

INTRODUCTION

The Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century (the Joint Subcommittee) was established by Senate Joint Resolution 47 during the 2014 Session of the General Assembly. The Joint Subcommittee was tasked with:

- i. Reviewing and coordinating with the work of the Governor's Taskforce on Improving Mental Health Services and Crisis Response;
- ii. Reviewing the laws of the Commonwealth governing the provision of mental health services, including involuntary commitment of persons in need of mental health care;
- iii. Assessing the systems of publicly funded mental health services, including emergency, forensic, and long-term mental health care and the services provided by local and regional jails and juvenile detention facilities;
- iv. Identifying gaps in services and the types of facilities and services that will be needed to serve the needs of the Commonwealth in the 21st century;
- v. Examining and incorporating the objectives of House Joint Resolution 240 (1996) and House Joint Resolution 225 (1998) into its study;
- vi. Reviewing and considering the report *The Behavioral Health Services Study Commission: A Study of Virginia's Publicly Funded Behavioral Health Services in the 21st Century*; and
- vii. Recommending statutory or regulatory changes to improve access to services, the quality of services, and outcomes for individuals in need of services.

During the 2017 Regular Session, the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century was extended for two years in the 2017 Appropriation Act (Chapter 836 of the Acts of Assembly of 2017). The Joint Subcommittee is scheduled to complete its work and issue its final report by December 1, 2019.

In the first year of the study, the Joint Subcommittee established three work groups to focus on specific issues related to crisis intervention, the continuum of care, and special populations. At the beginning of the 2016 interim, the work groups were restructured to create four work groups focused on system structure and financing; criminal justice diversion, crisis and emergency services, and housing. Expert advisory panels were established to support the work of each of the work groups. In 2017 the work groups were again reorganized, resulting in two work groups, one focused on system structure and financing and the second focused on criminal justice diversion. Issues related to crisis and emergency services were addressed by the System Structure and Financing Work Group.

Since 2014, much of the substantive work of the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century has been carried out by the work groups. This report describes the work of the System Structure and Financing Work Group (the Work Group), which prior to 2016 was known as the Continuum of Care Work Group.

2014

September 9, 2014

Organization and Work Plan

Work Group members identified a number of items for inclusion on the work plan, including determining the type and scope of mental health services currently available in the Commonwealth; determining the type and scope of services that should be available in the Commonwealth; evaluating the link between state institutions and community-based services, including the transition process, communication among providers, and follow-up care; funding of crisis services; prevention and early identification and intervention services; substance abuse services for individuals with co-occurring disorders; peer support services; recovery support services; housing for individuals receiving mental health services; employment opportunities for individuals receiving mental health services; the mismatch between mental health service needs and the availability of mental health services providers; recruitment and retention of mental health services providers; use of allied health professionals to expand access to services; service coordination and case management; role of the educational system in identifying individuals with mental health problems and service needs; standards around identification/diagnosis and data on the accuracy of diagnosis; and support and services for caregivers and families of individuals with mental illness. The Work Group also noted the need to focus on mental health services for individuals in jails, including identification of inmates with mental illness and mental health service needs, access to services for individuals in jails, and transition and follow-up services for individuals leaving jails.

Work Group members decided to focus first on the structure of mental health services in the Commonwealth and the types of services currently available to individuals in need of mental health services. The Work Group will then focus on identifying the types of mental health services that should be available in the Commonwealth, to identify gaps in service and service needs. Thereafter, the Work Group will establish proposals for establishing or expanding necessary mental health services to fill gaps and meet service needs, including proposals for any funding that may be necessary.

October 23, 2014

Overview of the Existing Mental Health Services System

Jim Martinez, Director of the Office of Mental Health Services, Department of Behavioral Health and Developmental Services (DBHDS), provided an overview of the existing mental health services system. He stated that the 40 community services boards (CSBs) are the entry point into the Commonwealth's publicly funded mental health services system. DBHDS enters into contracts with CSBs, which may provide services directly or enter into agreements with private providers for the provision of services. Performance contracts are the main tool through which DBHDS is able to hold CSBs accountable for services provided. DBHDS reviews at least five of the CSBs annually to determine compliance with the provisions of the performance contracts.

Services provided by CSBs vary substantially. The Code of Virginia requires CSBs to provide emergency services, preadmission screening and discharge planning, and, subject to the availability of funds for such purpose, case management services. CSBs may provide additional

services. Both public and private providers of mental health services are licensed by DBHDS. Medicaid is the major source of funding for the publicly funded mental health services system, with additional funds provided by the state and localities.

State hospitals for individuals with mental illness are another component of the publicly funded mental health services system. Mr. Martinez reported that the state hospital census has been declining. However, lack of community-based services poses a barrier to release for some. Discharge Assistance Planning funds are intended to help individuals with special needs secure services necessary for discharge from state hospitals, but funding is insufficient to keep up with demand.

Forensic services are another key component of the publicly funded mental health services system. DBHDS provides services for restoration of competence and for individuals who have been found not guilty by reason of insanity. Mr. Martinez noted that utilization of state hospital beds by forensic patients has increased substantially in recent years, with approximately one-third of all state hospital beds utilized by forensic patients at any given time. DBHDS has entered into partnerships with jails and law enforcement to prevent unnecessary criminal justice involvement of individuals with mental illness, including development of Crisis Intervention Teams and jail diversion programs. However, substantial work is still needed in this area.

Mr. Martinez noted that currently, the publicly funded mental health services system is focused on emergency services. He stated that a more balanced system would include a broader array, including diagnostic and evaluation services, group counseling, medication management, in-home services, substance abuse services, and a range of ancillary services. A substantial investment in community-based services would be necessary to achieve this balance. In closing, he stated that priorities could include:

- Ensuring consistent access to a consistent array of mental health and substance abuse services across the Commonwealth;
- Developing effective emergency services to serve as a safety net for people in crisis;
- Providing prevention and early intervention to reduce the need for crisis services;
- Providing access to supportive housing and supportive employment to facilitate recovery;
- Strategic and sustained funding for evidence-based programs; and
- Improving accountability and performance monitoring of CSBs.

Jennifer Faison, Executive Director, Virginia Association of Community Services Boards, spoke about the role of CSBs in providing publicly funded mental health services. She noted the current emphasis on emergency services and the need to ensure access to the full range of mental health services, including preventive, habilitative, and rehabilitative services, to prevent or mitigate crises. She stated that the public mental health services system had been the subject of at least 10 major studies since 1949 and that the consistent theme throughout these studies had been the need to expand community-based services to ensure consistent access to the full array of services throughout the Commonwealth. Lack of services and lack of capacity of existing services has consistently been identified as a problem. Lack of funding is a major contributor to these issues.

Jennifer Fidura, Executive Director, Virginia Network of Private Providers, and Jon Morris, Executive Director, Family Preservation Services, described the role of private providers in the publicly funded mental health services system. Ms. Fidura noted that the private sector provided more than 90 percent of nonemergency mental health services in the Commonwealth, with an even higher rate among children and adolescents. Most people receiving services from private providers are Medicaid recipients.

Mr. Morris gave an overview of Family Preservation Services, a private provider of community-based mental health services. He emphasized the importance of partnerships among private providers, the public mental health services system, schools, the criminal justice system, and law enforcement in serving individuals with mental illness and their families and identified several challenges to providing services, including changing eligibility rules and low reimbursement rates. He also identified several priorities for system transformation, including:

- Additional care coordination and integration of primary and behavioral health care;
- Outcomes-based performance expectations and accountable care models;
- Better data collection to guide rate setting and regulatory changes; and
- Expanded access to case management services to allow providers other CSBs to provide case management services.

Recommendations

The Work Group did not adopt any recommendations at the end of the 2014 interim.

2015

July 1, 2015

Association of Community-Based Service Providers

Dr. Denis Parker, Ph.D., provided an overview of the Association of Community-Based Service Providers, an organization dedicated to keeping member providers apprised of developments affecting delivery of mental health services.

National Alliance on Mental Illness

Mira Signer, Executive Director, National Alliance on Mental Illness (NAMI), provided an overview of NAMI, a statewide nonprofit organization that provides support, education, and advocacy to individuals with mental illness and their families. She identified 10 pillars of a high-quality state mental health services system, stating that the public mental health services system should be comprehensive; integrated; adequately funded; focused on wellness and recovery; safe and respectful; accessible; culturally competent; consumer-centered, consumer-driven, and family-driven; well-staffed and well-trained; and transparent and accountable.

Ms. Signer then described several strengths of the Commonwealth's publicly funded mental health services system, including the role of CSBs as a single point of entry into the system; local buy-in and support; and partnerships with private providers, which offer consumers treatment options and provide support to CSBs struggling with waiting lists and insufficient capacity. She also identified several challenges facing the Commonwealth's publicly funded mental health services system, including:

- Fragmentation and the lack of coordination and cohesion;
- Orientation toward crisis services;
- Unequal funding for community services provided through CSBs;
- Inconsistency in the array of services and access to services;
- Insufficient oversight of CSBs;
- Lack of clarity and guidance governing the relationship between public and private providers;
- Ability of private providers, especially private psychiatric hospitals, to deny services to patients;
- Insufficient housing for individuals receiving services; and
- Lack of parity in private insurance coverage.

Ms. Signer ended her presentation with a description of priorities identified through NAMI's membership needs assessment. These included:

- Integrating mental health with primary care;
- Increasing access to hospital and residential care services;
- Increasing availability of prevention services;
- Improving access to medications for the treatment of mental illness;
- Improving access to intensive outpatient services;
- Improving access to crisis stabilization services and acute care services; and
- Improving access to supportive housing.

