

Envisioning Mental Health Services in the 21st Century: Goals and Challenges

Progress Report to the Joint Subcommittee and Recommendations for Legislative Consideration in 2018*

Expert Advisory Panel on System Structure and Financing

**Presented by Richard J. Bonnie, Chair
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* This report, submitted on behalf of the entire Expert Advisory Panel, identifies priorities for the upcoming session that have emerged from the work of all four advisory panels and summarizes the advice and intentions of the Panel on System Structure and Financing.

I. INTRODUCTION

The Joint Subcommittee is charged with making recommendations to the General Assembly on how best to transform the Commonwealth's public mental health services system to assure that services are available and accessible to Virginians of all ages in the communities where they live. Three central goals identified by the Joint Subcommittee are (1) to provide a responsive system for evaluating and assisting individuals experiencing a mental health crisis; (2) to provide a timely and effective continuum of outpatient mental health services to enable people to address their mental health challenges and thereby prevent crises; and (3) to provide integrated health and behavioral health services, including housing and other needed living supports, to persons with serious and persistent mental illness, who tend to experience the greatest instability and the most frequent and serious crises requiring behavioral health and criminal justice interventions. Establishing accessible community services statewide will enable the Commonwealth to substantially reduce its investment in maintaining and operating state hospitals for crisis mental health admissions. State hospitals instead will focus on forensic patients (for evaluation and restoration to competency to stand trial, and treatment of those adjudged NGRI), and treatment of those with severe afflictions that cannot be safely served in the community.

The importance of achieving these changes in the operation of the public mental health system has been emphatically reiterated in successive studies by the General Assembly for four decades. Some progress has been made. The state hospital share of state general funds devoted to mental health has been reduced from nearly 70% to about 50% over the last decade. However, the proportion of public mental health funds devoted to state hospital care (which treats only 3% of the individuals receiving care in the state's public mental health system) remains considerably higher in the Commonwealth than in the vast majority of our sister states, where the average is less than 23%. The imbalance is also reflected in the relative paucity of state general funds allocated to community services (\$47 per capita in Virginia compared with \$89 per capita, on average, among the other states).

Rectifying this imbalance in funding for state hospitals and community services has long been the declared aim of the Commonwealth's mental health policy. However, it is now also an urgent fiscal priority. It has become clear that a transformed system cannot be achieved solely through a piecemeal investment in community services "as available funds permit." First, our state hospitals are facing an unprecedented surge in admissions and an increasing number of patients awaiting discharge without suitable community placements. Second, capital costs for maintaining the current and expected hospital capacity are projected to run into the hundreds of millions of dollars with 50% of hospitals currently operating years (and even decades) beyond their useful life. In other words "business as usual" is not sustainable without a huge investment in state hospitals at the very time that the Commonwealth intends to (and needs to) invest heavily in community services and supports.

An urgently needed short-term infusion of resources is necessary to stabilize the current situation and to put in place the conditions required to permanently reverse the unsafe and unsustainable trajectory of state hospital admissions. If we do not reverse the trajectory of state hospital utilization, we will undermine the transition to the community-based system that

the Commonwealth has been haltingly pursuing for several decades. Several specific stabilizing actions for consideration during the upcoming 2018 session will be identified below.

At the same time, the Commonwealth needs to continue to reaffirm its commitment to incremental expansion of the community capacity that will enable state hospitals to be gradually downsized, thereby allowing the “savings” from reduced state hospital utilization to be reinvested in community services and supports. The basic policy components of a plan for building the community system will be outlined below. The first component of this plan is STEP-VA, the vision of statewide community mental health services that the General Assembly embraced in 2017. The overall plan will be fleshed out by the Joint Subcommittee over the next two years.

In short, mental health reform in Virginia requires an immediate response as well as a strategy of gradual system transformation. We must make urgently needed improvements while continuing to implement a long-term plan for reform.

