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MSV MEDICAL SOCIETY OF VIRGINIA

(You Gotta) Fight for Your Right to Funding:
A Lobbying Strategy for State-Funded Programs in Virginia

Kelsey Wilkinson, EMPA Candidate 2024

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Abbreviations & Acronyms: Reference Guide

MSV — Medical Society of Virginia

MSVF– Medical Society of Virginia Foundation

GAP– Government Affairs and Health Policy (Department), MSV

APAL — Adult Psychiatric Access Line

DBHDS — Department of Behavioral Health and Developmental Services

DBP— Department of Planning and Budget

VMAP — Virginia Mental Health Access Program

RHRN — *Right Help, Right Now* Plan

BHP — Behavioral Health Professional

SUD— Substance Use Disorder

PCP — Primary care providers

CME— Continuing Medical Education

VA-AAP — Virginia Chapter of the American Academy of Pediatrics

RFP— Request for proposal

HRSA — Health Resources and Services Administration

OAA — Opioid Abatement Authority

Executive Summary

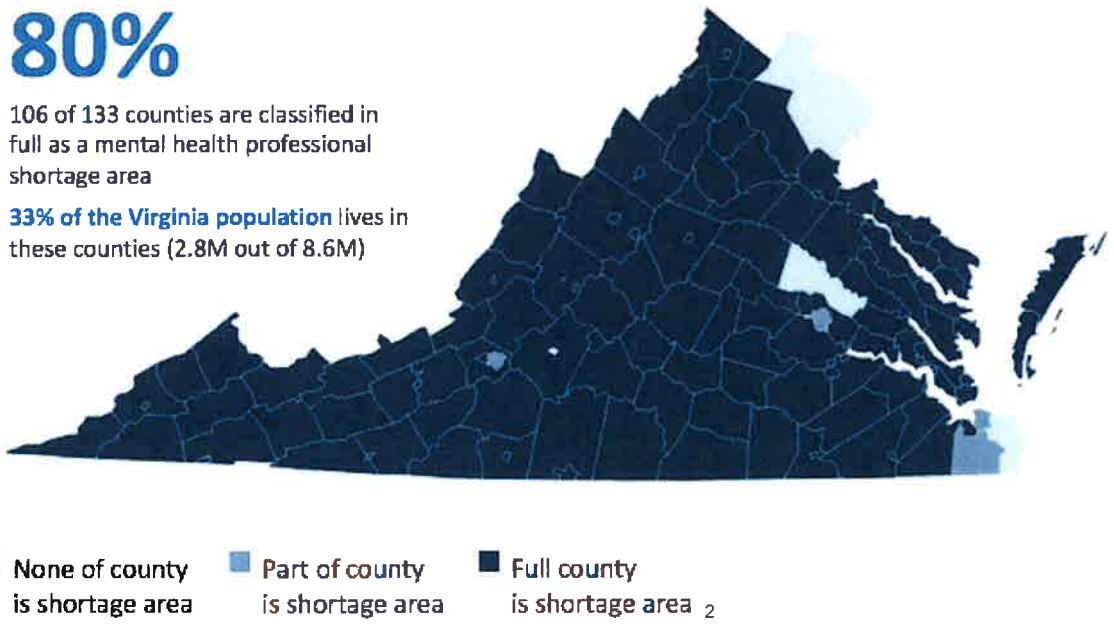
The Medical Society of Virginia, a professional association for physicians, PAs, and medical school students, is the contract administrator for a state-funded program known as the Virginia Mental Health Access Program. VMAP is a consultation and care navigation resource for clinicians to better screen, diagnose, and treat children's mental and behavioral health conditions. After this program's measurable successes, the state agency who oversees the contract, the Department of Behavioral Health and Developmental Services (DBHDS), began strategic discussions on how the Commonwealth could use the VMAP pediatric model to improve the mental and behavioral health care for adults. The new program, the Adult Psychiatric Access Line (APAL), is being piloted by DBHDS and financially supported by a one-time HRSA grant for $1.7 million to develop the framework and cover initial administrative costs. The MSV and DBHDS will need to request general funds from the General Assembly through the agency's budget process submitted to the Governor and the Department of Planning and Budget (DPB).

The MSV must strategically engage with the Governor and his Administration, the agency staff, and finally, the legislators prior to, and during, the 2025 legislative session. This document serves as a lobbying strategy for the Medical Society of Virginia's Government Affairs and Programs teams as they advocate for state funding to administer the program and improve health outcomes for Virginians struggling with substance use disorders.

Section I: Issue Introduction

Virginia is currently ranked 37th in the nation for patient access to mental health services.[1] In 2022, approximately 1.2 million Virginians were treated for a mental or behavioral health condition. Despite sizable investments at the state and federal level, Virginia's problem remains the same: Capacity is constrained across the Commonwealth's continuum of behavioral health care and **there are not enough specialized healthcare providers to meet patient demand.**

Figure 1. Virginia Health Professional Shortage Areas by County, Mental Health, HRSA

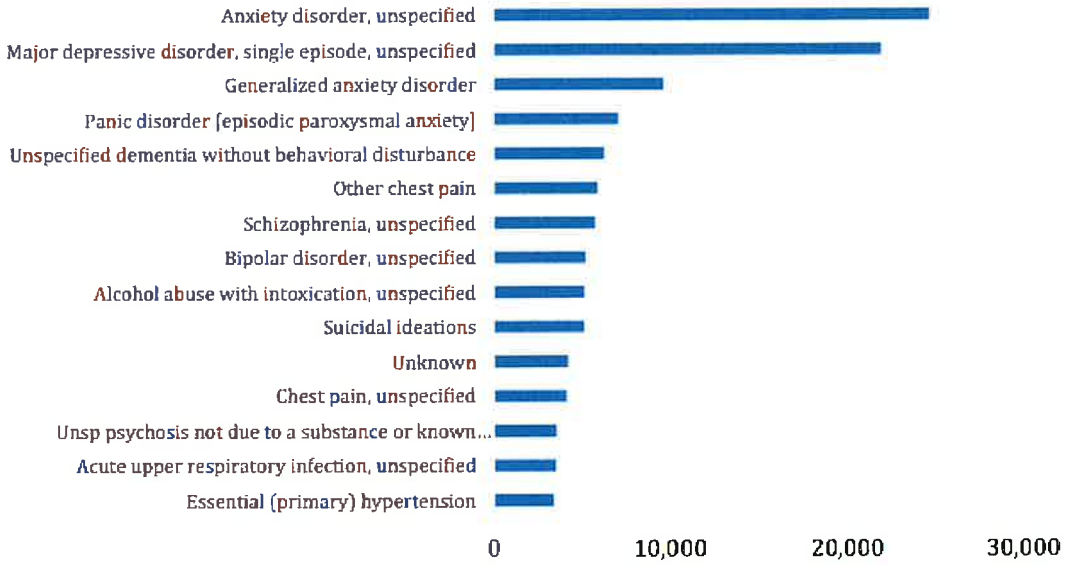


Taking a specific look at substance use disorder (SUD) within the broader continuum of behavioral health, Virginia faces additional challenges developing solutions to reduce

[1] "Ranking the States 2022," Mental Health National, accessed January 5, 2024, https://mhanational.org/issues/2022/ranking-states#one.
[2] Health Resources and Services Administration Mental Health Care Health Professional Shortage Areas, by State, as of September 30, 2022, data.HRSA.gov

adverse health outcomes and overdoses. 473,000 Virginians were treated for a substance use disorder but estimates project closer to 923,000 adults in 2022 that needed more robust treatment for SUD that did not, or could not, receive it.[3] According to the Virginia Department of Health, that same year there were 22,398 drug overdose emergency department (ED) visits and 2,490 drug overdose deaths, a 5% decrease and 6% increase from 2021, respectively.[4] This issue has not gone unnoticed by Virginia's elected officials with decades of legislative and regulatory efforts making incremental change, but in early 2022 special attention from soon-to-be-elected Governor Glenn Youngkin (R) gained national attention and altered Virginia's behavioral health system.

Figure 2. Most Common Diagnoses for mental health and substance abuse related ED visits (2016-2022)



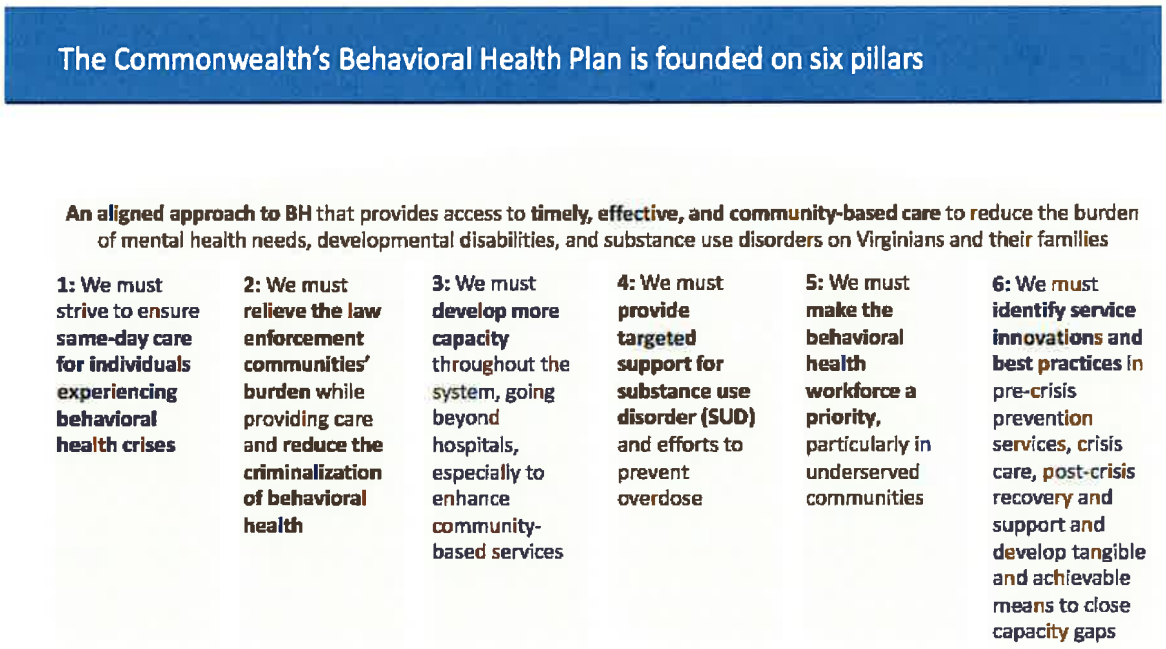
5 SOURCE: JCHC staff analysis of claims submitted to the All Payer Claims Database.

