Virginia Department of Behavioral Health & Developmental Services

DBHDS Update on Behavioral Health System Reform Efforts

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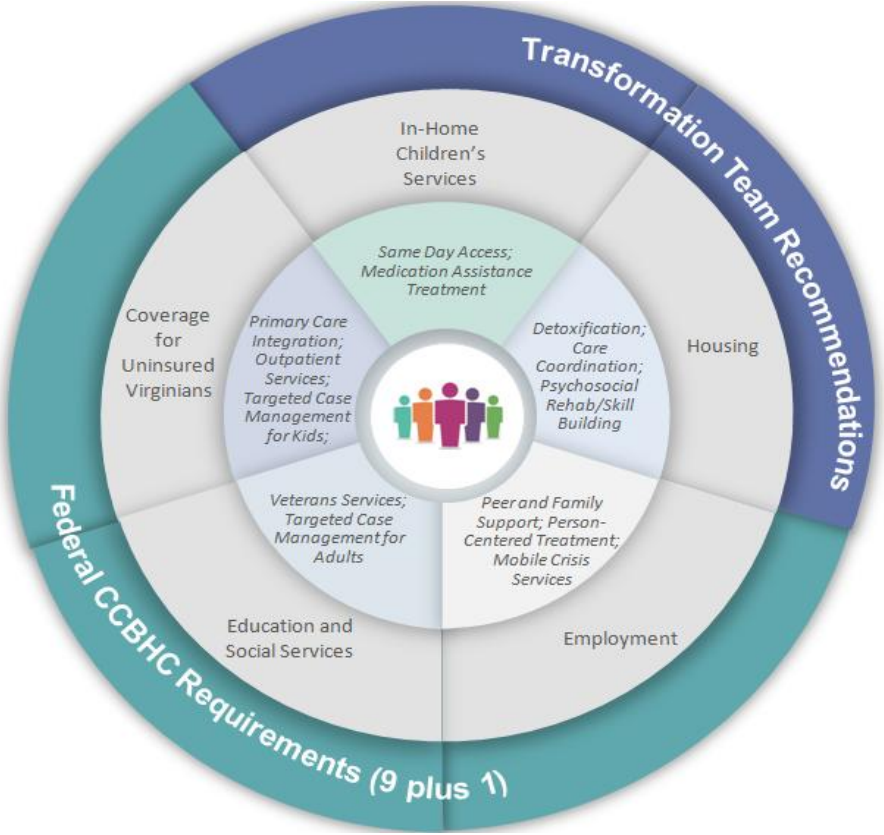
System Transformation, Excellence and Performance in Virginia (STEP-VA)



