



Virginia Department of
Behavioral Health &
Developmental Services

DBHDS Updates and STEP VA: System Transformation, Excellence and Performance in Virginia

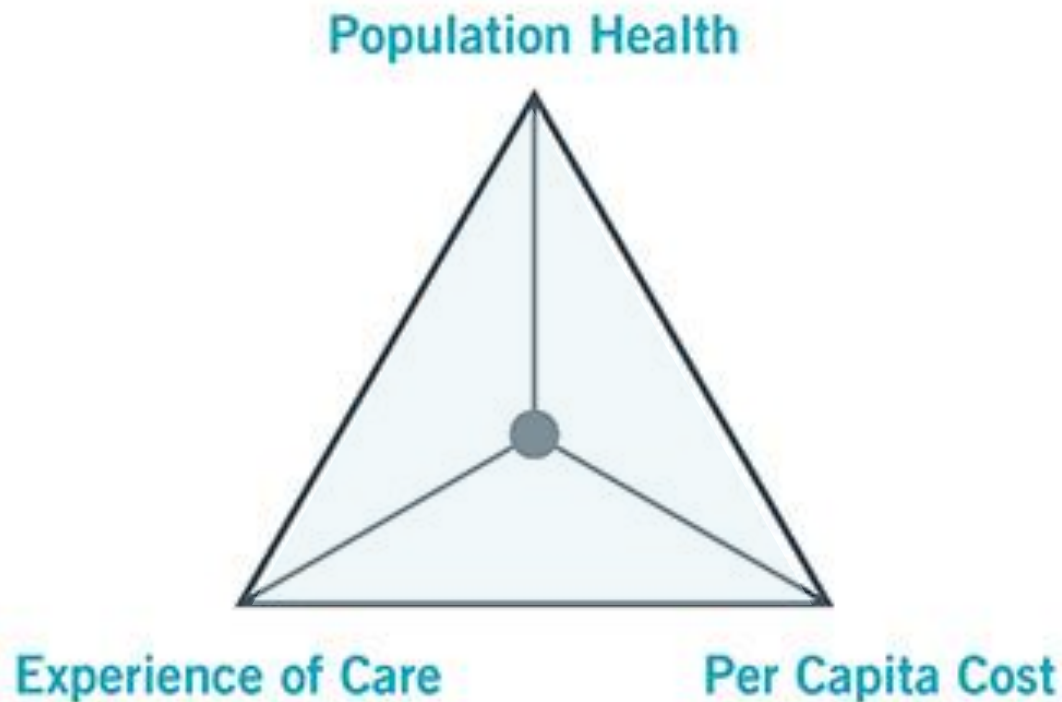
Virginia's pathway to excellence in behavioral healthcare



Jack Barber, MD
Interim Commissioner
Virginia Department of Behavioral Health
and Developmental Services