II. ACCESS TO SERVICES AND SUPPORTS

- A. STEP-VA
- B. Tele-Mental Health
- C. Housing and Support
- D. Safe and Effective Crisis Care
 - Safe and Respectful Transportation
 - Reducing TDO Admissions, Particularly to State Hospitals
- E. Services for Criminal Justice Population

A. STEP-VA

STEP-VA aims to establish the necessary capacity in every community to provide integrated behavioral health and health services to persons who lack health insurance and those who are underinsured. The General Assembly has already committed itself to the vision of services represented by STEP-VA. *Full funding to enable all community services boards to provide “same day access” and primary care screening by July 1, 2019 is a critically important first step in building a robust statewide community mental health services system. The “next step” funding for these services is \$13.4 million in FY 2019 and in FY 2020.*

B. TELE-MENTAL HEALTH

The Panel regards expanded use of tele-mental health services as an essential element of implementing STEP-VA. First, it is the only feasible way of reaching under-served communities. In the poorer and more rural communities of the state in particular, long distances and limited resources make it difficult to reach individuals needing mental health care. As a result, many individuals are not served until there is a crisis. It is important to develop, expand and strengthen

the tele-mental health network, so that physicians, nurse practitioners, and other health care providers can use tele-conferencing to reach patients directly for evaluation and care, and can “extend” mental health services by providing consultation services on the mental health needs of patients to primary care providers and others.

In addition, tele-mental health services are needed to improve emergency services, discussed below. In rural, urban and suburban communities, there is a shortage of emergency psychiatrists. Tele-mental health services can link community providers to psychiatric experts for consultation and even direct care to address the needs of individuals in crisis. In addition, tele-mental health services can enhance the ability of CSB evaluators to reach people in crisis in a timely manner for evaluation.

While many CSBs currently use tele-mental health services for limited purposes, many need additional financial support to enable them to complete needed infrastructure for these services and to train providers. ***Building the service infrastructure for providing tele-mental services is a high priority.*** Professionals who use technology to provide services must have the knowledge and skills to provide such services in a competent and safe manner. Although competence can be gained through a variety of methods, such as through supervision and peer observation, most mental health professionals have not been exposed to tele-mental health in either their professional education programs or in their practice settings. Until such a time when tele-mental health becomes a standard part of the curriculum in training programs, clinical practicum rotations and/or internship programs, the fastest way to ensure that providers obtain the needed competencies is through a formal training program. Fortunately, training modules that address topics such as presentation skills, HIPAA, laws and ethics, crisis planning and protocols already exist. A modest investment would ensure that the content stays current, relevant and enjoyable for the end-user and incentivize their participation.

An Expert Advisory Panel work group on tele-mental health was formed to develop a blueprint for policy proposals designed to remove impediments to greater use of tele-mental health services. The Policy Framework that was developed centered around barriers across six problem areas or domains. These included: Provider Barriers, Workforce Barriers, Financial Barriers, Patient/Client Barriers, Policy Barriers and Preventive Care Barriers. Twenty-nine policy initiatives/options were identified within the Policy Framework, twelve of which were put forth for priority consideration. The Joint Commission on Health Care (JCHC) has been conducting a two-year study of the work group’s report, with a focus on the twelve priority recommendations. See the Work Group’s report listed in the appendix and accessible on the SJ 47 webpage. Four of those twelve recommendations are now being put forth by the work group for funding within the 2018-2020 biennium budget as the ***“Appalachian Tele-mental Health Network Initiative (ATMHN) – Virginia Pilot”*** at an estimated cost of \$1.1 million per year for three years. The JCHC issued an interim report on November 21, 2107. The report provides an overview of current laws and regulations regarding tele-mental health and explains how these four actions would work synergistically to solidify and support a tele-mental health services structure in western Virginia.

The SJ 47 Panel on System Structure and Financing agrees with the tele-mental health work group and the JCHC interim report that the proposed Appalachian Tele-mental Health

Network Initiative is amenable for legislative action and merits consideration as a priority item in mental health reform in the 2018 session of the General Assembly. We say this for several reasons: (1) lack of timely access to needed mental health services is a challenge and a problem throughout the Commonwealth of Virginia, but it is most acute in rural southwest Virginia where mental health, behavioral health and substance abuse services are characterized by a lack of availability, acceptability and accessibility; (2) there is consensus among providers regarding both the need for and proven efficacy of these initiatives; (3) the current opioid crisis makes it increasingly urgent that action be taken now, rather than later; and (4) the costs of these initiatives are modest compared with their potential benefit.

C. HOUSING AND SUPPORT

The Commonwealth aims to establish and maintain broad access to permanent supportive housing (PSH) for persons with serious and persistent mental illness as well as transition housing and supports for persons who are discharged from psychiatric hospitals and need a temporary community placement while awaiting placement in permanent supportive housing.