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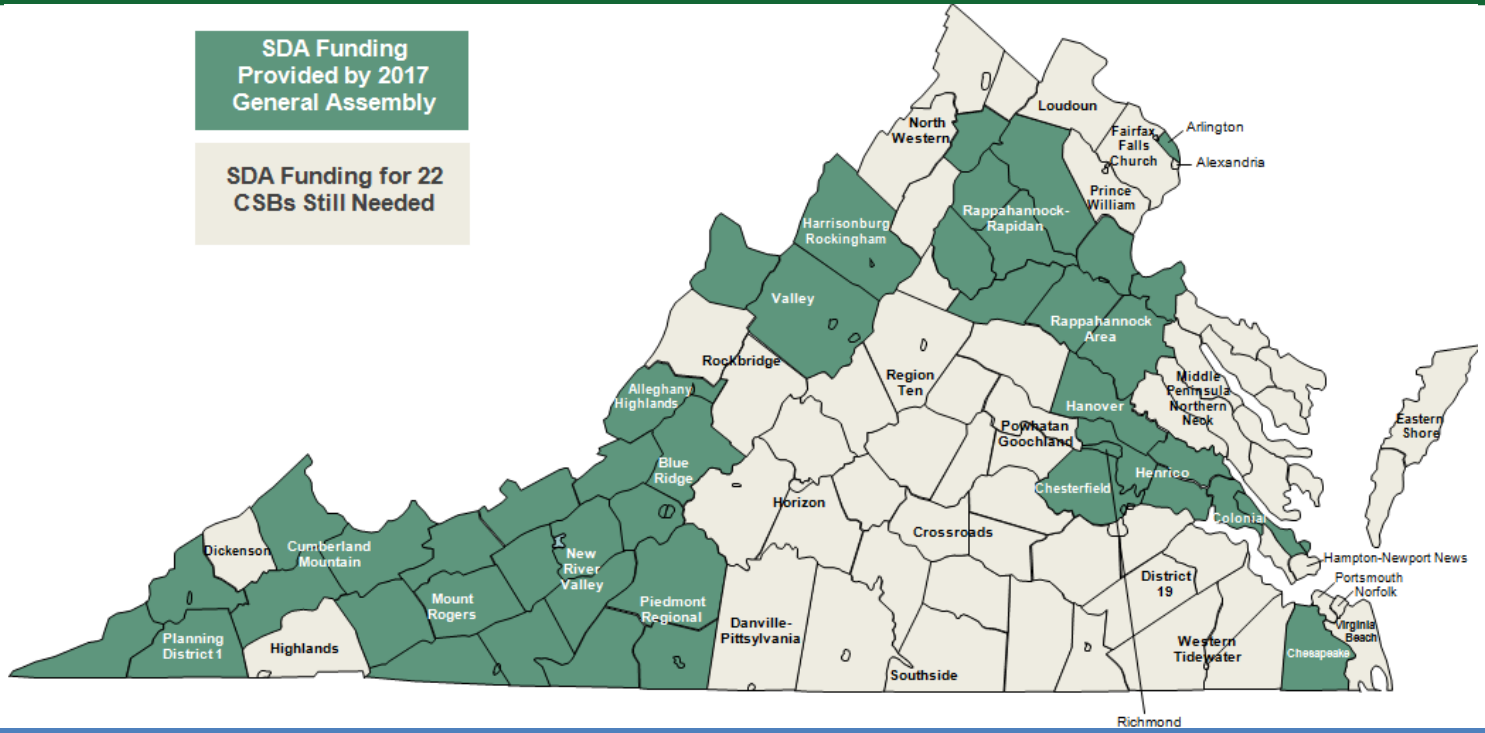
18 CSBs to Receive FY 2018 Same Day Access Funding



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

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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

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 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 ..translates to a **13-30 year shortened life expectancy** in SMI patients…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	**2017:** $4.9M GF / $4M NGF (GAP); only covers 18 of 40 CSBs
Primary Care Integration	July 1, 2019	–
Behavioral Health Crisis Services	July 1, 2021	–
Outpatient Behavioral Health	July 1, 2021	–
Psychiatric Rehabilitation	July 1, 2021	–
Peer/Family Support Services	July 1, 2021	–
Veterans Behavioral Health	July 1, 2021	–
Care Coordination	July 1, 2021	–
Targeted Case Management (Adults and Children)	July 1, 2021	–

Behavioral Health Services for Uninsured Virginians

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 for both Medicaid members and the uninsured.

3) Address the bifurcated funding streams for CSBs and state hospitals to better align services with needs and achieve better cost efficiency.

