a CNA, the original v-code/first contact date is counted for reporting purposes.

If there are multiple v-code entries within the 6-month look-back period, the first v-code date will be utilized to calculate the I-SERV measure.

10. What if a client declines to provide certain demographic information at the point of first contact?

Partial data may be able to be entered at first contact, depending upon your EHR requirements. Some systems may allow certain fields (i.e. SSN) to be marked as "not collected" (or similar) and updated at a later time. However, it is recommended to check with your EHR vendor for clarification on specific processes/requirements for these fields.

11. What if the first contact and CNA occur in different fiscal years?

The fiscal year in which the **date of CNA** occurs will be the year in which the I-SERV measure is reported.

12. What are the I-SERV implementation expectations?

The I-SERV measure was piloted by 9 CSBs beginning July 2025 and completed on February 1, 2026. The remaining CSBs were expected to begin implementation of I-SERV on February 1, 2026. The remainder of FY26 will be dedicated to technical assistance and troubleshooting related to implementation. FY26 data will not be evaluated for performance purposes.

13. Are there any current performance targets for FY26 for the I-SERV measure?

No. The CSBs and DBHDS will work together to establish baselines and benchmarks utilizing data collected in FY27.

14. Will technical assistance (TA) be available for the transition?

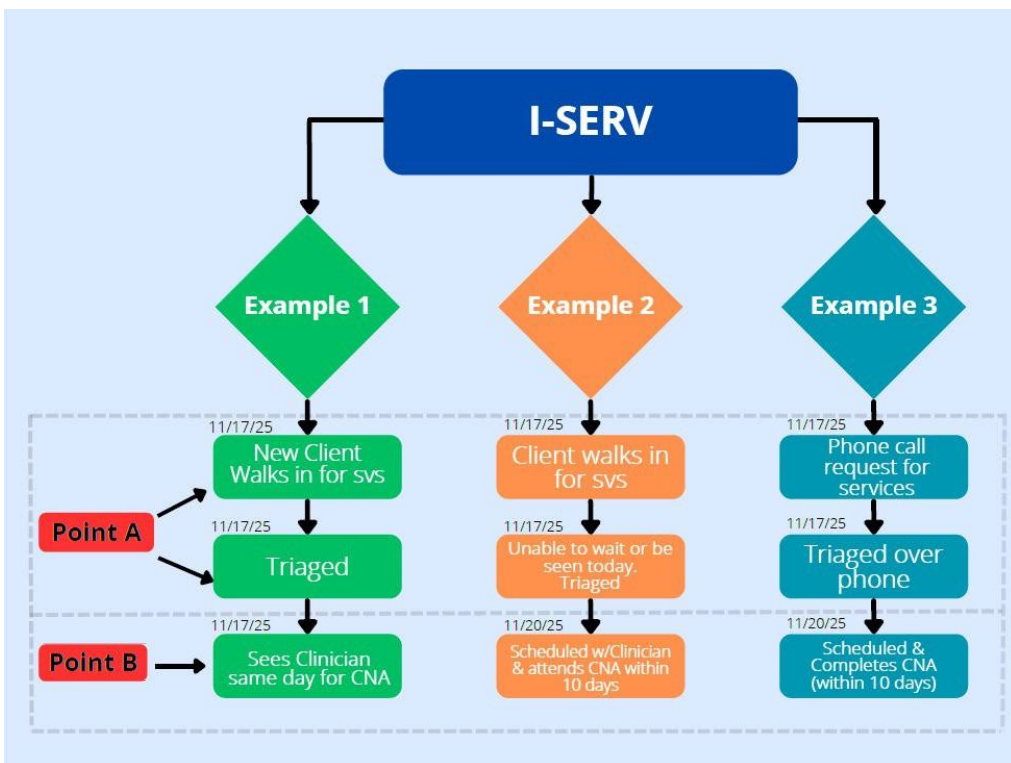
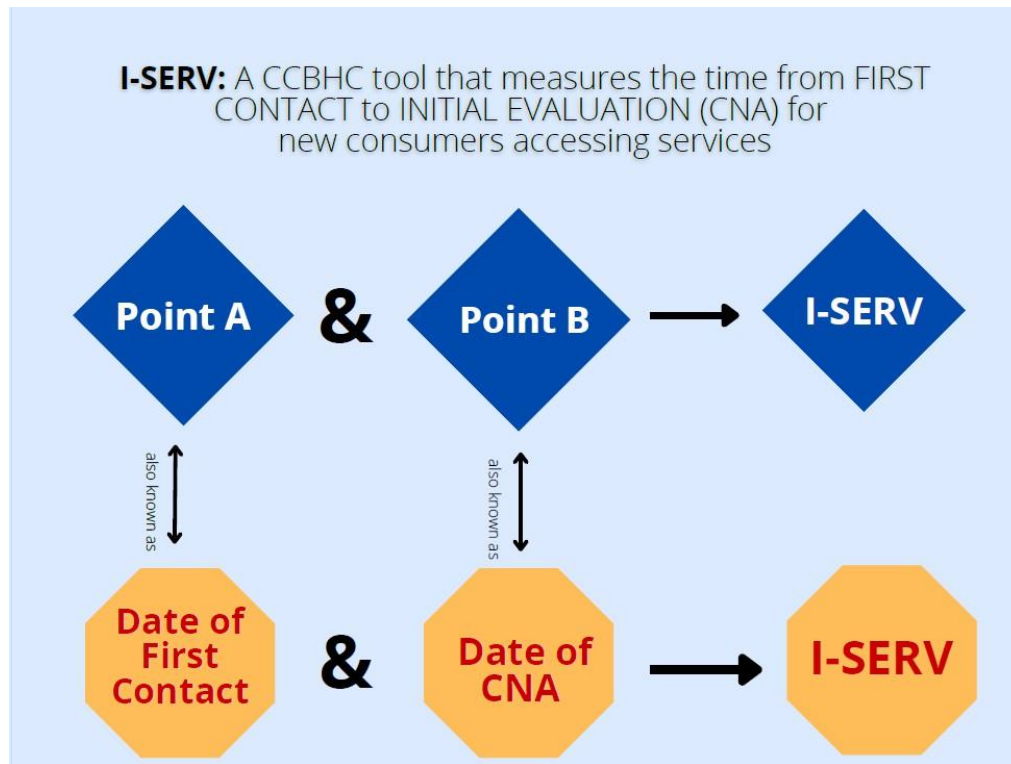
Yes:

- *(updated 6/2/26)* The I-SERV Pilot Workgroup previously offered **peer-to-peer TA sessions** in January and February 2026. Each participating pilot CSB's EHR is listed within the Resources section below for reference. In the event you are interested in seeking additional guidance from peer CSBs with the same EHR, you may contact the CSBs directly or request assistance with connecting to the pilot CSBs by contacting STEP-VA@dbhds.virginia.gov.
- I-SERV-dedicated STEP-VA office hours: **1st Tuesday of each month (Jan-July 2026)** at 1:00-1:30PM. I-SERV topic office hours will be offered after July as needed.
 - **Meeting link:**
 - [STEP-VA Office Hours Link](#)
 - Meeting ID: 259 635 045 248
 - Passcode: 7Nx7f8R7
- Weekly STEP-VA office hours: Every Tuesday, 1:00-1:30PM (All STEP-VA related questions, including I-SERV questions, are welcome)
 - Same link as above
- Individual TA: Available upon request
- Contact: STEP-VA@dbhds.virginia.gov to request individual TA or to request more information regarding the TA opportunities listed above

15. What resources are available for more information?

- SAMHSA's 2024 CCBHC Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual (**see pgs. 31-39 for information on I-SERV**): [Quality Measures for Behavior Health Clinics - Technical Specifications and Resource Manual](#)
 - *(updated 6/2/26) Note: This previously referenced resource link below (CCBHC Quality Measurement Frequently Asked Questions) is **no longer available** on the SAMHSA website. Please see the link above for the most up-to-date specifications from SAMHSA.*
 - [CCBHC Quality Measurement Frequently Asked Questions](#)
- Sample I-SERV Workflow Graphic: **See Attachment 1**
- *(updated 6/2/26)* Data used for I-SERV: **See Attachment 2**
- *(updated 6/2/26)* DBHDS Memo regarding CPT Code 90791: **See Attachment 3**
- Oct. 2025 STEP-VA Scope of Services Manual (or latest version, as available)
- FY26 Performance Contract (or FY27 Performance Contract, as available)
- Pilot CSBs by EHR:
 - **Credible**: Alexandria, Harrisonburg-Rockingham, Henrico, Mount Rogers, New River Valley, Southside, and Valley
 - **Oracle**: Virginia Beach
 - **Welligent**: Loudoun