During the 2017 GA Session, two budget items were adopted at the request of the Joint Subcommittee. One increased funding for PSH (from \$4.27 million per year to \$9.27 million per year in FY17-18); this funding is administered by DBHDS. Additionally, budget item 108 #1c (Housing Strategies for Mentally Ill Virginians) directs the Virginia Department of Housing and Community Development (DHCD) along with several other relevant state agencies, stakeholders, and advocacy groups (NAMI, VHA, and Virginia Sheriff's Association), to develop and implement strategies for housing individuals living with serious mental illness (SMI), as well as to recommend ways to finance housing and housing supportive services. Following the 2017 Session, DHCD has partnered with the Virginia Housing Development Authority (VHDA) to facilitate interviewing, discussing, and drafting recommendations for increasing housing opportunities and financing housing supportive services for individuals living with SMI. We expect that the DHCD/VHDA work group will recommend increases in state allocation for PSH and additions to the Virginia Housing Trust Fund, as well as ideas for streamlining allocation and use of PSH related funding and resources.

As noted above, the Commonwealth is facing an immediate challenge is finding transition placements for many patients ready to leave the state hospitals while the availability of PSH is being increased. ***For the upcoming session, DBHDS has proposed a multi-year “community integration plan” designed to reduce extraordinary barriers list (EBL) from 170 to 88 in two years and then on a continuing basis. Funding the community integration plan is needed whether or not the proposed “fiscal realignment” plan (discussed below) is implemented.***

D. SAFE AND EFFECTIVE CRISIS CARE

A key component of STEP-VA is ***safe and effective crisis care.*** Virginia's system for providing crisis services, and the legal framework within which it operates, have been under nearly constant scrutiny since the Virginia Tech tragedy in 2007. Numerous reports have been

written and a sequence of useful changes have been adopted to carry out well-considered recommendations – to expand available services and to modify the legal requirements so as to facilitate needed treatment and respect legal rights.

The most dramatic legal change since those of 2008 occurred in 2014, when the General Assembly enacted legislation requiring that state psychiatric hospitals serve as a guaranteed “placement of last resort” for individuals under an emergency custody order (ECO) found by CSB evaluators to meet the criteria for a temporary detention order (TDO). Statutory authority to hold a person under an ECO expires after 8 hours, and the person cannot be kept in custody any longer unless the evaluator from the local community services board has examined the person and recommended to the magistrate that a Temporary Detention Order (TDO) be issued to authorize temporary psychiatric hospitalization of the person (until an involuntary commitment hearing can be held within the following 72 hours). Before the magistrate can issue a TDO, a psychiatric hospital willing to accept the person must be identified and named in the TDO. If no private psychiatric hospital willing to take the person can be found within those 8 hours, a state psychiatric hospital must accept the person.

While this 2014 guarantee has served to ensure the safety of individuals who are in mental health crisis and who might otherwise leave the hospital at the expiration of the ECO, this guarantee has also been accompanied by a steady rise in the number of individuals being TDO’d to state hospitals and in the overall number of TDOs. The patient census in several state hospitals is approaching 100% (studies show that quality of care begins to deteriorate when the hospital census exceeds 85%). In addition, increasing numbers of individuals now have to be transported across the state, hundreds of miles from their home, just to reach an available hospital bed.

Virginia’s 8-hour evaluation period for individuals who are experiencing a mental health crisis is among the briefest in the nation. It also appears that Virginia may be the *only* state that guarantees that a state hospital will accept an individual under a TDO if no private psychiatric hospital will do so within a specified time. While private psychiatric hospitals accept the vast majority of the individuals for whom TDOs are issued in Virginia, it appears that the total percentage of TDOs that the private hospitals statewide have accepted, as well as the absolute number of patients that they have accepted, have declined since the “last resort” law went into effect. The reasons for this decline are not altogether clear and the Panel and the ILPPP research team are investigating the matter as part of their broader inquiry regarding the trends in evaluations and TDOs and other aspects of the emergency evaluation and crisis services system.

The Expert Panel on Crisis Response and Emergency Services, over the last 18 months, has been considering changes in the public mental health services system that could reduce the frequency and severity of mental health crises, and those that could best enable individuals who are in crisis to obtain the help they need in the timeliest and least restrictive manner possible. Among the topics being considered by the panel are the following:

- New service models to divert patients from emergency departments and acute care admissions

- New arrangements with private hospitals to divert patients who need acute hospitalization from state hospitals
- Modified legal structure that facilitates expedient crisis response and avoids unnecessary hospitalization and reduces length of stay if short-term hospitalization is needed
- System-wide Crisis Intervention Team (CIT) training and response
- Safe and respectful transportation

Over the coming year the Panel will develop a more complete vision for emergency services in Virginia. However, the current stresses on the system, and the difficulties now being encountered in efforts to mitigate them, suggest that legislative action may be indicated in several areas to create more favorable conditions for the fundamental changes that are needed in the long term.