[3] Delphin-Rittmon, Miriam E. "2020 National Survey on Drug Use and Health (NSDUH) Releases." SAMHSA.gov. Accessed January 8, 2024. https://www.samhsa.gov/data/release/2020-national-survey-drug-use-and-health-nsduh-releases.
[4] "Drug Overdose and Related Health Outcomes." Drug Overdose Data, May 1, 2024. https://www.vdh.virginia.gov/drug-overdose-data/.
[5] Jeff Lunardi, "Reducing Unnecessary Emergency Department Utilization," REPORT DOCUMENT #534-Commonwealth of Virginia, 2022, https://jchc.virginia.gov/documents/ED%20Utilization%20Staff%20Report.pdf.

The Policy Window: Right Help, Right Now

To address the growing need for mental health services, Virginia Governor Glenn Youngkin announced a series of policy and budgetary proposals to revolutionize the way Virginia manages behavioral healthcare during his first year in office in December of 2022. The objective remains to support Virginians before, during, and after a behavioral health crisis occurs. This comprehensive approach is founded on six pillars with strategic three-year goals and included directives for immediate action to get people the "right help, right now."[6]

Figure 3. The Six Pillars of the RHRN Plan



Shortly after the announcement of the plan henceforth known as "Right Help Right Now", the Governor revised the proposed executive budget to include over $500 million

[6] Littel, John. "Secretary of Health and Human Resources." Year 1: RHRN Behavioral Health Plan, February 2024. https://www.hhr.virginia.gov/media/governorvirginiagov/secretary-of-health-and-human-resources/pdf/behavioral-health/1-Year-Update-RHRN-FINAL-complete-Feb2024.pdf.

in new funding, including an initiative to fully-fund 30+ new mobile-crisis teams, expand mental health support programs in schools, tele-behavioral health services, and more.[7]

Governor Youngkin's leadership and popular bipartisan support for the RHRN budget items and bills increased visibility for behavioral health solutions and created a unique policy window for stakeholders working on programs and education that serve his plan's priorities.

A Focus on Substance Use Disorder and Overdoses

Pillar 4 of Governor Youngkin's Right Help, Right Now plan is to provide targeted support for substance use disorder and efforts to prevent overdose. The year one plan (state fiscal year 24) for Pillar 4 included $15 million proposed in the Governor's budget for a public awareness campaign to reduce fentanyl deaths, increased access to naloxone, and a designated portion of the opioid settlement fund for fentanyl. The landscape of substance use prevention, treatment and recovery programs includes federally and state funded initiatives, partnerships with educational institutions and community-based organizations. This pillar builds on the progress of these prior efforts to support substance use prevention, treatment, and recovery. A component of this pillar is to "expand innovative programs for proven and effective treatments across the continuum", thus opening a door to community partners who specialize in training, educational resources, and care navigation support for healthcare providers serving these patients.

A Focus on Integrating Behavioral Health Into Primary Care

Pillar 5 represents another area of need Governor Youngkin identified in his policy proposal to expand the capacity of healthcare providers treating and managing behavioral healthcare. Extending the capabilities of non-behavioral health providers—including primary care physicians, pediatricians, and other providers—can also expand the clinical professional pipeline (e.g., through training programs to upskill

[7] Littel, John. "Secretary of Health and Human Resources."RHRN Behavioral Health Plan, January 2023. https://www.hhr.virginia.gov/media/governorvirginiagov/secretary-of-health-and-human-resources/pdf/behavioral-health/Right-Help-Right-Now_01-11-23.pdf

behavioral health competencies). Increased access to behavioral health services, reduced emergency department and hospital visits, improved integration of physical care, and enhanced SUD service capacity are all "evidence-based metrics improved by integrating mental and behavioral health into all points of care".[8]

> *Primary care providers have a deep understanding of the role they play in their patients' everyday lives. With this program, PCPs will be better equipped to serve patients in partnership with mental health providers. Jane Doe could see me for her strep throat and discuss her ongoing treatment for depression and anxiety in one visit versus seeing two or three providers at two or three different visits months or weeks apart.-* Sterling Ransone, MD, FAAFP, Board Chair of the American Academy of Family Physicians

In his Year One RHNH Impact Report, Governor Youngkin commends the Virginia Mental Health Access Program (VMAP), a program managed by the Medical Society of Virginia, in creating an integrated service model for the pediatric population that could be duplicated to address the issues defined above for adults.[9] Considering the executive investment, bipartisan support from the General Assembly, and stakeholder interest, the RHRN Plan is a rare opportunity for organizations like the MSV to utilize their existing relationship with the legislature and the state agencies to once again serve as a program administrator for behavioral health education, training, and provider support.

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[8] DMAS: Virginia Medicaid Continuum of Behavioral Health Services Report, December 2018, https://www.dmas.virginia.gov/media/1414/2019-continuum-proposal-report.pdf.

[9] Littel, John. "Secretary of Health and Human Resources." Year 1: RHRN Behavioral Health Plan, February 2024. https://www.hhr.virginia.gov/media/governorvirginiagov/secretary-of-health-and-human-resources/pdf/behavioral-health/1-Year-Update-RHRN-FINAL-complete-Feb2024.pdf.

Section II: Program Introduction

A Key Stakeholder: The Medical Society of Virginia

Founded in December 1820, the Medical Society of Virginia is one of the largest healthcare professional associations in Virginia with more than 10,000 member physicians (medical doctors and doctors of osteopathy), physician assistants, PA students, and medical students practicing in every medical specialty, locality, and practice setting.[10] The society is organized into the MSV proper, the MSV Political Action Committee, the MSV Insurance Agency, and the MSV Foundation. Across these four sectors, the MSV employs approximately 75 staff members.

The MSV has decades of experience developing, administering, funding, and implementing statewide continuing education, training, and professional development programs for physicians and other clinicians. For this reason, the MSV has become a trusted partner in this space, working with state agencies, legislators, and other public officials as well as collaborating with other hospital and healthcare stakeholders and healthcare providers. Within the scope of their programming and most relevant to how the MSVF is uniquely qualified to manage education and training programs for clinicians is MSVF's role as the contract administrator for the statewide Virginia Mental Health Access Program (VMAP).

The contract is managed by the Virginia Department of Behavioral Health and Developmental Services (DBHDS), a state agency focused on crisis service management that annually serves 217,000 Virginians and families with behavioral health disorders and developmental disabilities.[11] The MSV's role as the administrator includes stakeholder coordination, curriculum development and management, budget

[10] "About the Medical Society of Virginia," About Us, 2024, https://www.msv.org/about/.
[11] "About DBHDS," Agency Mission Statement and Vision, 2024, https://dbhds.virginia.gov/about-dbhds/about-dbhds/.

management, sub-contracting, logistics, marketing, registration, education credits, evaluation, and reporting.

An Organizational Precedent and Model: Virginia Mental Health Access Program (VMAP)

VMAP is a statewide care navigation, consultation, and provider education program that strengthens the ability of primary care providers (PCPs) and family medicine clinicians to manage mild to moderate behavioral health needs of their pediatric patients.[12] The VMAP program prepares the healthcare workforce through training and education, assists patients and parents through care navigation, and connects behavioral health professionals with their colleagues through the VMAP call line and regionalized service hubs.

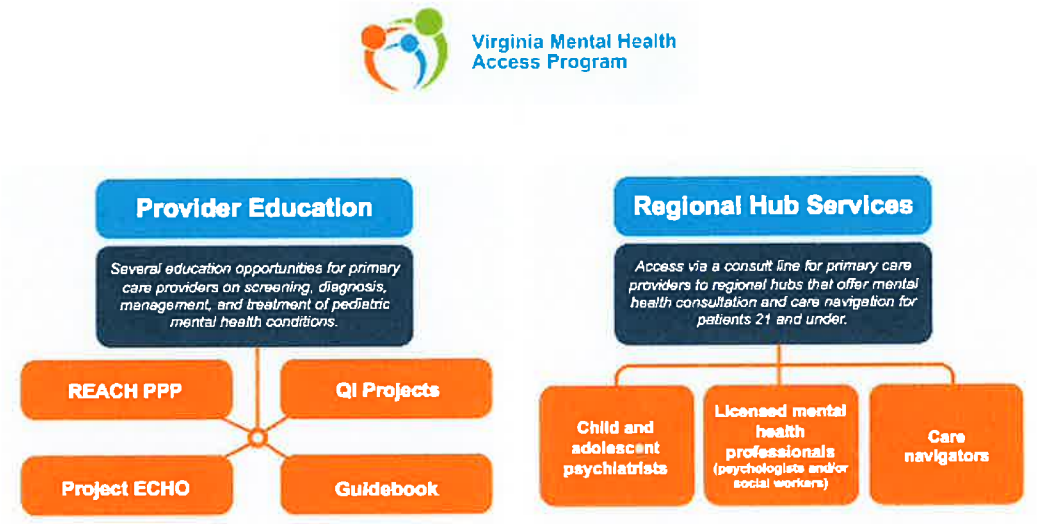
Figure 4: The Virginia Mental Health Access Program (VMAP) Process Graphic

What is now known as VMAP began in 2018 as a one-time HRSA grant-funded project for continuing medical education (CME) preparing primary care providers to manage pediatric mental health conditions, facilitated by the Virginia Chapter of the American Academy of Pediatrics (VA-AAP). As the demand for the training grew and required more management and oversight, VA-AAP reached out to the MSV Foundation, marking the beginning of a more comprehensive program requiring greater collaboration with state agencies and other stakeholders. Thanks to the collaboration between the MSV Government Affairs and Health Policy team and the Department of Behavioral Health and Developmental Services (DBHDS), the Virginia General Assembly allocated

[12] Virginia Mental Health Access Program, "About the VMAP Program", 2024, https://vmap.org/about-us/.