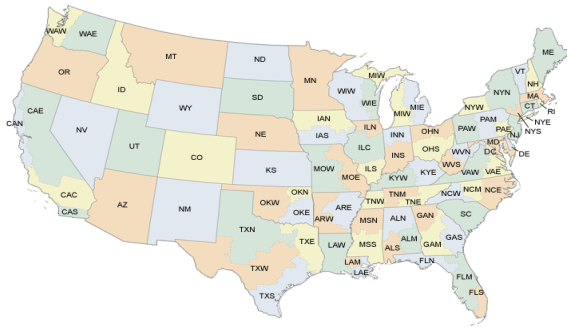
The National Healthcare Landscape

The IHI Triple Aim



From the Institute for Healthcare Improvement

The Behavioral Healthcare Landscape



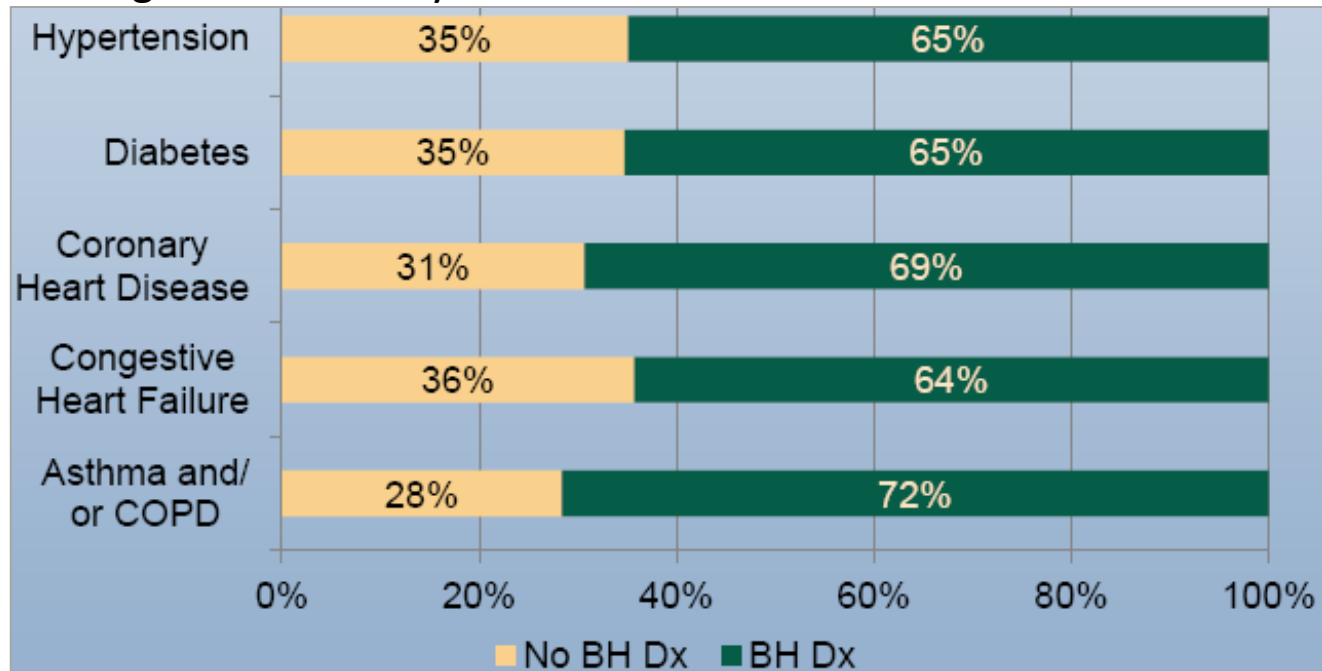
- **Comprehensive behavioral healthcare is essential to both population health and cost containment**
- Emphasis on prevention, early intervention and wellness
- Bidirectional Behavioral Health and Primary Health Care Integration
- Decreased reliance on institutional care
- Increased focus on community-based services and supports

- How does VA measure up nationally?
 - 35th in BH funding in 2013
 - 40th in consumers served per capita
 - 15th in the nation in terms of expenditures per client.
- Not maximizing our investment
 - **50% of GF funding supports 3% of persons served**