Safe and Respectful Transportation

One priority is to take the next step in developing and implementing an alternative model to the state’s current use of law enforcement officers to provide transportation to psychiatric facilities for persons in crisis. The goals of such a model include not only reducing the trauma and stigma experienced by many individuals who experience law enforcement transport as “criminalizing” them, but also relieving law enforcement from an obligation that is becoming increasingly time-consuming and burdensome, especially for smaller and rural departments. The General Assembly requested an interagency study on this issue last year reviewing the experience of other states as well as the evidence derived from a pilot project being conducted by the Mount Rogers CSB within a catchment area covering 5 additional CSBs. The study concluded that transportation for most persons experiencing a mental health crisis and placed under a TDO can be safely provided by properly trained non-law enforcement providers. However, the study’s report estimated the cost of doing so at \$10.2 million per year, and, while it cited the relief that this will provide to law enforcement, the report did not calculate the savings that law enforcement will experience in reduced “opportunity costs” (in crime control and other law enforcement functions) from being able to devote officers to community protection instead of mental health transportation. (The current research techniques may not yet be available to offer specific figures on cost savings, but law enforcement leaders can confirm that they are real and substantial.)

The Emergency Services Panel believes that the Task Force report’s estimated cost of providing the service statewide could be reduced, even without taking opportunity costs into account. The Panel also submits that it is imperative to take concerted action to ensure that children in mental health crisis do not have to experience law enforcement transport, in which children currently find themselves in handcuffs (and sometimes shackles) when being taken to the hospital for treatment. ***The Panel strongly recommends that the General Assembly fund two expanded pilot projects for non-law enforcement transportation for both children and adults during the upcoming biennium, accompanied by changes to the Code that would facilitate efficient and effective implementation of this vitally important reform. The estimated cost of doing so is no more than \$1.5 million annually.***

The Code changes needed to implement the pilot projects efficiently are specified in the report of the Transportation Work Group, “Decriminalizing Transportation for Children and Adults in Mental Health Crisis in Virginia: Proposed Next Steps.”

As further explained in the Work Group report, there are several pressing reasons to take the next step in implementing alternative transportation in the Commonwealth this session. Doing so will capture the sunk costs of a previous pilot and will gather better data on the safety and cost of what everyone agrees is a necessary reform.

1. Political will and stakeholder engagement and buy-in are high. The Mount Rogers pilot concluded October 31st. Law enforcement officials in that community are already feeling the effects of losing that service and strongly support continuation of the pilot. In the Region 10 catchment area, CSB staff, advocates, magistrates, and law enforcement have independently decided that they wish to pursue providing alternative transportation for children, an interest partially driven by recent adverse incidents involving police transport of children in mental health crisis. It is obviously most efficient to design a pilot project to serve both children and adults.
2. The absolute number of TDOs has increased in recent years, and we presume that out-of-area transports have also increased (and will have information shortly to examine the extent to which this is occurring). Given these developments, law enforcement has been spending increasing time transporting individuals in mental health crisis around the state. Therefore, the need for alternative transportation is greater now than ever.
3. Institutional knowledge gained through the implementation of the Mount Rogers pilot. Would be lost if the project were abruptly discontinued. Both Mount Rogers CSB staff and DBHDS staff are now familiar with successfully running a program that transports two-thirds of TDOs using alternative transportation, and if this project were to be shelved for several years, we would only have to re-tread this ground.

As noted above, presentations and non-binding cost estimates from vendors expressing interest in providing this transportation indicate that this service can be provided at a much lower per-transport cost than either the cost experienced in the Mount Rogers pilot project or the cost estimated by the Alternative Transportation Task Force. We believe that these lower estimates are indeed feasible if recent TDO utilization data are used to inform more efficient staffing patterns, as existing cost estimates assume a very high level of coverage resulting in roughly 10-15% coverage utilization. In addition, the experiences of the Mount Rogers project and of one of the interested vendors (G4S, which has provided similar transportation for several years in North Carolina) indicate that a markedly higher percentage of these TDO transports than the 50% projected by the Task Force report can be provided by non-law enforcement means.