September 24, 2015

Mandatory Outpatient Treatment

Brian Stetting, Policy Director, Treatment Advocacy Center, presented information on mandatory outpatient treatment. He described the consequences of nonadherence to treatment for mental illness and described mandatory outpatient treatment as a strategy to address nonadherence, particularly among those who do not believe they need treatment. He stated that the role of the court was the key to compliance with mandatory outpatient treatment. In cases in which a person is subject to a mandatory outpatient treatment order, the court and treatment providers establish a comprehensive treatment plan for the individual and consequences (readmission for involuntary inpatient treatment) to provide incentive to comply. Mr. Stetting noted that the mandatory outpatient treatment model also facilitates a rapid response in cases of noncompliance, catching nonadherence to treatment early and providing a proactive response.

Mr. Stetting also provided an overview of mandatory outpatient treatment in other states. Forty-five states have implemented mandatory outpatient treatment, providing opportunities for significant study and review of the effectiveness of mandatory outpatient treatment. Studies of state programs have identified a range of positive outcomes, including a reduction in

hospitalizations, suicides, arrests, and threats of or actual harm to others by individuals with mental illness. Studies have also indicated that in states that have implemented mandatory outpatient treatment, the costs associated with hospitalizations have decreased. Mandatory outpatient treatment has been recognized by the Substance Abuse and Mental Health Services Administration as an evidence-based practice and by the National Institute of Justice as a method of reducing crime and violence in communities.

Mr. Stetting then addressed the Commonwealth's mandatory outpatient treatment law. He stated that Virginia's law is unique in its organization and structure. The complexity of the statute and the program it creates has resulted in resistance to using mandatory outpatient treatment in appropriate cases. To address these issues, Mr. Stetting recommended:

- Implementing a step-down model of mandatory outpatient treatment for individuals for whom inpatient treatment is no longer appropriate;
- Eliminating the patient agreement requirement for mandatory outpatient treatment, which poses a barrier to mandatory outpatient treatment for many individuals. Instead, the law should require a finding that mandatory outpatient treatment is the most appropriate treatment, regardless of whether the person agrees to the need for treatment, as a condition for participation in mandatory outpatient treatment; and
- Extending the maximum time period for mandatory outpatient treatment beyond the currently authorized 90 days, which is insufficient for effective treatment.

In response to questions from the members of the Work Group, Mira Signer, Executive Director, National Alliance on Mental Illness (NAMI), stated that NAMI does support mandatory outpatient treatment as one tool for treating individuals with mental illness. However, she stated, it is important to ensure that adequate services are available. Ms. Signer also noted that the single standard for eligibility for mandatory outpatient treatment has been a barrier to use of mandatory outpatient treatment in the Commonwealth. The fact that criteria for inpatient and outpatient treatment are the same has led to some concerns regarding the safety of mandatory outpatient treatment. Daniel Herr, Assistant Commissioner for Behavioral Health Services, Department of Behavioral Health and Developmental Services, noted that mandatory outpatient treatment is an evidence-based practice and one model for the treatment of mental illness. He encouraged the Work Group to think of mandatory outpatient treatment as a program, which requires adequate services to be successful.

Public Comment

At the end of the meeting, the Work Group received public comment. A member of the public stated that lack of training for magistrates, particularly relating to mental illness, was an issue in the involuntary commitment process. A representative of the Psychiatric Society of Virginia noted that the organization supports mandatory outpatient treatment as a tool to help avoid crisis, but that there are challenges to providing services, including low reimbursement rates and a limited pipeline of health care providers. Another member of the public commented that for individuals with private insurance, receiving follow-up services after a period of inpatient treatment can be challenging because they may not be aware of or able to access services that a person moving through the publicly funded mental health services system might be able to access. Several additional members of the public spoke about ensuring access to the full range of

mental health services statewide and addressing gaps in service, insufficient capacity, and variation in the quality of services available.

November 13, 2015

Certified Community Behavioral Health Clinic Demonstration Program

Daniel Herr, Assistant Commissioner for Behavioral Health, Department of Behavioral Health and Developmental Services, presented information about the Certified Community Behavioral Health Clinic (CCBHC) Demonstration Program. He reported limited access to behavioral health services in the Commonwealth, with only 22 percent of individuals who need behavioral health services in the Commonwealth actually able to access such services, compared with the national average of about 60 percent. For community-based services, approximately 41 percent of Virginians are able to access services, compared with the national average of about 75 percent. At the same time, admissions to state facilities have increased approximately 20 percent, with admissions pursuant to a temporary detention order increasing 39 percent. As a result of these increases, the overall facility census has increased from 87 percent to more than 90 percent. The problem is exacerbated by the growing number of individuals ready for discharge from state hospitals for whom no community placement can be found. Mr. Herr reported that approximately 140 people are on the waiting list for discharge.

In light of these challenges, DBHDS has sought options for system transformation, creating transformation teams, receiving input from stakeholder groups and public comment, identifying priorities, and developing and implementing strategies. Key elements in the system transformation include:

- Formalizing and funding core services and supports across a continuum of care;
- Requiring reimbursement for case management services;
- Strengthening the community-based system of services and supports statewide;
- Standardizing quality of care expectations statewide;
- Aligning and maximizing effectiveness of available funding streams;
- Harnessing the power of data across agencies to utilize and improve health outcomes;
- Integrating behavioral health with physical health and social services;
- Strengthening the workforce to ensure access to services;
- Promoting a person-centered approach to care through policy and reimbursement; and
- Developing and conducting customized training to organizations that interact with the population served.

The CCBHC Demonstration Program offers a tool for implementing system change. The Program includes funding for planning and implementation of a system transformation. The Commonwealth's approach to system transformation will be known as System Transformation, Excellence, and Performance - Virginia (STEP-VA). The STEP-VA plan calls for improving access to and outcomes of behavioral health services by providing a full array of services, including screening, assessment and diagnostic services, outpatient mental health and substance

abuse services, crisis services, psychiatric rehabilitation services, peer and family support, primary care screening and monitoring, care for members of the armed forces, patient-centered treatment planning, and targeted case management. DBHDS is planning to implement STEP-VA at eight CSBs in the Commonwealth through the CCBHC Demonstration Program.

Virginia Association of Community-Based Providers

Mike Carlin, Executive Director, Virginia Association of Community-Based Providers, provided information about the publicly funded mental health services system from the private provider perspective. He noted that credentialing processes for mental health services providers is an issue. Variation in the requirements for licensure and reimbursement create confusion. For some providers, state law and regulations impose requirements for licensure, then Medicaid imposes additional requirements for reimbursement. For other providers, certifications or credentials are not required by state law or regulation. A cohesive regulatory scheme for providers of mental health services would be beneficial.

Adolescent Mandatory Outpatient Treatment

Rita Romano provided an overview of the mandatory outpatient treatment process as it is applied to adolescents. She reported that the Prince William County Community Services Board was using mandatory outpatient treatment for both adults and juveniles, but that use of mandatory outpatient treatment for juveniles had been minimal, with only three cases of juvenile mandatory outpatient treatment since 2012. Outcomes in all of those cases had been positive, with all three individuals continuing to participate in treatment following release from mandatory outpatient treatment. Despite these positive outcomes, use of juvenile mandatory outpatient treatment was minimal in part because Prince William County did not have any facilities for the temporary detention of juveniles, and hearings for juvenile temporary detention are required to be held where the juvenile is located. This requirement prevents Prince William County staff from being involved in decisions regarding ordering juvenile mandatory outpatient treatment. Confusing eligibility criteria for mandatory outpatient treatment is another barrier to the use of mandatory outpatient treatment for juveniles.

Recommendations

The Work Group did not adopt any legislative or budget recommendations at the end of the 2015 interim. However, the Work Group did voice continued support for efforts to implement the STEP-VA model.

2016

May 17, 2016

Introductions and Opening Remarks; Remarks of the Secretary of Health and Human Resources

Following the call to order and introductions, the Work Group invited Secretary of Health and Human Resources Bill Hazel to speak about mental health services. Secretary Hazel began by noting the fragmented nature of publicly funded mental health services and other health and human services in the Commonwealth and calling for greater coordination among the various agencies and systems providing these services. He identified the Certified Community Behavioral Health Clinic (CCBHC) model as a promising approach to the delivery of

coordinated services that will improve system efficiency and outcomes for individuals receiving services and requested General Assembly support. Senator Deeds suggested that the Joint Subcommittee could work with Secretary Hazel to prepare a general plan for moving the Commonwealth toward the CCBHC model during the 2016 interim and encouraging the General Assembly to approve and support the plan during the 2017 Session. More detailed planning would be completed during the 2017 interim.

In response to a question from Delegate Farrell, Secretary Hazel identified several strengths and weaknesses of the existing mental health services system. He pointed to the variability in services provided by CSBs across the Commonwealth, as well as variability in the quality of public mental health services staff. However, a number of challenges lead to difficulty in retaining qualified staff. Another challenge is the focus on crisis services: While the Commonwealth has developed a robust system of emergency services, fewer resources have been put into developing services to prevent emergencies and keep individuals from experiencing crisis. Additionally, existing methods of funding public mental health services limit the ability of CSBs to develop the full range of services that individuals in their communities might need. Finally, data collection and analysis could be improved.