Behavioral and Primary Healthcare Link

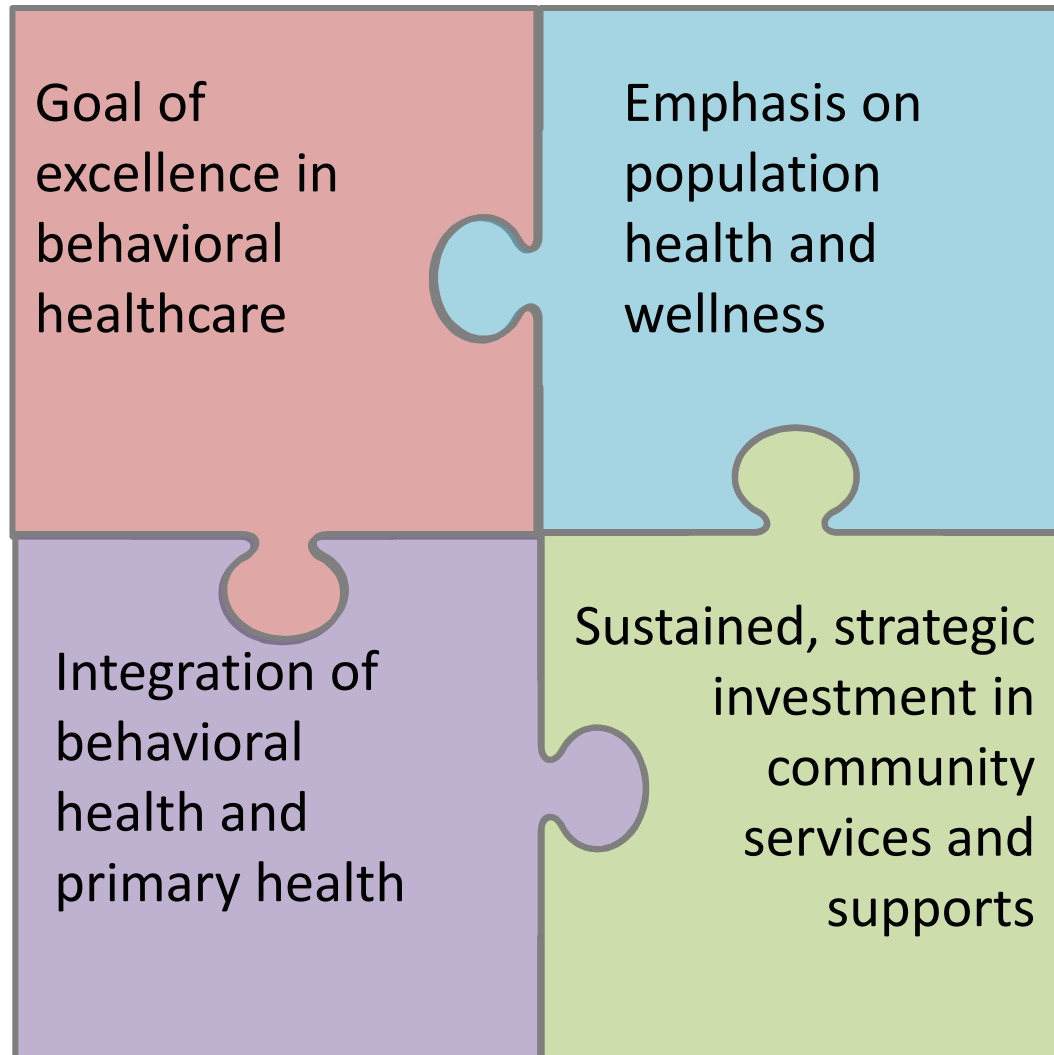
Prevalence of Behavioral Health Needs

Among Medicaid-Only Beneficiaries with Disabilities



For those with common chronic conditions, health care costs are as much as **75% higher** for those with mental illness compared to those without a mental illness and the addition of a co-occurring substance use disorder results in **2- to 3-fold higher** health care costs. – CMS

Key Elements to Transformation



The Excellence in Mental Health Act

- Establishes Certified Community Behavioral Health Clinics (CCBHCs)
- There are two phases:
 - Phase 1: Provides up to \$2M for CCBHC Planning Grants
 - Phase 2: Up to 8 CCBHC Planning Grant states will be selected to participate in the demonstration program
- SAMHSA is making a total of \$24,635,000 available – Up to 25 states may receive grants of up to \$2 million.
- In addition, DBHDS is contributing \$2 million of its own resources to ensure STEP VA's success.

The EMHA Opportunity

System Transformation, Excellence and Performance (STEP Virginia) The Path to a Healthy Virginia

What EMHA Offers:

- Same Day Access
- Standardized core community services
- 24/7 Mobile crisis
- Veterans services
- Robust child services
- Connections to primary care



What EMHA Solves:

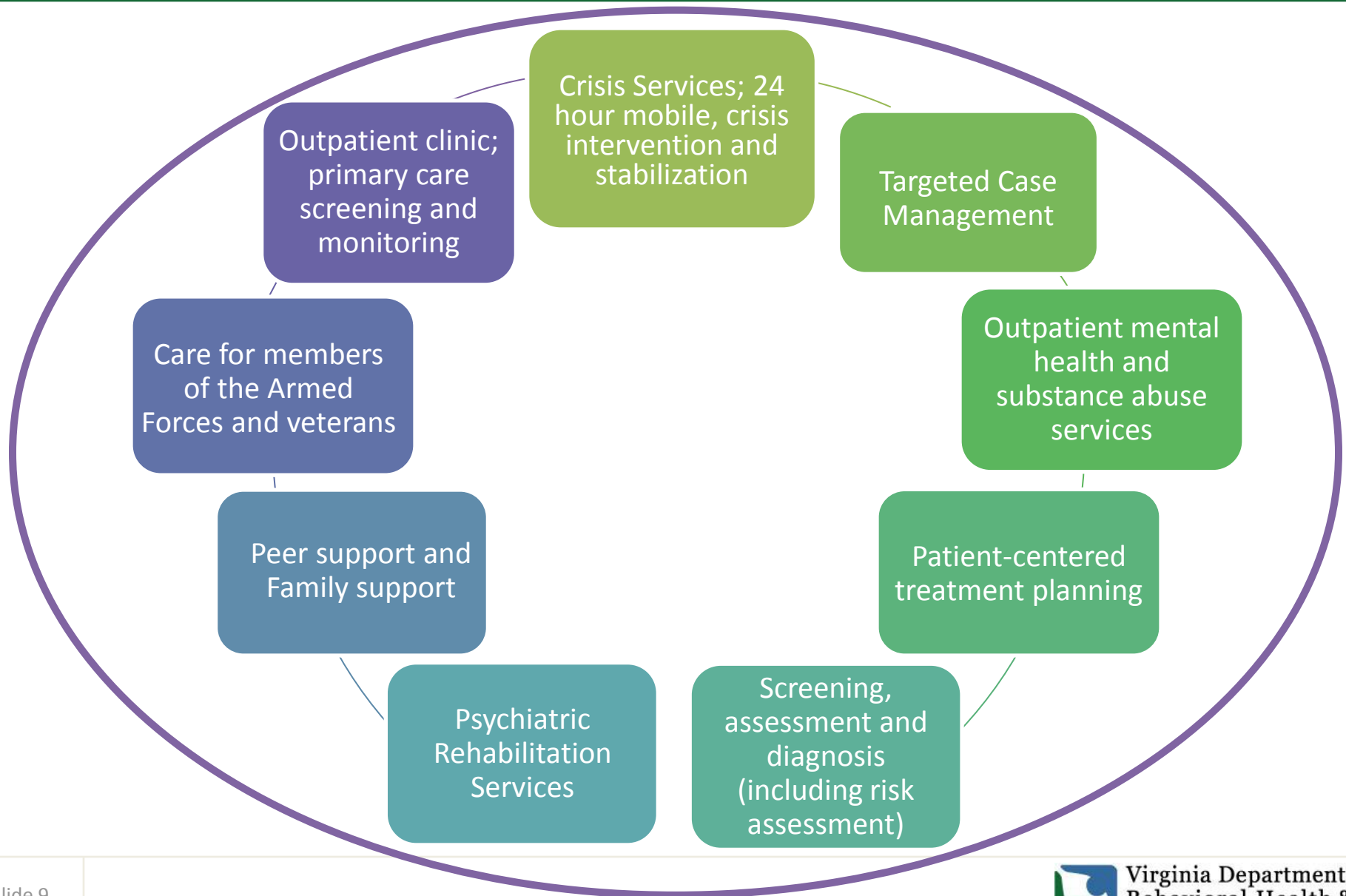
- Access
- Geographic disparities in service offerings
- Inconsistent quality
- Funding
- Capacity