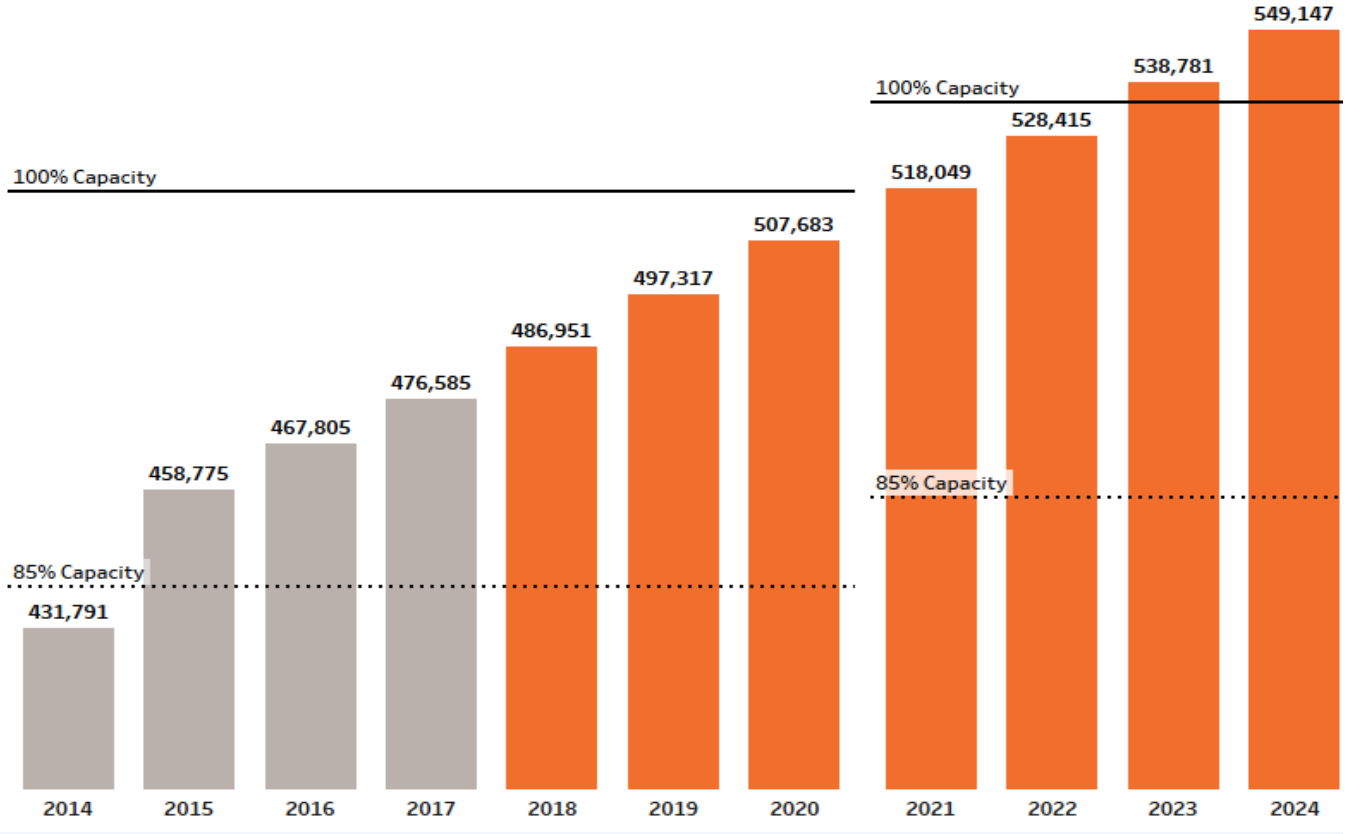
Cost of Business as Usual

	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)		1474 Beds	
Census*	1347	1375	1404	1432	1460	1488	1516**
Utilization	95%	97%	99%	97%	99%	101%	**103%**
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 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 2% 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.

Projected Bed Day Usage Increase, Business as Usual
(By Fiscal Year)



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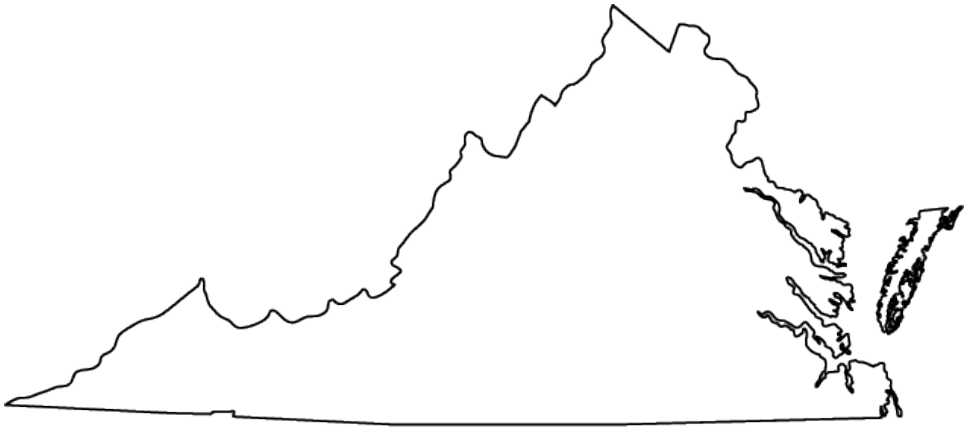
Emergency Evaluations and Temporary Detention Orders

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	TDOs Admitted to Private Hospitals
FY 2015	83,701	24,889	29.7%	(91.2%) 22,687
FY 2016	96,041	25,798	26.8%	(86.5%) 22,322
FY 2017	93,482	25,852	27.7%	(84.6%) 21,861

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 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 discharged or diverted from admission;*

iv. *financial incentive for CSBs 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 CSBs;*

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

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

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

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+)

Realignment Rationale

- Dollars are presently tied up in state hospitals supporting individuals no longer requiring an inpatient level of care and are NOT available to communities to develop and maintain less costly and more appropriate community placements and supports.
- Re-alignment would send dollars to CSBs up front and they would pay for community placements and state hospital beds as needed.
- This would create the opportunity in communities to develop placements and create “financial motivation” in communities and state hospitals to support people in the “least restrictive” or most “integrated” settings possible.