$1.23 million to fully actualize the Virginia Mental Health Access Program in the 2019 legislative session. Shortly after in 2020 the contract was awarded by DBHDS to the MSV Foundation who have since managed the statewide initiative as the program administrator to improve pediatric mental health care delivery.

Figure 5: VMAP Resource Graphic



Since 2020, VMAP has published two data-driven impact reports analyzing patient and provider findings and health outcomes to measure its successes and consider areas of improvement for the program.[13]

Some metrics of VMAP's success over the past four years include:

Provider Education

- Over 1,200 providers have registered to use VMAP.
- VMAP staff administered over 25,000 hours of certified continuing medical education (CME) training and maintenance of certification (MOC) programming.
- Of its registered providers, 74% are physicians, 21% are nurse practitioners, and 5% are physician assistants or selected "other" as their designation.

[13] Sandy Chung, MD, "VMAP Impact Report" Virginia Mental Health Access Program, 2022, 2023, https://vmap.org/wp-content/uploads/2022/07/VMAP-Impact-Report-2021.pdf. https://vmap.org/wp-content/uploads/2023/05/VMAP-Impact-Report-2022.pdf

Care Navigation and Provider Consultation Call Line

- Since the VMAP Line opened in August of 2019, it has received 6,229 calls from PCPs, completed 4,030 mental health and behavioral health consultations, completed 3,376 care navigation requests, and served 5,252 pediatric patients in Virginia.

Regional Hubs

- Since 2020, VMAP has established 7 regionally-based support hubs, allowing the care navigation and consultation call line to provide more tailored resources and customized clinical support for primary care physicians (PCPs) in that region, and subsequently their patients. The hubs represent partnerships with major hospital systems in that geographic region (such as Children's National Hospital System in the Northern region hub).

Because of VMAP's measurable success, **the MSV is now considering how to adapt this program to support Virginia's adult population based on the model for pediatric patients.**

Introducing APAL: Adult Psychiatric Access Line

In the spring of 2023 DBHDS Commissioner Smith approached the MSVF programs team and started a new program discussion: using the VMAP behavioral health care delivery model as a primary source in the development of similar resources for Virginia's adult population. According to the Virginia Health Care Foundation, 93 of Virginia's 133 localities are federally-designated Mental Health Professional Shortage Areas.[14] Two of those localities have no licensed BH professionals. 35 localities have no trained BH prescriber.[15] Integration of behavioral health across healthcare access points and care delivery systems is among the highest priorities when addressing comprehensive population health.

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[14] Debbie Oswalt, "Capacity of Virginia's Licensed Behavioral Health Workforce," Assessment of the Capacity of Virginia's Licensed Behavioral Health Workforce, August 16, 2022, https://www.vhcf.org/data/capacity-of-virginias-licensed-behavioral-health-workforce/.

[15] Data for Psychiatrists and Psych NPs and LPCs, LCSWs LPCs practicing in Virginia (in 2021 and 2020, respectively): Healthcare Workforce Data Center, Virginia Department of Health Professions.

With the growing realization that common mental illnesses (anxiety, depression, etc) are increasingly presented and treated outside of a traditional psychiatric space, utilization of collaborative care models involving the participation of BH professionals in primary care expands patient access to specialists and improves the effectiveness of mental health care.[16] While primary care providers (PCPs) can prescribe behavioral health medicines, most PCPs have little training in psychopharmacology and many report feeling uncomfortable doing so, as a result.[17] **This is the need addressed by MSV's newly proposed program: the Adult Psychiatric Access Line (APAL).** Using the VMAP model, APAL will be a one year grant-funded pilot program facilitated by DBHDS.

The agency and the MSV decided to establish the APAL program as a pilot to address the multifaceted behavioral and mental health conditions that are more unique to adults than the existing model for the pediatric population. In November of 2023, MSV submitted an application for DBHDS' request for proposal (RFP) identifying substance use as the initial area of focus for a pilot. As referenced in the RFP, 7.3% of Virginia adults struggled with substance use disorder (approximately 461,360 Virginians) but 94% of those affected did not receive treatment.[18]

Addiction Medicine specialists are not the only healthcare professionals regularly treating patients with SUD. With the support and resources provided by a mechanism like APAL, healthcare providers, particularly primary care and emergency personnel, will have the additional tools and knowledge to effectively and appropriately help diagnose, prescribe, and assist patients in navigating their own recovery care.

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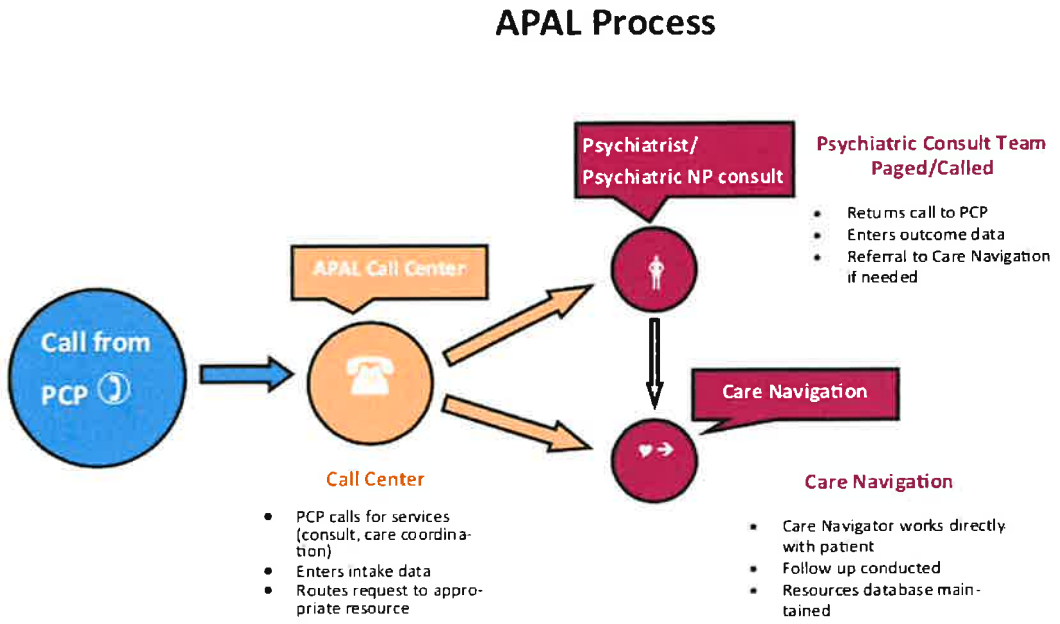
[16] Regier DA, Goldberg ID, Taube CA. The de facto US mental health services system. A public health perspective. Arch Gen Psychiatry. 1978;35(6):685–693.
[17] Debbie Oswalt, "Capacity of Virginia's Licensed Behavioral Health Workforce," Assessment of the Capacity of Virginia's Licensed Behavioral Health Workforce, August 16, 2022, https://www.vhcf.org/data/capacity-of-virginias-licensed-behavioral-health-workforce/.
[18] Delphin-Rittmon, Miriam E. "2020 National Survey on Drug Use and Health (NSDUH) Releases." SAMHSA.gov. Accessed January 8, 2024. https://www.samhsa.gov/newsroom/press-announcements/20230104/samhsa-announces-nsduh-results-detailing-mental-illness-substance-use-levels-2021

Figure 8. Adult Psychiatric Access Line Graphic



Provider Education

- The MSV is initiating a comprehensive training program for Primary Care Providers (PCPs) in collaboration with the American Society of Addiction Medicine (ASAM) and the Virginia chapter of the Academy of Family Physicians (VAFP).
- This initiative includes the use of the Fundamentals of Addiction Medicine (FAME) model, a program developed by ASAM to educate PCPs and other healthcare stakeholders on best practices for screening, diagnosis, management, and treatment of addiction and substance use disorders.
- The training sessions, conducted virtually and in 3-day intensives, include didactic presentations, case reviews, and CME credits in addition to digitally accessible dashboards and resources.

Care Navigation and Provider Consultation Call Line

- The APAL Addiction Medicine Call Line will be available for primary care providers seeking assistance with screening and diagnostic tools, building a treatment plan, or finding available addiction treatment centers for their patients aged 18+.

- MSV will develop a network of addiction medicine experts and licensed behavioral health providers, as well as Peer Recovery Specialists (PRSs), to provide expert consultation services and care navigation resources for primary care providers and their patients.
- Care navigation services will be provided by licensed behavioral health professionals, PRSs, and licensed clinical social workers, similar to the VMAP model.