Overview of the Purpose and Scope of the Work Group

Staff provided an overview of the purpose and scope of the Work Group. The Work Group was created by the Joint Subcommittee to evaluate the existing publicly funded mental health services system, including the types of services provided by the publicly funded mental health services system, the organization and structure of the publicly funded mental health services system through which such services are provided, and the oversight and control of the publicly funded mental health services system, and to make recommendations for reform of the existing publicly funded mental health services system to ensure consistent delivery of a full array of high-quality mental health prevention, treatment, and recovery support services across the age range in a timely and effective manner throughout the Commonwealth. Specific topics that the Work Group might consider include:

- The appropriate degree of centralization or decentralization of the system;
- The appropriate balance of community-based and institutional services;
- The types of services to be provided to ensure appropriate access to the full array of services for children, adolescents, young adults, adults, and elderly adults;
- Methods of ensuring timely access to appropriate services;
- Appropriate oversight of services, including the quality of services and service outcomes; and
- The cost of reforms to the existing system necessary to implement changes recommended by the Work Group and options for financing such changes.

Senator Emmett W. Hanger, Jr., has been appointed to serve as the chairman of the Work Group. The other members of the Work Group are Senator R. Creigh Deeds and Delegate Peter F. Farrell.

Update on Activities of the Expert Advisory Panels

Staff also provided an update on the activities of the expert advisory panels in the absence of Professor Richard J. Bonnie, Director of the Institute of Law, Psychiatry and Public Policy at the University of Virginia School of Law, who has been charged with overseeing the creation and work of the expert advisory panels and who was unable to attend the Work Group meeting.

Work of the Expert Advisory Panels

At its first meeting of the 2016 interim, the Joint Subcommittee announced the creation of four expert advisory panels, one for each of the Joint Subcommittee's four work groups. The purpose of the expert advisory panels is to provide research assistance and other support to the work groups as they carry out their work during the 2016 and 2017 interims. All four expert advisory panels have held at least one meeting, some in person and others by conference call, and are working to develop work plans, identify research priorities, and begin collecting information. Expert advisory panel chairs are also participating in monthly conference calls to communicate with each other and Joint Subcommittee staff to coordinate panel and work group activities.

Research Activities

Through a contract with DBHDS and with funding provided by DBHDS, the Institute of Law, Psychiatry and Public Policy at the University of Virginia, of which Professor Richard Bonnie is the Director, has assembled a research team that includes public health data analysts, a health economist, and several graduate students in public policy, law, and public health to provide research support to the expert panels and the work groups. The research team has already begun work, planning structured interviews with the directors of every CSB in the Commonwealth beginning in June 2016 and preparing a detailed written survey to collect information about emergency services from CSBs' Emergency Services Directors that will be distributed in July 2016. The research team is also preparing an updated report on the impact of legislative changes affecting the delivery of mental health services, particularly emergency services, during the 2014 Session of the General Assembly as well as a study of emergency department waiting times for CSB prescreening evaluations. Updates on the activities of the research team will be provided to the work groups and the Joint Subcommittee regularly, and members of the work groups are encouraged to identify research topics for the research teams moving forward.

System Structure and Financing Expert Advisory Panel

The System Structure and Financing Expert Advisory Panel, chaired by Professor Richard Bonnie, met for the first time on April 12, 2016. At the meeting, members discussed challenges affecting the existing public mental health services system; options for organization of a more efficient public mental health services system; various options for funding of the public mental health services system, including expanded access to Medicaid; the need for coordination among and across agencies and secretariats and between the executive and legislative branches of state government to facilitate the successful reform and ongoing operation of the public mental health services system; the need for leadership in the development of mental health policy, coordination of education and information about challenges affecting the public mental health services system and solutions that can resolve those challenges, and oversight of implementation of strategies and solutions on an ongoing basis; and other factors affecting the delivery of public mental health services. Moving forward, the System Structure and Financing Expert Advisory Panel plans to look more closely at (i) how the public mental health services system is structured in other states to identify alternative services system models; (ii) examples of state-local system structures in the Commonwealth, including the public health system, the social services system, and the

public school system; and (iii) the content of performance contracts between the DBHDS and the CSBs.

Discussion of 2016 Work Plan

At the end of the meeting, the Work Group discussed its work plan for the 2016 interim. Staff presented a draft work plan setting out several items for further study. These include consideration of what the overarching system structure should look like, the types of services to be provided, ways to improve the delivery of those services, and how the system is to be financed. Specific issues to be studied might include the balance of state and local authority and control over the delivery of mental health services; the role of private contracted providers of services; target populations and the provision of services across the lifespan; the appropriate mix of inpatient and outpatient services, voluntary and involuntary services, and crisis and prevention services; ensuring adequate availability and accessibility of services; ensuring quality of services; ensuring continued delivery of services to individuals in transition, including individuals transitioning from involuntary to voluntary services, inpatient to outpatient services, and between localities; and coordination between various services systems, including the public mental health services system, the criminal justice system, the educational system, and the social services system.

At the request of the Work Group, members of the audience identified various issues that the Work Group might wish to explore further. These included the role of localities and the contributions of the private sector in funding mental health services; the relationship between private providers and the public mental health services system; challenges posed by uninsured individuals in need of mental health services; the impact of the Governor's Access Plan program; and potential costs and benefits of expanding Medicaid.

Looking forward, the Work Group agreed that a presentation on the financing of public mental health services would be beneficial. The Work Group also asked for demographic information about individuals receiving services from CSBs and updates on the work of the System Structure and Financing Expert Advisory Panel.

June 23, 2016

Presentation: Update on Activities of the System Structure and Financing Expert Advisory Panel

Dr. Richard Bonnie, Director of the Institute of Law, Psychiatry and Public Policy at the University of Virginia School of Law and Chairman of the System Structure and Financing Expert Advisory Panel, provided an update on the System Structure and Financing Expert Advisory Panel's activities since the last Work Group meeting. He reported that the System Structure and Financing Expert Advisory Panel had met twice in person and once by telephone, with a number of meetings scheduled to take place throughout the rest of the summer. Members had prepared three items for the Work Group to consider:

- *Initial Report on System Governance Structure.* Members of the System Structure and Financing Expert Advisory Panel evaluated research on system governance structures, starting with the report *Mental Health Governance: A Review of State Models and Guide for Nevada Decision Makers*, prepared by the Guinn Center for Policy Priorities in December 2014 to assist Nevada lawmakers in determining the appropriate structure for

the public mental health services system in that state. The report identified three system governance structures: (i) completely state-operated community-based services delivered by state agencies with no local government role (four states); (ii) state-funded services delivered by public or private agencies pursuant to contracts with the state with no local government role (31 states); and (iii) locally controlled community-based services delivered directly or by private agencies pursuant to contracts with the local government supported by some level of state funding (15 states). Currently, Virginia falls in the third category. In recent years, at least one state (North Carolina) has transitioned from one system governance structure (locally controlled) to another (state-controlled services delivered by public and private agencies pursuant to contracts with the state).

The System Structure and Financing Expert Advisory Panel considered these various models and the potential positive and negative outcomes of transitioning from the current model to another model. Ultimately, members concluded that the best option would be to retain the current system governance structure, with local control over service delivery. The members felt this model preserves the important flexibility of the system to respond to diverse local needs. Members did determine, however, that an increase in state control over the delivery of services within this model, potentially through changes to performance contracts with CSBs, would be beneficial, as greater state control could help address issues of inadequate and inconsistent services and service delivery. The System Structure and Financing Expert Advisory Panel will provide additional recommendations related to improvements in state control over service delivery at future meetings.

- *Problem Statement and Work Plan.* The problem statement and work plan describes the nature of the issues that the System Structure and Financing Expert Advisory Panel seeks to address, specifically unmet needs for mental health services, inadequate access to mental health services, inconsistency in available mental health services, and underutilization of mental health services by those in need. The document also describes the System Structure and Financing Expert Advisory Panel's work plan for developing recommendations to address these issues. The work plan includes (i) defining the necessary array of services and target populations to be served, (ii) identifying options for increasing available funding for services to provide the minimum necessary array to individuals not covered by private insurance, and (iii) enhancing state direction and oversight of public mental health services system through DBHDS. The System Structure and Financing Expert Advisory Panel will provide additional information on and recommendations related to these topics at future meetings.
- *Governance Structure-Finance Diagram.* The governance structure-finance diagram provides a visual map of the system governance structure, representing relationships between the various system participants.

Dr. Bonnie also noted that the survey of CSB executive directors was ongoing; that interviews were being conducted to collect information about executive directors' perceptions regarding the needs, strengths, and weaknesses of the current system and the priorities for reform; and that results of the surveys should be available at the next meeting.

At the end of Dr. Bonnie's presentation, the Work Group members agreed to support conclusions set out in the initial report on system governance structure, contingent on some reforms to improve oversight and accountability in the future. Senator Deeds noted that it would

be beneficial to determine why some localities invest such a substantial amount of local funds in the local services system while others invest only the required minimum. Dr. Bonnie stated that the research staff was working to collect data and information about local government involvement and how local government investment has been encouraged in other states. Senator Hanger noted the importance of investing in reforms to the mental health services system now, to prevent even more substantial problems in the future, and encouraged the System Structure and Financing Expert Advisory Panel to continue evaluating other states to see what lessons could be learned from their successes and their failures.

