Virginia Department of Behavioral Health & Developmental Services

Update on Financial Realignment of Virginia's Public Behavioral Health System

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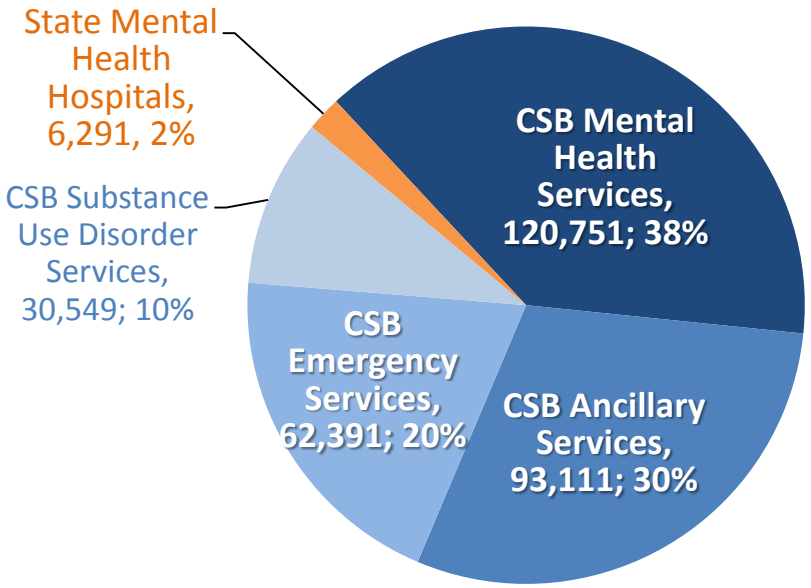
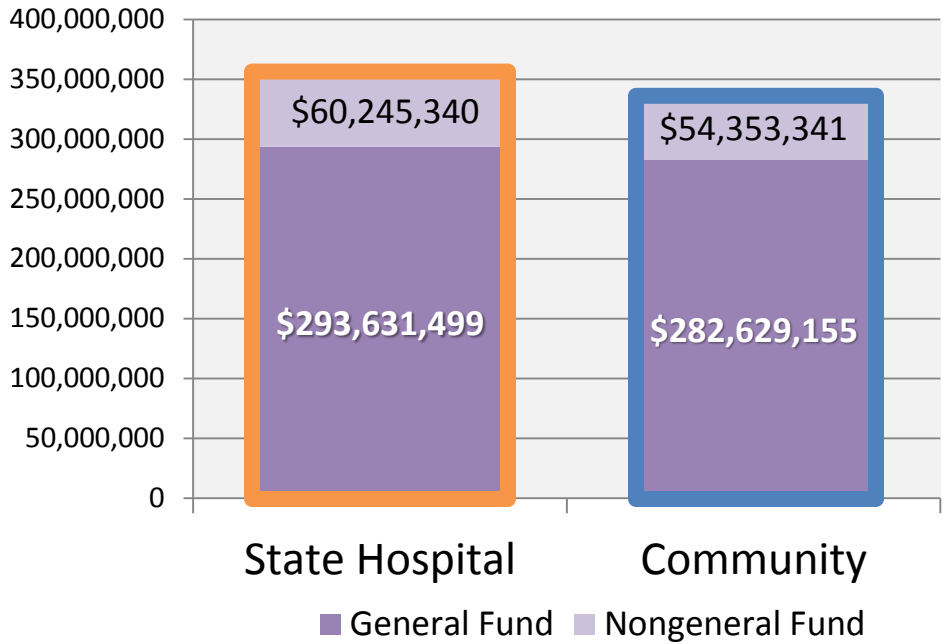
Virginia's Behavioral Health Services (FY 2017)

Individuals Served - Hospital & Community



Spending - Hospital & Community



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Emergency Evaluations and Temporary Detention Orders (TDOs)

Every 24-hours across the Commonwealth there are:

256
EMERGENCY EVALUATIONS CONDUCTED

71
TDOs ISSUED

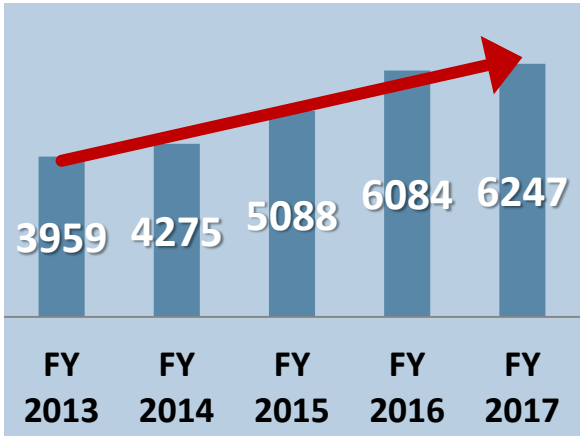
Year	Evaluations	TDOs	% of Evaluations Leading to TDOs	TDOs Admitted to Private Hospitals
FY 2015	83,701	24,889	29.7%	(91.2%) 22,687
FY 2016	96,041	25,798	26.8%	(86.5%) 22,322
FY 2017	93,482	25,852	27.7%	(84.6%) 21,861

Of Note:

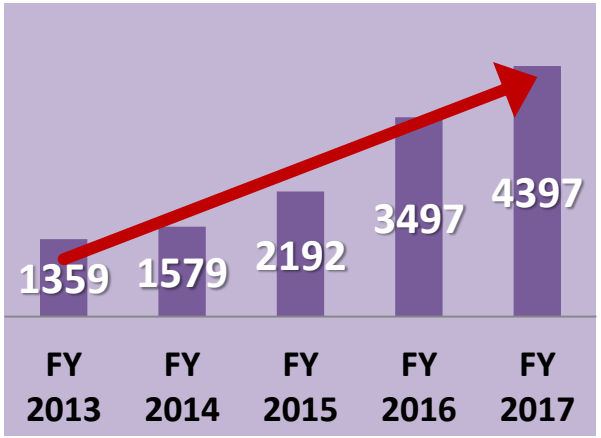
- First quarter FY18 TDOs project to 27,090 annualized, with state hospitals taking 19% and private hospitals taking 81%.
- Oct. 2017, Western State – 69% of civil TDOs had insurance.
- July 2017, N. VA Mental Health Hospital – 52% of admissions had insurance.

Hospital Admissions and Discharges

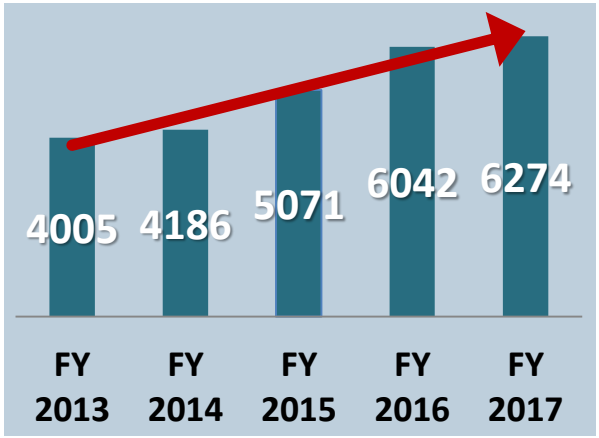
Total State Hospital Admissions, FY13 - FY17