Regional Hubs

- MSV has identified an addiction medicine provider with locations in Richmond willing to serve as the pilot Central hub for APAL who have submitted a letter of intent (LOI) to begin to develop the regionalized hub services.
- The hub system and processes will be modeled after VMAP operations, providing telephonic and video consultation resources as well as care navigation services. Specialist consultation will be available with an Addiction Medicine Provider (AMP) or Licensed Psychiatric Provider (LPP).

With the award of the RFP's grant funding, the MSV and the programs team at DBHDS must now shift their focus to the upcoming budgetary cycle to request appropriations from the general fund.

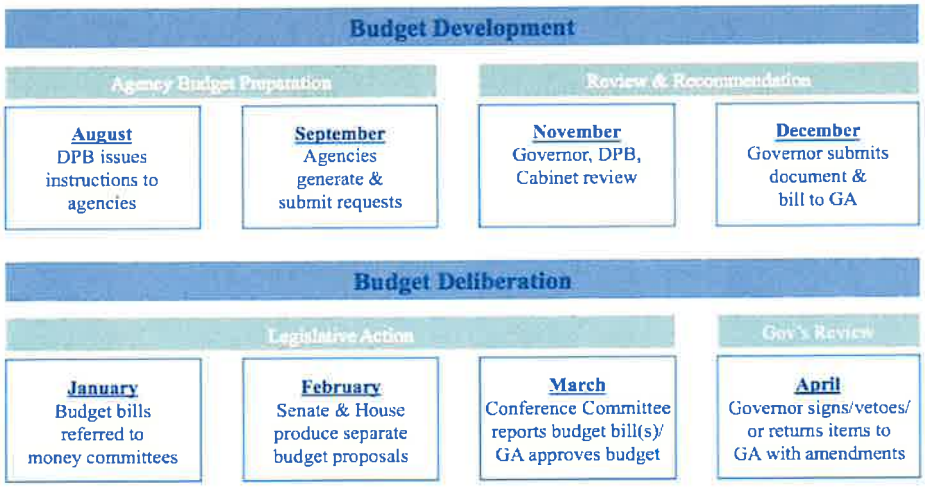
Section III: Virginia's Government Affairs and Budgetary Process

A Summary of Virginia's State Budget Development Timeline

Virginia has a two-year, biennium budget. The governor presents an executive budget proposal to the legislature in December for the upcoming two fiscal years or amendments to the current two-year budget. During the legislative session in the following year, the House and Senate each propose amendments to the governor's proposal. After each legislative chamber procedurally rejects the other's proposal to begin negotiations, the House and Senate appoint "conferees" who discuss the budget at greater length and present a "conference report". If the House and Senate approve

the report, the General Assembly adopts the biennial budget in March or April. The governor then has a final opportunity to propose amendments and line-item vetoes to the budget, which the legislature then votes up or down during the "reconvene session" typically six weeks after the conclusion of the regular session.[19] The Department of Planning and Budget (DPB), the agency that develops, manages, and executes the budget, visually explains the process here:

Figure 7. Virginia's Budget Timeline



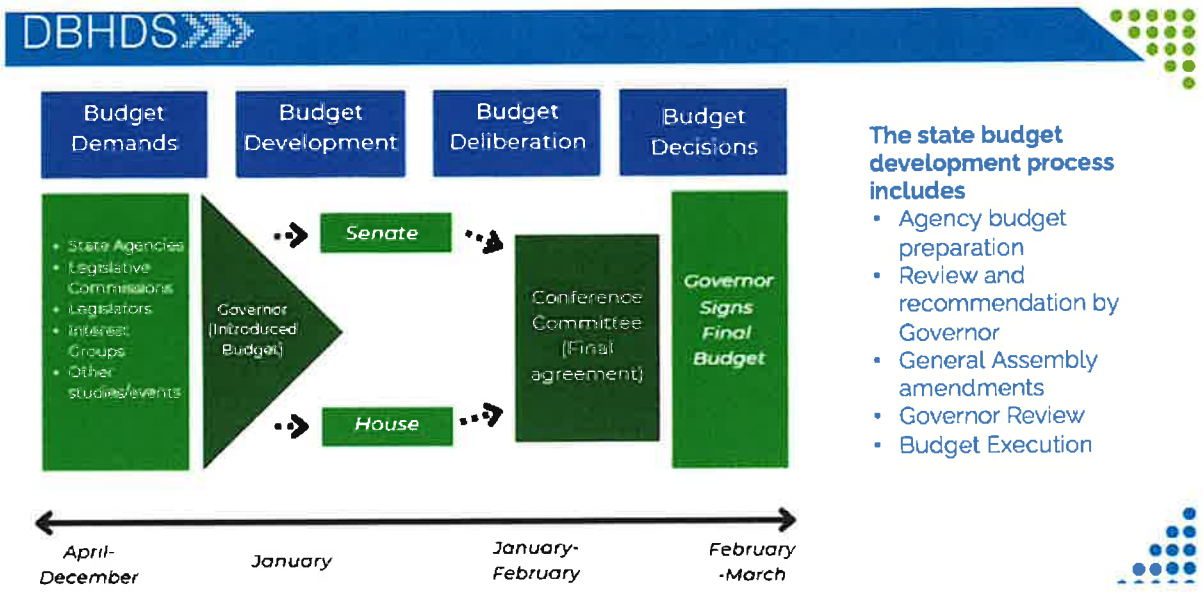
[20]

The most important intersection with the state budget's timeline for the APAL program and therefore the MSV is at the agency level. It is crucial to secure buy-in from the Department of Behavioral Health and Developmental Services (DBHDS) to submit the request as a part of the agency budget and award the contract to a 501-c3 like the Medical Society of Virginia (as accomplished by the VMAP program). As shown above, DPB issues instructions to all the state agencies for budget proposals every year. Beginning in April or May, agencies generate requests. The agency then works with the Secretary of Health and Human Resources and the Commissioner to finalize their submissions for DPB in September. Below is the timeline as explained by the agency:

[19] FY24-26 Virginia State Budget, Department of Planning and Budget, Legislative Services, 2024, https://budget.lis.virginia.gov/bill/2024/1/

[20] Michael Tweedy, "Understanding Virginia's Budget Process", Virginia Senate Finance Committee staff, October 4, 2018, https://vacsb.org/wp-content/uploads/2017/11/Understanding_Virginias_Budget_Process_MTweedy.pdf

Figure 8. Department of Behavioral Health and Developmental Service Budget Timeline



As of April 17, 2024, the Governor and Virginia's General Assembly have reconvened to finalize, and hopefully, pass a biennial budget for FY 24-26. The Governor presented his version of the executive budget in December of 2023 and the legislature, per procedure, amended the budget bill substantially in both chambers putting the bill into conference before sending it to the Governor for consideration on March 27, 2024. It is politically unlikely for the Governor to formally offer amendments in December of 2024 to a biennial budget he signed in May of the same year.[21] The strategic plan for APAL should therefore reflect the intended goal of receiving state funds for the budgetary year beginning July 1, 2025 (FY26). Though being included in the Governor's original budget presentation is a substantive advantage, APAL is "off cycle" to be included in the executive budget and will have to be offered as an amendment or wait until 2026 for the development of the next biennial budget under the leadership of a different Governor and Administration.

[21] See budgetary limitations section for more analysis on the political state of the budget.

Current Budgetary Efforts to Address Behavioral Health Care Needs

Any budgetary request from an agency or community partner that is funded by the state should consider existing projects, programs, and initiatives with the same strategic goals or intended outcomes. As discussed in Section I, the leadership of Governor Glen Youngkin and his Right Help, Right Now plan for innovating the behavioral health services model presents a unique policy window to acquire funding for the APAL program. Though the model is unique, there are other legislative and budgetary efforts to improve behavioral and mental health outcomes for adults.

To date, Virginia's General Assembly has adjourned "sine die", or the conclusion of the 2024 legislation session, with direction from Governor Youngkin to reconvene to continue budget negotiations on April 17, 2024. The reconvene session will result in a finalized budget for fiscal years 2025-2026- more specifically July 1, 2024 through June 30, 2026. If both chambers agree to the Governor's amendments to their budget, it will include the following relevant healthcare items: [22]

- The reallocation of $10 million in state fiscal year (SFY) 2025 funding from Comprehensive Psychiatric Emergency Programs and similar models to other behavioral health initiatives, such as STEP-VA, discharge planning, and housing supports;
- In behavioral health, $25 million over two years to expand and modernize the comprehensive crisis services system;
- $30.5 million over the biennium to combat the opioid epidemic in the Commonwealth;
- $14.7 million over the biennium for Virginia's Behavioral Health Loan Repayment Program. This helps expand the program to add child and adolescent psychiatry fellows to the list of Tier 1 providers eligible for the program, add Tier III providers who are mental health professionals who do not already qualify for the program, and to add academic medical centers as a preferred practice site.

[22] House Appropriations staff, "An Overview of Virginia's Biennial Budget FY 2024 - 2026", House Bill 30, January 10, 2024, https://hac.virginia.gov/documents/2024/HB%2030%20Summary%20Document%20with%20Cover.pdf

APAL Grant Funding and Future General Fund Request

As explained in Section II, after applying to an RFP posted by DBHDS, the MSV was granted $1.7 million to pilot the APAL program with a focus on addiction medicine services. The pricing and fee schedule are as follows. A more comprehensive iteration of this table can be found in Appendix A.

