Virginia Department of Behavioral Health & Developmental Services

DBHDS Update on Behavioral Health System Reform Efforts

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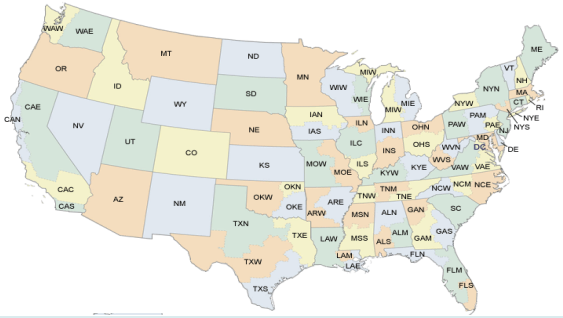
DBHDS Non-Behavioral Health Items

- Capacity of VCBR
- DOJ Settlement Agreement
- Federal Government
- Workforce Challenges
- Electronic Health Record
- Northrop Grumman Disentanglement
- Oversight: Licensing staff, Quality staff, Data Warehouse, Service Process Quality Management (SPQM)

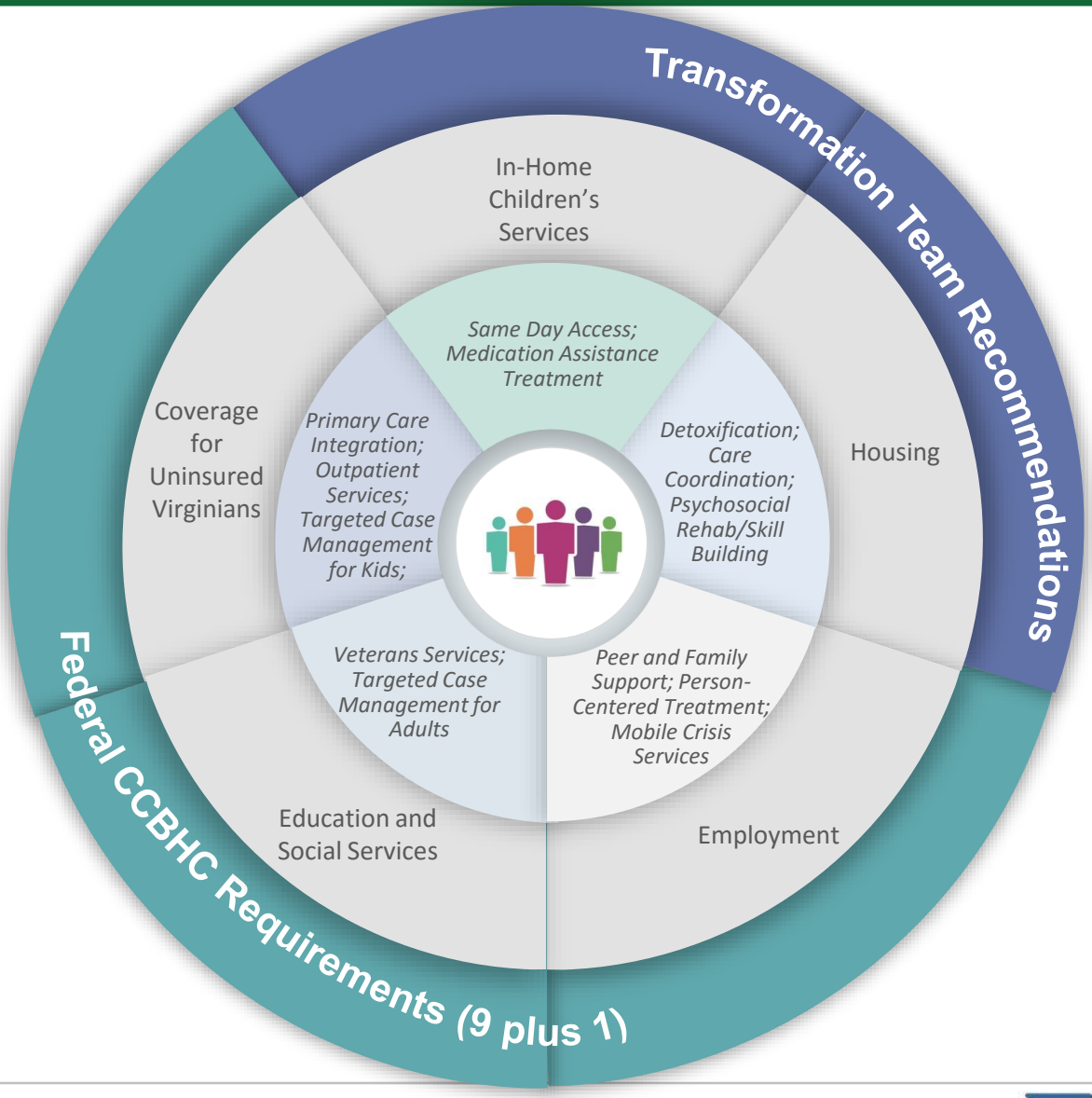
The Behavioral Healthcare (BH) Landscape