Summary: STEP VA Application and Objectives

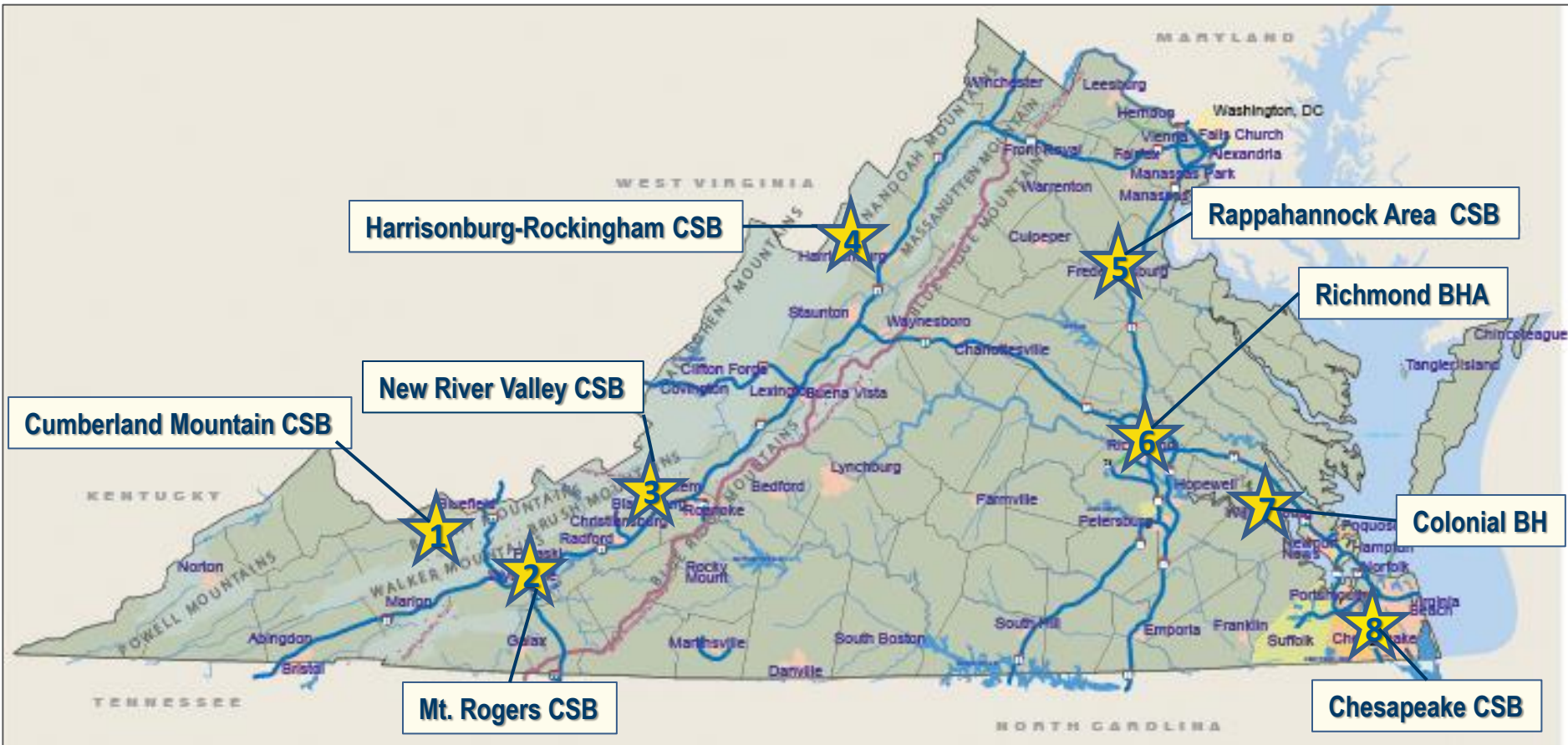
- Virginia's application was submitted before the Aug. 5, 2015 deadline.
- The objectives of STEP VA include:
 1. Establishment of the CCBHC certification process,
 2. Implementation of evidence-based practices in all CCBHCs,
 3. Promotion of bidirectional primary health and behavioral health integration,
 4. Provision of same day access,
 5. Reduction in health disparities, and
 6. Establishment of a Prospective Payment System (PPS) providing bonus payments for achieving quality outcomes.



