Virginia Department of Behavioral Health & Developmental Services

Transforming Virginia to a Stronger, More Accountable Publicly-Funded Behavioral Health System

DBHDS Updates

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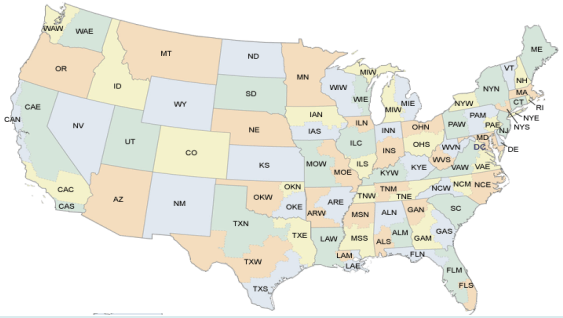
Recent Progress Improving Virginia's Behavioral Health System

Recent Progress Improving Virginia's Behavioral Health System
Implemented New Civil Commitment Laws: No person has gone without a bed since July 1, 2014, despite a 157% increase in TDO admissions and a 54% increase in total state hospital admissions since FY 2013, including a 43% increase following the passage the General Assembly's last resort legislation.
More Improvements to Emergency System: Implemented new standards and processes for emergency evaluators (July 1, 2016). This joint effort of DBHDS and the CSBs was not required by legislative direction.
Jail waiting List: 12 months ago, the list was at 85 people with 75 waiting more than seven days. As of 9/23, the list was 32. The Washington Post reported the national average for state jail waiting lists is 78.
Transformation: Completed planning grant for certified community behavioral health centers, and developed plan for multi-year, stakeholder-involved system transformation initiative that is ready for further discussion.
SUD Services to Battle Opioid Epidemic: Completed a pilot program and providing training in the use of naloxone for community members; working with DMAS on the state's application to CMS for a SUD Waiver.
Prevention: Trained 26,000 in Mental Health First Aid, worked with VDH and others to identify 11 areas most impacted by opiate abuse, and established networks to combat tobacco and e-cigarettes use in teens.
Hospital Operations: Implemented two encompassing overhauls of clinical operations at two hospitals and created a new hospital "health index" initiated to anticipate problems sooner.
Internal Operations: Making budget processes more transparent and bilateral with hospitals and CO offices, Strengthening licensing with reorganization and staff additions.
IT: Data Warehouse won COVITS award last year and continues to mature. The electronic health record system now at 3 hospitals and was recently nominated for a COVITS award.

The Behavioral Healthcare (BH) Landscape

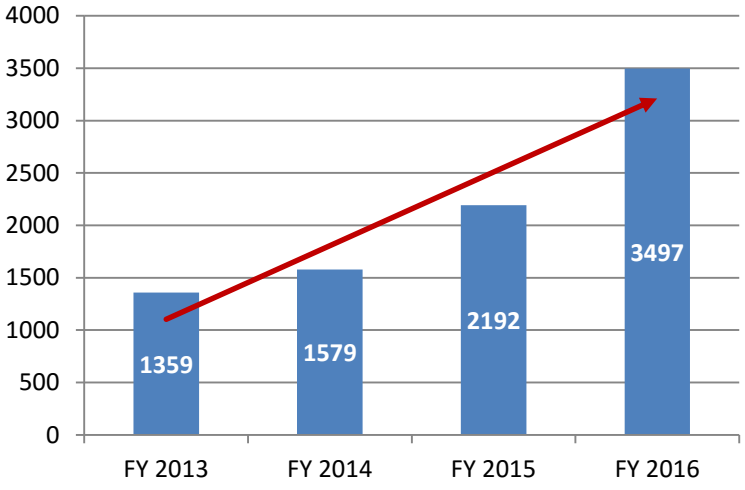


- Comprehensive BH is essential to population health and cost containment
- BH issues drive up to 35% of medical care costs and individuals with BH disorders cost up to 2-3 times as much as those without
- Integration of BH and primary care, as well as housing, employment, schools, social services
- 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)**
- **From 2009-2012, 12 states closed 15 MH hospitals**