- Comprehensive BH is essential to population health and cost containment
- BH issues drive up to 35% of medical care costs and individuals with BH disorders cost up to 2-3 times as much as those without
- Integration of BH and primary care, as well as housing, employment, schools, social services
- Decreased reliance on institutions and increased focus on community services
- State hospital capacity average: 15 beds per 100,000 people
- **National average of state spending on hospitals = 23% of overall BH budget**
- **National average of state spending on community = 75% of overall BH budget (~$89 per capita,2013)**
- From 2009-2012, 12 states closed 15 MH hospitals

- How does VA measure up nationally? 31st in BH funding in 2013 GFs, non-Medicaid: $92.58 per person. Median (Ohio) is $100.29 per person
- Not maximizing our investment
- Roughly 50% of GF funding supports 3% of persons served
- State Hospital Capacity: 17.3 beds per 100,000 people
- **Virginia spending on hospitals = 49% of overall BH budget in FY18**
- **Virginia spending on community = 48.5% of overall BH budget, FY18 ($47 per capita, 2013)**
- Average 200+ individuals ready for discharge in VA's mental health hospitals
- VA has never closed a MH hospital

System Transformation, Excellence and Performance in Virginia (STEP-VA)



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18 CSBs to Receive FY 2018 Same Day Access Funding

1st Group of CSBs	2nd Group of CSBs	3rd Group of CSBs
Already implemented some form of Same Day Access (SDA). Will each receive full FY 2018 funding of $270,000 on July 1, 2017.	**Currently planning SDA implementation. Will each receive prorated FY 2018 funds 60 days prior to implementation with the full $270,000 in ongoing funds beginning in FY 2019.**	**Participated in 2015-2016 federal grant which increased readiness to implement SDA. Will each receive prorated FY 2018 funds 60 days prior to implementation with the full $270,000 in ongoing funds beginning in FY 2019.**
1. Alleghany Highlands CSB 2. Blue Ridge BH 3. Chesterfield CSB 4. Harrisonburg-Rockingham CSB 5. Henrico CSB 6. Mount Rodgers CSB 7. Rappahannock-Rapidan CSB 8. Valley CSB	1. Arlington CSB 2. Chesapeake IBH 3. Hanover County CSB 4. New River Valley CSB 5. Piedmont CSB 6. Rappahannock Area CSB	1. Colonial BH 2. Cumberland Mountain CSB 3. Planning District 1 4. Richmond Behavioral Health Authority

Funds need to be committed during the 2018 General Assembly Session to implement Same Day Access in the remaining 22 CSBs

Primary Care Screening and Monitoring

- In 2017, the General Assembly required all CSBs to provide outpatient primary care screening and monitoring services by July 1, 2019.
- Primary care screening and monitoring for individuals seeking services from CSBs will increase the likelihood of those at risk of physical health issues getting preventative and primary care for physical health conditions.
- Primary care screening and monitoring includes elements such as checking blood pressure, BMI, temperature, blood sugar and other health risks.
- Care coordination is vital in this process to ensure individuals are linked with health care providers and follow up is done to address any barriers to services to address health risks.

