COMMONWEALTH of VIRGINIA

ALISON G. LAND, FACHE
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

October 19, 2020

The Honorable Janet Howell, Chair
Senate Finance Committee
Pocahontas Building
900 East Main Street
Richmond, VA 23219

Dear Senator Howell,

Pursuant to Item 321 C.3 of the 2020 Appropriations Act, the purpose of this letter is to report on the recommendations on the allocation and use of the Discharge Assistance Program (DAP). Specifically, the language requires:

> *The Department of Behavioral Health and Developmental Services shall establish and facilitate a workgroup to review and make recommendations on the allocation and use of discharge assistance funding, including recommendations for creating the services and housing needed for individuals leaving state hospitals. The Department shall submit its recommendation to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2020.*

Please see attached the report pursuant to Item 321 C.3 of the 2020 Appropriations Act. Staff are available should you have any questions.

Sincerely,

Alison Land

Alison G. Land, FACHE
Commissioner
Department of Behavioral Health & Developmental Services

CC:
Vanessa Walker Harris, MD
Susan Massart
Mike Tweedy

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October 19, 2020

The Honorable Luke Torian, Chair
House Appropriations Committee
Pocahontas Building
900 East Main Street
Richmond, VA 23219

Dear Delegate Torian,

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October 19, 2020

Governor Ralph Northam
Patrick Henry Building
1111 E Broad St
Richmond, VA 23219

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Department of Behavioral Health & Developmental Services

CC:
Vanessa Walker Harris, MD
Susan Massart
Mike Tweedy

Virginia Department of Behavioral Health & Developmental Services

Item 321 C.3: Report on Discharge Assistance Planning

Monday, October 19, 2020

1220 BANK STREET • P.O. BOX 1797 • RICHMOND, VIRGINIA 23218-1797 PHONE: (804) 786-3921 • FAX: (804) 371-6638 • WEB SITE: WWW.DBHDS.VIRGINIA.GOV

Preface

Pursuant to Item 321 C.3 of the 2020 Appropriations Act, the purpose of this letter is to report on the recommendations on the allocation and use of the Discharge Assistance Program (DAP). Specifically, the language requires:

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Executive Summary

The purpose of this report is to provide a summary and recommendations from the Discharge Assistance Program (DAP) Workgroup, Item 321 C.3 of the 2020 Appropriations Act, on the allocation and use of DAP based on the collective views of the behavioral health and developmental disability system stakeholders. The DAP program began in 1997 as a solution to alleviate census pressures at one state psychiatric hospital. The concept was to utilize funds to support individuals with extraordinary barriers to discharge. Since that time, the program has grown to include all eight adult psychiatric hospitals with a budget of over forty million dollars. The program is as critical today as it was two decades ago. The program provides flexibility for stakeholders, including the Department of Behavioral Health and Developmental Services (DBHDS), their eight psychiatric facilities, and Community Services Boards to tailor specific and individualized services for people with serious mental illness that cannot be provided through other state or federal programs. Without DAP, many more individuals would require long-term inpatient psychiatric care in DBHDS facilities.

The workgroup met with key stakeholders to discuss the need for reforms to DAP allocation and recommend services to meet the needs of the DAP population in order to increase the sustainability of the program. The group agreed that DAP funds currently fill gaps created by lack of services and funding options for special populations discharging from a DBHDS psychiatric facility. DBHDS currently has the opportunity to better utilize the DAP funds as well as partner with other state agencies to expand the services needed for those discharging from a state facility.

The workgroup determined that the top challenges encountered in identifying services for recently discharged patients include inconsistent availability of affordable supervised living options, lack of services for individuals with dementia and traumatic brain injury, and administrative burden on parties who manage DAP. To address these issues, the workgroup developed the following recommended updates and investments in the DAP program to promote more effective utilization of funds as well as to continue to provide effective services for special populations.

- Create opportunities to support the culture of least restrictive and highly integrated community living options and avoid long-term inpatient treatment where feasible
- Invest in a needs assessment for individuals leaving state facilities and available, appropriate integrated living options
- Invest in and support rate setting for supervised living options to provide for consistency, effective utilization, and recovery-oriented practices in supervised living arrangements.
- Partner with the Department of Aging and Rehabilitative Services (DARS) and the Department of Medicaid Assisted Services (DMAS) to develop services and funding for individuals with dementia and traumatic brain injury without a serious mental illness
- Support IT infrastructure to reduce administrative burden on DAP management at the community services board level