Enabling alternative transportation projects to move forward in the area originally envisioned by the Mount Rogers project (a region that includes the service area of the Mount Rogers CSB and five neighboring CSBs) and in the area served by the Region 10 CSB (which includes urban, suburban and rural jurisdictions) would provide a much clearer picture of the effectiveness and cost efficiencies of non-law enforcement transport, as well as a clearer picture of the positive impacts on the adults and children who are served by this and on the law enforcement agencies that are largely relieved of this often time-consuming obligation.

Reducing TDO Admissions, Particularly to State Hospitals

The other legislative priority relating to emergency services is addressing the causes and possible solutions for the increase in TDO admissions in general, as well as admissions to state hospitals in particular. Several options are available, including requesting a JLARC study or directing the Secretary of HHR or the DBHDS to convene the relevant stakeholders for a consensus report. Another possibility is for the Joint Subcommittee to request the Expert Advisory Panel to carry out a study with the assistance of ILPPP and DBHDS and with the expectation of full cooperation by the private psychiatric hospitals and CSBs. The statement of task for such a study might include:

- Identify the factors that prevent private hospitals from admitting patients under a TDO and propose possible legislative or executive actions that can be taken to remove these impediments;
- Review models, such as psychiatric emergency centers, for providing crisis care to persons experiencing a psychiatric crisis that could provide cost-effective alternatives to emergency departments and inpatient admission to mental health facilities, and develop possible approaches for implementing such initiatives in Virginia;
- Consider whether amendments to Title 37.2, chapter 8 of the Virginia Code would facilitate successful crisis care without the need for temporary detention orders and involuntary treatment, alleviate pressures on emergency departments, and facilitate TDO admissions to private hospitals when hospitalization is indicated

E. SERVICES FOR THE CRIMINAL JUSTICE POPULATION

The Commonwealth has taken notable steps in attending to the issues that arise from the intersection of the mental health and criminal justice systems. Much work remains to be done, however, as jails and prisons continue to represent a microcosm of the problems faced elsewhere in providing mental health services to those who need them. Improving the capacity of the CSBs through STEP-VA will significantly benefit persons involved in the criminal justice system, particularly if cross-system barriers can be overcome. Programs of criminal justice diversion, with accompanying services, should be bolstered at the earliest stages of criminal justice interaction with people with mental health concerns. Improvements in the identification of those with mental health treatment needs are underway, with the next steps requiring capacity-building to provide treatment through better links with service providers and through complete diversion out of the criminal justice system when appropriate. The Criminal Justice Diversion Expert Panel will be mapping the existing programs and gaps around the Commonwealth in the coming year. *The most urgent objective is to implement the effort initiated by the General Assembly over the last two years to assure adequate mental health screening of all jail inmates and to work with CSBs to create the necessary protocols for providing urgently needed services.* There is a rich opportunity for working with local criminal justice agencies, CSBs and other services providers

to implement evidence-based practices. The Panel will be monitoring these activities and working with the Governor’s Center for Behavioral Health and Justice (CBHJ) to facilitate the necessary cross-system linkages and to coordinate the necessary implementation research. ***The Panel also recommends that the General Assembly consider making the functions served by the CBHJ (interagency coordination, policy development and implementation) a standing responsibility of the Governor under Section 2.2-200.***

III. STRUCTURE AND FINANCING

A. Financing

B. Fiscal Structure of the Public Services Delivery System

- Managed Care and Data Alignment [Alignment of DMAS and DBHDS]
- Fiscal Realignment and Reinvestment [Shift of funds from state hospitals to CSBs]

C. Governance of the Public Services Delivery System

D. Workforce Development

E. Data Infrastructure

A. Financing

Across the nation, the Medicaid program, a still-evolving partnership between the federal and state governments, has played an increasingly important role in financing mental health services and supports for the nation’s least advantaged citizens. It is likely that the role of Medicaid will become more prominent in the coming years. The GAP program was an important step forward and the General Assembly is poised to deliberate about the next step in the Virginia’s participation in the Medicaid program. The Expert Panel on System Structure and Financing is reviewing possible options and will report separately to the Joint Subcommittee on this topic. It is expected that the number of previously uninsured persons enrolled in Medicaid will increase and that the number of Medicaid-covered individuals served by the CSBs will also increase, with important implications for the Commonwealth’s matching funds and for CSB budgets. However, it is also likely that state general funds will continue to play an indispensable role in the financing of mental health services and supports in the Commonwealth. That being so, one of the continuing challenges of mental health reform is to weave these two strands of financing into an efficient and effective public services system, regardless of whether the clients are served by public or private providers and whether or not they are insured.