Presentation: Community Services Board Performance Contracts

Daniel Herr, Assistant Commissioner of Behavioral Health Services, Department of Behavioral Health and Developmental Services, provided information about CSB performance contracts. As set out in the Code of Virginia, CSBs are the single point of entry into the publicly funded behavioral health and developmental services system. Services provided by CSBs are funded through a mix of local, state, and federal funds. Performance contracts define the relationship between and the responsibilities of DBHDS and CSBs, communicate state and federal accountability requirements for CSBs, and provide the mechanism by which DBHDS allocates funds for community services. Performance contracts are renegotiated every year, following a process that involves public notice of and comment on a draft contract, and must be signed by the CSB chairperson, the CSB executive director, and the Commissioner of Behavioral Health and Developmental Services. Each contract consists of a standard contract and 10 exhibits. The contract is the same for all 40 CSBs in the Commonwealth. Most of the exhibits are the same for all of the CSBs in the Commonwealth, but several contain information and agreements that are specific to individual CSBs. These include Exhibit A, which details the funds available to and services provided by a CSB, and Exhibit D, which details individual CSB performance measures. The performance contract also incorporates by reference a partnership agreement that describes the roles and responsibilities of the CSB, DBHDS, and state hospitals and training centers and includes sections on core values, accountability, inclusion of individuals receiving services, quality improvement, and technical assistance.

Mr. Herr reported that DBHDS evaluates and monitors CSB performance pursuant to performance contracts in various ways through the year, including mid-year and end-of-fiscal-year financial reports on funds and expenditures, reports on individuals served and types of services provided, audits conducted by certified public accountants of operating boards and behavioral health authorities and financial reviews of CSBs identified as “high risk,” and program and clinical reviews conducted by regional consultants to provide oversight and technical assistance. Mr. Herr noted that DBHDS is developing behavioral health services quality monitoring processes with measures and benchmarks to provide further oversight and accountability.

At the end of his presentation, Mr. Herr noted that Item 315.FF of the 2016 Appropriation Act requires DBHDS to develop a plan to implement a performance-based contracting system for CSBs. Research has shown that the most successful performance-based contracting models use mutually agreed-upon measures between funder and provider and incorporate small, incremental rewards and penalties rather than large rewards and penalties. Research also indicates that the focus should be on the visibility of provider performance while minimizing disruption to services. These concepts will be incorporated into DBHDS’s plan. A report on the plan shall be provided to the General Assembly by November 1, 2016.

Presentation: Public Mental Health Spending in Virginia

Mike Tweedy, Legislative Fiscal Analyst, Health and Human Resources, Virginia Senate Finance Committee, provided an overview of public mental health services system financing in the Commonwealth. Mr. Tweedy reported that nationally the public share of mental health spending has increased over time, with total spending increasing from \$32.4 billion in 1986 to an expected \$238.4 billion in 2020. Financing of public mental health services consists of a combination of out-of-pocket, private insurance, local, state, Medicaid, Medicare, and other federal funds. Over time, the proportion of state and local spending has decreased while the proportion of Medicaid and Medicare spending has increased, with substantial increases in the portion of public mental health services funded by Medicaid. Taking into account the state share of Medicaid, state funds are the single largest source of funding for public mental health services in the Commonwealth. In fiscal year 2014-2015 (FY 2015), 56% of funds for public mental health services in the Commonwealth were state funds, 30% were federal funds, 10% were local funds, and 4% came from other sources. That year, total public mental health funding was \$1.75 billion, with 43% of funds allocated to CSBs, 19% to state hospitals, 3% to DBHDS's central office support, and 35% to Medicaid. During the same period, the Commonwealth ranked 6th in the nation in terms of state spending on state psychiatric hospitals, 22nd in state funding of community-based programs, and 15th in terms of total expenditures for public mental health services. During FY 2015, CSBs received a total of \$747.8 million in funding, including \$252.1 million in state funds, \$160.5 million in local funds, \$256.5 million in fees (primarily Medicaid payments to CSBs for services provided to program participants), \$54 million in federal funds, and \$24.7 million from other sources. Local funding for CSBs varies substantially across the Commonwealth, with a few CSBs accounting for a substantial portion of the local funds spent on public mental health services.

August 22, 2016

Presentation: Update on Activities of the System Structure and Financing Expert Advisory Panel

Staff read a report on the activities of the System Structure and Financing Expert Advisory Panel prepared by Dr. Richard Bonnie, Director of the Institute of Law, Psychiatry and Public Policy at the University of Virginia School of Law and Chairman of the System Structure and Financing Expert Advisory Panel. The report summarized several topics that the System Structure and Financing Expert Advisory Panel was investigating:

- ***Closing gaps in service capacity and access*** - The System Structure and Financing Expert Advisory Panel continued to move forward with analysis of the elements required to transform the public mental health services system in the 21st century and implement the elements of the STEP-VA model developed by DBHDS. As part of this effort, the System Structure and Financing Expert Advisory Panel would be working with the experts at DBHDS to develop reasonable estimates of the cost of achieving the level of service capacity envisioned in the STEP-VA plan on a statewide basis over the next decade.
- ***Creating necessary data capacity*** - The System Structure and Financing Expert Advisory Panel believes that a transformed public mental health services system requires a robust data system to measure performance and outcomes. Unfortunately, the necessary data

infrastructure does not yet exist, and many of the necessary data elements are not yet available. With assistance from DBHDS and other state agencies, the System Structure and Financing Expert Advisory Panel is attempting to identify the gaps and make timely recommendations to build the necessary data capability to support the transformed system of care.

- ***Solving cross-system challenges*** - The System Structure and Financing Expert Advisory Panel believes that several of the most significant challenges to delivery of services to vulnerable populations result from gaps and misalignments in services across systems, including challenges related to safe transportation for persons in crisis and delivery of necessary services to juveniles and adults in detention or as they are released from custody. Because these challenges involve structural problems, especially at the local level, the System Structure and Financing Expert Advisory Panel is working with the expert panels on criminal justice diversion and crisis response to study local innovations and facilitate creative solutions.
- ***Coordinating publicly funded mental health services*** - The System Structure and Financing Expert Advisory Panel has been exploring opportunities for improving alignment of Medicaid-funded mental health services and services funded by state general funds. The financing of mental health services with federal, state, and local revenues has become increasingly complex, especially in the context of recent federal health care reform initiatives and the promising trend toward integration of behavioral health and general medical care. The System Structure and Financing Expert Advisory Panel's work in this important domain is in a learning phase, and the System Structure and Financing Expert Advisory Panel expects to continue this inquiry in the months ahead.
- ***Linking CSB funding to state hospital use*** - The System Structure and Financing Expert Advisory Panel has been reviewing the concept of linking CSB funding to state hospital utilization. Since the advent of the "last resort" legislation in July 2014, admissions to state hospitals have increased 42% (from 4,275 in FY14 to 6,082 in FY16), while temporary detention order (TDO) admissions to state hospitals have increased 164% (from 1,319 in FY14 to 3,477 in FY16). At the same time, on any given day approximately 150 individuals are on the DBHDS Extraordinary Barriers List (EBL). These individuals no longer need state hospital care but remain hospitalized for want of a suitable community support plan. The EBL cohort uses a significant amount of state hospital resources that could be devoted to acute care. In response to this situation, DBHDS has initiated a dialogue with CSBs about the possibility of linking CSB funding to state hospital utilization targets in order to create financial incentives to reduce state hospital usage to safer levels and to assure that CSBs will have access to acute beds within their region when necessary. Mechanisms that link community funding to state hospital utilization exist in many other states, and the System Structure and Financing Expert Advisory Panel is currently researching these mechanisms to develop possible options.

The report also identified the System Structure and Financing Expert Advisory Panel's immediate priorities. Specifically, the System Structure and Financing Expert Advisory Panel is working on preparation of a report in the fall of 2017 that will lay out policy and budget recommendations for the 2018 Session of the General Assembly. Dr. Bonnie noted that he had

asked each of the other expert advisory panels to identify possible recommendations for statutory or budget changes that appear to be urgent or that are otherwise ripe for consideration by the Joint Subcommittee and to provide those recommendations to the System Structure and Financing Expert Advisory Panel for review at its meeting in late September. The System Structure and Financing Expert Advisory Panel will present any recommendations for the 2017 Session of the General Assembly to the Work Group at the Work Group's October meeting.

Presentation: Implementation of the CCBHC Model: Service Definitions, Service Descriptions and Community Services Boards Needs Assessment

Daniel Herr, Assistant Commissioner of Behavioral Health Services, Department of Behavioral Health and Developmental Services, provided information about the 10 core services of the CCBHC-type model. These include same-day access to assessment and screening, outpatient clinical primary care screening and monitoring, crisis services, person-centered treatment planning, outpatient mental health and substance abuse services, psychiatric rehabilitation services, peer and family support services, mental health services for members of the armed forces and veterans with limited access to services provided through Veterans Administration medical facilities, care coordination services, and targeted case management. Mr. Herr also described the results of the community needs assessment performed by DBHDS. The needs assessment sought to establish community demographics, prevalence rates, penetration rates, and relevant social indicators for mental health service needs at each CSB. The needs assessment also compared identified units of services needed to existing units of service for each category and the gap between existing services and the population needs. This will allow DBHDS and CSBs to develop plans for addressing service needs and barriers to service development, identify timeframes for developing and implementing new or additional services, and create a matrix for costs of developing and implementing services.