				RFP#: 720-5011
QTY	UOM	DESCRIPTION	UNIT COSTS	TOTAL COSTS
1		State Infrastructure & Hub Operations Total	$	$900,000
1		Technology & Database	$	$351,000
1		Education & Training	$	$110,000
1		Communications, Outreach, & Engagement	$	$90,000
1		Indirect Costs	$	$275,690
		TOTAL COSTS:		$1,726,690

The MSV has contracted physician leads serving as the medical leadership and specialists for the program. To date, Dr. Varun Chaundry, MD, MA, DFAPA (*CMO-Psychiatry*), Sterling Ransone, MD, FAAFP (*Medical Director- Primary Care*), and James Thompson, MD (*Medical Director- Addiction Medicine*) have signed agreements employing them into the program. For "Technology and Database", the MSV are in conversation with the SalesForce vendor that manages the case management, screening tools, and care navigation resource software for the VMAP program to build out the same structure for APAL.

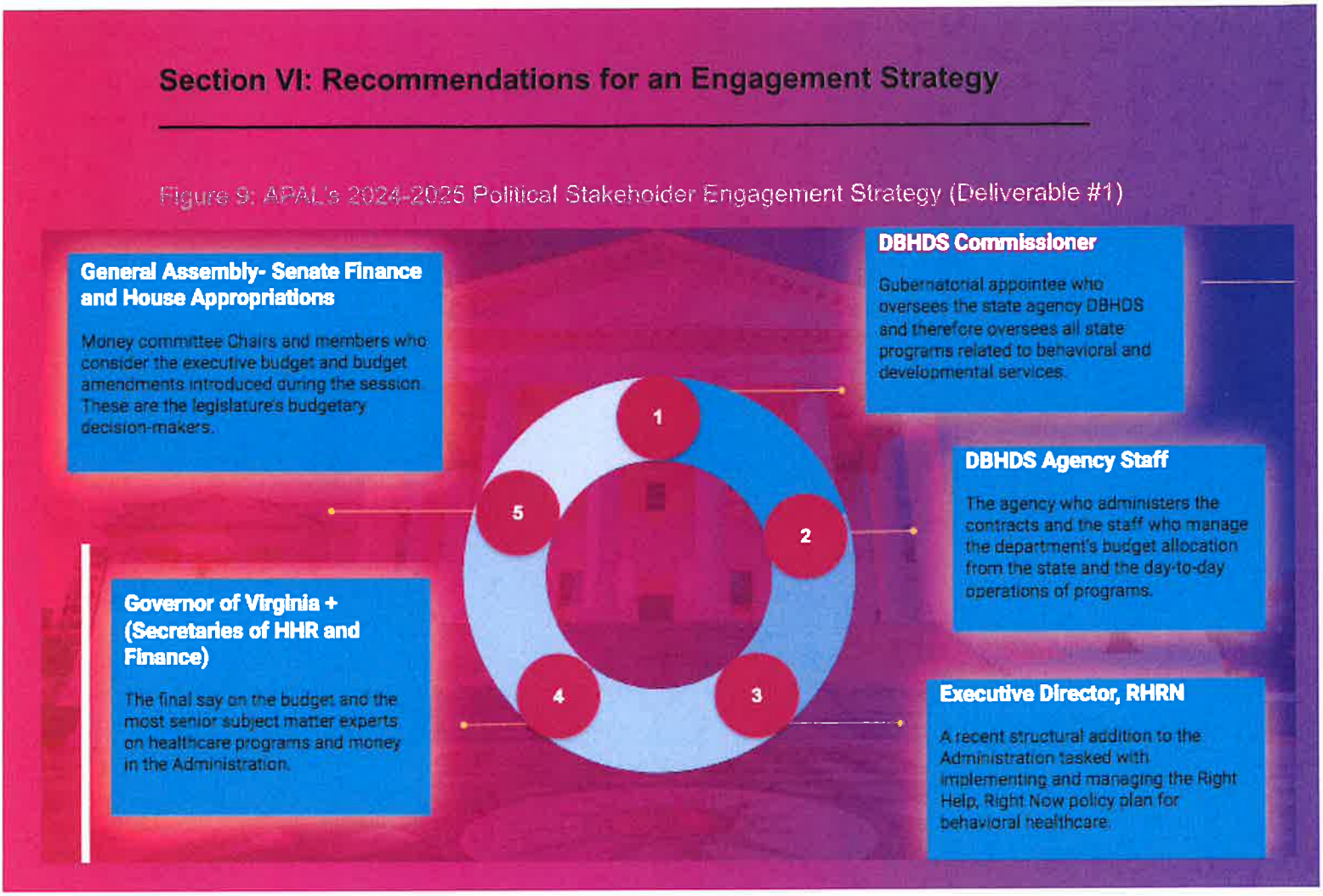
As the program launches this year and prepares to request general funds to support its continuity, these cost assessments allow the agency and later the legislature to see the operating expenses the MSV currently anticipates and eventually requires to operate the APAL program with state funds. This budget plan is a crucial component of preparing to lobby for a state-supported program.

Section IV: Strategic Goals and Explanation of Deliverables

The following two sections describe the Outreach and Engagement Strategy (Section VI) and Lobby Materials (Section VII) with insight provided from interviews and anecdotal evidence that contribute to the strategic messaging and lobbying decisions. Developing a plan to connect with stakeholders and determining what is featured on the advocacy materials and correspondence help organizations and program administrators like the MSV think about the long-term methodology of their advocacy.

Section VI: Recommendations for an Engagement Strategy

Figure 9: APAL's 2024-2025 Political Stakeholder Engagement Strategy (Deliverable #1)



> *"When the department submits budget requests to the Governor's office for consideration and inclusion in their executive budget, The Governor doesn't say submit what you want- you submit what the Governor tells you you want. The agency, DBHDS, is theoretically an institutional agency whose operations are not political, but you're still subject to the Administration and their priorities, their direction."-* *Colleen Grady, MPA, Executive Budget Manager, DBHDS*

The MSV should begin with the Behavioral Health Commissioner. As explained in Figures 7 and 8 in Section III, the Commissioner is the main representative of the Governor in terms of behavioral health policy and is the executive leader of the corresponding state agency, DBHDS. Without buy-in from the Commissioner, and their authorization to the agency staff to prepare the budget request accordingly with his

"stamp of approval", many programs will never advance past their pilots. This is arguably the most important relationship within this strategy and therefore **maintaining contact with the Commissioner throughout the engagement process is vital.** The conversation at this level should be fairly involved, but leave ample room for questions, comments, and concerns that allow the MSV to inform subsequent conversations and follow up to highlight clinical, technological, or logistical elements accordingly. According to the same figures in Section III, these meetings or calls should begin in the spring of 2024 and continue throughout the summer.

Commissioner Nelson Smith, DBHDS

Nelson Smith was appointed by Governor Glenn Youngkin in 2022 to be the commissioner of the Virginia Department of Behavioral Health and Developmental Services (DBHDS). Before joining the private sector, Nelson served in the U.S. Army's 5th Special Forces Group, where he was recognized with the Purple Heart, four Bronze Star Medals, and the Green Beret. After retiring from the military, he pursued an MBA from Kellogg School of Management at Northwestern University and transitioned to a career in behavioral healthcare administration.

> *"Repeated outreach and updates are key. Have a meeting with the Commissioner then call the Secretary. Talk to the agency then update the Commissioner. Email the Governor. Schedule a site visit or submit a status report. Keep them in the loop and apprised of updates. Keep your priorities on the top of their mind when they make their budgetary priorities, when they talk to the agency, when they hold a press conference, really at every step."-- Carolyn McCrae, PhD*

Though the Commissioner and the agency itself are labeled separately, their functions within the broader engagement strategy are somewhat synonymous. If for no other reason, **care should be taken with the agency staff directly as well.** With almost 6,000 employees, DBHDS is one of the largest agencies in Virginia, with dedicated budget, program administration, and legislative/ policy teams that will all be relevant to the work of the MSV and the APAL program's funding appropriation. Where the budget department prepares the language, submits the request, and works with DPB, the legislative/ policy staff communicate with the Administration during the legislative

session and are often directed to "stand up" on bills endorsed by the Governor. All of these are small actions that contribute to the larger strategy which makes the staff at every level important.

The Youngkin Administration has branded and promoted their behavioral health policies, the *Right Help, Right Now* Plan as a central point in the Governor's stump speeches. In March of 2024, Governor Youngkin announced the creation of the *Right Help, Right Now* Executive Director role, a position within the executive branch positioned to further elevate his legislative and budgetary agenda related to mental and behavioral health care. It's difficult to say what strategy should be used or what should be the information of focus in meetings with them at this point, but it is a unique opportunity for stakeholder education. The timing of this outreach is less imperative, but given the recent appointment of the ED, MSV is positioned to connect as soon as possible and promote the MSV's programs as a whole and gradually move towards APAL-related discussions.

Hallie Pence, Executive Director of Right Help, Right Now

Hallie Pence was appointed to the role of Executive Director the Right Help, Right Now behavioral healthcare plan in March of 2024. Miss Pence is the former Deputy Policy Director and Policy Advisor for the Youngkin Administration. Prior to her work in the executive branch, Hallie worked for a number of Congressional offices of Virginia's representatives including Reps. Rob Hurt, Ben Cline, and Tom Garrett. Hallie is a University of Virginia graduate with a bachelor's in government and philosophy.

The next step in MSV's outreach should be **programmatic budget conversations with the Secretaries of Health and Human Resources (HHR) and Finance.** The Secretaries oversee and direct the formulation of departmental budgets for their assigned agencies. Engaging with both the Secretary that manages the entirety of the budget and the Secretary that oversees the health agency requesting your program funds are of equal importance when getting the program attention and getting the budgetary provision included when the executive budget is written.