9 (plus 1) Components of Excellence



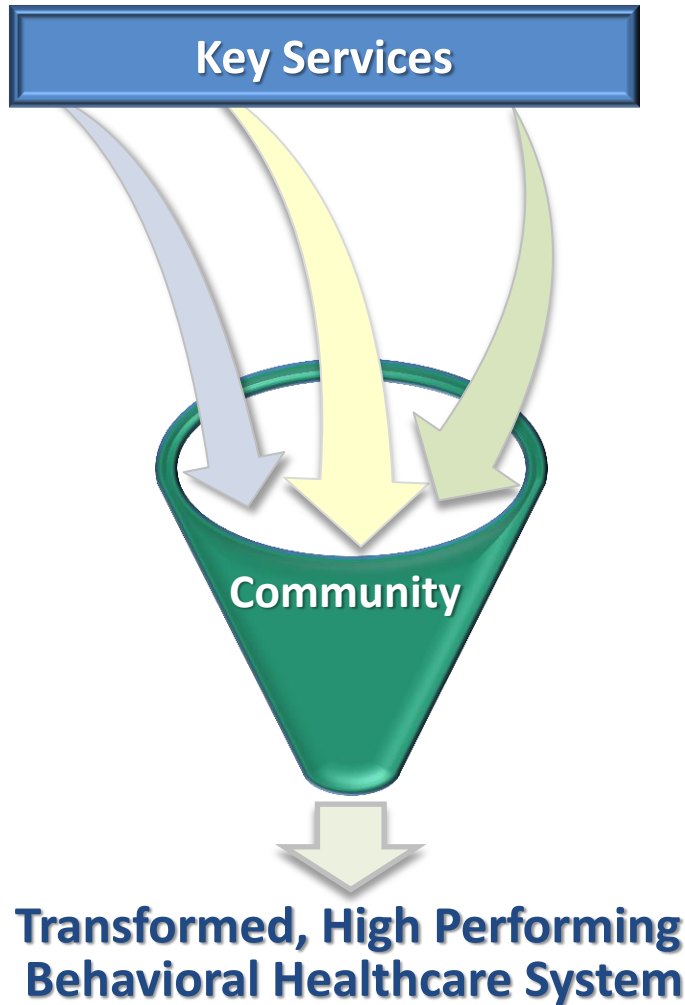
Virginia's Eight CCBHCs



1. Cumberland Mountain CSB
2. Mt. Rogers CSB
3. New River Valley CSB
4. Harrisonburg-Rockingham CSB

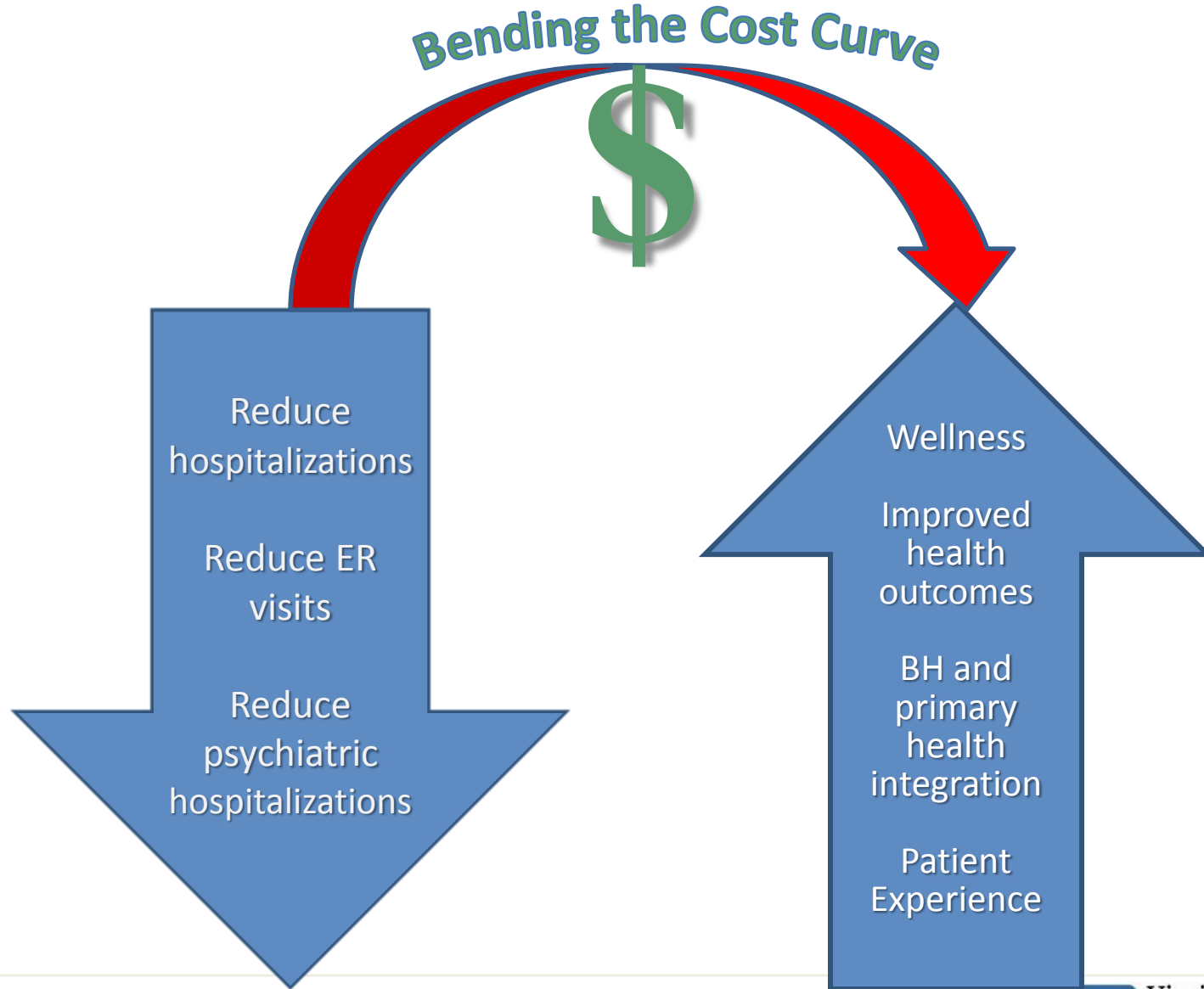
5. Rappahannock Area CSB
6. Richmond Behavioral Health Authority
7. Colonial Behavioral Health
8. Chesapeake CSB