Presentation: Community Services Board Data Collection options

Alan Wass presented information about data collection options for CSBs. He noted that currently data collection is difficult and latency is high; data gathered does not offer CSBs insight into their own business efficiency or effectiveness; metrics are not industry standard making comparative analyses difficult; and there is little in the current design to support measuring outcomes. At the same time, many stakeholders want data on CSBs' activities and outcomes to inform data-driven decision making. To address this need, DBHDS has reviewed data collection options. The process has been process-focused and has taken into account available technology. Five options have been reviewed and the pros and cons of each option have been evaluated. The final recommendation, Mr. Wass reported, was that DBHDS execute a project to move to standard metrics, measures, and data transmissions. This should involve engaging a consulting firm to drive business metric development; engaging electronic health records vendors to assess basic or add-on data mart or data warehouse performance products; assessing any third-party data products as needed; establishing direct, secure communication with CSBs; driving adoption of meaningful use outcome measures, business metrics that support the CSBs and inform DBHDS, and measures to support the needs of individuals receiving care; and adopting a "balanced score card" approach to key metrics.

Presentation: Local Government Perspectives on Publicly Funded Mental Health Services

Michael Murphy, Assistant City Manager, Charlottesville, spoke about the role of local governments in providing mental health services. He noted that the services provided by local

governments encompass more than just services provided through CSBs, including foster care services; services provided through the Children's Services Act; services provided in jails; law enforcement, fire, and emergency medical services response; drug courts; home visiting groups; and funding for mental health nonprofit organizations. Local governments collaborate with a range of service providers to address mental health and substance abuse service needs. He noted that needs continue to exist and that local governments continue to work toward filling those needs.

Janet Areson, Director of Policy Development, Virginia Municipal League, provided an overview of the many types of mental health and related services that localities provide.

September 30, 2016

Update on Activities of the System Structure and Financing Expert Advisory Panel

Dr. Richard Bonnie, Director of the Institute of Law, Psychiatry and Public Policy at the University of Virginia School of Law and Chairman of the System Structure and Financing Expert Advisory Panel, reported that the System Structure and Financing Expert Advisory Panel had been working on a number of issues related to goals and responsibilities of the public mental health services system: oversight, accountability, leadership, and coordination of the public mental health services system; mandated services for CSBs; state hospital utilization rates; and options for financing changes to the mental health services system.

Preliminary Report and Recommendations on Core Services

Staff presented a preliminary report that described the 10 services included in the STEP-VA model of public behavioral health services developed by DBHDS. The report also set out estimates of funding required to implement each of the 10 services described and identified two priorities for implementation: same-day access to services and outpatient primary care screening, monitoring, and referral. Following discussion of the reasons for identifying these two priorities, the Work Group voted to adopt the plan as described in the preliminary report and to move forward with the priorities identified.

Update from DBHDS

Dr. Jack Barber, Interim Commissioner, Department of Behavioral Health and Developmental Services, spoke with the Work Group regarding how the estimates of costs for implementation of the 10 services identified in the preliminary report were determined and spoke about how the priorities were identified. Delegate Farrell inquired as to whether DBHDS was concerned about overloading the existing services system by implementing same-day access without investing in development of additional services. Dr. Barber described the benefits to individuals receiving services from CSBs of implementing same-day access, including improving connection to services and improving follow-through with services, as well as introducing greater efficiency in business practices and reducing no-shows for appointments.

Senator Hanger mentioned the impact of recent legislative changes on state hospital bed utilization. He specifically mentioned the need to examine the Commonwealth's relationship with private facilities and to develop better partnerships to address the need for beds. Dr. Barber addressed the need to make sure beds are available for those in need, noting that private facilities tend to accept many individuals involved in the temporary detention and involuntary commitment process but that the need for state hospital beds has increased. He emphasized the

need to address both the needs of individuals entering the system and the needs of individuals who are ready for discharge.

State Hospital Utilization Rates

Jim Martinez, a member of the System Structure and Financing Expert Advisory Panel, described research into options for addressing state hospital bed utilization. A copy of the report can be found on the Joint Subcommittee's website at <http://dls.virginia.gov/groups/mhs/bed%20utilization.pdf>. System Structure and Financing Expert Advisory Panel members stated that additional research into the issue was required and that recommendations would be forthcoming at a later meeting.

October 26, 2016

Update on Activities of the Expert Advisory Panel

Dr. Richard Bonnie, Director of the Institute of Law, Psychiatry and Public Policy at the University of Virginia School of Law and Chairman of the System Structure and Financing Expert Advisory Panel, provided an update on the activities of the System Structure and Financing Expert Advisory Panel.

Report on Core Services

Dr. Bonnie presented the System Structure and Financing Expert Advisory Panel's Interim Report on Core Services, noting the fragmented nature of the services system, inconsistent availability of services due to variability among CSBs, and lack of clear accountability and oversight. He noted that the Commonwealth needs a clear vision of what the behavioral health system should look like and a road map to reach that goal. The System Structure and Financing Expert Advisory Panel has studied the STEP-VA plan developed by DBHDS and believes that it meets these needs. The STEP-VA plan lays out 10 core services that should be provided by the behavioral health system. DBHDS has identified same-day access, primary health screening and referral, and outpatient mental health and substance abuse services as priorities and has developed a multiyear, multiphase plan for financing and implementing STEP-VA.

Staff presented a Preliminary Report on Services that set out service descriptions for the 10 services envisioned in the STEP-VA model and the estimated costs of implementing each of those services. Following some discussion of the need to develop a more complete plan for implementation of STEP-VA moving forward, the Work Group agreed that the STEP-VA model represented a good blueprint for the Commonwealth's behavioral health system moving forward and agreed to support both the model and the implementation of same-day access and primary health screening and referral as priorities for the 2017 Session of the General Assembly.

Report on Hospital Bed Utilization

Dr. Richard Bonnie and Jim Martinez presented the System Structure and Financing Expert Advisory Panel's Proposal on Managing State Hospital Utilization. They reported that since Virginia's "last resort" legislation took effect in July 2014, admissions to Virginia's nine state hospitals have increased 54% over FY 2013. Admissions to state hospitals of individuals under TDOs have increased 157% over the same time period. Simultaneously, the proportion of TDO admissions going to private or community hospitals statewide has decreased significantly. In addition, as many as 150–180 individuals on any given day are clinically ready for discharge

from Virginia state hospitals but continue to occupy much-needed beds, often well beyond the necessary period of hospitalization and at great expense to the Commonwealth. State hospitals are consistently operating at utilization levels of 95% or higher, while best practices indicate that patient and staff safety is reduced at utilization levels over 85%. At times, several state hospitals have been at 100% of operating capacity, causing delayed admissions for some individuals, as well as the use of temporary beds. In addition, there has been regular diversion of individuals from their home catchment areas to state hospitals much farther away, which causes transportation challenges for law enforcement and creates additional care coordination problems for care providers. These developments have occurred amid declining budgets over the last decade and have contributed to increased staff turnover.

At a recent System Structure and Financing Expert Advisory Panel meeting, DBHDS reported that it began an ongoing dialogue with Virginia CSBs and state hospitals in May 2016, with the goal of raising awareness of the inherent risks and liabilities of the current situation, and to explore strategies that would reduce and stabilize state hospital utilization of CSBs at safer levels (e.g., 90%), build community program capacity, and ensure that CSBs within each state hospital's region would have necessary access to acute beds. A number of strategies have been implemented, and DBHDS has also set aside \$8.7 million in one-time funds from existing budgets to allocate to regions and CSBs for system capacity-building.

The System Structure and Financing Expert Advisory Panel strongly supports these DBHDS and CSB initiatives. The System Structure and Financing Expert Advisory Panel also recognizes, however, that excessive demand on state hospital beds has been an ongoing challenge for the behavioral health system for decades and that the current initiatives are limited in scope and funded with one-time dollars. The System Structure and Financing Expert Advisory Panel is also convinced that permanent and lasting change will not be achieved without permanent and lasting support, including funds and other resources, as well as leadership commitment. Moreover, these initiatives do not address the structural incentives built into the system that are almost certainly producing or exacerbating the increased pressure on state hospitals. These structural incentives include the "last resort" laws, the bias toward involuntary (versus voluntary) care in the provision of short-term treatment for temporary detention and in transportation, the "free care" provided by state hospitals to CSBs, and the discretion granted to private hospitals regarding all admissions. The System Structure and Financing Expert Advisory Panel believes that these and possibly other structural incentives warrant further study in the upcoming year, which may yield important keys to achieving a more balanced and accountable community-based system of care for Virginia in the long term.

In light of these issues, and on the basis of extensive discussion, the System Structure and Financing Expert Advisory Panel offered four recommendations:

- 1) That DBHDS, CSBs, and state hospitals implement the agreed-upon FY 2017 census reduction initiatives and periodically (upon request) report on the progress and impact of these initiatives on the Extraordinary Barriers List and overall state hospital use to the System Structure and Financing Expert Advisory Panel, Work Group, and Joint Subcommittee.
- 2) That DBHDS and CSBs develop budget request(s) for FY 2018 to support continued targeted CSB and regional interventions to stabilize and maintain state hospital utilization at no more than 90% of the January 1, 2017, operating capacity of each DBHDS state hospital.

- 3) That the System Structure and Financing Expert Advisory Panel and Work Group continue to study the statutory, policy, financing, and administrative elements of the current behavioral health system that are not aligned with strategic and operational objectives, or that create impediments to efficient and effective care, and recommend solutions to the Joint Subcommittee by October 30, 2017, including the use of financial risks and incentives to achieve targeted performance objectives.
- 4) That DBHDS, in cooperation with the Department of Medical Assistance Services (DMAS), study the potential use of the Involuntary Mental Commitment Fund (IMCF) for both voluntary inpatient treatment and involuntary temporary detention, in order to create an incentive to reduce the use of involuntary treatment statewide. The two agencies shall also study the possible transfer of the IMCF fund from DMAS management to DBHDS control and any other strategies for improving the use of these funds.