Total Temporary Detention Order Admissions, FY13 - FY17



Total State Hospital Discharges FY13 - FY17



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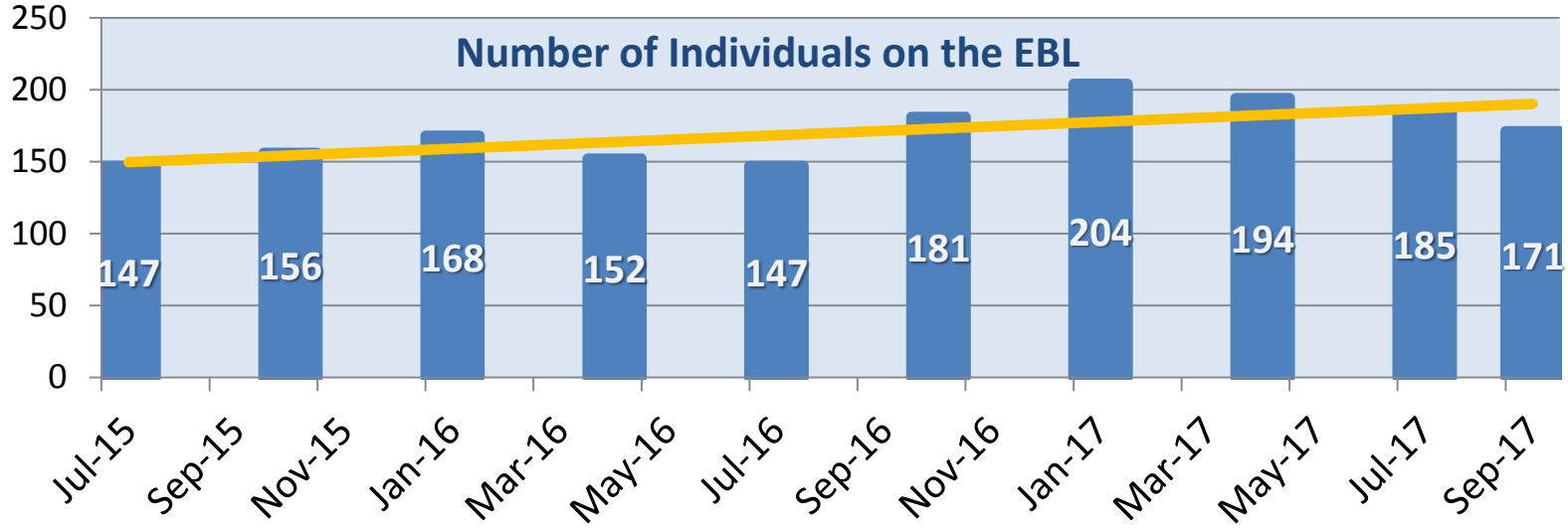
Extraordinary Barriers to Discharge List (EBL)

In September 2017, there were **171** individuals in state hospitals who were clinically ready for discharge for more than 14 days but appropriate community services were unavailable to facilitate a safe discharge. This is 13 percent of the total statewide census. A special effort this year discharged 122 people from the EBL, but approximately 575 people are added every year.



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Jail Waiting List
(November 17, 2017)

Hospital	# Waiting	# Waiting Longer Than 7 Days
CSH	7	0
ESH	5	0
WSH	1	0
SWVMHI	1	0
SVMHI	0	0
Catawba	0	0
PGH	0	0
NVMHI	0	0
Total	**12**	**0**

Workforce Challenges

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

State Hospital Staffing Vacancy Rates – August 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 with other incentives. “Pay not equal to workload" was among the top five reasons cited for leaving a case management position.

RN = Registered nurse

DSA = Direct service associate

Cost of Business as Usual

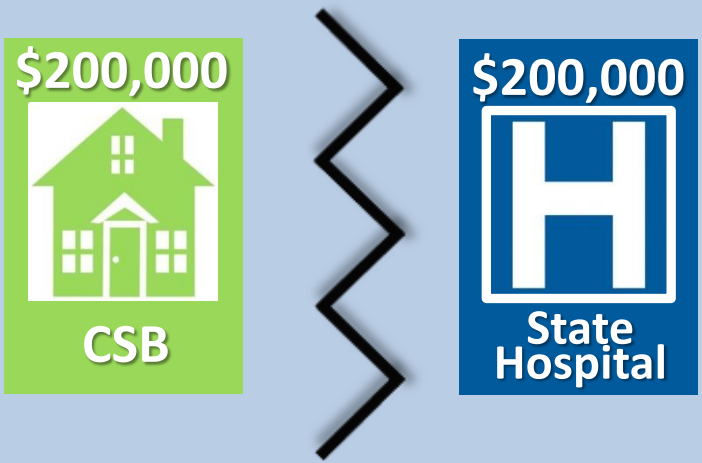
	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024*
Business as Usual	Maintain Current 1418 Beds			Add 56 Beds at Western State Hospital (WSH)		1474 Beds	
Census*	1347	1375	1404	1432	1460	1489	1516**
Utilization	95%	97%	99%	97%	99%	101%	**103%**
Staffing Cost		$5.8M	$6.2M	$6.2M	$6.2M	$6.2M	$6.2M
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		$1.4M	$6.2M	$8.3M	$8.3M	$8.3M	$8.3M
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% utilization; FY 2017 = 93% utilization.