According to the timeline resources in Section III, meetings with the Secretary's should occur by July 1, 2024 to discuss the benefits of the program, outcome metrics, and its relevance to RHRN. After the agency submits its budget requests to the Administration, the MSV should plan to once again meet with the Secretaries to discuss the budgetary provisions in more detail between September and October 2024 in preparation for the Cabinet and DPB's review and recommendation to the Governor in November.

Secretary John Littel, HHR
Secretary Littel has held senior roles at Magellan Health, Anthem, and Amerigroup, as well as at both the federal and state government levels. He also previously served as the chair of the Virginia Health Care Foundation and on the boards of the Family and Children's Trust Fund, and 26 years ago, he served as the Deputy Secretary of HHR in Virginia. Littel earned his bachelor's degree in Philosophy and Political Science from the University of Scranton and J.D. from The Columbus School of Law at Catholic University. He is a Virginia Beach native with three grown children and a wife, Marianne.

Stephen Emery Cummings
Secretary Cummings is an experienced leader in the domestic and international financial services industry, most recently serving as President and Chief Executive Officer of Mitsubishi UFJ Financial Group, Chairman of UBS's Investment Banking, Global Head of Corporate and Investment Banking at Wachovia Bank, and as CEO at Bowles Hollowell Conner & Co. Secretary Cummings has an MBA from Columbia University Graduate School of Business and a Bachelor of Arts degree from Colby College.

> *"Best way to get my attention on the budget? Flood the zone. Let's talk early and often. I'll let you know when and if I have questions, but I'm not going to ask about something I can't remember! "-- Senator Mamie Locke (D), Virginia SD23- Hampton Roads, Newport News*

The final set of stakeholders involved in the outreach and engagement strategy are the 140 legislators of the Virginia General Assembly. Though every member of the body votes on the budget, those legislators who do not serve on the money committees of both chambers will not see individual budget items, such as APAL's program funding,

until it is a line item of a much larger budget bill. Therefore, the MSV should focus on the **House Appropriations and Senate Finance Committee members.** House Appropriations and Senate Finance have additional staffing for their committee within the larger Division of Legislative Services in partnership with the Department of Planning and Budget due to the subject matter expertise and institutional knowledge required for budget development and writing. These staffers are also relevant stakeholders and if possible, meetings should be scheduled just prior to the start of the session in January of 2025. Once a budget has been produced by each chamber, the budget bill inevitably goes to conference and each body appoints three members of their money committee to serve as budget conferees. At this point in the process, depending on the year (even or odd), the MSV should direct the attention of their lobbyists and membership to **targeted outreach and meetings with the budget conferees.**

> *"It's hard to meet or discuss items that aren't your bill, your budget amendment, or aren't docketed to be considered in your committee that day. That's the order of priority for me: what's mine and what's before me that day. If you're asking for money for a program and it's supported by the agency, you've met with the Commissioner, they want it, and it's not contentious or contested, it's more about awareness than it is support."-- Senator Schuyler VanValkenburg (D), Virginia SD16- Henrico County & the Greater Richmond area*

Section VII: Deliverable #2- Lobbying Materials

> *"If you distribute one pagers and letters and your ultimate goal is state money, I want it to focus on a couple things: What is the problem you're trying to solve and why is this the best solution to invest in? Why this versus something else? Why are you the one lobbying for it? Why are you the best person to spend it? Why is the state's money the best funding for it? Why now?"-- Delegate Otto Wachsmann (R), House District 83- Emporia, Brunswick, Southampton, and Sussex counties*

As explained in Section IV, lobbying materials such as one pagers and stakeholder letters are commonly used as messaging documents by the Society's Government Affairs team, physician members, medical students, and medical speciality organizations who align with the policy-work and programming of the MSV. Both were developed to initially serve as messaging documents for the Administration as explained in the outreach strategy, but are adaptable with minor changes for a new audience to serve the legislators during session. The following subsections break down the features of the two deliverables:

Strategic Features of the One-Pager (Appendix B)

- The color palette of the one-pager reflects the program branding and the colors featured in the program operations (Figure 6) graphic to create brand consistency and an association with other materials.
- The header of the document features the logos of the program administrator and the state agency to align newly proposed budgetary "asks" with existing institutional efforts. It essentially puts the "sign off" from the state on the top of the page as far as operational and logistical requirements are concerned.
- The "Problem" and "Solution" headers isolate the information and logically flow the Solution section into the program introduction and explanation, positively reinforcing the MSV's role. This call and response messaging structure also creates urgency, as if not complying with the request is refusing to act when the answer is present.
- Colored text boxes and Virginia specific information or data are more digestible when highlighting evidence for the effectiveness of the proposed program and how success can be measured. It is intentionally located next to the "Problem" header as the featured statistic speaks to the lack of qualified mental health providers. Further, the text box at the top right clearly indicates the status of the budget item in the process. Once the legislative session begins, the one-pager can be updated with the item number and patron for legislator's convenience and clarity.

- The back of the page features the answers to potential frequently asked questions that are written to address potential barriers, opposition, or concerns in advance of administrative or legislative scrutiny.
- Mentioning the five-year strategic plan shows the Programs and Government Affairs teams at the MSV are considering the long-term needs.
- Lastly, it includes the major physician leaders as signatories and the list of lobbyists that have more personal relationships to the Administration.

Strategic Features of the Letter (Appendix C)

- The introductory paragraph frames the role and responsibility the MSV has with the request and states the bottom line up front. For even more clarity, the subject line of the letter explicitly states that the budgetary request will come on behalf of the MSV through the agency's budget. This allows the Governor, the Secretaries of HHR and Finance, and the Commissioner to locate the program most efficiently in a sea of thousands of budget items.
- The letter mentions how focused the Governor has been on substance use in the Commonwealth and focuses on his existing support for the successful VMAP program that Governor Youngkin explicitly commends in the RHRN Plan. Once the representatives of the Administration are reminded of MSV's role as the contract administrator, the letter shifts to APAL while continuing to relate and draw similarities between the programs.
- The letter also mentions how the start-up costs have been covered by a grant. This is specifically included for the Secretary of HHR and Finance who are tasked with greater oversight on the contracts and their funding usage.
- This letter will later be adapted for budget conferees and the chairs of House Appropriations and Senate Finance.

Section VII: Institutional and Budgetary Limitations

#1— The Uniqueness of the Policy Window

As explained in Section I, the *Right Help, Right Now* plan and Governor Youngkin's continued prioritization of mental and behavioral health improvements in the Commonwealth is advantageous to stakeholders like the Medical Society working on programs that require state funding. Though the MSV, DBHDS, and other stakeholders working in this space benefit from the Governor's support and leadership, it is also a potential limitation for the long-term viability of the program. APAL will inevitably be a referenced talking point on the Governor's press tours and therefore a piece of his administration's legacy as we have already seen with VMAP. The MSV also has a strong working relationship with the referenced stakeholders and institutional knowledge of the needs of the agency when it comes to acquiring program funding. For instance, when DBHDS listed their RFP that was later granted to the MSV to pilot the APAL program, it required a substantial 5-year budget and strategic plan be submitted for review. While other stakeholders will certainly approach the Governor's office to lobby state funds for work in the behavioral health policy space, the MSV is in a unique position with existing buy-in from the agency and the Commissioner in the form of "seed money" for APAL, a track record with VMAP, and a historical relationship with programs, budget, and executive staff.

Another consideration of this unique policy window is how state-based programming like APAL is typically a useful model for other states with comparable medical societies or nonprofits looking to administer similar programs or projects. The policy window, the historic working relationship with stakeholders, and the organizational investment in both in-house and external government affairs and lobbying professionals uniquely posture the MSV to succeed in obtaining funding and institutional support for these programs. Based primarily on the interviews with agency staff and legislators, perhaps

the greatest strength for obtaining APAL funding is the MSV's track record with the VMAP program and the institutional knowledge of the society from the perspective of the agency and the General Assembly. Other organizations or other states would likely run into great difficulty attempting to adapt these deliverables and the APAL model and therefore difficulty duplicating the program. This is not a limitation for MSV's pursuit for state funds, but it is an implication for national adult health outcomes related behavioral and mental health conditions if the program is successful in Virginia but unable to be duplicated due to political, institutional, and budgetary factors.

#2— The Politics of Virginia's Budget

There are real political implications for well-intended programs that are strongly, publicly supported by a partisan leader. At the time of this publication, Governor Youngkin (R) and Chair of Senate Finance Louise Lucas (D) have exchanged contentious blows in the chamber, on social media, and in the news over the FY 24-26 budget leading up to the reconvene budget session at the end of April 2024. Experts in the field say it is not out of the realm of possibility for a full-budget veto considering the level of disagreement lawmakers in the Democratic majority and the Governor have over tax cuts, regulation of skill games, and the failure of Youngkin's plan to bring a $2 billion publicly-financed sports arena for the Washington Wizards and Capitals to Alexandria.[23] With many of the Governor's budgetary priorities not reflected in the final version sent to his desk by the General Assembly for consideration, Youngkin has expressed his disappointment in the form of vetoes with 82 bills vetoed to date with over half of the bills from the session still pending action. These included major democratic priorities such as raising the minimum wage and gun reform legislation.[24] Comparatively, predecessor Terry McAuliffe (D) vetoed 120 bills over his four year term in office. Though a full-budget veto this is a nuclear option, it is a viable political concern being discussed and therefore a reasonable limitation of potentially obtaining state funding for APAL in the upcoming budget cycle.

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[23] Gregory S Schneider and Laura Vozella, "Youngkin doesn't rule out rare budget veto as Va. deadline looms Monday", April 12, 2024, https://www.washingtonpost.com/dc-md-va/2024/04/06/virginia-budget-youngkin-veto-deadline/.