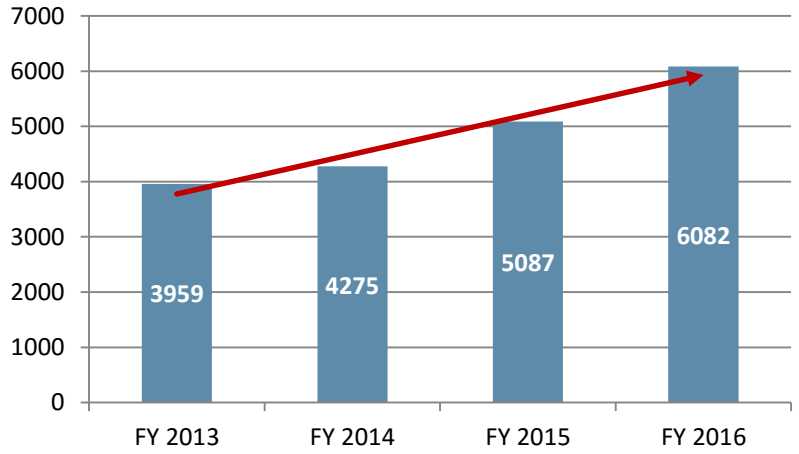
- How does VA measure up nationally? 31st in BH funding in 2013 GFs, non-Medicaid: $92.58 per person. Median (Ohio) is $100.29 per person
- Not maximizing our investment
- Roughly 50% of GF funding supports 3% of persons served
- State Hospital Capacity: 17.3 beds per 100,000 people
- Virginia spending on hospitals = 46% of overall BH budget
- Virginia spending on community = 51% of overall BH budget ($47 per capita)
- Average 200+ individuals ready for discharge in VA's mental health hospitals
- VA has never closed a MH hospital

Last Resort and State Hospital Admissions

TDO Admissions to State Hospitals*
(FY 2013 – FY 2016)



Total State Hospital Admissions*
(FY 2013 – FY 2016)



*** Includes children and adolescent, adult and geriatric admissions**

- **Since "Last resort" legislation was passed, a bed was provided for everyone under a TDO who needed a bed since the law was implemented July 1, 2014.**
- **Since FY 2013, TDO admissions have increased 157% and all hospital admissions 54%.**

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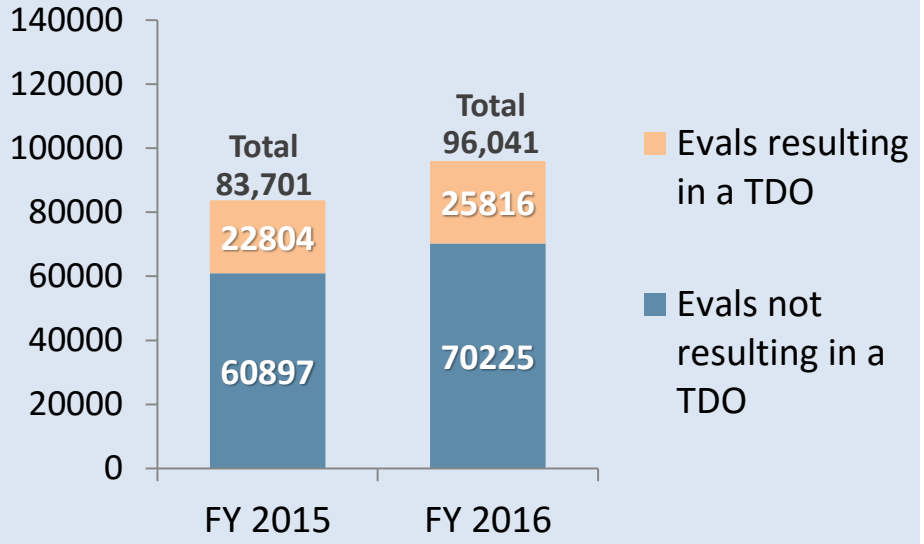
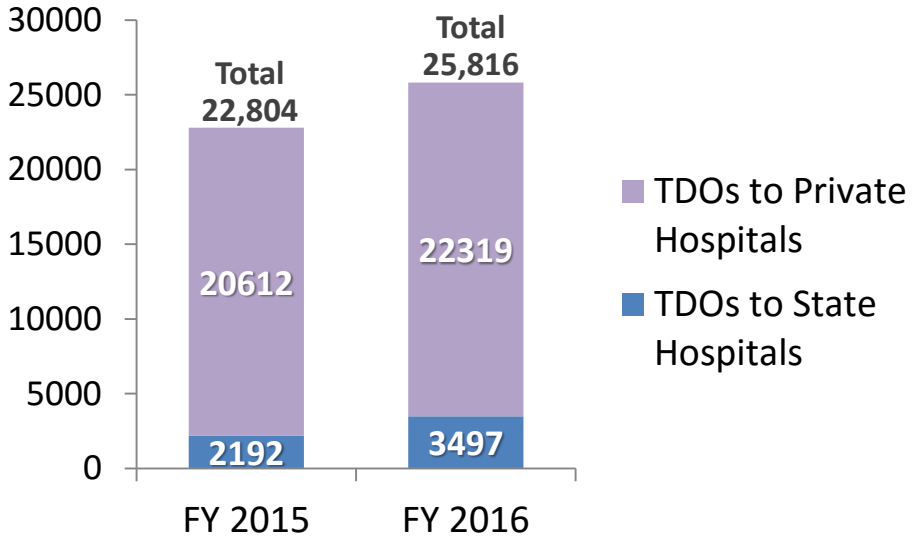
Emergency Evaluations and Temporary Detention Orders (TDOs)