"People with severe mental illness (SMI) … have an excess mortality, being two or three times as high as that in the general population. This mortality gap, which translates to a **13-30 year shortened life expectancy** in SMI patients has widened in recent decades even in countries where the quality of the health care system is generally acknowledged to be good. About **60% of this excess mortality is due to physical illness**." - Journal of World Psychiatry (Feb. 2011)

Next Step Funding

	FY 2019	FY 2020	GF Total
Same Day Access for 22 remaining CSBs	$ 5.9M	$5.9M	$11.8M
Primary Care Screening and Monitoring in 40 CSBs	$7.5M	$7.5M	$15M

GA Code-Required Implementation Dates for STEP-VA Services

STEP-VA Service	GA Implementation Date Requirement	Funds Allocated
Same Day Access	July 1, 2019	$4.9M GF and $4M NGF (GAP) *(2017 Session);* only for 18 out of 40 CSBs
Primary Care Integration	July 1, 2019	
Crisis Services for Behavioral Health	July 1, 2021	–
Outpatient Behavioral Health	July 1, 2021	–
Psychiatric Rehabilitation	July 1, 2021	–
Peer Support and Family Support Services	July 1, 2021	–
Veterans Behavioral Health Services	July 1, 2021	–
Care Coordination	July 1, 2021	–
Targeted Case Management (Adults and Children)	July 1, 2021	–

Behavioral Health Services for Uninsured Virginians

- Health care has steadily moved towards “managed care” with payment for outcomes rather than “fee for service.”
- Virginia needs to align managed Medicaid services with services for the uninsured supported by general fund dollars so that it has one system of standards and outcome measures.
- However, Virginia’s community behavioral health system features inconsistent capacity and access. Its current funding is inadequate to cover the uninsured with behavioral health disorders in an outcome based system.

Three steps must be taken to transition Virginia’s public safety net services:

1) Build/expand the services, access, and measures incorporated into **STEP-VA**.
Timeframe: 4 Years
(per Code)

2) Align DMAS managed care behavioral health programs with **STEP-VA** so the same metrics and standards apply to the care provided to both Medicaid members and the uninsured.
Timeframe: 1-4 Years

3) Address the bifurcated funding streams for CSBs and state hospitals to better align services with needs and achieve better cost efficiency.
Timeframe: 1-4 Years