Report on Telemental Health

Dr. Bonnie described recent efforts to increase the use of telemental health services in the Commonwealth. Telemental health is the use of electronic information and telecommunications technologies to support the delivery of behavioral health services at a distance. This includes clinical care, patient and professional health-related education, public health, and administration. A variety of modalities can be used to deliver these services, including live interactive videoconferencing, remote monitoring, and mobile applications. Providers of telemental health include psychiatrists, psychologists, social workers, psychiatric nurse practitioners, and licensed professional counselors.

Significant challenges to access to and provision of mental health services exist in the Commonwealth. Resources available to local and regional CSBs and behavioral health authorities have not kept pace with the increasing number of persons in need of services. This is particularly true in rural and other underserved communities. Multiple reviews of the telemental health literature regarding its efficacy for diagnosis and assessment across a variety of populations (adult, child, geriatric) and for a variety of disorders and settings have largely shown that it is comparable to in-person care. Telehealth-enabled new models of care (e.g., remote monitoring/hovering, interprofessional collaborative care teams, mobile health) have also demonstrated very positive outcomes. Telemental health is therefore not only a viable but an essential tool for bridging the existing care gap. However, despite its demonstrated utility, telemental health has not been widely adopted within the Commonwealth.

During the 2016 interim, the System Structure and Financing Expert Advisory Panel and Crisis Response and Emergency Services Expert Advisory Panel jointly established a Telemental Health Work Group to develop policy proposals to remove impediments to greater use of telemental health services. Specifically, the Telemental Health Work Group was asked to identify barriers to greater use of telemental health services in the Commonwealth and to identify policy options for overcoming those barriers.

In October 2016, the Telemental Health Work Group reported on 30 policy options to address six specific barriers to greater use of telemental health services. The Telemental Health Work Group also provided 12 specific recommendations for immediate consideration. These recommendations addressed provider barriers, workforce barriers, financial barriers, patient/client barriers, and policy barriers. Despite the thorough work of the Telemental Health Work Group, additional analysis and evaluation of policy options may be required. Therefore,

the Telemental Health Work Group recommends that the Joint Commission on Health Care (JCHC) be asked to review the Report of the Telemental Health Work Group on Policy Development, established by the Joint Subcommittee; study the issues and proposals set forth in the report; and develop recommendations for increasing the use of telemental health services in the Commonwealth. The JCHC should report its findings and recommendations to the Joint Subcommittee by December 1, 2017.

Report on Data Sharing Challenges

Dr. Bonnie noted that the System Structure and Financing Expert Advisory Panel had identified data sharing challenges as a major barrier to the transformation of the behavioral health system. One specific challenge relates to the sharing of data regarding TDOs and outcomes between the Supreme Court of Virginia's data systems and the data systems of DBHDS. To address this issue and allow for greater sharing of data, the System Structure and Financing Expert Advisory Panel proposed a revision to § 37.2-818 of the Code of Virginia that would require district courts to transmit records and information pertaining to proceedings, hearings, and orders provided for pursuant to Chapter 8 (§ 37.2-800 et seq.) of Title 37.2 of the Code of Virginia (dealing with emergency custody, temporary detention, and involuntary commitment, including identifiable information) to DBHDS upon request for the purpose of enabling DBHDS to maintain statistical archives, conduct research, and otherwise carry out its responsibilities.

Comments on Recommendations of Other Expert Advisory Panels

Dr. Bonnie provided a brief overview of proposals developed in the other expert advisory panels, including several proposals related to housing for individuals with serious mental illness, alternative transportation, and developing alternative service models for emergency services to take pressure off hospital emergency departments.

Discussion of Final Recommendations for 2017 Session

Following the update on activities of the System Structure and Financing Expert Advisory Panel, the Work Group discussed recommendations for the 2017 Session. Recommendations identified as priorities included implementation of same-day access to screening and outpatient primary care screening and monitoring services included in the STEP-VA model, expansion of telemental health services, amendments to § 37.2-818 of the Code of Virginia to encourage data sharing, and recommendations to address utilization of state hospitals. Senator Deeds noted that the Joint Subcommittee will need to finalize its recommendations at the December 6, 2016, meeting.

December 6, 2016

Update on activities of the System Structure and Financing Expert Advisory Panel

Dr. Richard Bonnie Director of the Institute of Law, Psychiatry and Public Policy at the University of Virginia School of Law and Chairman of the System Structure and Financing Expert Advisory Panel, provided a brief update on the work of the expert advisory panels. Following his presentation, the members of the Work Group asked for additional information on issues related to structure of the system, highlighting the need to develop strategies to address lack of consistency and uniformity of services, to ensure effectiveness and efficiency, to address fragmentation. The members asked for information about different models of service delivery. Dr. Bonnie noted that the expert advisory panels were working with DBHDS to secure data for a more thorough analysis and will have more information in the future.

Recommendations for 2017

At the end of the meeting, the Work Group adopted the following recommendations:

- **RECOMMENDATION 1:** Endorse the goal of the Commonwealth's public mental health services system of providing access to 10 services that would ensure that all individuals with mental illness receive needed services and fully fund the statewide implementation of two of these 10 services: same-day access to mental health screening services (estimated cost: \$1.5 million in FY 2017, \$12.3 million in FY 2018, and \$17.3 million annually thereafter) and outpatient primary care screening and monitoring services (estimated cost: \$3.72 million in FY 2019 and \$7.44 million annually thereafter). The 10 service goals are as follows:
 - Emergency services;
 - Same-day access to mental health screening services;
 - Outpatient primary care screening and monitoring services;
 - Crisis services;
 - Outpatient mental health and substance abuse services;
 - Psychiatric rehabilitation services;
 - Peer support and family support services;
 - Mental health services for members of the armed forces and veterans;
 - Care coordination services; and
 - Case management services, including targeted mental health case management services.
- **RECOMMENDATION 2:** Request the Joint Commission on Health Care to review the Work Group's report on telemental health services and develop recommendations for increasing the use of telemental health services.
- **RECOMMENDATION 3:** Amend § 37.2-818 of the Code of Virginia to allow transmission of records related to involuntary admission proceedings to DBHDS to enable it to maintain statistical archives and conduct research on the consequences and characteristics of such proceedings.
- **RECOMMENDATION 4:** Manage the utilization of Virginia's state hospitals through the following:
 - Implementation of the census reduction initiatives adopted by DBHDS and the CSBs;
 - Development of budget requests by DBHDS for FY 2018 to stabilize and maintain state hospital utilization at no more than 90 percent of capacity;
 - Continued study by the Work Group of the statutory, policy, financing, and administrative elements of the current mental health services system that are not aligned with the Work Group's strategic and operational objectives; and

- Study by DBHDS and DMAS of the potential use of the Involuntary Mental Commitment Fund for both involuntary and voluntary temporary detention.

2017

June 12, 2017

Update on Activities of the System Structure and Financing Expert Advisory Panel

Dr. Richard Bonnie, Director of the Institute of Law, Psychiatry and Public Policy at the University of Virginia School of Law and Chairman of the System Structure and Financing Expert Advisory Panel, provided an update on the activities of the System Structure and Financing Expert Advisory Panel. Dr. Bonnie noted that at the beginning of the 2016 interim, the System Structure and Financing Expert Advisory Panel concluded that the existing system structure should be preserved and, rather than making significant changes to the system, the General Assembly should focus on addressing eight key needs identified as necessary for improving the statewide system of delivering publicly funded mental health services for children and adults. These included (i) ensuring access to a full array of core services; (ii) aligning services provided and mechanisms of accountability across the system and providers; (iii) assuring timely, safe, and effective provision of emergency services; (iv) developing an integrated data system to collect, protect, and ensure the appropriate and timely sharing of data; (v) identifying and utilizing the most appropriate criteria and measures for monitoring outcomes and performance; (vi) strengthening oversight and authority of the state to ensure that goals of the publicly funded mental health services system are being met; (vii) facilitating local and regional cooperation in providing services; (viii) developing an effective system of reeducating, training, and retaining a skilled workforce; and (ix) using such workforce effectively and efficiently to provide necessary services. Actions taken during the 2017 Session of the General Assembly indicate that the General Assembly has begun to address some of these issues.

Looking forward to the 2017 interim and beyond, Dr. Bonnie reported that the System Structure and Financing Expert Advisory Panel will continue to focus on realigning the fiscal relationship between the state hospitals and CSBs; monitoring efforts of DMAS and DBHDS to align mental health services provided to uninsured clients of CSBs with those provided to Medicaid covered clients enrolled in managed care; developing and supporting an integrated data system to collect and share information about individuals served, services provided, and the outcomes and impacts of those services; developing criteria and measures of outcomes for publicly funded services; and supporting the integration of behavioral health and primary medical care services. The System Structure and Financing Expert Advisory Panel will also begin to examine the authorities and responsibilities of state agencies in delivering mental health services and the roles, needs, and responsibilities of local governments in the delivery of mental health services in the Commonwealth. The System Structure and Financing Expert Advisory Panel will also continue to monitor federal actions related to health care reform.