[24] Legislative Information System, Commonwealth of Virginia, Vetoed Legislation: Regular Session 2024, https://lis.virginia.gov/cgi-bin/legp604.exe?241+lst+VET

#3– Always Asking for Money

In interviewing legislators and staffers from the General Assembly, a theme emerged in their responses that frequency of request is more relevant than the amount of money requested. **A budgetary ask for $1 million every fiscal year for ten years is less attractive than the larger $10 million ask in FY24 that is not repeatedly seen and requested.** Though asking for more money at once may seem counterintuitive during competitive budget cycles, reducing the volume of requests from the state agencies or the amount of line item budget amendments during the legislative session is a noticeable testament to lobbying professionalism and experience. It also speaks to the procedural knowledge of the nonprofits or partners working with state agencies and offices. APAL's current strategic plan is only currently built out for 5 years. APAL's pilot is meant to use the VMAP model for the adult population for substance use services and scale up into broader patient support for adult behavioral and mental health services. Without an even longer-term understanding of the cost assessment of the program, this best practice recommendation is hard to implement.

Further, as referenced before, the MSV is also the program administrator for the VMAP program. MSV's CEO Melina Davis has clearly communicated to MSV staff and community partners that APAL's establishment will not replace the prioritization the organization has for VMAP and its state funding. From a government affairs perspective, there are limitations to lobbying multiple budgetary requests at once. Inevitably legislators or budget staff will consider that MSV is growing in state-funded program contracts as a financial beneficiary. This limitation is manageable with clear collaboration and communication between MSV Foundation, GAP, and senior leadership teams internally to avoid overlapping requests in a given budget cycle. However, patient needs, program growth, and other externalities can be difficult to predict. The MSV may consider an additional policy staffer to manage the lobbying strategy for the budget to ensure additional programs do not limit our overall lobbying capacity and effectiveness.

Section VIII: Final Reflection on Deliverables and Conclusion

Though the initial intent of these materials and the accompanying strategy is for the Governor and other governing officials from the Administration, the deliverables are adaptable. Having one-pagers, talking point documents, letters, etc. that are living documents easily amended to reflect new or changing information is key. A one page document summarizing the context and support for a program's funding is viewed differently by the stakeholders involved. The Governor's perspective is different from a legislators. Conversing with respect to their different roles make the lobbying efforts more effective. In that same vein, even with methodically developed messaging, materials, and compelling data, **lobbying is essentially an institutional web of relationships with governance as the commonality.** In my anecdotal experience, there are successful lobbyists who have an evident track record of success for their organizations or clients without the use of materials such as one-pagers, FAQ documents, letters, or talking points. Even with the best materials, there is no replacement for consistent relationship management and communication.

Perhaps the most important takeaway from Deliverable #1, the Outreach and Engagement Strategy, is that **lobbying is never linear.** Though each stakeholder is represented in the graphic by a number, it is more cyclic and dependent on who is the subject matter expert on the conversation at hand. When the Governor asks about the relationship between this program and the agency, it is a best practice to return to the Commissioner and the agency staff to maintain consistency in response between players working together. Though stakeholders can serve as program administrators and subject matter experts, the Governor's Administration is a political mechanism that relies on its own staff and appointees to speak to the policy issues and projects at hand. The Commissioner's continued support is a critical piece to successfully lobbying the state's administrative and executive bodies for program funding. Without multiple touches, the program might not be referenced in strategic meetings of the agency or be

featured solutions to the agency's long-term goals to address SUD in the Commonwealth.

A Final Comment on The Status of APAL's Funding

As the process of standing up APAL has unfolded, other revenue streams are being more actively pursued at this time. Considering the scope of the program, APAL is a candidate for funds from the Opioid Abatement Authority (OAA), an independent body of the Commonwealth of Virginia supporting those affected by the opioid epidemic through financial support from the Fund, in the form of grants, donations, or other assistance, for efforts to treat, prevent, and reduce opioid use disorder and the misuse of opioids in Virginia.[25] On March 19, 2024, the OAA launched its Request for Proposals (RFP) from Agencies of the Commonwealth for abatement project awards for the 2024-2025 performance period. The Commonwealth's settlement distribution memorandum of understanding (MOU) and the Code of Virginia directs the OAA to allocate 15% of the Opioid Abatement Fund for awards to state agencies.[26] The RFP deadline is May 24, 2024 and the application from the MSV is currently underway.

DBHDS, the partnering agency, only received a $522,000 award from the OAA dispersed across various programs and projects they administer or manage.[27] The agency's entire previous OAA disbursement would barely cover 6% of APAL's 5-years budget estimate of $32 million.[28] Though the potential award amount is dramatically less than the cost of the program, applying for this grant in partnership with DBHDS is further advancing the agency's buy- in for the success of APAL and positions the MSV better for future state funds appropriated by the General Assembly which will still be necessary.

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[25] Article 12. Opioid Abatement Authority, 2021, Sp. Sess. I, cc. 306, 307, https://www.oaa.virginia.gov/

[26] Virginia Opioid Abatement Authority, "Agency Request for Proposals" March 12, 2024, https://www.oaa.virginia.gov/media/governorvirginiagov/oaa/pdf/News-Update-State-Agency-RFP-Launch.pdf

[27] "Virginia Opioid Abatement Authority: 2023 Annual Report", 2023, https://www.oaa.virginia.gov/media/governorvirginiagov/oaa/img/news-and-announcements/2023-OAA-Annual-Report-FINAL.pdf

[28] APAL 5 Year Budget.xlsx (sharepoint.com)

Appendix A: APAL Comprehensive 5-Year Strategic Budget

Description	Entity	FTE	Pilot	Year 2	Year 3	Year 4	Year 5
Chief Medical Officer - Psychiatry	Boarded Psychiatrist	10%	$ 30,000.00	$ 45,000.00	$ 60,000.00	$ 75,000.00	$ 75,000.00
Medical Director – Primary Care	Boarded Family Physician	20%	$ 50,000.00	$ 75,000.00	$ 100,000.00	$ 100,000.00	$ 100,000.00
Medical Director – Addiction Medicine	Boarded Addiction Medicine Physician	10%	$ 25,000.00	$ 25,000.00	$ 50,000.00	$ 50,000.00	$ 50,000.00
Medical Director - Education	Boarded Addiction Medicine Physician	10%		$ 25,000.00	$ 25,000.00	$ 50,000.00	$ 50,000.00
Medical Director - Geriatric Mental Health	Boarded Geropsychiatrist	10%		$ 25,000.00	$ 25,000.00	$ 50,000.00	$ 50,000.00
	Boarded adult						
Project Adm/Quality Assurance/Legal	MSV		$ 35,000.00	$ 45,000.00	$ 55,000.00	$ 60,000.00	$ 65,000.00
Financial Services	MSV		$ 25,000.00	$ 50,000.00	$ 65,000.00	$ 68,250.00	$ 73,250.00
Care Navigator (Peer Recovery Specialist)	Central Hub	100%	$ 69,000.00	$ 141,450.00	$ 219,247.50	$ 230,209.88	$ 241,720.37
AMP/LMHP on call *(available for consultation)*	Central Hub	100%	$ 92,000.00	$ 100,000.00	$ 105,000.00	$ 110,250.00	$ 115,762.50
LCSW	Central Hub	50%	$ 46,000.00	$ 100,000.00	$ 105,000.00	$ 110,250.00	$ 115,762.50
Care Navigator (Peer Recovery Specialist)	Western Hub	100%	$ 37,500.00	$ 69,000.00	$ 141,450.00	$ 289,972.50	$ 304,471.13
AMP/LMHP on call *(available for consultation)*	Western Hub	100%	$ 50,000.00	$ 100,000.00	$ 105,000.00	$ 215,250.00	$ 226,012.50
LCSW	Western Hub	50%	$ 25,000.00	$ 100,000.00	$ 105,000.00	$ 215,250.00	$ 226,012.50
Care Navigator (Peer Recovery Specialist)	Eastern Hub	100%		$ 75,000.00	$ 153,750.00	$ 238,312.50	$ 250,228.13
AMP/LMHP on call *(available for consultation)*	Eastern Hub	100%		$ 100,000.00	$ 105,000.00	$ 110,250.00	$ 115,762.50
LCSW	Eastern Hub	100%		$ 100,000.00	$ 100,000.00	$ 105,000.00	$ 110,250.00
Care Navigator (Peer Recovery Specialist)	Northern Hub	100%		$ 75,000.00	$ 153,750.00	$ 238,312.50	$ 250,228.13
AMP/LMHP on call *(available for consultation)*	Northern Hub	100%		$ 100,000.00	$ 105,000.00	$ 110,250.00	$ 115,762.50
LCSW	Northern Hub	100%		$ 100,000.00	$ 100,000.00	$ 105,000.00	$ 110,250.00
Care Navigator (Peer Recovery Specialist)	Southwestern Hub	100%		$ 75,000.00	$ 153,750.00	$ 238,312.50	$ 250,228.13
AMP/LMHP on call *(available for consultation)*	Southwestern Hub	100%		$ 100,000.00	$ 105,000.00	$ 110,250.00	$ 115,762.50
LCSW	Southwestern Hub	100%		$ 100,000.00	$ 100,000.00	$ 105,000.00	$ 110,250.00
Care Navigator	Central Hub	100%		$ 75,000.00	$ 150,000.00	$ 157,500.00	$ 165,375.00
Geropsych on call *(available for consultation)*	Central Hub	100%		$ 227,157.00	$ 238,514.85	$ 369,698.02	$ 388,182.92
LCSW	Central Hub	100%		$ 75,000.00	$ 78,750.00	$ 82,687.50	$ 86,821.88
Care Navigator	Western Hub	100%		$ 37,500.00	$ 75,000.00	$ 78,750.00	$ 161,437.50
Geropsych on call *(available for consultation)*	Western Hub	100%		$ 113,578.50	$ 232,835.93	$ 360,895.68	$ 739,836.15
LCSW	Western Hub	100%		$ 50,000.00	$ 102,500.00	$ 107,625.00	$ 220,631.25
Care Navigator	Eastern Hub	100%			$ 75,000.00	$ 78,750.00	$ 82,687.50
Geropsych on call *(available for consultation)*	Eastern Hub	100%			$ 227,157.00	$ 238,514.85	$ 250,440.59
LCSW	Eastern Hub	100%			$ 75,000.00	$ 78,750.00	$ 82,687.50
Care Navigator	Northern Hub	100%			$ 75,000.00	$ 78,750.00	$ 82,687.50
LCSW	Southwestern Hub	100%			$ 75,000.00	$ 78,750.00	$ 82,687.50
Care Navigator	Central Hub	100%				$ 75,000.00	$ 78,750.00
Psych on call *(available for consultation)*	Central Hub	100%				$ 249,863.00	$ 262,356.15
LCSW	Central Hub	100%				$ 75,000.00	$ 78,750.00
Care Navigator	Western Hub	100%				$ 75,000.00	$ 78,750.00
Psych on call *(available for consultation)*	Western Hub	100%				$ 249,863.00	$ 262,356.15
LCSW	Western Hub	100%				$ 75,000.00	$ 78,750.00
Care Navigator	Eastern Hub	100%					$ 75,000.00
Psych on call *(available for consultation)*	Eastern Hub	100%					$ 249,863.00
LCSW	Eastern Hub	100%					$ 75,000.00
Care Navigator	Northern Hub	100%					$ 75,000.00
Psych on call *(available for consultation)*	Northern Hub	100%					$ 249,863.00
LCSW	Northern Hub	100%					$ 75,000.00
Care Navigator	Southwestern Hub	100%					$ 75,000.00
APAL Program Director	MSV	100%	$ 110,000.00	$ 115,500.00	$ 121,275.00	$ 127,338.75	$ 133,705.69
Operations/Call Line Manager	MSV	100%	$ 57,000.00	$ 75,000.00	$ 78,750.00	$ 82,687.50	$ 86,821.88
Education Coordinator	MSV	100%		$ 60,000.00	$ 63,000.00	$ 66,150.00	$ 69,457.50
Data & Analytics Coordinator	MSV	100%	$ 75,000.00	$ 78,750.00	$ 82,687.50	$ 86,821.88	$ 91,162.97
Engagement Manager	MSV	100%			$ 65,000.00	$ 68,250.00	$ 71,662.50
Event Coordinator	MSV	100%			$ 65,001.00	$ 68,251.05	$ 71,663.60
Database: Salesforce Software	MSV		$ 148,000.00	$ 150,000.00	$ 50,000.00	$ 150,000.00	$ 50,000.00
Database: Salesforce Licenses	MSV		$ 26,000.00	$ 52,000.00	$ 110,000.00	$ 175,000.00	$ 250,000.00
Unite Us system access	MSV		$ 5,000.00	$ 250,000.00	$ 150,000.00	$ 150,000.00	$ 150,000.00
Education	ASAM / VAFP /Echos		$ 110,000.00	$ 165,000.00	$ 288,750.00	$ 505,312.50	$ 757,968.75
Website Hosting	MSV		$ 10,000.00	$ 15,000.00	$ 15,000.00	$ 20,000.00	$ 20,000.00
Communications, Outreach, & Engagement	MSV		$ 80,000.00	$ 100,000.00	$ 120,000.00	$ 150,000.00	$ 175,000.00
Conferences & Annual Meetings	MSV			$ 20,000.00	$ 30,000.00	$ 40,000.00	$ 45,000.00