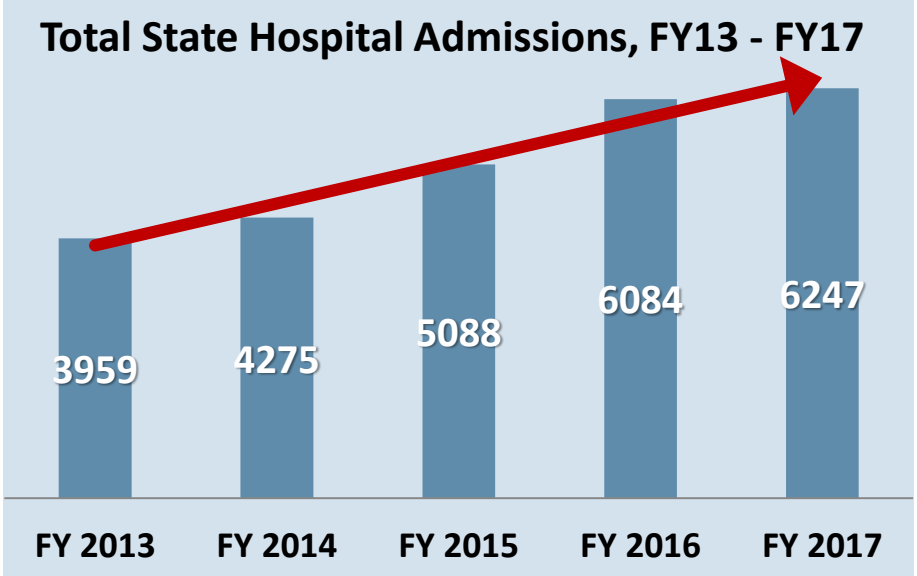
Cost of Business as Usual

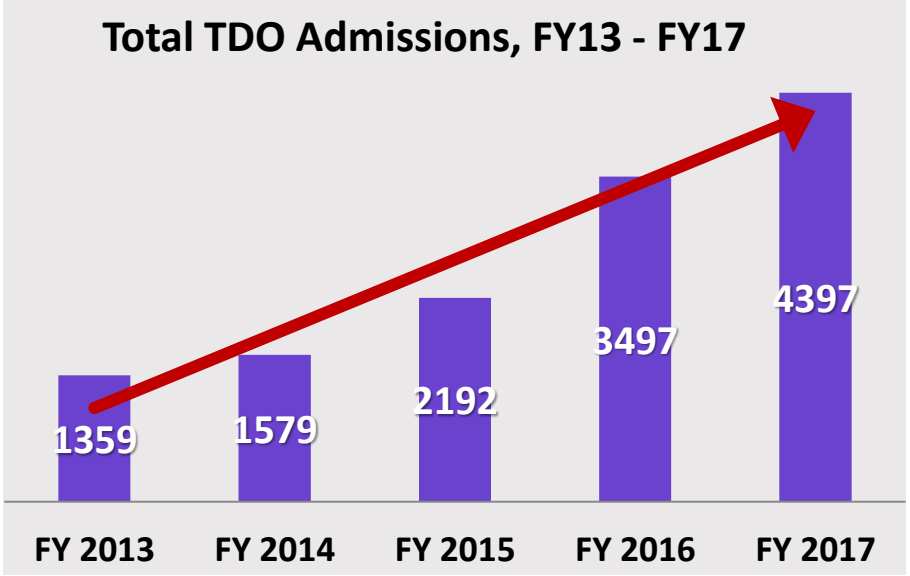
	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024*
Business as Usual	Maintain Current 1418 Beds			Add 56 Beds at Western State Hospital (WSH)		New 300 Bed Central State Hospital (CSH)	
Census*	1347	1375	1404	1432	1460	1488	1516**
Utilization	95%	97%	99%	97%	99%	98%	**100%**
Staffing Cost		$11M	$11M	$11M	$11M	$11M	$11M
Discharge Assistance Planning (DAP)/Local Inpatient Purchase of Services (LIPOS) Cost		$4.9M	$9.8M	$14.7M	$19.6M	$24.5M	$29.4M
Staffing added beds CSH						$3.5M	$3.5M
Staffing for 56-Bed WSH			$7M	$7M	$7M	$7M	$7M
Permanent Supportive Housing (PSH) Cost		$3M	$6M	$9M	$12M	$15M	$18M

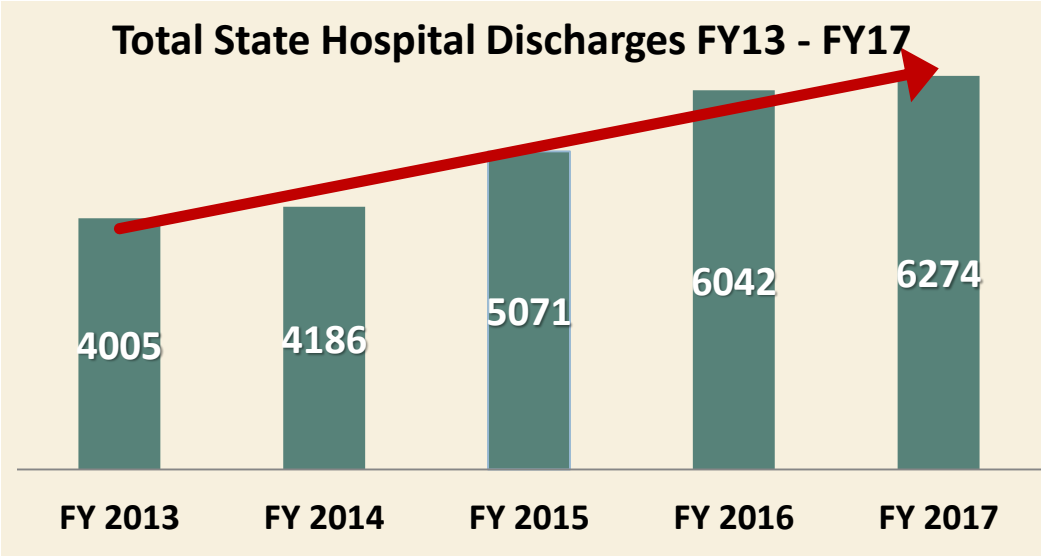
* Census projections are based on the 22% per year growth experienced since "last resort" legislation went into effect in FY 2014: FY 2014 = 87%; FY 2017 = 93%.