B. Fiscal Structure of the Public Services Delivery System

As described above, additional resources are needed to expand the array and capacity of essential behavioral health services throughout the Commonwealth. At the same time, ***it is necessary to fundamentally alter the fiscal structure supporting these services.***

State hospital census projections demonstrate that “business as usual” – i.e., continued 2% annual growth in state hospital admissions and continued incremental investment at FY 2019

levels in state hospital staffing, DAP, Permanent Supportive Housing (PSH), and new state hospital beds – will not fully abate the increased demand for state hospitals. The additional annual costs associated with this increased demand, and the attendant maintenance costs of ever-larger state hospitals, are unsustainable, and would cripple development of needed community services. ***Redesigning the fiscal structure of the public system of care will align fiscal practices with service objectives, increase community service capacity, improve efficiency and accountability, and achieve greater value for the Commonwealth’s investment.*** Two essential components of this effort are presently underway.

Managed Care and Alignment of DMAS and DBHDS

The transition to managed care under the Commonwealth’s Medicaid program will have a significant impact on the ways in which services are delivered by CSBs and private providers to Medicaid-covered clients. Going forward, it is essential that DBHDS and DMAS align the behavioral health services and mechanisms of accountability for Medicaid-enrolled clients with those for uninsured clients so that CSBs and private providers operate under a single seamless set of requirements for all clients. The Panel commends the leadership of both agencies for undertaking this challenge. ***It is expected that all services to all clients, regardless of funding source, will be managed uniformly using standardized managed care practices and tools*** (e.g., use of standard level of functioning assessment instrument with all clients, use of standardized utilization review procedures, standardized data reporting, etc.). ***This initiative will include the development and use of outcome-oriented performance measures*** that will enable CSBs and private providers, DBHDS and DMAS to efficiently and comprehensively monitor and manage system performance while assuring accountability for federal requirements and to the Commonwealth. This is an important step forward. It also highlights the need to build the data infrastructure that will be necessary to assure quality and efficiency and provide the foundation for on-going policy development.

Fiscal Realignment and Reinvestment

A second major undertaking essential to the transformation effort is the restructuring of state hospital funding. Item 284 E.1. of the Appropriations Act requires the Secretary of Health and Human Resources, with DBHDS and other stakeholders, to prepare a plan for “financial realignment of Virginia’s public behavioral health system.”

Under the evolving plan, DBHDS would be authorized to replace the current separate funding of CSBs and state hospitals with an approach whereby all state hospital funds aside from construction and building maintenance will be allocated to CSBs. CSBs will then purchase state hospital bed days as needed or use the funds to develop alternatives to state hospitalization and other community services. This approach creates a strong financial incentive to avoid expensive hospitalization, and is expected to significantly reduce the use of state hospitals over time. ***The Panel strongly supports this realignment with the proviso that the transition should be carefully planned and gradually implemented to avoid major dislocations.*** As presently conceived, it will be implemented over a four-year time period, with the first two years devoted entirely to establishing the transitional placements by implementing the “community integration plan” envisioned by SUPPORT-VA. As the Panel noted earlier in this

report, the investment in post-discharge transitional placements is needed now to relieve the pressure on state hospitals regardless of whether the recommended fiscal realignment is adopted. However, there is also some virtue in allowing a year for digesting and vetting the HHR plan for fiscal realignment before legislative action directing or authorizing it. Any needed legislative action can be undertaken in 2019.

It is important to emphasize that the fiscal realignment plan is a structural change that is separable from building the services and supports envisioned by STEP-VA and the “community integration plan” described above. The fiscal realignment plan is intended to reduce the utilization of state hospitals through creation of a financial incentive to develop and use less expensive non-hospital alternatives, and to foster development of supportive community services and supports that enable individuals at risk of hospitalization to live in the community.