- Partner with DMAS to include MCOs in discharge planning
- Support programs and mental health professionals in nursing facilities to increase acceptance rate of individuals needing nursing home care leaving state facilities

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Background

Discharge Assistance Program (DAP) funds originated in 1998 at Central State Hospital and Northern Virginia Mental Health Institute. The DAP program was expanded statewide in 1999 in response to a Department of Justice review that stated "the Commonwealth does not have a sufficient number of community residential and other mental health support services to meet the needs of Western State patients." The goal of DAP at that time was to discharge identified long-stay patients who no longer required hospitalization but could not be supported in the community without specialized services and supports. Individual DAP plans were created that identified the care each individual required as well as the costs of that care. While initially DAP was allocated and managed at the individual CSB level, it is currently allocated and managed at the regional level. Currently, DAP helps to fill in gaps in community-based services for individuals leaving state psychiatric facilities, many of which are being addressed or will be addressed through Behavioral Health Enhancement and STEP-VA programming.[1]

Individuals Served by DAP

DAP must be initiated at the end of state hospitalization to address barriers to discharge. These individual discharge assistance program plans (IDAPPs) can cover both one-time costs, such as transportation or apartment set-up costs, or ongoing costs, such as health, psychiatric, or residential services. The total number of individuals served by DAP grew 65 percent from FY15 to FY18, increasing from 1,123 individuals served annually to 1,860 individuals served annually. From FY18 to FY19, the number served increased another 6 percent, to 1,995 individuals. For the first three quarters of FY20, DAP served 1,485 people with individual DAP funds.

Table 1: Number of Individuals Served and Amount Spent FY18-20

Fiscal Year	Number Served	Amount
FY18	1,860	$ 32,400,000.00
FY19	1,955	$ 35,000,000.00
F20 Qtr 1-3	1,485	$ 34,470,000.00

DAP Costs, FY19-FY20

In FY19, $34,149,266 in DAP funds were allocated directly to the five major CSB regions and two sub-regions for use for individual discharge plans (see Table 1 for an overview of the regions). Through this funding, 1,995 individuals were served. This number includes a combination of individuals already discharged from state facilities in previous years, as well as 556 new discharges in FY19. Therefore 28 percent of the individuals served with IDAPPS were new discharges. Translated in to dollars, these 566 new discharges were served in the community with $4,960,336. Had these same individuals remained hospitalized through FY19, the total cost

[1] More information on Behavioral Health Enhancement can be found in "Special Report: Medicaid Behavioral Health Services Realignment". (Dec 2019). Available at: https://rga.lis.virginia.gov/Published/2019/RD743
More information on STEP-VA can be found in "Annual Report on the Implementation of Senate Bill 1005 and House Bill 1549 (2017) and Item 312.DD of the 2019 Appropriation Act". (Oct 2019). Available at: https://rga.lis.virginia.gov/Published/2019/RD656

would have reached $82,065,745.29.[2] These 566 new discharges served with IDAPPs had used a total of 108,741 state hospital bed days prior to discharge.

Table 1: Primary DBHDS Regions and Their CSBs

Primary DBHDS Regions	
DBHDS Region 1 (9 CSBs)	**DBHDS Region 3** (continued)
Alleghany Highlands CSB	New River Valley Community Services
Harrisonburg-Rockingham CSB	Piedmont Community Services[2]
Horizon Behavioral Health	Planning District One Behavioral Health Services
Northwestern Community Services	Southside CSB[2]
Rappahannock Area CSB	**DBHDS Region 4** (7 CSBs)
Rappahannock-Rapidan CSB	Chesterfield CSB
Region Ten CSB	Crossroads CSB
Rockbridge Area Community Services	District 19 CSB
Valley CSB	Goochland-Powhatan Community Services
DBHDS Region 2 (5 CSBs)	Hanover County CSB
Alexandria CSB	Henrico Area MH and Developmental Services
Arlington County CSB	Richmond Behavioral Health Authority
Fairfax-Falls Church CSB	**DBHDS Region 5** (9 CSBs)
Loudoun County Department of Mental Health, Substance Abuse and Developmental Services	Chesapeake Integrated Behavioral Healthcare
	Colonial Behavioral Health
Prince William County CSB	Eastern Shore CSB
DBHDS Region 3 (10 CSBs)	Hampton-Newport News CSB
Blue Ridge Behavioral Healthcare[1]	Middle Peninsula-Northern Neck CSB
Cumberland Mountain CSB	Norfolk CSB
Danville-Pittsylvania Community Services[2]	Portsmouth Department of Behavioral Healthcare Services
Dickenson County Behavioral Health Services	
Highlands Community Services	Virginia Beach CSB
Mount Rogers CSB	Western Tidewater CSB

[1] Part of sub-region 3.a in Region 3

[2] Part of sub-region 3.b in Region 3

There are two sub-regions in Region 3, sub-regions 3.a and 3.b, related to the catchment areas of Catawba Hospital (adult psychiatric beds) and Southern Virginia Mental Health Institute respectively, utilization of beds in those state hospitals, and the allocation and use of DAP and LIPOS funds. CSBs in these sub-regions are part of Primary DBHDS Region 3 for all other purposes.