Update on Activities of the Department of Behavioral Health and Developmental Services

Dr. Jack Barber, Interim Commissioner, Department of Behavioral Health and Developmental Services, provided an update on DBHDS activities. He provided an overview of current demands on the public behavioral health system and recent successes in reducing waiting lists and improving access to services. Dr. Barber also described current challenges facing the public behavioral health system and recent successes in transforming the system, including progress in

implementing the STEP-VA model. Key among these successes is the implementation of same-day access to assessment and screening. Funding provided by the General Assembly during the 2017 Session will allow 18 CSBs to move forward with implementation. Dr. Barber also highlighted the work being done in service process quality management, next steps for implementation of STEP-VA, efforts to provide behavioral health services for uninsured Virginians, workforce issues affecting state hospitals, an increase in the number of individuals on the Extraordinary Barriers List, the impact of stable housing on state hospitals and permanent supportive housing initiatives underway in the Commonwealth, and the status of the justice-involved transformation team's recommendations.

Update on Development of an Alternative Transportation Model Pursuant to House Bill 1426 (2017)/Senate Bill 1221 (2017)

Will Frank, Director of Legislative Affairs, Department of Behavioral Health and Developmental Services, and Shannon Dion, Director of Policy and Legislative Affairs, Department of Criminal Justice Services, provided an update of activities related to development of an alternative transportation model pursuant to House Bill 1426 and Senate Bill 1221. The bills directed the Commissioner of Behavioral Health and Developmental Services and the Director of Criminal Justice Services, in conjunction with relevant stakeholders, to develop a model for the use of alternative transportation providers to provide safe and efficient transportation of individuals involved in the emergency custody or involuntary admission process as an alternative to transportation by law enforcement. The legislation provided that the model should include criteria for the certification of alternative transportation providers, including the development of a training curriculum required to achieve such certification, and should identify the appropriate agency responsible for providing such training and such certification. The legislation also directed the Commissioner of Behavioral Health and Developmental Services and the Director of Criminal Justice Services to identify any barriers to the use of alternative transportation in the Commonwealth and detail the costs associated with the implementation of such a model, along with the cost savings and benefits associated with the successful implementation of such a model. The Director of Behavioral Health and Developmental Services and the Commissioner of Criminal Justice Services are required to complete the model by October 1, 2017, and to report on the model to the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century, the House Committee for Courts of Justice, and the Senate Committee for Courts of Justice.

Mr. Frank and Ms. Dion reported that a work group of relevant stakeholders has been formed and that two meetings were held in May 2017 to begin the work of developing a model of alternative transportation that focuses on recovery and provides a true alternative to transportation by law enforcement. A third meeting is scheduled for late July and the work group plans to have a draft report available for review by work group participants by August 1. The final report will be made available to the General Assembly by October 1, 2017.

Update on Activities of the Crisis Response and Emergency Services Expert Advisory Panel

John Oliver, Chairman of the Crisis Response and Emergency Services Expert Advisory Panel, provided an update on the activities and priorities of the Crisis Response and Emergency Services Expert Advisory Panel for the 2017 interim. Mr. Oliver noted that during the 2016 interim, the Crisis Response and Emergency Services Expert Advisory Panel identified four challenges to the emergency mental health services system as top priorities for reform. These

included the need for (i) psychiatric emergency centers to provide assessment of and care for individuals experiencing mental health crisis; (ii) increased use of telepsychiatry to facilitate timely assessment, including pre-admission screening by CSB evaluators, of and treatment for individuals experiencing mental health crisis in underserved areas of the Commonwealth; (iii) alternatives to transportation by law enforcement for people experiencing mental health crisis; and (iv) a standardized set of emergency mental health services that should be available to all individuals experiencing mental health crisis, regardless of an individual's location in the Commonwealth. Looking ahead to 2017, the Crisis Response and Emergency Services Expert Advisory Panel will focus on these issues as well as the need for a more robust system of mandatory outpatient treatment.

Presentation on Work of the Farley Health Policy Center of the University of Colorado School of Medicine in the Commonwealth

Dr. Benjamin F. Miller, PsyD., Director, Eugene S. Farley Health Policy Center, presented on the work of the Farley Center and policy considerations for advancing mental health in the Commonwealth. Dr. Miller began by emphasizing the need to create a culture of whole health that integrates behavioral health and primary care. He reported that the Farley Center had received a \$1 million grant from the Robert Wood Johnson Foundation to advance the integration of care by providing technical assistance to policy makers and piloting efforts to better connect health care stakeholders. Key elements to be addressed in any process of integration include:

- Access - developing a “no wrong door” policy for entry into the services system;
- Attribution - determining who holds the risk for people with mental health service needs;
- Accountability - holding those involved in the delivery of mental health services accountable in meeting mental health service needs;
- Alignment - ensuring that state agencies and other stakeholders are working together in an integrated model of service delivery;
- Analytics - building upon a foundation of data and information to develop an effective and efficient services system; and
- Ask - determining what the Commonwealth needs to do to move forward in developing and implementing an effective, integrated services system.

Dr. Miller noted that Virginia has a unique opportunity to make transformative systems changes that fully integrate behavioral and primary health care. Guiding principles for such a transformation might include standards for mental health and substance use services; oversight of delivery and financing; transparency of process; and accountability of goals, including costs, outcomes, and other quality measures. Five key areas of focus for the Commonwealth include standards of care and competencies for delivery across multiple settings; workforce; data and information exchange and coordination of care; payment reform; and development of sound policies to support transformation and integration.

Discussion of 2017 Work Plan

The Work Group members briefly discussed options for the work plan for the 2017 interim. Staff will coordinate with Work Group members to develop a plan and will make the plan available at the next Work Group meeting.

November 27, 2017

Implementation of STEP-VA and Financial Realignment

Dr. Jack Barber, Interim Commissioner, Department of Behavioral Health and Developmental Services, gave an update on implementation of STEP-VA and DBHDS's financial realignment strategy. He provided an overview of state spending for inpatient and community-based services, the number of emergency evaluations and temporary detention orders each year, changes in state hospital admission and discharge rates in recent years, waiting lists for discharge from state hospitals, and waiting lists for services in jails. He noted that all state hospitals experience extremely high censuses and that adequately staffing state hospitals is a problem, adding to the challenge created by high censuses. The increase in the number of temporary detention orders (TDOs) and a reduction in the portion of individuals subject to a TDO served by private hospitals are significant drivers of high censuses at state hospitals.

To address the problem of high state hospital censuses, Dr. Barber proposed a fiscal realignment strategy. The basic strategy, as outlined by Dr. Barber, is to increase availability of community-based services to reduce demand for services in state hospitals and to provide financial incentives to CSBs to utilize community-based rather than state hospital placements. In year one, DBHDS will focus on building community-based services to provide an alternative to state hospital placements. During this year, DBHDS will also focus on transitioning individuals on the Extraordinary Barriers List from state hospital placements to community-based placements. In year two, DBHDS will focus on establishing bed utilization targets for CSBs and finalizing reimbursement and refund procedures based on bed utilization. DBHDS will continue to work CSBs to develop community-based service capacity during this period. During year three, DBHDS will work with CSBs to transition individuals from state hospitals to newly developed community-based services and to increase utilization of community-based services by individuals entering the publicly funded mental health services system. In the final year, DBHDS will fully implement the realignment strategy, with specific bed utilization targets for each CSB. In cases in which a CSB's bed utilization exceeds the established rate, the CSB will be required to pay for the bed day at a rate based on non-fixed costs of hospital care. In cases in which a CSB's bed utilization rate is less than the established maximum, the CSB will receive a refund from the state hospital, the amount of which is determined in the same way as the payment for bed days in excess of the established rate. The final year will also include revisions to performance contracts to ensure successful implementation of the financial realignment plan. Dr. Barber stated that successful implementation of the financial realignment plan is expected to reduce the rate of increase in state hospital censuses by FY 2021, reducing the cost of providing care and allowing more individuals to receive services in their communities.

Report on Alternative Transportation Pursuant to House Bill 1426 & Senate Bill 1221

Will Frank, Director of Legislative Affairs, Department of Behavioral Health and Developmental Services, and Shannon Dion, Director of Policy and Legislative Affairs, Department of Criminal Justice Services, reported on the work of the Alternative Transportation Work Group established pursuant to HB 1426 (Garrett) and SB 1221 (Barker). Those bills required the Commissioner of

Behavioral Health and Developmental Services (the Commissioner) and the Director of Criminal Justice Services (the Director) to develop a model for the use of alternative transportation providers to provide safe and efficient transportation of individuals involved in the emergency custody or involuntary admissions process as an alternative to transportation by law enforcement. The bills required the model to include criteria for the certification of alternative transportation providers, including an appropriate training curriculum for certification, and to identify the appropriate agency to be responsible for training and certification of providers. The Commissioner and Director were also charged with identifying barriers to the use of alternative transportation in the Commonwealth and detailing the costs and benefits associated with implementation of the alternative transportation model and any expected cost savings.

Mr. Frank and Ms. Dion reported involvement of a wide range of stakeholders at a series of three meetings over the course of the interim. At the end of the three meetings, the work group recommended that the Commonwealth establish a statewide alternative transportation system to provide transportation for individuals under a TDO from a location to a facility ordered by a magistrate. The work group also recommended that the system be safe and behavioral health recovery focused, relieve stress on law-enforcement agencies currently providing transportation, and reduce the stigma of mental illness and substance abuse.