Attachment 1: Sample I-SERV Workflow



Attachment 2: I-SERV Tech Specs

(updated 6/25/26)

Data Utilized for I-SERV:

Updated 6/25/2026

6-Month Lookback Period	First Eleven Months of MY	Last 30 Days of MY
	Measurement Year (MY): 12-month reporting period	
Denominator Lookback Period: First eleven months of the MY plus a six-month lookback period to identify new episodes of care.		
	Numerator Measurement Period: Measurement Year (MY)	

#	Criteria	Table	Fields	Value	Notes
1	All New Individuals with a preliminary triage at first contact	PR-1 – Procedure Segment Fields PV1 - Patient Visit Segment Fields	Procedure Code Service Date Admit Date	V0009 MMDDYYYY as Date of First Contact Admit Date >= Date of First Contact - 6 months and Admit Date < Date of First Contact	Must be a new individual defined as someone who has not been served at the CSB in the past 6 months. No PV1 at the CSB site in the past 6 months Individual must have no PV1 Admit Date within the 6 months prior to the Date of First Contact
2	All New Individuals aged 12 and older	PID – Patient Identification Fields	Date of Birth	Service Date - Date of Birth >= 12 years	
3	All New Individuals with a Comprehensive Needs Assessment (CNA)	PR-1- Procedure Segment Fields	Procedure Code Service Date	90791 MMDDYYYY as Assessment Date	
4	All New Individuals with a Comprehensive Needs Assessment (CNA) ages 12 and up	PID – Patient Identification Fields	Date of Birth	Assessment Date - Date of Birth >= 12 years	
5	All New Individuals with a Comprehensive Needs Assessment			Assessment Date – Date of First Contact <= 10 business days	Mean number of days will be the total number of days between First
	(CNA) within 10 business days				Contact and Assessment Date for all members of the denominator population divided by the number of individuals in the denominator population

Calculation of Measure:

- Criteria (1-5) / Criteria (1-4)
- Mean = Total business days between First Contact and CNA / Number of individuals in Denominator

Attachment 3: DBHDS Memo



COMMONWEALTH of VIRGINIA

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Post Office Box 1797
Richmond, Virginia 23218-1797

Memo To: Community Services Boards (CSBs)

From: DBHDS Date: April 30, 2026

Subject: Update to Same Day Access (SDA) Assessment Reporting – Effective July 1, 2026

Overview Effective July 1, 2026, DBHDS is updating the standard for reporting Same Day Access (SDA) assessments.

CSBs are no longer required to report SDA-specific assessment elements via HL7 under “assessments.” Instead, these encounters will be reported using CPT Code 90791.

This change is intended to improve clarity and consistency in how SDA assessments are defined, reported, and used in performance measurement.

Alignment with I-SERV Measure This update aligns SDA reporting with the I-SERV measure definition. The Comprehensive Needs Assessment (CNA) used for I-SERV will now be identified using CPT Code 90791.

This is not only a reporting change, but it also directly impacts how the measure is calculated and ensures consistency between clinical practice, reporting, and performance measurement across all CSBs.

Clarifying SDA and CNA Terminology For reporting and measurement purposes, the “SDA assessment” refers to the initial Comprehensive Needs Assessment (CNA).

This includes CNAs completed the same day services are requested, or at any point in time after.

Standardizing this definition is intended to reduce variation in interpretation across CSBs.