Realignment Requirements

- Identify start-up funding in the community to acquire property, do renovations, identify apartments, hire and train staff.
- Avoid impact on any local funds consistent with purpose of better managing state general funds.
- Manage financial risk in communities and state hospitals.
- Develop consistent funding formulas (as possible) while taking into account wide variations in bed utilization, average daily census, and differences in localities.
- Build community capacity first (based upon review of what other states have done).
- While it is not possible to perfectly anticipate the funding must be sufficient to produce the capacity.

Two Plans Currently Being Examined

Option 1

All 40 CSBs are included by FY 2020

Option 2

Phase-in during the next biennium with ten CSBs; the rest to follow in the next biennium

Options feature $200,000 per each annual census reduction (365 bed days) and target census reduction of 100 statewide by FY 2020 for Option 1 or by FY 2022 for Option 2.

State Hospital Census FY 2014 and FY 2017
(1st Day of the Month Census)

	CH	CSH	ESH	NVMHI	PGH	SVMHI	SWVMHI	WSH	Average
FY 2014	86%	66%	88%	97%	90%	93%	92%	86%	**87%**
FY 2017	94%	86%	100%	86%	97%	90%	94%	95%	**93%**

55-69%	70-84%	85-99%	100%+

A census of **85%** or lower is considered safest for both patients and staff

Workforce Challenges

- Direct care staff turnover is the highest turnover rates in 10 years, a huge issue for managing state hospital census.

State Hospital Staffing Vacancy Rates – July 2017

	CAT	CSH	CCCA	ESH	NVMHI	PGH	SVMHI	SWVMHI	WSH
Direct Care DSAs	18%	10%	19%	30%	7%	35%	11%	6%	0%
Direct Care RNs	26%	24%	50%	27%	14%	39%	12%	12%	27%

- The average salary trails the national market. Hospitals are facing staffing shortages and overtime is increasing as a result.
- RN vacancy rate across nine hospitals is 25.7%; Direct Care vacancy rate is 16.8%.
- CSBs are losing case managers to the Health Plans who are paying $10-15,000 more along with other incentives. “Pay not equal to workload" was among the top five reasons cited for leaving a case management position.

CSB Summary of Identified Needs

In July 2017, DBHDS requested that CSBs identify strategies and resources for reducing state hospital utilization.

Crisis Services	Housing	Services and Supports
Crisis stabilization and detoxification units, mobile crisis teams, expanded contracts with private hospitals	Permanent supportive housing, transitional group homes, intensive residential settings, assisted living facilities	In-home supports, jail based services, clinical support for nursing homes, discharge planning for private hospitals, increased use of peer support services, case management, outpatient therapy, PACT teams, psychosocial programming, and increased access to outpatient psychiatry

Basic Concept by Fiscal Year

Year One

- Fund the build-out of community capacity.
- As capacity increases, individuals are discharged from state hospitals when clinically ready, causing the state hospital census to decrease by target number of individuals.
- When hospital units can be closed, hospital flexible spending can be reduced.

Year Two

- CSBs begin purchasing state hospital beds.
- Hospital flexible funds made available by unit closure can be transferred to CSBs to help provide ongoing support for the new community capacity.
- CSBs may be able to retain more funds by further limiting utilization only to those who can only be safely served in the state hospital.

Year Three

The realignment is established, but is not static. Project annual increase in demand costs of $2 million each year statewide.

Financial Realignment

NEED	State hospital census must decrease and utilization must be based on clinical need for this level of care
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
GOALS	• Manageable state hospital census • 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.

Targets

State Hospitals

- Larger hospitals with high bed use rates would reduce bed capacity by one operating unit to achieve the savings needed for community investment.
- Smaller hospitals would operate at 88% or less of capacity.
- Long-term statewide EBL reduction, especially for those on EBL>90 days.