More Emergency Evaluations

- CSB clinicians conducted 15% more evaluations in FY 2016 than FY 2015.
- Of those, 13% more resulted in TDOs in FY 2016.
- This equates to 263 emergency evaluations and 71 TDOs issued PER DAY.





TDOs and Private Hospital Admissions

- Some private hospitals accept patients for treatment who are under a TDO.
- Private hospital TDO admissions are declining.
- Private hospitals cite: Behavioral acuity, medical acuity, and clinically inappropriate (dementia, autism, TBI, etc.).

State Hospital Admissions: FY 2013 – FY 2016

	FY 2013	FY 2014	FY 2015	FY 2016	% Increase Since FY 2013
Catawba	249	244	345	456	83%
Central State	514	521	620	799	55%
CCCA	691	833	931*	1,018*	47%
Eastern State	242	569	628	766	217%
NVMHI	693	546	822	1,059	53%
Piedmont	59	74	115	105	78%
SVMHI	261	310	282	374	43%
SWVMHI	720	772	730	931	29%
WSH	530	671	786	832	57%
TOTAL	**3,959**	**4,275**	**5,087**	**6,340**	**54%**

* Includes diversions starting in FY 2015 when DBHDS initiated a contract with Poplar Springs.

10-24% | 25-49% | 50-74% | 75-100% | 100%+

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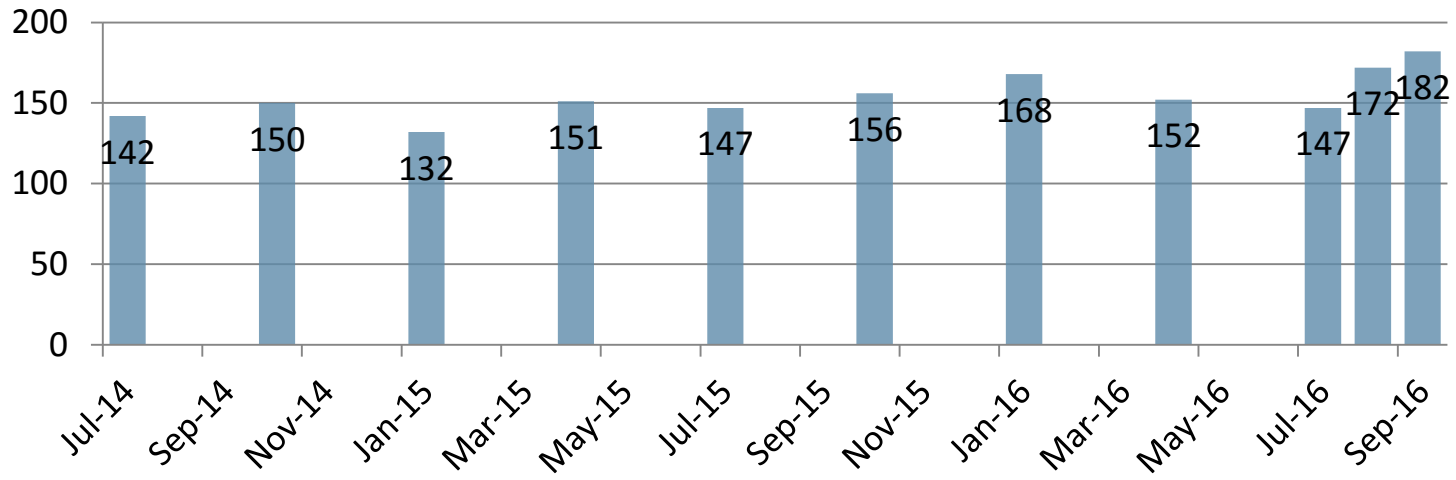
Extraordinary Barriers to Discharge List (EBL)

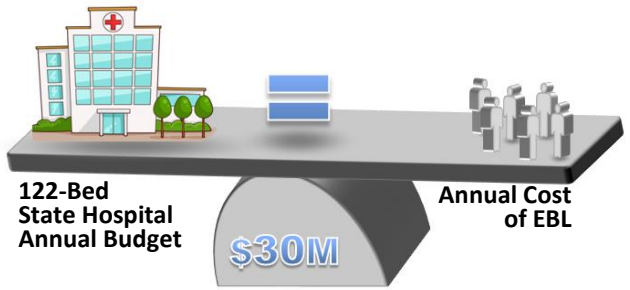
Current EBL Status

There are currently **182** individuals in state hospitals who have been clinically ready for discharge for more than 30 days but appropriate community services are not available to facilitate a safe discharge.

Number of Individuals on the EBL



While costs may continue in the community for those eventually discharged from the EBL and some of the vacated hospital beds may be filled, individuals on the EBL in 2015 used bed days that equate to the operational budget of a 122-bed state hospital, or a cost of about $30 million.