Key Community Services Investments



- Comprehensive Outpatient Services
- Robust Crisis Services; 24 hour mobile, crisis intervention and stabilization
- Permanent Supportive Housing
- Supported Employment
- Children's Mental Health/Trauma Services
- Transition Age/First Break
- Geropsychiatric Care
- Jail Diversion & Community Re-entry
- Behavioral Health Services to Veterans
- Acute Detoxification
- Prevention and Early Intervention

What EMHA and CCBHCs Can Achieve in Virginia



THE VISION: A Life in the Community



Four Transformation Teams

Four initial focus areas of the Transformation Initiative

- Adult Behavioral Health
- Adult Developmental Services
- Children & Adolescent Behavioral Health Services
- Services to Individuals Who are Justice-involved

Three Phase Approach

- 1. Team Meetings** – Four teams meet for about six months to develop recommendations around specific questions.
- 2. Stakeholder Review** – A Stakeholder Group comprised of providers, advocates, family members, and persons with lived experience receive and review the teams' recommendations.
- 3. Public Comment** – Intensive, six week public comment period:
 - Recommendations posted on the DBHDS website along with a link to submit public comment.
 - Commissioner and Transformation Team Co-Chairs hold public meetings across the Commonwealth: Williamsburg, Charlottesville, Woodbridge and Wytheville.

Spring 2015 Recommendations: Ten “Core” Themes

Ten themes emerged across all of the recommendations:

- 1** Formalize and fund core services and supports across a continuum of care – focus on the Right Services and the Right Place at the Right Time
- 2** Require reimbursement for case management services
- 3** Strengthen the community-based system of services and supports statewide
- 4** Standardize quality of care expectations statewide
- 5** Align and maximize effectiveness of available funding streams
- 6** Harness the power of data across agencies in the Secretariat to utilize and improve health outcomes
- 7** Integrate behavioral health with physical health and social services
- 8** Strengthen the workforce to ensure access to services
- 9** Promote through policy and reimbursement a person-centered approach to care, merging the activities and processes of mental health, substance abuse, and DD/ID with those of child welfare, juvenile justice, educational, and health services
- 10** Develop and conduct customized trainings to organizations who interact with populations – Employers, Schools, Jails, etc.

Overall Recommendations

1. Increase access to services, including screening and assessment.
2. Expand person-centered/patient-centered practices.
3. Improve the spectrum of crisis services.
4. Implement and fund more targeted case management.
5. Strengthen peer and family services.
6. Ensure better integration of behavioral healthcare with primary care along with employment, housing, education, and other social services.

Fall 2015 Transformation Cycle

- In May, Transformation Teams received a new charge and members to provide needed expertise to effectively address the new questions for the Fall 2015 transformation cycle.
- Teams have all started the next cycle. The cycle will include meetings with the Stakeholder Group, presentation of recommendations to the Commissioner, and public town hall meetings.
- More information on the Transformation Teams is available on the DBHDS website.
<http://www.dbhds.virginia.gov/about-dbhds/commissioner-transformation-teams>

Involuntary Commitment Work Group

CHAPTER 742

An Act to direct the Commissioner of Behavioral Health and Developmental Services to develop a comprehensive plan to authorize psychiatrists and emergency physicians to evaluate individuals for involuntary civil admission.