CSBs

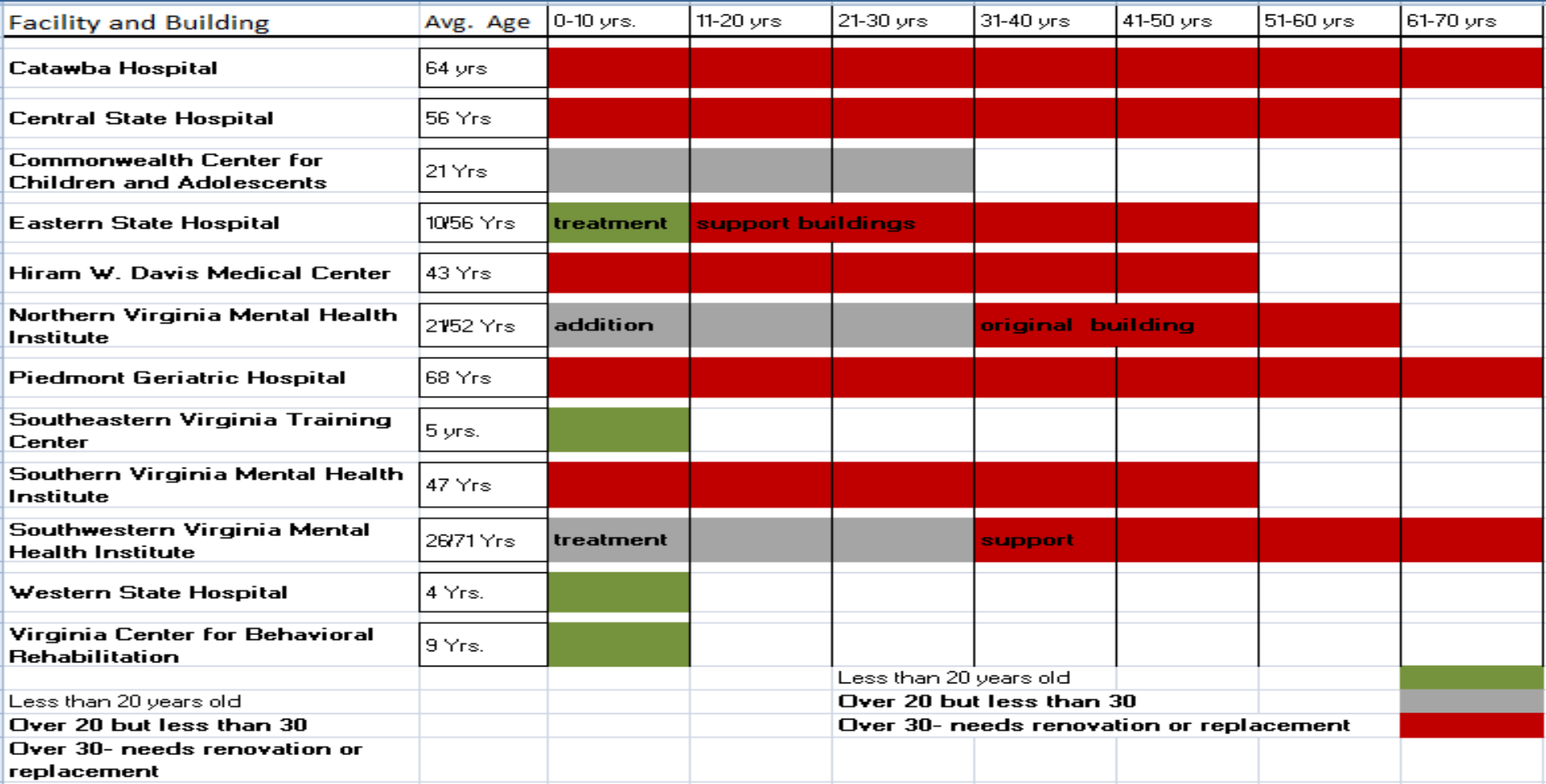
(Usage of beds per 100,000 for adult population, excluding most NGRIs)

- Less than 4 beds/100,000 – No bed reduction; however, could use funds at discretion to drive use even lower.
- Average daily census (ADC) less than 4: No reduction.
- Target census reduction based on bed use/100,000 and ADC.
- Purchase bed days above target census. Refund days below target census on monthly basis.