** FY 2024: Demand decreases IF outpatient services, permanent supportive housing and crisis services for STEP-VA are all fully implemented.

Hospital Admissions and Discharges







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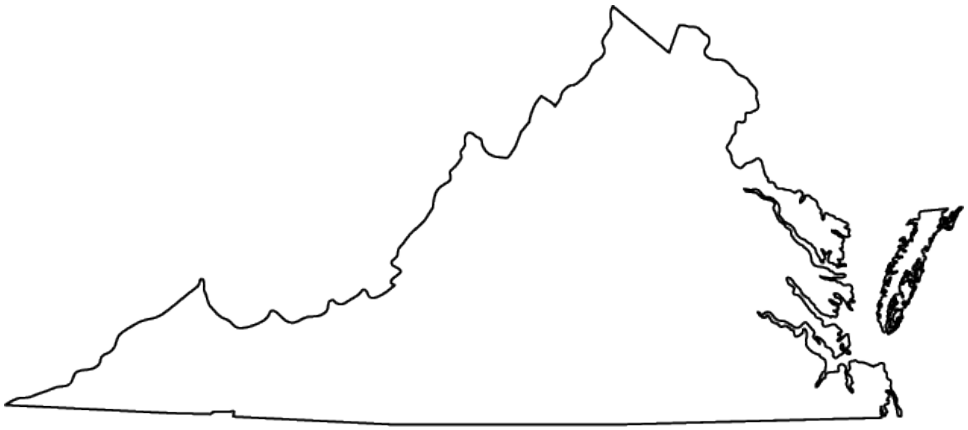
Emergency Evaluations and Temporary Detention Orders

Every 24-hours across the Commonwealth there are:



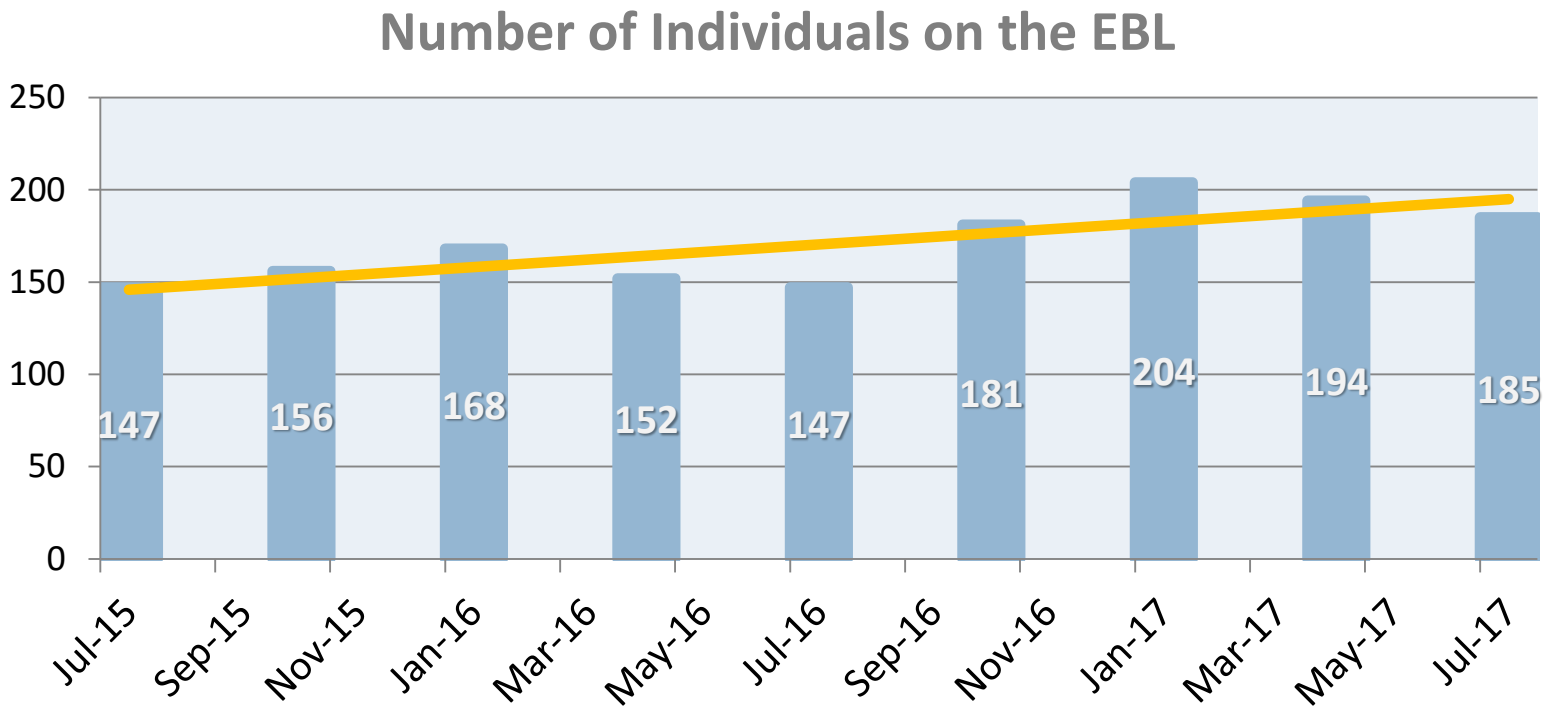
256 EMERGENCY EVALUATIONS CONDUCTED

71 TEMPORARY DETENTION ORDERS ISSUED

Year	Number of Crisis Evaluations	Number of TDOs	% of Evaluations Leading to TDOs	Number of TDOs admitted to Private Hospitals
FY 2015	83,701	24,889	29.7%	22,687
FY 2016	96,041	25,798	26.8%	22,322
FY 2017	93,482	25,852	27.7%	21,861

Hospital Challenges – Extraordinary Barriers to Discharge List (EBL)

In August 2017, there were **179** individuals in state hospitals who have been clinically ready for discharge for more than 14 days but appropriate community services are not available to facilitate a safe discharge. This is still 13 percent of the total statewide census.



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EBL and Bed Reduction Strategies

- In Spring 2017, DBHDS provided regions $2.5 million in one-time bridge funds for individual service plans and expanded housing and service capacity.
- As of June 30, 2017, a total of 122 individuals on the EBL had been appropriately discharged from state hospitals (93% of the goal).
- Also, DBHDS challenged Region V CSBs to propose discharge plans for 20 geriatric individuals from ESH by September 2017 and five more by November so those beds could be available for adult jail transfers.
- Western Tidewater CSB (WTCSB) is developing a 65 bed transitional living program for older adults, including those currently hospitalized at ESH.
- The project will be funded through new Discharge Assistance Funds (DAP), the new funds for a geropsychiatric team, and with existing DAP dollars.
- A similar project is being developed with Region Ten CSB.

These projects are critical to help release immediate pressure on state hospital censuses, but are considered <u>temporary</u>: they buy time until a more permanent solution is implemented.