For the first three quarters of FY20, 1,437 individuals have been served with IDAPPs. From July 1, 2019 to March 31, 2020, $25,615,484 in DAP was been spent supporting ongoing and one-time costs for these individuals. They have received 24 hour/day supervised care and housing, community-based services, medication assistance, and startup costs for community transition. Of those 1,437 served, 329 were new hospital discharges (23%). Those same 329 individuals accounted for 127,318 hospital bed days. Had those individuals remained hospitalized through

[2] Based on the average daily hospital bed-day cost of $754.69

the end of FY2020, the cost would have been $62,830,961.26. In comparison, the total amount of DAP funds spent on those 329 individuals was $2,601,056.

In FY20, DBHDS worked toward tracking DAP spending based on more specific service-type categories. For the first half of FY20, regions reported spending $18,927,182 on IDAPPs statewide. Eighty-one percent of that funding, or $15,306,509, was spent to support individuals in supervised living situations which included assisted living facilities, nursing homes, mental health group homes, developmental disability supervised living options, traumatic brain injury placements, and memory care placements, for which no other funding was available. Over one million was spent for residential traumatic brain injury services for 10 individuals.
Over twelve percent of the funding was spent on services including case management, mental health skill building, psychosocial rehabilitation, and supported employment.

Individuals may have multiple IDAPPs including one-time, ongoing, or a combination of both, depending on circumstances and needs. The 1,437 individuals that were served during the first three quarters of FY2020 used 1,683 IDAPPs. The average statewide cost of an ongoing plan is $37,681.42 annually. The average statewide cost of a one-time plan is $6,976.32.

Increased Need and Funding Turnover

In FY18, DBDHS regions spent a total of $29,408,124 to support 1,860 individuals. In FY19, that amount grew to $35,149,266 to support 1,995 individuals. It was projected that regions would spend $40,273,760 based on encumbrances for FY20. This reflects an average growth rate of 17.3% each fiscal year.

DBHDS has increased utilization of DAP as the state hospital census has grown and the need for funded discharge placements has increased. Annual fund turnover – meaning the amount of funding that was allocated and then unallocated (and available for reallocation to a new plan) – has been reviewed since FY18. This turnover can occur due to the death of an individual, reduction in services as result of a decreased need, determination of the individual to no longer need the funding, return to hospitalization, or determination of a new funding source to cover needed services.

- In FY18 only 10.9% of the funds were turned over.
- In FY19, this increased to 22.54% in conjunction with the expansion of the DBHDS Community Integration Team and their consistent participation in CSB regional utilization review.
- For FY20 quarters 1-3, turnover was a 28.25%.

Infrastructure Funding

Beginning in FY18, $3,129,873 annually has been provided to support three CSB-run assisted living facilities. These are located in Nelson County, Western Tidewater, and Pulaski County. The facilities are designed to serve a minimum of 140 hospital discharges annually. Five million in funds are provided for contracted intensive and transitional community programs for individuals who are discharged from state facilities, including:

- Five eight-bed group homes
- 24-hour/daily intensive care

- Supervision and support
- Assistance with medication education
- Monitoring, support, and assistance in engaging/transition to community-based activities
- Support towards transitioning to a lower level of care as appropriate

2020 DAP Workgroup

From May through September of 2020, DBHDS convened a workgroup which included representation from the Virginia Association of Community Services Boards, its Executive Directors Forum, the five major CSB regions and the two sub-regions, the Virginia Department of Medical Assistance Services (DMAS), the Virginia Department for Aging and Rehabilitative Services (DARS), and the Virginia Department of Social Services (VDSS). A full list of stakeholders is available in Appendix A.

The workgroup met to review available DAP data, including individuals served, costs and spending over time. It also agreed on a list of common DAP services and articulated the challenges associated with DAP. Finally, the workgroup agreed on a set of recommendations to address gaps in care and promote cost-efficiency within the program.