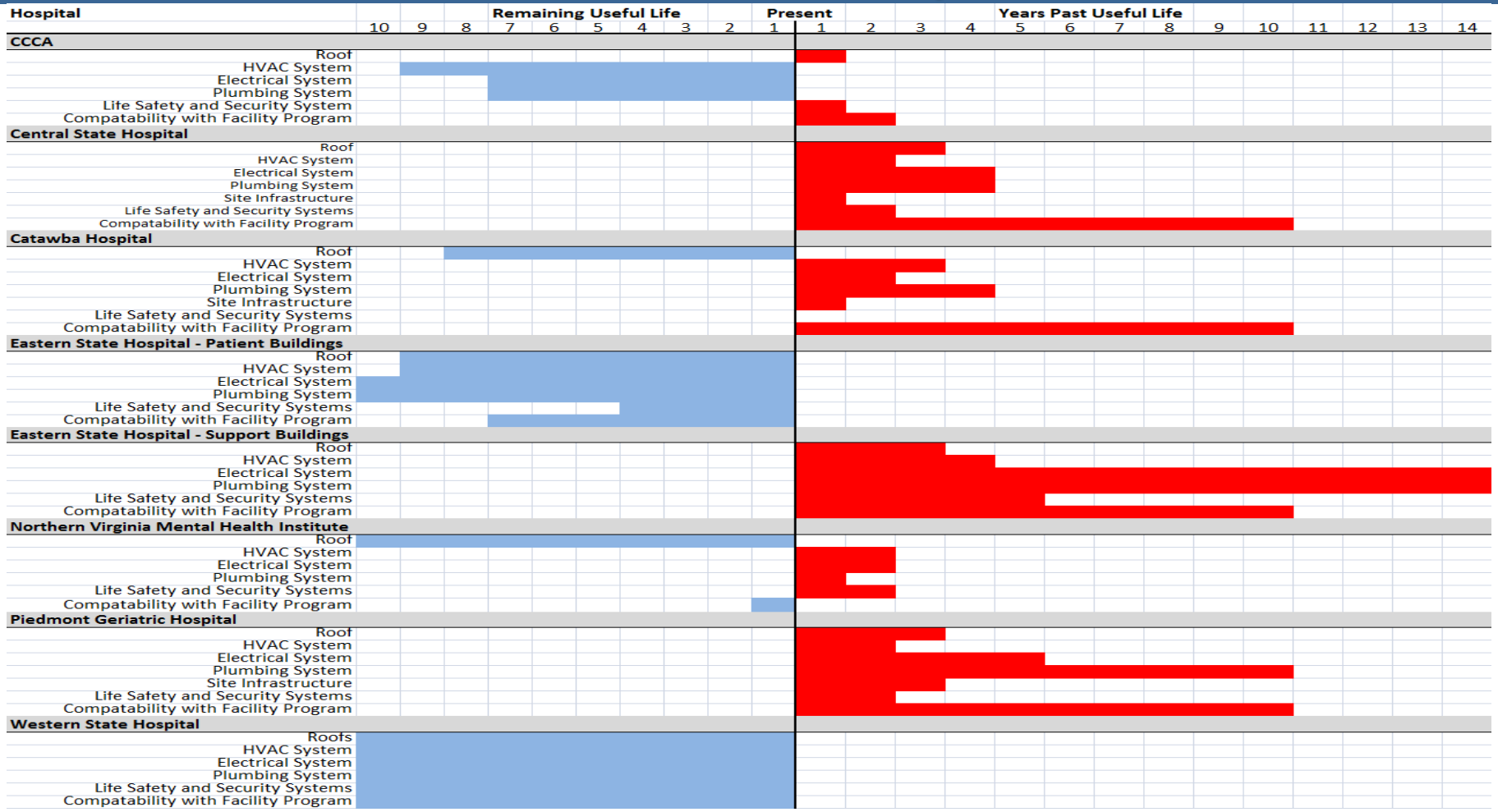
Impact on Business as Usual

- Reduces the number of individuals no longer needing a hospital level of care and decrease the amount of time individuals wait on the Extraordinary Barrier to Discharge List (EBL).
- Helps build the placement and support capacity in the community system, addresses infrastructure critical to making STEP-VA a success on the service capacity side, and helps shift the balance of state spending in the direction of what is seen in other states.
- Reduces state hospital utilization closer to best practice rate of 85%.
- The number of beds required in state hospitals would be determined by actual need rather than history or “guesstimates.”
- Avoids spending similar amounts of money over the next 5-6 years on ever more hospital beds and hospital staff.

Age of Facility Structures



Useful Life Analysis



Jail Waiting List
(August 30, 2017)

Hospital	# Waiting	# Waiting Longer Than 7 Days
CSH	4	0
ESH	3	0
WSH	1	0
SWVMHI	1	0
SVMHI	0	0
Catawba	0	0
PGH	0	0
NVMHI	0	0
Total	**9**	**0**