General Assembly Requirement for Financial Realignment Plan

This plan shall include (Item 284 E.1.):

i. *a timeline and funding mechanism to eliminate the extraordinary barriers list in state hospitals and to maximize the use of community resources for individuals discharged or diverted from state facility care;*

ii. *sources for bridge funding, to ensure continuity of care in transitioning patients to the community, and to address one-time, non-recurring expenses associated with the implementation of these reinvestment projects;*

iii. *state hospital appropriations that can be made available to CSBs to expand community mental health and substance abuse program capacity to serve individuals who are discharged or diverted from admission;*

iv. *financial incentive for community services boards to serve individuals in the community rather than state hospitals;*

v. *detailed state hospital employee transition plans that identify all available employment options for each affected position, including transfers to vacant positions in either DBHDS facilities or community services boards;*

vi. *Legislation/Appropriation Act language needed to achieve financial realignment; and*

vii. *matrices to assess performance outcomes.*

The plan is due December 1, 2017

Why Consider Financial Realignment?

Increasing state hospital census lead to FY 2020 projections of 99% with a high monthly average of 104%

Both hospital utilization and the extraordinary barriers to discharge list have increased despite a 55% increase in discharges and $24M invested in discharge-related community programs (DAP/LIPOS/ PACT/PSH) in past 3 years

GF sent to hospitals and CSBs but funds are in separate cost centers and independent of each other

At any time in FY 2017, an average of 200 (out of ~1320) people couldn't be safely discharged from state hospitals

State hospital admissions have increased 58% and discharges 55%

No financial pressure for state hospitals to treat and discharge as quickly as possible

No community financial impact when people no longer need state hospital care but cannot be safely discharged

State hospitals are at no cost to CSBs, jails and DMAS (except small number may bill Medicaid under CCC+)

Financial Realignment Plan Development

- **Objective:** Enhance integrated community based options while reducing bed census pressures at the MH Hospitals.
- **Measures:** State hospital utilization, number of individuals on the EBL
- **Requirements:**
  - Address CSB and state hospital challenges and risks.
  - Building community capacity through STEP-VA (This plan is incomplete without sustained effort).
  - Bridge or development support 3-12 months prior to inception of business operational changes (requires one-time bridge funding).
  - CBSs would receive additional funding up front, while the larger MH Hospitals would realize reductions in their base operating plans (to be saved on the "back end" if census declines).
  - CSB funds would come from new GFs and state hospital funds
  - CSBs would have the option of buying MH Hospitals beds or increasing community / programs and capacity, or some combination.
  - Greater financial flexibility to shift resources between DBHDS facilities and CSB and across fiscal years.

Financial Realignment

NEED	A system in which CSBs purchases the level of service needed for each individual for the time needed
POSSIBLE STRATEGY	Send state hospital funds to CSBs who pay the hospitals for individuals requiring that level of care
POSSIBLE PLANS	**FY19:** Build/develop and discharge; Mix of one-time and ongoing funds **FY20:** Bed purchase, maintain lower utilization. Continuation of ongoing funds above plus additional funds plus ongoing from state hospitals with decreased census
GOAL	Manageable state hospital census
GOAL	Avoid spending increasingly more on the hospitals at the cost of impeding capacity to build community system

DBHDS is currently working with CSBs to address concerns and develop the plan.

Age of Facility Structures

Facility and Building	Avg. Age	0-10 yrs.	11-20 yrs	21-30 yrs	31-40 yrs	41-50 yrs	51-60 yrs	61-70 yrs
Catawba Hospital	64 yrs							
Central State Hospital	56 Yrs							
Commonwealth Center for Children and Adolescents	21 Yrs							
Eastern State Hospital	10/56 Yrs	treatment	support buildings					
Hiram W. Davis Medical Center	43 Yrs							
Nothern Virginia Mental Health Institute	21/52 Yrs	addition			original building			
Piedmont Geriatric Hospital	68 Yrs							
Southeastern Virginia Training Center	5 yrs.							
Southern Virginia Mental Health Institute	47 Yrs							
Southwestern Virginia Mental Health Institute	26/71 Yrs	treatment			support			
Western State Hospital	4 Yrs.							
Virginia Center for Behavioral Rehabilitation	9 Yrs.							