Appendix B: APAL One-Pager

MSV FOUNDATION DBHDS

Support APAL's substance use disorder services Budget Amendment

Adult Psychiatric Access Line

Support Funding to Expand the Pilot

The Adult Psychiatric Access Line (APAL) is a statewide consult and care navigation program designed for adults struggling with substance use disorders to access specialized mental health services and prepare primary care and emergency clinicians to support patients' behavioral health needs through training and education.

93 of Virginia's 133 localities are federally-designated Mental Health Professional Shortage Areas.

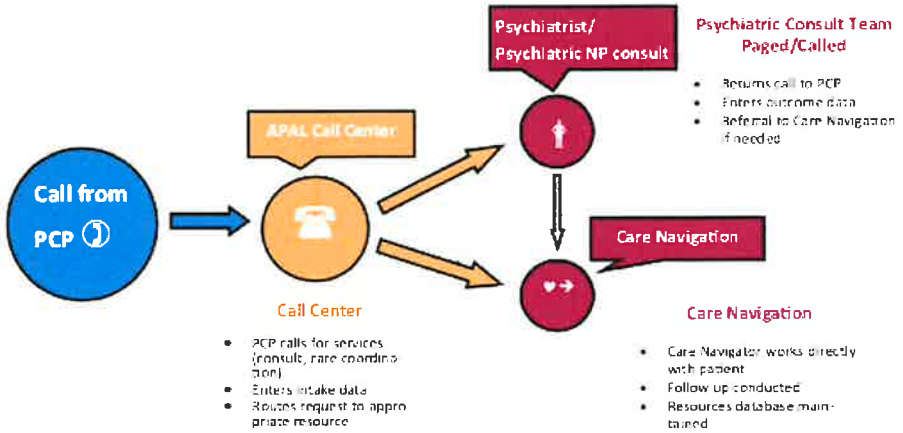
Virginia Health Care Foundation, 2022

The Problem: Too Few Providers

Despite sizable investments at the state and federal level, Virginia's capacity is constrained across the Commonwealth's continuum of behavioral health care. **There are not enough specialized healthcare providers to meet patient demand for behavioral and mental health services.** Virginia faces significant challenges in developing specialized solutions to reduce adverse health outcomes related to substance use disorders.

The Solution: The Adult Psychiatric Access Line

With the support and resources provided by APAL, healthcare providers, particularly those in primary care and emergency settings, will have the tools and knowledge to help effectively diagnose, prescribe, and assist patients in navigating substance use recovery care. APAL's care model is based on four components: **Provider education** on screening, diagnosis, management, and treatment of SUDs; access to **telephonic consultations** via regional hubs comprised of addiction medicine specialists and psychiatrists, psychologists, and/or social workers; **care navigation assistance** to help identify additional regional mental health services and resources; and **telehealth visits** for care continuity.



Appendix C: Stakeholder Support & Budget Request Letter

MSV℠ MEDICAL SOCIETY OF VIRGINIA

VASAM Virginia Society of Addiction Medicine

VAFP VIRGINIA'S FAMILY PHYSICIANS

September 15, 2024

Governor Glenn Youngkin
Via Electronic Mail: Glenn.Youngkin@governor.virginia.gov
CC: Secretary of HHR John Littel John.littel@governor.virginia.gov,
Deputy Secretary of HHR James Williams James.williams@governor.virginia.gov
DBHDS Commissioner Nelson Smith, nelson.smith@dbhds.virginia.gov
DBHDS Director, Office of Substance Use Services, Candace Roney, candace.roney@dbhds.virginia.gov

Re: Support DBHDS' Agency Budget Request for APAL

Dear Governor Youngkin:

The Medical Society of Virginia represents Virginia's physicians, PA, residents, and medical students. On behalf of these members and our colleagues from the Virginia Society of Addiction Medicine, I am writing today to ask you to **support the Adult Psychiatric Access Program (APAL) budget amendment.**

According to the Right Help, Right Now Year 1 Update, your administration has seen measurable success across the six pillars of transformative plans and initiatives. In keeping with those goals and to further support these efforts, the MSV believe we are uniquely positioned to contribute to the work of pillars three and four related to care delivery of substance use service support and behavioral healthcare integration through the Adult Psychiatric Access Program.

You and your administration have been historic supporters and champions of the Virginia Mental Health Access Program, a statewide initiative to improve access to behavioral and mental health services for Virginia's pediatric population. Much like RNRN's Year 1 Update, we are proud to share VMAP's 2022 Impact Report that demonstrates the progress and growth the program has seen to date.

After several conversations with Commissioner Smith about using VMAP's provider education, consultation, and care delivery model for Virginia's adult behavioral health patient population, we are happy to report the **MSV has been awarded a grant-funded program administrator contract with DBHDS to pilot APAL for substance use disorder.** This one-time allocation of $1.7 million will be used to implement critical support for primary care providers managing behavioral health conditions and ensure more Virginians have access to providers who are better able to screen, diagnose, manage, and treat substance abuse disorders.

As the program administrator, the MSV has already prepared a five-year strategic plan and cost estimate for APAL post-pilot, including scaling the program to geriatric and young adult care. We look forward to discussing the program and sharing these assessments with you at your convenience.

I want to thank you and your administration once again for your support for VMAP and your continued leadership in reforming the Commonwealth's behavioral healthcare system. Integration of behavioral health across healthcare access points and care delivery systems is among the highest priorities when addressing comprehensive population health.

The MSV stands ready to serve as a resource or offer any other help necessary to you and your administration. To discuss this matter further, please contact Clark Barrineau, Vice President of Government Affairs and Health Policy at the Medical Society of Virginia, at cbarrineau@msv.org.

Sincerely,

Alice Coombs, MD
MSV President

Dr. Varun Chaundry, MD, MA, DFAPA
CMO- Psychiatry

Sterling Ransone, MD, FAAFP
Medical Director- Primary Care

James Thompson, MD
Medical Director- Addiction Medicine