When to Use CPT Code 90791 CPT Code 90791 should be used for initial psychiatric diagnostic evaluations without medical services, including:

- New patient diagnostic assessments
- Comprehensive evaluations to determine a preliminary diagnosis
- Development of an initial treatment plan
- Evaluations conducted via telehealth
- Encounters where no medical services (e.g., medication management) are provided

When Not to Use CPT Code 90791 CPT Code 90791 should not be used in the following situations:

- Established patient visits. If you're seeing an established patient, even for a new issue, use a different code, such as CPT Code 90837.
- Follow-up or continuing care sessions. This code does not apply to follow-up visits or ongoing therapy sessions. Once you've completed the initial evaluation and established a treatment plan, subsequent visits require different codes based on the type and duration of the service provided.
- Encounters that include medical services
- Brief screenings or assessments
- Encounters requiring interactive complexity, unless paired with the appropriate add-on code

Operational Considerations This guidance is intended for reporting standardization purposes, regardless of existing billing practices.

While many CSBs may already use CPT Code 90791 within intake or CNA workflows, this change ensures consistent identification of the CNA in data submissions and performance measurement, independent of how services are billed.

- You may discontinue: Reporting SDA-specific assessment elements via HL7 under assessment data elements
- Continue: Submission of all other required HL7 data elements and encounters as currently defined

This change only impacts how SDA/CNA assessments are identified in reporting and does not alter broader HL7 submission requirements.

Action Required

- Update internal workflows and EHR configurations to reflect this change by July 1, 2026
- Ensure staff are trained on appropriate use of CPT Code 90791 for initial CNA/SDA assessments
- You may discontinue SDA-specific assessment element reporting via HL7

For questions or additional guidance, please contact:

- Rebekkah Bodanske – rebekkah.bodanske@dbhds.virginia.gov
- Meredith Nusbaum – Meredith.Nusbaum@dbhds.virginia.gov

Frequently Asked Questions (FAQs)

WHODAS 2.0

World Health Organization Disability Assessment Schedule 2.0

Background:

The Department of Behavioral Health and Developmental Services (DBHDS) launched a pilot of the World Health Organization Disability Assessment Schedule (WHODAS 2.0) from January to June 2025 to evaluate its potential as a statewide outcome measurement tool. The pilot sought to replace the Daily Living Activities-20 (DLA-20), which had been widely used but is not evidence-based and imposed significant administrative burden.

DBHDS collaborated with the WHODAS 2.0 Pilot Workgroup and the STEP-VA Advisory Committee (STAC 2.0) in the development and implementation of this pilot, following concerns raised by community services boards (CSBs) particularly regarding the administrative burden associated with the DLA-20. Throughout the course of the pilot, 5,302 individuals were screened, with 1,149 individuals receiving follow up screenings. The WHODAS 2.0 was tested in multiple contexts, ranging from intake screenings to longitudinal outcome tracking, and was administered through clinician, self, and proxy modes.

The findings demonstrated that the WHODAS 2.0 is both feasible and effective. Staff reported the tool is easier and faster to use than the DLA-20, particularly when using the short version, and that it reduced administrative burden. The tool also proved flexible, supporting both baseline and longitudinal measurement. The WHODAS 2.0 pilot demonstrated that Virginia's behavioral health system can adopt an evidence-based, efficient, and scalable outcome measure that better supports program evaluation, resource allocation, and continuous improvement across the Commonwealth.

After careful research, review, comparison, and piloting, the WHODAS 2.0 best addressed the CSBs concerns related to the DLA-20 while simultaneously offering a comparable option that meets the requirements of STEP-VA. Thus, the WHODAS 2.0 will be replacing the DLA-20 beginning in FY27.

1. Where can we find the 12-item adult version and 36-item children's version of WHODAS 2.0?

The WHODAS 2.0 manual includes all *adult* versions of the assessment tool and can be found here: [Measuring health and disability : manual for WHO Disability Assessment Schedule \(WHODAS 2.0\)](#).

- There are multiple versions of the WHODAS 2.0 tool for adults. DBHDS encourages CSBs to use the 12-question version for adults. If a CSB elects to have the 36-question adult version built into their EHR, the scores will only come from the 12 questions from the short version.

The *child and youth* version can be found here: [WHODAS 2 Children and Youth](#).

- The above-referenced adult versions of the WHODAS 2.0 are valid for individuals 18 years and older. However, WHO additionally supported an adaptation of the tool for youth 10-17 years of age (and perhaps younger with parent/guardian input).