Less than 20 years old
Over 20 but less than 30
Over 30- needs renovation or replacement

Less than 20 years old
Over 20 but less than 30
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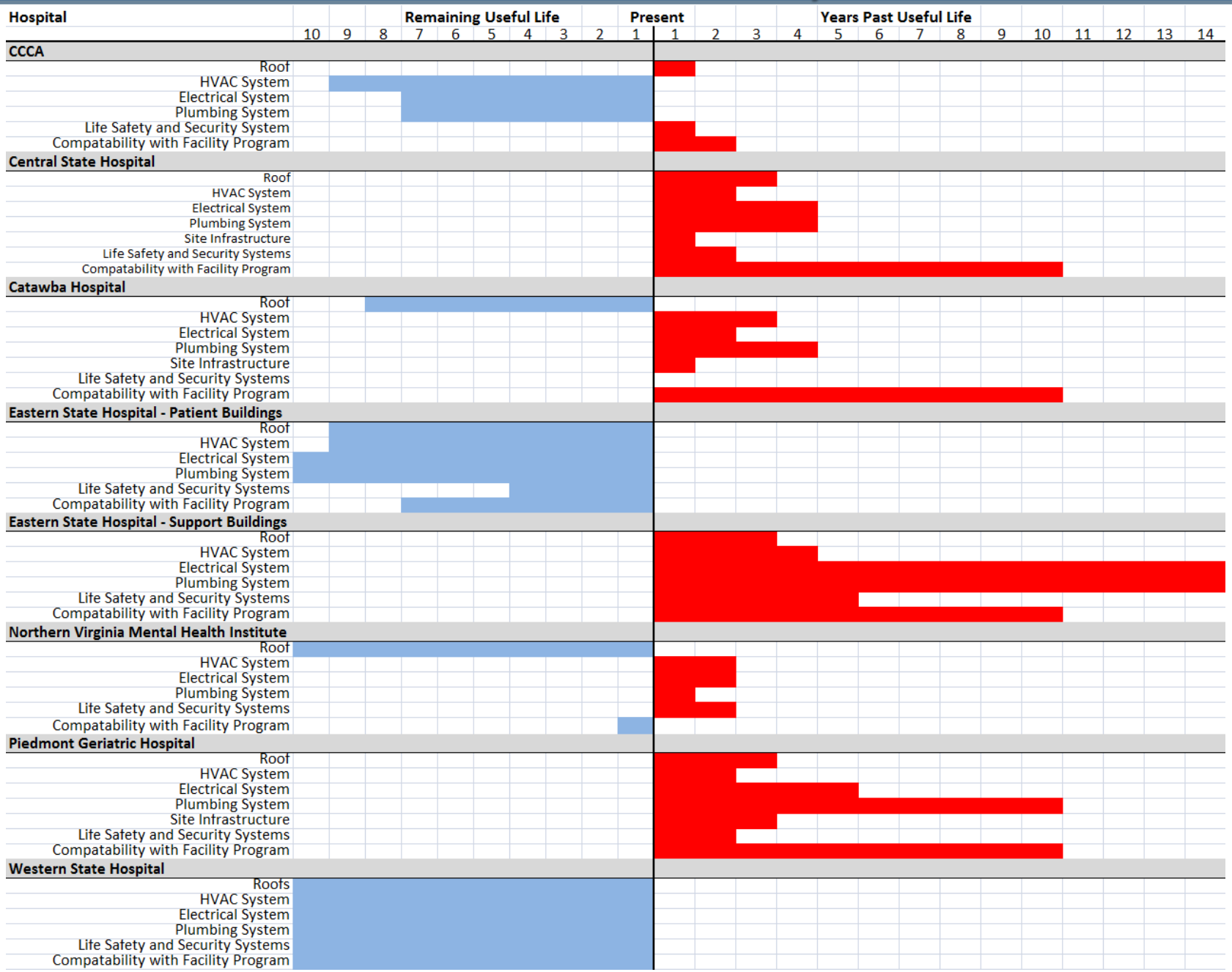
Useful Life Analysis



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