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State Hospital Utilization

	Beds	Aug. 18, 2016	Aug. 20, 2016	Aug. 23, 2016
Catawba	110	97.3	98.2	98.2
Central State	277	89.1	85.6	88.4
Eastern State	302	99.3	99.7	99.7
NVMHI	134	97.8	94.0	90.3
Piedmont	123	99.2	98.4	99.2
SVMHI	72	91.7	88.9	93.1
SWVMHI	179	94.4	94.4	96.6
WSH	246	96.3	92.7	96.7

Forensic Waiting List (Sept. 30, 2016)

Facility	# Waiting	# Waiting Longer Than 7 Days	Notes
CSH	8	4	Three of the individuals are waiting to be assessed by and/or treated by HPR V Jail Team
ESH	11	5	
WSH	2	0	
SWVMHI	0	0	
SVMHI	1	1	
Catawba	0	0	
PGH	1	0	
NVMHI	0	0	
Total	**23**	**10**	

Emergency Evaluators

New Standards and Processes for Emergency Evaluators (July 1, 2016). This joint effort of DBHDS and the Virginia Association of Community Services Boards was not prompted by legislative direction.

- All new emergency evaluator hires must have Masters or Doctorate
- All supervisors must be licensed and have two years experience
- 24/7 access to licensed emergency clinician
- DBHDS certification required
- Required minimum 12 hours supervision annually
- Required minimum 16 hours continuing education
- Formal quality assurance monitoring
- Recertification every two years
- Evaluators lacking new educational requirement must have eight years experience to continue

Improvement Processes at ESH and CCCA

DBHDS is working with state hospitals, particularly Eastern State Hospital (ESH) and the Commonwealth Center for Children & Adolescents (CCCA), to strengthen operations, improve processes and staffing, overcome current survey challenges and reduce risks on future surveys.