Major DAP Spending Areas and Associated Challenges

The two primary areas of DAP spending are around living options for discharged patients as well as community services. For individuals with diagnoses of dementia, traumatic brain injury (TBI), or patients with serious medical comorbidities, identifying options within the network of available residential settings and services can be a significant challenge. Below, both areas of need and associated challenges identifying options are described.

Living Options and Housing

Mental health recovery, as well as physical health and wellbeing, is deeply interconnected with housing stability. For individuals who are on the Ready for Discharge (RFD) list and the Extraordinary Barriers List (EBL) at state facilities, placement and housing in both independent and supervised settings is the largest barrier to discharge. Given that 81 percent of DAP funding for the first two quarters of FY20 was spent on living options, it is imperative to address the community residential challenges for the state psychiatric hospital discharge population. The current options range from independent living, to assisted living, to more intensive settings like group homes and nursing facilities

DAP is intended to support the value of least restricted, most integrated setting for individuals discharging from state psychiatric facilities. The DBHDS core taxonomy (Core Services Taxonomy 7.3, available in Appendix B) defines residential housing options. Most individuals using DAP require supervised residential services. Below are living options most frequently used for individuals discharging from state facilities.

1. **Independent housing**: refers to a housing structure not related to any services or supports for the individual. This could be funded with client funds or through a voucher program from partner agencies such Housing and Urban Development.

2. **Permanent Supportive Housing (PSH):** a specific program model in which a consumer lives in a house, apartment, or similar setting, alone or with others, and has considerable responsibility for residential maintenance but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities. Criteria identified for supported housing programs include housing choice, functional separation of housing from service provision, affordability, community integration (with persons who do not have mental illness), and right to tenure, service choice, service individualization and service availability.

3. **Supervised Living Apartments:** include individual apartments clustered together with 24-hour staff available for oversight. Often these type of settings require participation in mental health services and are typically offered by Community Services Boards. These housing options are limited and expensive, but they often offer mental health treatment. Outside of DAP funding or private pay, there are no funding options for this type of housing for individuals with a primary diagnosis of a mental health disorder. These residential options can range from transitional to permanent.

4. **Supervised Living Group Homes**: offers supportive oversight, supervision, and mental health services, but in a small group setting. Options here are limited and expensive. Outside of DAP funding or private pay, there are no funding options for this type of housing for individuals with a primary diagnosis of a mental health disorder. These residential options can range from transitional to permanent.

5. **Supervised Living- Assisted Living Facilities (ALF):** larger homes geared toward individuals who need assistance with activities of daily living. They are licensed by the Department of Social Services and can be paid for with Auxiliary Grant through the Department for Aging and Rehabilitative Services; however, often Auxiliary Grant does not provide for the support needs of the psychiatric population. While the majority of DAP funding supports this type of living, there is no direct mental health services tied to this type of housing.

   DBHDS provides infrastructure funding for 140 beds annually in CSB-run assisted living facilities. Services provided in these facilities include mental health services, along with standard room and board. For other assisted living facilities not funded directly by DBHDS, services offered specific to the mental health population vary widely. In addition, rates for these facilities also vary. Auxiliary Grant (AG) is an available resource for funding assisted living services for individuals who need assistance with paying for ALF costs; however, as DAP has increased, facilities frequently site the AG as insufficient in funding the needs of those with mental health diagnoses. In some cases, DAP and AG funds are used together, but due to regulations, they can only do so if the facility provides services beyond room and board. There are additional concerns with housing individuals with mental health disorders discharging from state facilities in large

assisted living facilities, as is it does not align with the agency value of least restrictive and most integrated setting.

6. **Supervised Living- ALF Memory Care**: this is the same as above with the exception that some ALFs have units within the facility dedicated to patients who require memory care. These units are locked, have a slightly higher staff to patient ratio, and have increased expectations regarding activities. These units are only for individuals with a diagnosis of dementia.

   For individuals with dementia, care can be provided in a variety of settings, but for most, memory care units are the best setting to meet their specialized needs. These secured units operate as part of an assisted living facility, but are more expensive than a traditional assisted living facility, and rarely are there other funding sources outside of private pay options available for memory care units. The Auxiliary Grant is not sufficient for this type of setting.

   A second layer of complexity is that the secured units are locked, essentially creating a setting of moving a patient from one locked unit (state psychiatric facility) to another (secure, locked memory care unit). In doing so, DBHDS must adequately assess the need for this level of care to assure this is the least restrictive setting possible.

7. **Supervised Living- Nursing Home**: for individuals with higher medical needs. Often large congregate settings, they are most often paid for by Medicaid; however, some facilities are private and require DAP.