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

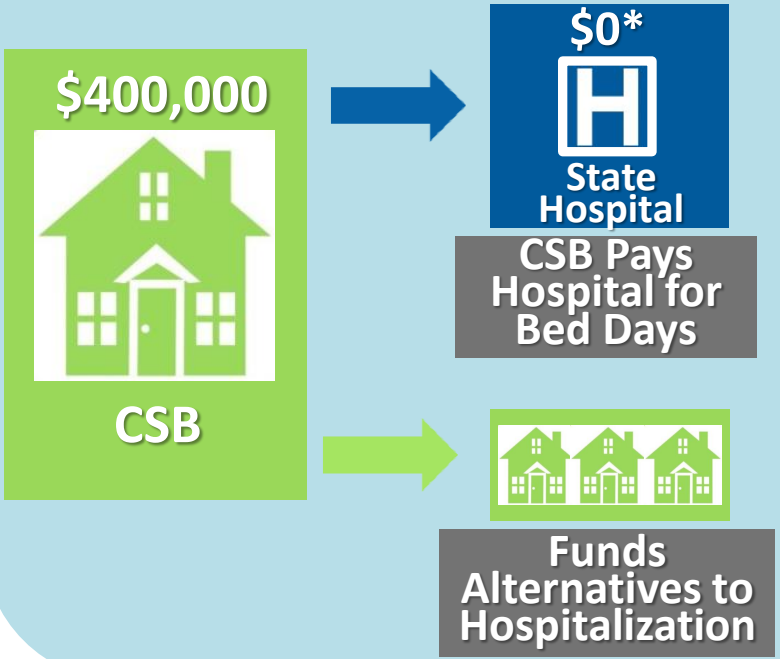
Basic Realignment Concept

Current



NO CONNECTION

Realignment



These are not real dollars in this concept example. The $0 would reflect only a determined amount of non-fixed hospital expenses, not the hospitals' entire budgets.

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FY 2019 – Year One – Community Integration Plan

Year One Goal – Build alternatives to state hospital placement.
Projected Results – 178 discharges; Reduce the EBL from 170 to 117.

Implement a community integration plan to prepare for financial realignment:

- Develop new supervised living homes and assisted living facilities attached to permanent supportive housing. This facilitates transitions to integrated placements and makes room for more discharges. Leads to 104 discharges.
- 50 additional discharge assistance slots (DAP) leads to 50 discharges.
- Develop four safe and appropriate transitional supervised living homes specifically for the individuals who have been found Not Guilty by Reason of Insanity (NGRI) and are court-determined to be ready for discharge. Leads to 24 discharges.
- Begin a standard utilization review process to ensure that individuals in state hospitals who no longer meet continued stay criteria are promptly identified.

FY 2020 – Year Two

Year Two Goal: Finalize bed utilization targets and funding distribution. Projected Results – 144 discharges; Reduce the EBL from 117 to 88.

- Continue community integration plan: leads to 70 discharges through supervised and assisted living, 24 through NGRI homes, 50 more through DAP
- Transition to continued stay criteria from EBL.
- Complete implementation of standardized reporting related to utilization.
- Bed reduction targets will be based on factors including the utilization of state hospitals per 100,000 population, ADC, access to private hospitalization, regional/geographic factors, and judicial practices.
- DBHDS approval of community capacity options developed by CSBs or regions.
- Finalize reimbursement/refund procedures based on bed utilization.
- Finalization of any further *Code*/regulatory changes required for financial realignment to include precluding local funds from being used to support state hospital care.

FY 2021 – Year Three

End of Year Three Goal – Reduce the state hospital average daily census (ADC) by 80.