C. Governance of the Public Services Delivery System

The Panel is committed to building on and improving the existing structure of publicly funded mental health service delivery. The Panel arrived at this approach after a thorough review of other systems across the country, finding that most states resemble Virginia’s combination of locally controlled community services agencies and state oversight as opposed to a unified state system or exclusive reliance on private providers. This approach is also based on the firm belief that ***local and regional public agencies under state oversight is still the best fit for the Commonwealth’s needs, just as it was four decades ago. While the current system has weaknesses, those weaknesses can be remedied. Furthermore, there is no assurance that any other approach would produce better results than an improved version of the current structure.***

The Panel also notes that fundamental alteration of the system structure would be highly disruptive and costly. The transition would require a massive expenditure of time and resources and would not, until many years down the road, allow the direct investment in services and supports that all stakeholders acknowledge are needed. This kind of fundamental alteration would also erase the decades-long relationships that have developed between many of the CSBs and their local governments, as well as many other community partnerships and programs, particularly among public entities. For example, ending CSB collaborations with jails, schools, courts, and other agencies, which have been tailored to local circumstances, would likely erase beneficial services, alienate important constituencies, and jeopardize local government funding and support.

DBHDS, in partnership with HHR and DMAS, are undertaking a number of initiatives aimed at transforming the system by expanding services, and improving data management and administrative operations. In addition to those efforts, the Panel has recognized the need to review and improve system governance. To that end, the ***Panel has begun studying two broad subjects: the authorities and responsibilities of state agencies in delivering mental health services; and the roles and responsibilities of local governments and regional collaborations.***

Authorities and Responsibilities of State Agencies

To be successful, the transformation initiatives already begun (for example, STEP-VA) and under development (for example, fiscal realignment of financing of state hospitals and community services) will require (i) adoption of outcome-oriented performance criteria and measures, (ii) intensified data collection and monitoring, and (iii) active oversight by DBHDS. This study will examine whether DBHDS has the capacity to carry out these essential functions and, if not, what changes may be needed, including additional resources or statutory authority. Additional questions include whether CSBs, as presently organized, have the capacity and local support to carry out their responsibilities under STEP-VA, SUPPORT-VA, fiscal realignment and other system transformation initiatives. The study will focus primarily on DBHDS, with some attention given to DMAS. Consideration of the roles of other state agencies will be deferred until 2019.

The Panel will review enabling statutes of the Code of Virginia and other policy documents related to the DBHDS's oversight authority over CSBs. It will also conduct interviews with stakeholders from DBHDS, CSBs and local governments, during which the Panel will explore DBHDS's governing authority as established in *Code* and the Performance Contract, and how it is operationalized in practice; whether DBHDS is using its powers most effectively and to the fullest extent needed; and the capacity and limitations of its current oversight infrastructure. The panel will also present interview subjects with scenarios to explore how DBHDS might respond to new realities, focusing on four related areas of operations: the monitoring of CSB services; the oversight of CSB financial operations; the supervision of CSB administrative operations; and the provision of technical assistance.

Roles and Responsibilities of Local Governments and Regional Collaborations

As previously noted, the active involvement by many local governments in the system – including in some localities, very significant financial support – and the various interagency agreements and collaborations between CSBs and local public and private entities, such as law enforcement, were key considerations in the decision to maintain but reform the current structure of the system. That said, the degree of local government involvement has varied dramatically across the state, with a clear divide between the more affluent urban and suburban communities and the often cash-strapped rural regions. In addition, DBHDS has encouraged and incentivized regional cooperation and collaboration through a number of measures including, for example, region-based funding to support local inpatient psychiatric care for uninsured individuals who are in mental health crisis.

In examining how to build on and improve this existing structure, the Panel will review issues that include: the nature and variation in local governance and local investment in public mental health across the state; the collaboration of CSBs with other human services agencies; the collaboration among CSBs within their Health Planning Regions (HPRs); the ways in which additional local funding may be used to improve services and outcomes; the feasibility of consolidation of some CSBs without disrupting access to services; models within Virginia that might be replicated, with regard to regional and interagency collaboration; and the experience of other states with a similar structure.

D. Workforce Development

The Commonwealth has long recognized that it faces a shortage of qualified mental health professionals, including licensed clinical social workers (LCSW), psychiatrists, and counselors (LPCs, PhDs, etc.). According to the U.S. Health Resources and Services Administration (HRSA), Virginia's workforce is meeting just 57% of the need for mental health services, while the state has 79 total health professional shortage area designations. These designations refer to geographic areas, populations and facilities with too few mental health care providers and services.

In 2010, the Commonwealth's Commission on Mental Health Reform reported that the mental health workforce was "understaffed, undertrained, and under-resourced," and that turnover was high in large part due to low pay and high caseloads. This level of turnover was disruptive and highly inefficient. These concerns were echoed in the 2016 Survey of CSB Executive Directors. In that survey, over 80% of participating CSBs attributed workforce shortages to a lack of funding, which resulted in less competitive salaries, but in addition, it meant that CSBs could not afford to adequately staff all of its services lines. The CSBs most commonly reported experiencing shortages of outpatient clinicians. Other commonly reported staff shortages included emergency services staff, case managers, discharge planning staff, PACT team staff, and peer recovery specialists.