ESH Improvements

- Implementing Plan of Correction for ESH's clinical operation (assessment to treatment planning to treatment to discharge planning with a clear focus on resolving clinical issues that prevent discharge).
- 18-Month Goal: ESH will have restored acute psychiatric certification and improve on measures related to the "treatment corridor" of the ESH Plan of Improvement.

CCCA Improvements

- Implement plan for Commonwealth Center for Children & Adolescents to better meet current mission.
- 18-Month Goal: CCCA, in collaboration with CSBs, DSS, and DJJ, will change operational processes to reduce the average length of stay to 14 days.

Updates on

Certified Community Behavioral Health Clinics (CCBHC)

and

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

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CCBHC Service Rankings

CSB	BH Crisis	Screening Assess-ment	Same Day Access	Person Centered Treatment	OP MH and SU	OP PC Screening	Targeted Case Manage-ment	Psychiatric Rehab	Peer Family Support	Armed Forces Veterans	Care Coordin-ation
Chesapeake	2	2	3	1	3	3	1	1	1	3	2
Colonial	3	2	1	1	3	3	1	1	2	2	2
Cumberland	3	3	3	2	3	3	2	1	2	3	3
Harrisonburg-Rockingham	2	2	1	1	3	3	2	1	1	2	3
Mt. Rogers	2	1	1	2	3	3	1	2	2	2	2
New River Valley	2	2	2	1	3	3	1	1	1	2	2
Rappahannock	3	2	2	2	3	3	1	1	1	2	2
Richmond	2	2	2	2	3	1	1	1	1	2	2

Rating System

1 – Ready to implement
2 – Mostly ready to implement
3 – Ready to implement with remediation
4 – Not ready to implement

Cost to Achieve CCBHC Certification

Cost for Eight CSBs to Achieve CCBHC Certification			
	One-Time Costs	Ongoing Costs	New Medicaid Revenue
TOTAL	$6.52M	$38.02M	$20.43M

Important Context:

- Virginia spends $47 per capita on community BH services against a national average of $89 per capita
- Virginia spends 51% of its BH GF dollars in the community versus national average of 75%
- Virginia's total GF expenditure for BH is $92.58 per capita. Ohio is the median at $100.29 per capita.
- Only 50% of individuals served by the CSBs have any form of coverage.

Other State Decisions on Demonstration Grant

- 24 states (including Virginia) received federal grant funds to plan for CCBHCs; of these, eight may be awarded funds for a demonstration grant.
- A number of the states are determining that the cost to the states to achieve certification for its CCBHCs is greater than the enhanced federal match (65%) through the demonstration grant.
- Even if needed GF dollars could be secured through the legislative process, the enhanced match only extends for two years (FY18 and FY19). Then, Virginia would have to make up the difference or revert to prior service levels.
- DBHDS understands that at this time, up to half of the 24 planning grant states have said they do not plan to apply for the demonstration grant for the reasons listed above.

2015 Federal Planning Grant for CCBHCs – Accomplishments

The CCBHC planning grant provided a vehicle to push access, quality, consistency and accountability in Virginia. Major accomplishments include:

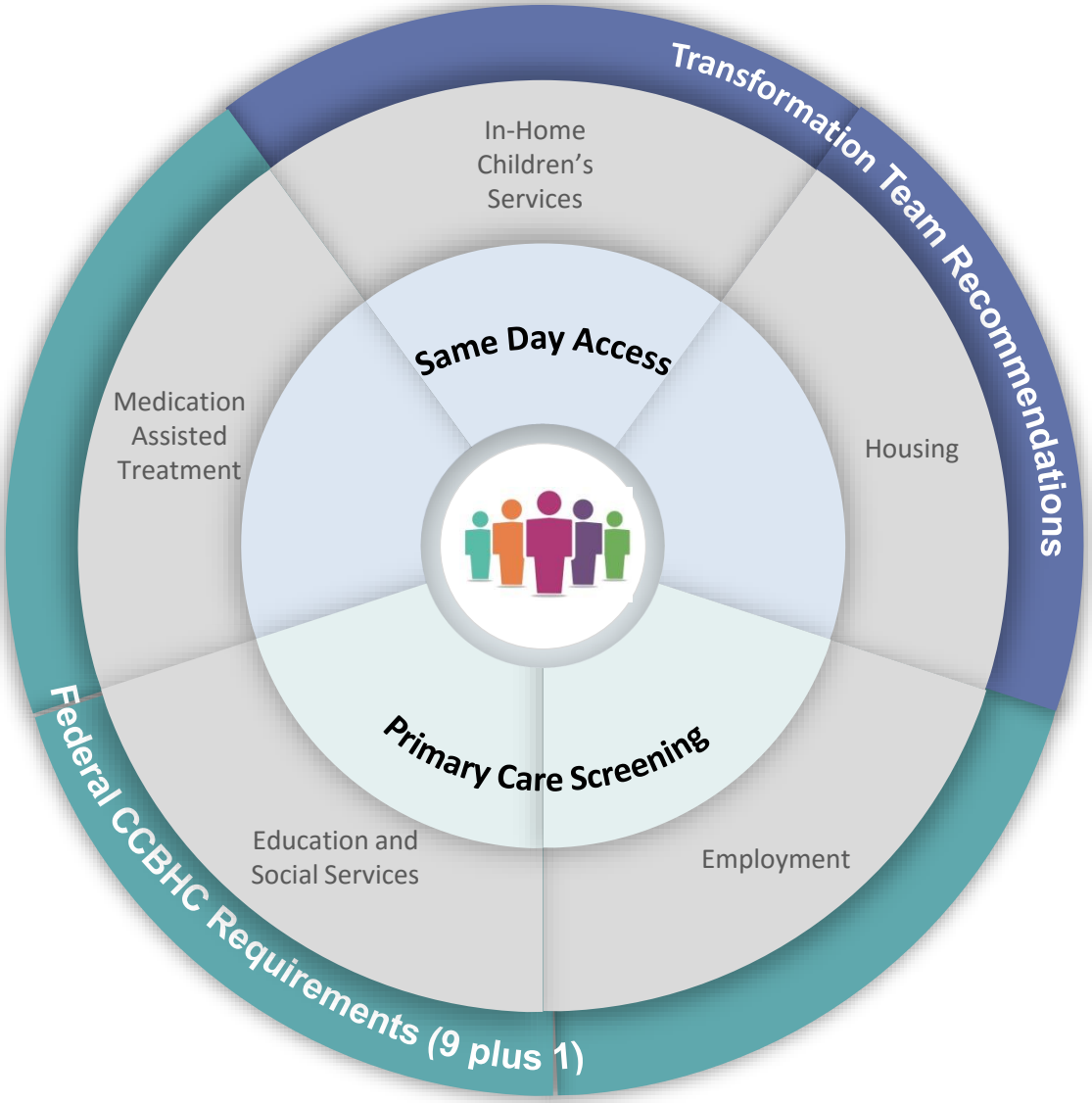
- ✓ Developed a comprehensive definition of core services for Virginia, including best practices
- ✓ Developing cost models to provide specific services at each of eight CSBs
- ✓ Conducted community needs assessment to establish prevalence and penetration rates, identify units of service needed and document gaps
- ✓ Conducted an IT needs assessment relative to data collection and reporting capability required for accountability
- ✓ Delineated service requirements to integrate physical and behavioral health while screening all clients for medical conditions and same day access
- ✓ Solidified agreement for consistent, standardized services easily accessible to all individuals as a shared value and priority for the behavioral health system
- ✓ Demonstrated the DBHDS value of transparency, candor, and purposeful collaboration to CSBs and stakeholders