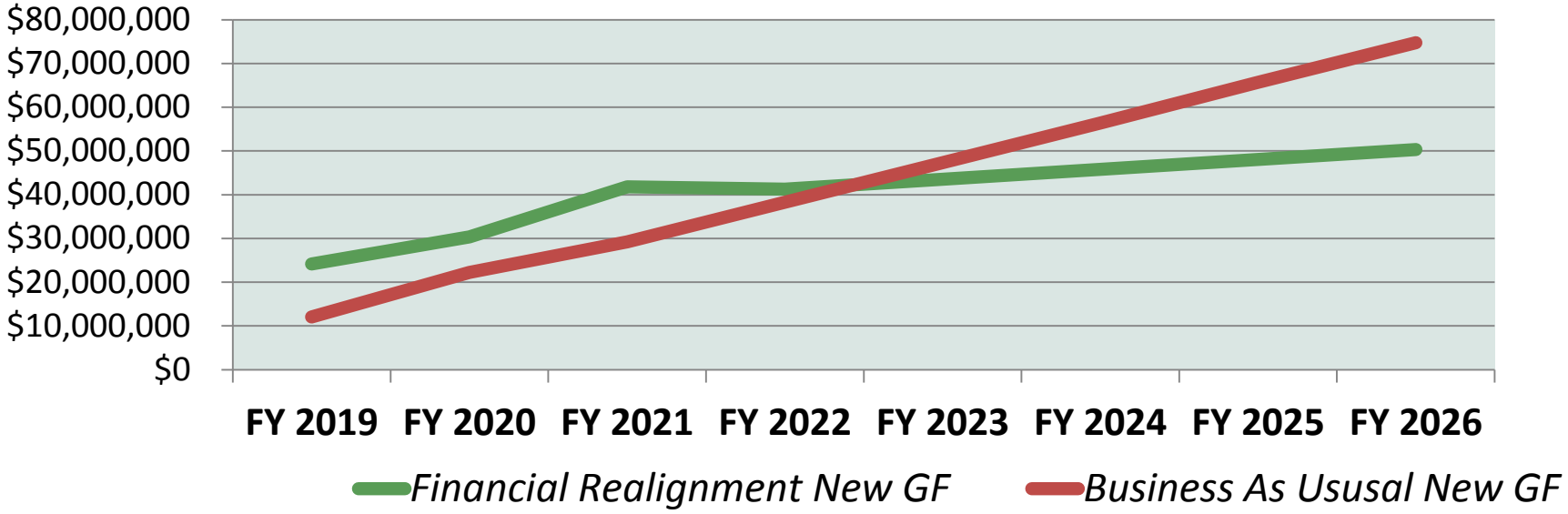
- Community integration plan is ongoing.
- Financial Realignment Start-Up: Based on plans approved by DBHDS in FY 2020, CSBs and/or Regions begin building needed services, may include:
  - new assisted living facilities,
  - crisis stabilization units,
  - contracting with private providers when necessary.
- Standardized utilization review and monthly report processes will continue.
- Census reduction achieved by end of fiscal year.

FY 2022 – Year Four

Year Four Goal – Implement full realignment.
Projected Results – Reduce and maintain census at ADC of 1,280 vs *current* projection of 1,460 for FY 2022.

- Bed utilization targets established for each CSB. Targets will be converted to a monthly utilization target for each CSB.
- The payment for bed day based on non-fixed costs of hospital care.
- Bed utilization above the monthly target will result in the CSB being billed for the days utilized above the target. Bed utilization below the monthly target will result in a "refund" from the state hospital.
- Add provisions to the performance contract between DBHDS and the CSBs to preclude local funds from being used for state hospital bed purchase.

Cost of Financial Realignment vs. Business as Usual



	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26
Business as Usual GF	$12.0M	$22.2M	$29.2M	$38.3M	$47.3M	$56.4M	$65.7M	$74.8M
Realignment GF	$24.2M	$30.4M	$41.8M	$41.2M	$43.5M	$45.8M	$48.0M	$50.3M

Service Process Quality Management (SPQM)

- SPQM is off-the-shelf technology that provides the ability to strategize for the future, manage operations, develop continuous improvement strategies, and demonstrate outcomes to public and private payers.

- It provides “standardized data to ensure a statewide ‘apples to apples’ comparison of data elements.”
- The one-time cost to implement SPQM in all 40 CSBs is $1.1M and the ongoing operation total for all CSBs is $362,300.

In Conclusion

Financial realignment impacts “business as usual” by:

- Reducing the number of individuals no longer needing a hospital level of care and decreases the amount of time individuals wait on the EBL.
- Helping build placement and support capacity in the community system, and addresses infrastructure critical to making STEP-VA services successful.
- Reducing state hospital utilization closer to best practice rate of 85%.
- Changing the determination of the number of beds required in state hospitals to be by actual need rather than history or estimates.
- Avoiding spending similar amounts of money over the next 5-6 years on more hospital beds/staff to the impediment of building community capacity.
- Introducing managed care principles: financial support of appropriate service/cost, utilization review with continued stay criteria, multiple data points to monitor performance/make adjustments.