Mental health workforce shortage and mal-distribution have been a long-standing issue in the Commonwealth and nationwide, and the Panel recognizes that it is one of the most critical factors needed to improve access to services in the publicly funded mental health services system. The Panel intends to study the current workforce and make recommendations for how to better engage and leverage the full continuum of the mental/behavioral health professionals, including licensed social workers, counselors, psychologists, psychiatric nurse practitioners and psychiatrists. Secondly, ensuring that all those who enter the field are competent in providing tele-mental health services and able to access and leverage telehealth technologies would significantly improve the issue of mal-distribution, as would enhancing the competencies of community-based clinicians to address behavioral health issues. The Extension for Community Healthcare Outcomes (ECHO®) is an evidence-based model for improving the care received by patients across the lifespan by providing community-based clinicians, particularly those in rural and underserved areas, with skills and knowledge to treat complex patients, such as those with mental health issues in their own practices. In this model, expert interdisciplinary specialist teams ("hubs") connect with primary care clinicians ("spokes") through regular teleECHO™ clinics. Through the telehealth technology, Project ECHO provides community-based clinicians with knowledge, decision support, and specialty consultation services. These learning communities allow primary care providers to co-manage patients who have complex care needs who would normally have been referred out for services.

The Panel intends to continue to study the best methods for promoting education and training for those who want to enter the field of mental health, developing tools for the development of individuals already in the workforce, and improving methods and incentives for employee retention.

E. Data Infrastructure

Improving the data infrastructure of Virginia’s mental health system is critical for actualizing meaningful changes with any of the system revisions under consideration. As has been noted to the Subcommittee, “data are foundational” to mental health services reform. The figures currently available that document the volume of pressures and problems within the system are valuable for underscoring the need for change, but those data are insufficient alone for guiding decision making and employing resources efficiently. What is more, the national development toward process- and outcomes-focused services provision requires robust data infrastructures.

It is clear that Virginia’s public mental health system as a whole is under great strain and there is no substantial relief in sight without making changes. However, the sources of that strain are many, and the relative impact of those sources likely varies across localities based on locality characteristics such as client make-up, service demands, availability of community services, including private providers, variation in magistrate and special justice practices, funding, geography, and volume of law enforcement agencies. ***Without improvements in data, such as better, standardized linking across systems and expansion of data collection to include process and outcomes data, improvements to the mental health services system will be limited in their success. Coordination between DBHDS and DMAS is essential as is data-sharing with other executive branch agencies, including all health agencies as well as relevant public safety agencies such as DCJS and DOC.***

Improvement in data infrastructure will support DBHDS and DMAS in their respective oversight roles, facilitating better and more timely feedback to providers, and better identification of areas of need and responses to them. Improvement in data infrastructure will support CSBs and state hospitals in better managing and deploying their resources and, thus, better serving their clients. Data infrastructure improvements also align with several recommendations identified by various work groups in recent years, such as groups that studied the need for the STEP-VA model, which noted among core themes the necessity of “[h]arness[ing] the power of data across agencies in the Secretariat to utilize and improve health outcomes.”

One already identified component needed for data infrastructure improvement is SPQM, which indeed will be key in creating a state-level data store that captures meaningful service provision data and allows DBHDS and CSBs to capitalize on data to use their funds efficiently while better serving their clients. ***The Panel will continue to monitor the improvements in the DBHDS data infrastructure and its capacity to share data with other agencies.***

List of Referenced Documents Prepared by Expert Advisory Panels and Work Groups

- Progress Report of SJ 47 Expert Advisory Panel on Crisis Response and Emergency Services, November 27, 2017
- Progress Report from SJ Work Group on Transportation, November 27, 2017

- Progress Report from SJ 47 Expert Panel on Criminal Justice Diversion, November 28, 2017
- Next Steps for Expanding Access to Mental Health Services in Virginia: Priority Recommendations of the Tele-mental Health Work Group on Policy Development (October, 2017)
- Progress Report of SJ 47 Expert Advisory Panel on Housing, November 28, 2017
- Special Interim Report on Financing Behavioral Health System Transformation, November 27, 2017