To achieve these goals, the work group made a number of specific recommendations related to criteria for vehicles to be used for alternative transportation, criteria for drivers providing alternative transportation, training requirements for drivers, operational procedures for providers of alternative transportation, and dispatch procedures for alternative transportation. The work group recommended that DBHDS be the lead agency for implementation of the model and contract with five regional providers to ensure access to alternative transportation statewide. Additional consensus items from the work group included:

- DBHDS should establish a pilot program to study the use of alternative transportation for juveniles subject to emergency custody or temporary detention orders;
- DBHDS should establish a quality and review committee to monitor implementation of the model and to continue identifying factors affecting alternative transportation in the Commonwealth;
- The Code of Virginia should be amended to make alternative transportation the primary option for transportation of individuals subject to emergency custody and temporary detention orders, with the option of utilizing law-enforcement officers for such purpose only in cases in which alternative transportation is unavailable or is found to be inappropriate due to safety concerns;
- DBHDS should provide education and outreach to CSB evaluators and magistrates regarding the availability of and criteria for alternative transportation providers; and
- The Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century and its work groups and advisory panels should continue to study options for funding the alternative transportation system and integration of the program with Medicaid.

Mr. Frank and Ms. Dion also reported that during the 2017 interim DBHDS had issued a Request for Information to gather additional data on the potential costs of and challenges associated with implementation of a statewide alternative transportation model. DBHDS

received three responses, two of which included cost estimates. The first estimate, from G4S Secure Solutions, was \$4,837,300 for providing dispatch services, drivers, and vehicles in each of the five regions. The second estimate, from Steadfast Investigations and Security, was \$287,028 for similar services. Both of these bids were significantly lower than the \$10.2 million previously estimated by DBHDS. Mr. Frank and Ms. Dion explained that the original estimate had been based on the cost of the Mt. Rogers demonstration project, which had included significant expense in establishing a dispatch service. By utilizing a provider with already-established dispatch services like G4S Secure Solutions or Steadfast Investigations and Security, the Commonwealth could see substantial savings. Mr. Frank and Ms. Dion also noted that the Commonwealth and localities might experience savings from a reduction in overtime pay for law-enforcement officers.

Update on Activities of the System Structure and Financing Expert Advisory Panel and the Crisis Response and Emergency Services Panel

Dr. Richard Bonnie, Director of the Institute of Law, Psychiatry and Public Policy at the University of Virginia School of Law and Chairman of the System Structure and Financing Expert Advisory Panel, and John Oliver, Chair of the Crisis Response and Emergency Services Panel, provided an update on activities of the expert advisory panels. Dr. Bonnie stated that the System Structure and Financing Expert Advisory Panel continued to focus on implementation of STEP-VA and DBHDS's financial realignment strategy; development of telemental health services; development of permanent supportive housing; safe and effective crisis care, including alternative transportation and options for reducing admissions of individuals subject to TDOs for inpatient care at state hospitals; and data collection. The System Structure and Financing Expert Advisory Panel is also undertaking a study of the governance of the public mental health services system, including the relationship between DBHDS and CSBs, and local governance issues.

Discussion of Recommendations

At the end of the meeting, the Work Group adopted 11 recommendations:

1. Continue implementation of STEP-VA: Fully fund same-day access to assessment and screening and outpatient primary care screening and monitoring services by 2019; fund additional services required by Chapters 607 and 683 of the Acts of Assembly of 2017 by 2021.
2. Provide funding for expansion of telemental health infrastructure: Fund the Appalachian Telemental Health Network Initiative (\$1.1 million per year for 3 years).
3. Provide additional funding to establish and maintain broad access to permanent supportive housing for persons with serious and persistent mental illness.
4. Provide additional funding to establish and maintain transition housing and supports to serve as a temporary community-based placement for individuals transitioning from psychiatric hospitals to permanent supportive housing (individuals awaiting placement in permanent supportive housing).
5. Provide funding to support implementation of the DBHDS "community integration plan" to reduce the number of individuals on the Extraordinary Barriers List awaiting release from state hospitals (this will help reduce the overall state hospital census).

6. Provide funding for phased implementation of an alternative transportation model to reduce demands on law enforcement; the model should be implemented first in Health Planning Region 3 and Health Planning Region 10.
7. Reduce the overall number of TDO admissions to reduce the burden on hospitals, especially state hospitals: Consider further study to identify factors that prevent private hospitals from admitting patients under a TDO and propose legislative or executive actions to remove those barriers and review models for providing crisis care that could provide cost-effective alternatives to emergency departments and inpatient admissions to mental health facilities (e.g., psychiatric emergency centers) and develop recommendations.
8. Take steps to develop capacity to provide mental health treatment for individuals in jails by better linking with service providers.
9. Improve diversion out of the criminal justice system in cases in which it is appropriate.
10. Ensure cooperation between DBHDS and DMAS to align behavioral health services and mechanisms of accountability for Medicaid enrolled clients and uninsured clients receiving services through CSBs so the public and private mental health services systems operate under a single seamless set of requirements for all clients, with all clients managed uniformly using standardized managed care practices and tools, regardless of payment source.
11. Support DBHDS plan for fiscal realignment of the public behavioral health system.

November 28, 2017

While the Work Group was not scheduled to meet on November 28, the Work Group did convene for a brief meeting following the meeting of the full Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century held that day. At the meeting, the Work Group members discussed information presented by Dr. Ben Miller at the full meeting of the Joint Subcommittee and received some additional information from Dr. Kate Neuhausen, Chief Medical Officer, Department of Medical Assistance Services (DMAS), and Karen Kimsey, Deputy Director of Complex Care and Services, Department of Medical Assistance Services. Dr. Neuhausen and Ms. Kimsey reported that DMAS was working with Dr. Miller to redesign the behavioral health system to create a better system of care. The redesign would include establishing multiple points of entry, aligning payment and delivery systems, and emphasizing services that are preventive, evidence-based, and trauma informed. Development of the new system will take approximately two years.

Recommendations

At the end of the 2017 Interim, the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century adopted the following recommendations proposed by the Work Group:

- **RECOMMENDATION 1: Study of temporary detention.** The System Structure and Financing Expert Advisory Panel should establish a work group to study measures to facilitate effective emergency intervention services and reduce admissions pursuant to temporary detention orders at state hospitals.

OUTCOME: A letter was sent to the System Structure and Financing Expert Advisory Panel requesting that the System Structure and Financing Expert Advisory Panel establish a work group to study measures to facilitate effective emergency intervention services and reduce admissions pursuant to temporary detention orders at state hospitals; a report is expected by the end of 2018.

- **RECOMMENDATION 2: Telemental health services.** The Work Group recommended a budget amendment to provide \$1.1 million per year for three years to Appalachian Telemental Health Network Initiative.

OUTCOME: The Senate budget included \$1.1 million in each year to establish the Appalachian Telemental Health Network Initiative; funding was not included in the House budget.

- **RECOMMENDATION 3: Alternative transportation.** The Work Group recommended a budget amendment to provide \$1.7 million per year to support and expand alternative transportation pilot programs in the area served by the Mount Rogers Community Services Board and the area served by the Region 10 Community Services Board. After some discussion of the benefits of a pilot program or establishment of a statewide program, the Joint Subcommittee adopted a recommendation that a budget amendment be introduced to provide \$10.2 million to fund statewide implementation of the alternative transportation model proposed in RD 337 (2017) - Virginia Department of Behavioral Health and Developmental Services and Virginia Department of Criminal Justice Services: Alternative Transportation Work Group Final Report.

OUTCOME: The Senate budget included \$2.5 million in the first year and \$4.5 million in the second year for alternative transportation for adults and children under a temporary detention order; funding was not included in the House budget.

- **RECOMMENDATION 4: STEP-VA.** The Work Group recommended continued support for ongoing efforts to implement STEP-VA in accordance with the provisions of Chapters 607 and 683 of the Acts of Assembly of 2017. The Governor's proposed budget included \$11.8 million in general funds to expand access to same-day mental health screening and evaluation to every CSB in the Commonwealth and an additional \$6.4 million to complete implementation of same-day access and \$11.2 million in general funds to support outpatient clinics to provide primary health care screenings for individuals receiving services at CSBs.

OUTCOME: The House budget included funding for same-day access to mental health screening and evaluation services and primary health care screenings for individuals receiving services at CSBs; the Senate budget eliminated funding for primary health care screenings for individuals receiving services at CSBs in the first year and reduced funding for primary health care screenings for individuals receiving services at CSBs to \$3,720,000 in the second year.

- **RECOMMENDATION 5: Community integration plan.** The Work Group recommended continued support for the efforts of DBHDS to reduce the census at state hospitals by improving community integration of individuals with mental illness. The Governor's proposed budget included \$4.8 million in general funds to support needed community-based services as a result of the mental health facility census and \$6.9 million

in general funds to provide discharge planning assistance to assist in discharging approximately 80–90 people on the Extraordinary Barriers List currently awaiting discharge from state hospitals.

OUTCOME: The House budget included \$4.6 million in general funds to support community services to facilitate reduction of the state hospital census; funding was not included in the Senate budget. The House budget also included \$6.9 million for discharge assistance planning to assist in discharging people on the Extraordinary Barriers List; the Senate budget reduced the amount to \$3.4 million for such purpose.

- **RECOMMENDATION 6: Plan for fiscal realignment.** The Work Group recommended continued support for the development of the Secretary of Health and Human Resources' plan for fiscal realignment of the public behavioral health system in accordance with Item 284 of the Appropriation Act of 2017.

OUTCOME: The Work Group will continue to monitor the implementation of the plan for fiscal realignment.

- **RECOMMENDATION 7: Funding options.** The Work Group recommended continued exploration of options for funding the public mental health services system, including options available under the Affordable Care Act.

OUTCOME: The Work Group will continue to explore options for funding the public mental health services system, including options available under the Affordable Care Act.