2. What ages is the children's version appropriate for?

The WHODAS 2.0 can be administered for ages 7+.

- Ages 11–18: Youth should complete the 36-item version as a self-report when possible.
- Ages 10 and under: A parent or guardian should complete the assessment on the child's behalf.

3. Who can administer the WHODAS 2.0?

The tool can be administered:

- By the individual (self-report)
- By a clinician
- By a proxy (e.g., caregiver, family member, or guardian) – (*Updated 3/19/26*) The proxy versions of the tool in the manual provide a possible list of proxy responders.

(*Updated 3/19/26*) Section 5.2 of the manual discusses the various modes of administering the WHODAS 2.0. More details are available in the DBHDS memo and online resources. See the Resources section below.

4. How often should WHODAS 2.0 be administered?

Every 6 months.

5. How will the WHODAS 2.0 be used across STEP-VA service lines?

The primary service program will administer the assessment. Not every program serving a client is required to administer a WHODAS 2.0.

6. What data elements and scoring details are required for reporting?

- Domain scores will be collected.
 - Will review data based on the sum of scores in each domain
 - **Scores per item for all versions are 0-4.** *Note: The WHODAS website links to a 2012 version of the manual referencing scoring from 1-5, but the website itself references a change from what is in the manual and appears to be the most recent information.*
 - Because DBHDS is not using the WHODAS for clinical purposes and is only using it for program evaluative purposes, domain-level scoring is appropriate for both 12-question and 36-question versions.
- Data elements for submission include:
 - Summed domain scores (one score per domain)
 - Date of screening
- Crosswalk of domains across versions:

Domain	12 Item	36 Item	Youth
1	S3	D1.4	Q1-6
1	S6	D1.1	
2	S1	D2.1	Q7-11
2	S7	D2.5	
3	S8	D3.1	Q12-15
3	S9	D3.2	
4	S10	D4.1	Q16-20
4	S11	D4.2	
5	S2	D5.1	Q21-29
5	S12	D5.5	
6	S4	D6.1	Q30-35
6	S5	D6.5	

7. Can CSBs implement the WHODAS 2.0 before the July 1, 2026 implementation date?

Yes. Early implementation is allowed. Please notify DBHDS of your start date by emailing STEP-VA@dbhds.virginia.gov.

8. If we implement early, do we still need to use the DLA-20?

No. The WHODAS 2.0 is intended to replace the DLA-20, so once WHODAS 2.0 is fully implemented, the DLA-20 is no longer required.

9. Can we phase in WHODAS 2.0 while phasing out the DLA-20?

This is not recommended. Using both tools simultaneously increases manual work and complicates data tracking. A single-tool approach is preferred.

10. Is the WHODAS 2.0 available in other languages?

(Updated 8/31/26) Yes. DBHDS has agreed to host translated versions at the following location: [TM-DBHDS-CSB-EHR-Collaboration-External - Documents - General - All Documents](#). This channel contains critical information regarding WHO Translation Guidelines which should be **read prior to use** of translated versions. Access to this channel is limited, and there is currently at least one existing staff person at each CSB with access. Please check with your agency to coordinate access to needed materials. Translations have been sourced by CSBs and the WHO, and any WHO-approved materials are noted as such. Some translations were sourced by CSBs and are unofficial. Some of these may not have been yet vetted by the WHO but may still be helpful when working with individuals in languages other than English. Please note that DBHDS hosts these translations as a courtesy to CSBs caring for individuals across Virginia. DBHDS has not independently verified the accuracy of these translations, and as such, CSBs use and implement these at their own discretion.

Per the WHO upon granting permission for use to the Commonwealth of Virginia: *“Please note that WHODAS has now been included in the new ICD-11 under V Supplementary section for functioning assessment and has been translated into Arabic, Chinese, English, French, Russian, Spanish and Turkish. Several more languages are underway.”*

Per the non-exclusive license agreement granted by the WHO: *“User shall not modify, abridge, condense, translate, adapt, recase or transform the WHODAS 2.0 in any manner or form, including but not limited to any minor or significant change in wording or organization, or administration procedures, of the WHODAS 2.0. If User thinks that changes are necessary for its work, or if translation is necessary, User must obtain written approval from WHO in advance of making such changes.”* As such, if any non-English versions are needed, please use only WHO-approved translations. Note that WHO is not responsible for the quality of non-WHO-produced translations. If an additional language is needed, please contact DBHDS at STEP-VA@dbhds.virginia.gov so that DBHDS may initiate the request process with WHO.