What Virginia Must Solve

ACCESS	• Must improve access to services across Virginia • Over-reliance on crisis services • ~50% of people served by CSBs lack coverage • Health disparities (geographic, socioeconomic)
QUALITY	• Over reliance on costly institutional care • Consistent implementation of best practices • Meeting Olmstead/ADA- Requiring integrated services
CONSISTENCY	• CSB services vary considerably across Virginia • Size, geography, local funding, reimbursement disparities, local priorities, etc.
ACCOUNTABILITY	• Outdated data infrastructure and reporting • Variances in governance, related to funding streams • Quality/Performance/Engagement

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

- The new system must be made of responsive, consistent community services that do more than address each crisis.
- STEP-VA builds on federal CCBHC requirements and transformation team recommendations with services Virginians need.
- Would provide critical support for individuals at risk of incarceration, those in crisis and those in need of stable housing.
- The result is Virginia-specific to meet current and future needs of Virginians with mental illness and their families.



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Same Day Access (SDA)

- A person calls or appears at the CSB and is assessed the same day. Based on assessment is scheduled for appropriate initial treatment within ten days.
- Is the best lever to begin shifting care away from crisis response when individuals are more at risk for themselves and for others.

- Reflects the critical need to "start at the front door" in terms of standardization and accountability.
- Implementing SDA requires a change in CSBs' business practices, scheduling, documentation, caseload management, and utilization of shorter term, more focused and practical therapies.
- Addresses two critical principles of recovery: HOPE and CONNECTION (to helpful others).
- Best practice that virtually eliminates "no show" appointments, increases adherence to follow-up appointments, reduces the "wait time" for appointments, and makes more cost-effective use of staff resources.

Example of Funding Timeline With Cost Estimates

An example timeline for funding services based on needs assessment and gap analysis:

Service	FY 2016-2018		FY 2018 – 2020		FY 2020 – 2022	FY 2022 – 2024	FY 2024 – 2026
Same Day Access	FY17: $1.5M GF	FY18: $12.3M GF	FY19: $17.3M GF (ongoing)				
Primary Care			FY19: $3.72M GF	FY20: $7.44M GF (ongoing)			
Peer Services			Fund at 100%				
Medication Assisted Treatment			Fund at 33%		Fund at 100%		
In-Home					Fund at 100%		
Outpatient					Fund at 50%	Fund at 100%	
Detoxification					Fund at 50%	Fund at 100%	
Rehabilitative Services						Fund at 50%	Fund at 100%
Mobile Crisis							Fund at 100%

Justice Involved Transformation Team

- Crafted by system stakeholders during an intensive, two-year process, which ended in 2016.
- Implementation for 22 justice involved recommendations is targeted over a six year period.
- The following recommendations have already been implemented:

Recommendation	Implemented
There needs to be an oversight system of evaluators who conduct pre-trial evaluations to ensure the evaluations meet the standard of practice: • Only evaluators who meet a minimal standard of practice should be allowed to conduct pre-trial evaluations. • For evaluators who produce poor evaluations, there needs to be a system of remediation.	• HB 582 passed in 2016 to create oversight system of pre-trial evaluations. • DBHDS has reached out to courts, commonwealth attorneys, and public defenders to acquire the names of evaluators providing court appointed evaluations and has implemented an application process.
Judges need to receive education on the Risk Need Responsivity model of risk management. Judges need to better understand the screening process, what the research shows about the positive effect of diverting low-risk offenders, and to be trained in how to use the risk screening as a guide in determining level of supervision.	In 2015 DBHDS received a federal grant and sponsored a Risk Need Responsivity conference for 150 people.

