Expert Advisory Panel on System Structure and Finance
November 5, 2018

Current Functions of the DBHDS Regions and Possible Alternatives

In its previous reports to the Joint Subcommittee, the Panel has reviewed the advantages and disadvantages of the Commonwealth's current system of service delivery and governance as compared with alternative models used in other states. In our view, displacing the CSB/DBHDS structure is inadvisable because, among other reasons, it would sacrifice the engagement of, and collaborations with, local agencies that have developed over many decades. Moreover, in the 11 jurisdictions operated by local governments, it would sacrifice substantial local investment as well as the political accountability produced by this governance structure. The Panel believes that greater accountability for access and quality of services in other localities, and in the system as a whole, can be achieved through strengthened oversight by DBHDS, grounded in outcome-based performance, intensive monitoring, and financial incentives, including fiscal realignment of the relationship between state hospitals and CBSs.

Over the course of the SJ 47 study, Members have asked about the current role of the DBHDS regions and have wondered whether a stronger regional role would be useful. The purpose of this brief report is to consider the potential advantages and disadvantages of regional administration in the Virginia public mental health services system.

The Current Role of DBHDS Regions

The five existing DBHDS regions are collaborative bodies set up by CSBs for the purposes of strategic planning, for managing programs and funding relating to state hospital utilization, and for administering a select number of high intensity, low incidence programs. CSBs initially created these organizations for the purposes of managing issues relating to state hospital utilization, but over time their responsibilities and functions have grown. The regions have proven to be best suited for programs that require collaboration in order to maximize effectiveness, or that can only be scaled at a regional level.

The regional organizations do not have any official legal authority or standing; nor are they a formal arm of DBHDS. As collaborative bodies, they do not have a significant amount of dedicated staffing or administrative infrastructure. The member CSBs share administrative and planning responsibilities, while one CSB per region serves as the regional fiscal agent, which manages any funds that flow through the region. Each region is staffed by one full-time regional manager, who is employed by the fiscal agent CSB, but whose position is funded by DBHDS. Regions may have a small number of additional staff members who are also employed by a participating CSB. There are no formal shared regional administrative elements, such as EHRs or billing processes. Regional services are delivered by a member CSB on behalf of the region, or through contracts with private providers.

Current Regional Functions

The primary functions of the regions are to manage funding streams and programs relating to hospital utilization, and to manage services that are high intensity, but low incidence and as such can be delivered more efficiently when done in partnership with multiple CSBs. The regions also provide a venue for collaborative problem solving, which can offer CSBs the flexibility to respond to challenges that may be unique to their part of the state.

The boundaries of the regions track closely with the catchment areas of the state hospitals, making them well positioned to address challenges relating to hospital utilization. Specific utilization-related programs managed by regions include funding for discharge assistance planning (DAP) and local inpatient purchase of services (LIPOS). DAP funds support individuals who have experienced long lengths of stay in the hospital and who have complex health or legal needs that create barriers to discharge. These funds are intended to facilitate the transition from the hospital to the community. LIPOS funds pay for private hospital beds for uninsured individuals.

Regions are also responsible for a select number of programs that can be managed more efficiently when scaled at a regional level. These tend to be high cost, high intensity and low incidence. Examples of these types of programs and services include crisis stabilization units (CSUs) and the regional education assessment crisis services habilitation program (REACH). CSUs operate as a diversion or step-down from inpatient hospitalization, and REACH is a crisis prevention and stabilization system for individuals with intellectual or developmental disabilities. For each of these programs, services are either delivered by a CSB or through a contract with private entity.

Regions, for the most part, have found their appropriate niche. However, there may be opportunities to provide additional services on a regional basis in the future as STEP-VA is implemented. Those services could include such things as mental health services for veterans and aspects of crisis services, including residential services, housing and mobile teams.

Past Efforts at Expanding the Role of Regions

In past years, the Department experimented with allocating new state funds for a range of services on a regional basis. After receiving the funds, the regions would then apportion them to the CSBs based on a collective sense of need and ability to put the funds to use quickly. These other services proved to be better delivered and administered at the local level and this practice was discontinued after the Department concluded that the practice was duplicative and unnecessary.

Alternative Regional Models

Under current policy, the regions themselves are not signatories to the performance contract. Instead, DBHDS monitors regional activities on a CSB by CSB basis. DBHDS also funds the salary of one regional manager in each of the five regions. However, the Department could consider alternatives to its current regional structure that would increase the level of oversight

conducted at the regional level, and position the regions as hubs for broader DBHDS oversight and support.

In a select number of other states, regions are used as a way to distribute the oversight and support functions of the state agency. Rather than a two-tiered system in which a centralized state agency oversees the operations of decentralized locally-run service delivery entities, these states use a three-tiered system in which regional field offices provide much of the oversight, and act as an intermediary between the state and local agencies.

Georgia is an example of such a state. In Georgia, there are 25 CSBs, which are subdivided into six regions. The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) staffs and runs one field office in each of those six regions. The field offices oversee the implementation of statewide initiatives, monitor services to ensure quality and access, investigate and resolve complaints and provide technical assistance.

If this model were implemented in Virginia, DBHDS would install regional field offices in each of the five existing DBHDS regions. These field offices would be closer to CSB operations than the Central Office, and in theory, better informed about and more responsive to the needs, challenges, and successes of the CSBs, and able to provide effective oversight. The field office model would also maintain the current CSB structure, including its associated strengths, such as local engagement and local funding.

Regional management would have several drawbacks, however. For example, some CSBs may see an additional layer of oversight as unnecessary or excessive, particularly if those CSBs receive a substantial portion of their funding from local governments and are already politically accountable to local officials. Aside from concerns about burdensome oversight, the Department could also encounter staffing challenges. In order for the field offices to add value to the existing system, they would have to be staffed by a team with the proper expertise. As most of these individuals currently work for the Central Office in Richmond, DBHDS would either need to find new staff in other parts of the state or encourage existing staff to move to the regions were staffing up proved more difficult. The costs of this approach could outweigh the benefits, as DBHDS leadership concluded the last time this possibility was studied.

Discussion

Whether the efficiency and quality of the services system would be enhanced by devolution of oversight to DBHDS regional offices should be assessed over time as the implementation of STEP-VA, expansion of Medicaid, and fiscal realignment proceed over time, as the data system is put in place, and as reliable data begin to accumulate. As the Panel has previously observed, it is likely that, over time, the system "on the ground" will evolve, possibly leading to integration or consolidation of some currently existing CBSs under strengthened administrative oversight. Whether installing new regional field offices would be a useful managerial complement to the other tools available to the Department to strengthen the accountability of CSBs (performance requirements in contracts, financial incentives, monitoring outcomes, and remedial action for deficient performance) remains to be seen. It is not clear, a priori, that staffing regional offices with an added layer of DBHDS management would meaningfully improve oversight and accountability.