[H 2368]

Approved April 15, 2015

Be it enacted by the General Assembly of Virginia:

1. § 1. *The Commissioner of Behavioral Health and Developmental Services (the Commissioner) shall, in conjunction with relevant stakeholders including the Virginia Association of Community Services Boards, the National Alliance on Mental Illness - Virginia, the Psychiatric Society of Virginia, the Virginia College of Emergency Physicians, the Virginia Hospital and Healthcare Association, the Virginia Academy of Clinical Psychologists, the Medical Society of Virginia, and the University of Virginia Institute for Law, Psychiatry, and Public Policy, review the current practice of conducting emergency evaluations for individuals subject to involuntary civil admission. Such review shall identify community services boards and catchment areas where significant delays in responding to emergency evaluations are occurring or have occurred in recent years. Further, the Commissioner shall develop a comprehensive plan to authorize psychiatrists and emergency physicians to evaluate individuals for involuntary civil admission where appropriate to expedite emergency evaluations. The review and comprehensive plan including recommendations shall be completed by November 15, 2015, and reported to the Governor and the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century, the House Committee on Health, Welfare and Institutions, and the Senate Committee on Education and Health.*

Workgroup Structure and Goal

- 15 member study group including policy experts, including UVA ILPPP staff, psychiatrists, emergency room physician, psychologists, emergency services clinician, advocacy groups.
- Held eight two-hour meetings, met monthly since February.
- **Goal:** Determine whether allowing additional mental health professionals to initiate TDOs would improve emergency mental health services quality, efficiency and access.
- **Guiding principles:**
 1. Improve the experience of persons served
 2. Maintain system monitoring
 3. Promote outcome measurement

TDO Assessment Process

COLOR CODES – ELEMENTS & PHASES OF THE TDO ASSESSMENT PROCESS

CSB/ Emergency Services (ES) Clinician

Emergency Medical Physician/Emergency Department (ED)

Shared: CSB, ED, Law Enforcement (LE), Emergency Medical Physician

Shared: CSB, ED, Emergency Medical Physician

Courts/Magistrate/ Special Justice

Shared: LE & CSB

State Operated Psychiatric Hospital

*** Note: Medical Assessment/TDOs can be sought at any point during this process if the individual is exhibited symptoms requiring medical treatment.**

Elements & Phases of the TDO Assessment Process

PHASE 1

Referral Options

Individual at CSB for evaluation for TDO

Individual in ED for evaluation for TDO

Medical assessment sought*

Individual in their home for evaluation for TDO

Individual in the community* for evaluation for TDO

LE has Individual in custody for evaluation for TDO

PHASE 2

Initial Notification

Regional state hospital notified of potential TDO admission

Mental Health professional identified to complete TDO evaluation

PHASE 3

Assessment Conducted

Prescreening Report/ Involuntary detention assessment conducted (including risk assessment)

Custody maintained

MSE/interview completed

Appropriate clinical history and records reviewed

Appropriate and relevant collateral contacts made

Past & present treatment providers contacted

Advance directives reviewed

Preadmission screening report completed

Least restrictive alternatives reviewed

PHASE 4

Assessment Results

Regional state hospital notified of assessment results

Custody maintained

TDO criteria met

Medical assessment sought*

TDO criteria not met

Voluntary hospitalization

Community-based treatment referral

Released with discharge instructions and linkages

Medical TDO obtained if warranted*

PHASE 5

Disposition Reviewed

Psychiatric Bed Registry accessed

Custody maintained

Appropriate community hospitals/CSU contacted

Information faxed to potential admitting hospital

Physician-to-physician communication re: admission

Community-based hospital/CSU denies admission

Linkage with admitting community-based hospital/CSU

SOPH hospitalization as last resort hospital

PHASE 6

Disposition Completed

Magistrate contacted to request TDO to identified hospital/CSU

Custody maintained

TDO completed and executed

Individual transported to TDO facility

Commitment hearing scheduled

Prescreening evaluation presented at hearing

Determination of:
Involuntary commitment
Voluntary commitment
MOT
Release

*Schools, jails, police station, shelters

8 hour maximum