Justice Involved Target One Recommendations
(Implementation Targeted During 2016 – 2018)

Recommendation	Actions Taken
Discharge planning services should be available and/or standardized services for incarcerated individuals, including: application for resumption of benefits; assistance in locating affordable, safe housing; aftercare appointment for mental health services with strong preference for same day access; "Warm" handoff from jail to community treatment provider.	
A system for the prompt screening, assessment, and identification of justice involved individuals with BH and/or ID issues needs to be in place in every jail, detention center, and correctional center.	• DCJS has received funding for jail based mental health pilot projects.
Develop mechanisms for notification (upon entry) and ongoing communication between jails/detention centers/correctional centers and CSBs to allow more seamless transition for individuals from jail/detention centers/correctional centers back to the community.	• Last session bills passed to improve communication between Courts and providers/evaluators. • Working with DCJS on jail based mental health pilot projects. DBHDS is collaborating with DCJS on this project.
Localities should be supported in developing mental health dockets as part of problem solving courts: • Dockets should include MH, SA, and Veterans • Need to identify ongoing funding to support dockets • Need funding to purchase services, for housing, and for transportation.	• GA required DBHDS to study and make recommendations about problem solving courts; also allocated funds to DBHDS to expand Permanent Supportive Housing initiative. • In 2015 DBHDS received a federal grant to support 1-2 behavioral health dockets starting in October 2016.
Do not dictate provider of jail/detention based services, but instead set minimum standards for services: 1. Every jail should have 1+ employee with primary job to aid in coordinating release planning. 2. Each CSB should have 1+ employee with primary job to coordinate release planning for individuals leaving jail and needing follow up services from the CSB. Funding is required.	• Working with DCJS on jail based mental health pilot projects. • DBHDS initiated an MOU (4/1/2016) between VADOC, DBHDS, and all 40 CSBs on discharge planning for individuals with mental health issues who are being released from VADOC facilities.

Justice Involved Target Two and Three Recommendations
(Implementation Targeted During 2018 – 2022)

- 15 more justice involved team recommendations are targeted during 2018-2022.
- Examples of Target Two and Target Three recommendations include:

Target Two Examples(2018-2020):

- There should be CIT and CIT Assessment Sites within reach of every Virginia jurisdiction.
- Crisis Stabilization Programs should be integrated into the emergency response network and should be expanded to include possible admission of individuals destined for incarceration.
- A follow-up appointment with a psychiatrist should be scheduled prior to justice-involved individuals' release from jail/ detention centers/ correctional centers.

Target Three Examples (2020-2022):

- Develop a way to ensure individuals can either receive the medications they were receiving prior to incarceration and/or a mechanism for prompt psychiatric assessment with resulting prescription for medications (when needed).
- There needs to be continuity of medical insurance coverage during incarceration to allow for better transition back to community upon release (i.e., immediate coverage of medications upon release as well as offset the cost of treatment in jail).

What STEP-VA Can Address

ACCESS

- ✓ Regardless of ability to pay (sliding scale fees) and place of residence
- ✓ At convenient times & places
- ✓ Prompt intake & engagement in services
- ✓ Crisis management 24/7/365
- ✓ Prioritizes children, veterans, SED, SUD, SMI

QUALITY

- ✓ Evidence-based practices
- ✓ Improved coordination and integration
- ✓ EHR/Data-quality improvement, reducing disparities & research
- ✓ Person/family centered, trauma informed,
- ✓ Culturally competent
- ✓ Recovery oriented care

CONSISTENCY

- ✓ Specific required services
- ✓ Uniform definition of services
- ✓ Full array of services for mental health & substance abuse needs
- ✓ Basic primary care assessment and linkage
- ✓ Important support services

ACCOUNTABILITY

- ✓ Know what we are paying for, services provided, number of individuals served
- ✓ Expanded and improved data collection
- ✓ Uniform metrics, outcomes
- ✓ State certification required

What Virginia's Transformed System Can Deliver

Decreased

- Psych & Medical Hospitalizations
- Emergency Department Visits
- Incarcerations
- Homelessness
- Premature Mortality/Suicides

Increased

- Individuals w/ SMI in Stable Housing
- Primary Care Visits
- Person Centered Care (improve engagement)
- Trauma Informed Care (Improve Engagement)
- Cultural Competence (Improve Engagement)
- Improved Data Collection

- Special focus on Veterans, SMI, SED, SUD
- Consistent Service Array
- Maximized Access to Services and Numbers Served
- Better BH Outcomes
- Lower Cost/ Higher Quality
- Common Metrics
- Pay for Performance