Below are some resources for accessing the tool in other languages:

1. The Spanish version of the manual can be found here: [WHODAS 2.0 Manual - Spanish](#).
2. A listing of links to other available translated versions can be found here by scrolling down to “Other Languages”: [Medición de la salud y la discapacidad: manual para el cuestionario de evaluación de la discapacidad de la OMS: WHODAS 2.0](#).
3. Other versions may be found here by changing the language in the top right corner of the page. The WHODAS 2.0 is included under Section V *Supplementary section for functioning assessment*: [ICD-11 for Mortality and Morbidity Statistics](#).
4. For additional information on translations and adaptations: [WHO Copyright, Licensing and Permissions](#).
5. CSBs may also utilize other translation resources available at their disposal, as appropriate and in alignment with WHO guidelines.

11. Will DBHDS provide webinars or trainings on administration of the WHODAS 2.0?

No. The manual advises on best practices and tips for administration. In particular, chapters 5, 7, 9, & 10 of the manual are likely to be of the most help with administration and training. In addition, Part 3 of the manual offers flashcards to assist with administration if needed (*Updated 3/19/26*). It is recommended to review the manual and remaining questions may be discussed during technical assistance opportunities.

*(Updated 3/19/26) Note: The flashcards in the manual utilize the previous 1-5 scale. If using these, please be aware that the **updated scale now uses 0-4** for the responses.*

12. Will technical assistance (TA) be available for the transition?

(Updated 8/31/26) Yes:

- WHODAS-dedicated STEP-VA office hours were provided monthly on the **3rd Tuesday of each month** (Jan–July 2026). Moving forward, TA may be available at weekly STEP-VA Office hours at the link below or via individual request at the email below.
 - Weekly STEP-VA office hours: Every Tuesday, 1:00–1:30 PM (All STEP-VA related questions, including WHODAS 2.0 questions, are welcome)
 - [STEP-VA Office Hours Link](#)
 - Meeting ID: 259 635 045 248
 - Passcode: 7Nx7f8R7
 - Individual TA: Available upon request
 - Contact: STEP-VA@dbhds.virginia.gov to request individual TA or to request the link for weekly office hours.
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13. What resources are available for more information?

- WHODAS 2.0 Manual: [Measuring health and disability : manual for WHO Disability Assessment Schedule \(WHODAS 2.0\)](#) ; [WHODAS-03\(23Nov09\).book](#)
- WHODAS – Child: [WHODAS 2 Children and Youth](#)
 - Additional info on psychometric properties of youth version:
 - [Validation of the “World Health Organization Disability Assessment Schedule for Children, WHODAS-Child” in Rwanda | PLOS One](#)
 - [WHODAS-Child - Disability Assessment Schedule](#)
- WHODAS 2.0 Website: [WHO Disability Assessment Schedule \(WHODAS 2.0\)](#)
- Versions in other languages (updated 6/2/26):
 - [Medición de la salud y la discapacidad: manual para el cuestionario de evaluación de la discapacidad de la OMS: WHODAS 2.0](#) (Spanish)
 - Scroll down to “Other Languages” for links to additional translated versions.
 - [ICD-11 for Mortality and Morbidity Statistics](#)

- Other versions may be found here by changing the language in the top right corner of the page. The WHODAS 2.0 is included under Section V *Supplementary section for functioning assessment*.
- DBHDS WHODAS 2.0 Memo: Sent to EDs on 10/3/25 and 11/20/25 [WHODAS 2.0 memo](#)
- *(updated 6/2/26)* Instructions for Integrating the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) into EHR Systems: Sent via email to all the CSBs and EHR vendors recipients of HL7 Expansion Monthly Office Hours meeting on January 6, 2026. [WHODAS Instructions](#).
- Pilot CSBs: Chesapeake, Middle Peninsula-Northern Neck, Western Tidewater, and Mount Rogers