   For individuals with TBI, there is a lack of services in the community that are accessible to this subpopulation and no funding available to support them. Additionally, for individuals who need nursing care but have behavioral disturbances, nursing facilities can provide long-term care funded through Medicaid, but for individuals who have behavioral disturbances, private facilities often have to be explored, which typically requires the utilization DAP funds. There are also some barriers to nursing homes accepting patients discharged from state mental health hospitals, including perceptions around federal regulations regarding limiting the use of psychotropic medication. DBHDS is actively working with nursing homes to clarify these regulations and alleviate this barrier.

Community Services

For most patients discharging from state facilities, their needs extend beyond housing. Often these individuals need a combination of supervised housing and mental health treatment. Finding the combination of services and supports to help DAP individuals maintain stability in the community is a significant challenge. As mentioned previously, supervised living has no public funding source. Often these types of environments are funded by rent paid by the individual and the services funded by DAP. These services include supportive staff, medication management, and overnight supervision.

It would be remiss to address the services challenges for DAP without addressing the fact that DAP is a resource only available to individuals leaving state psychiatric facilities. Services that help divert from state hospital admissions could potentially decrease DAP costs. As addressed in STEP-VA program plans, a continuum of crisis services are needed to support individuals in the community to decrease psychiatric hospitalizations. Other components of STEP-VA, including outpatient services, psychosocial rehabilitation, and case management, as well as behavioral health enhancement Medicaid rates, would help to ensure a comprehensive continuum of care for Medicaid members.

Medicaid-funded services for individuals with dementia and behavioral disturbances (without a serious mental illness) are difficult to obtain. DAP has remained consistent with Medicaid definitions for services and therefore has not paid for services for individuals who would not meet the criteria for services from Medicaid.

In FY19, there were 875 patients admitted to state facilities with a diagnosis of dementia. The average length of stay (LOS) for this population was 400 days as compared to an average LOS of 100 days for other individuals. According to a DBHDS data from 2019, 81 percent of these individuals were hospitalized from a private residence or an ALF or nursing facility. As mentioned earlier, the lack of available support and living options for this population contributes to hospitalization and use of DAP to enable discharge. Many of these individuals could be diverted from the state hospital with the development and support of services in the community.

DARS is charged with serving those with TBI. They currently offer 14 services among nine providers. These services include case management, life skills training, Clubhouse (psychosocial rehabilitation), vocational services, and support groups. These services do not include residential services. In FY19, $1,306,247 in DAP funds were spent on residential TBI services for 10 individuals. These services are not widely covered by other funding sources.

DAP is trending toward a model with established services and service rates due to the increased need and utilization of this funding source. This model differs from the original use of DAP, which allowed for flexibility and creativity to discharge individuals with extraordinary barriers. While DAP funding remains a far less costly alternative to inpatient care, community providers of services, especially of housing options, are familiar with DAP, and as such it has been described as a sellers' market for the service thus driving up the cost of services and DAP funding needs. To help lower the cost of care, DBHDS has implemented utilization and justification measures to assure that funding is being used to meet the medical needs of those individuals being discharged. A recommendation in this report will support tiered rates that will further support consistency in services and costs across the state.

DBHDS has funded some transitional supervised housing options for individuals with the intent that services be provided following transition from these housing options by the CSBs. The housing options funded often includes psychiatric services, mental health skill building services, transitional services, and case coordination. However, there is often a disconnect between private providers of services and CSBs in communication and coordinating care for individuals with SMI undergoing this transition.

Administration of DAP Dollars

Over the past two fiscal years, DBHDS has made concerted efforts to provide consistent interpretation of the regulations regarding DAP funds. This includes the manner in which individual contributions to services are calculated. The DBHDS DAP manual was updated in July 2020 to include consistent and clear regulations for all of the CSB regions and sub-regions. DBHDS remains involved in all DAP plan approvals to ensure consistency in how funds are spent and the ways in which data is tracked.

The majority of DAP is allocated in grants to localities. Services, primarily supervised living options, are purchased via agreements through the local CSBs and are subject to the contracting processes for each locality, as well as their financial procedures. These procedures can create discharge delays for patients in state psychiatric facilities. They can also create unnecessary delays for small one-time purchases.

DAP presents administrative burdens at the local CSB and regional levels. They are required to collect and report data, and the systems utilized often require duplication. Specifically CSBs are required to enter data on Word document forms that are submitted at the time of DAP approval. They are also required to submit some of the same data via an Excel spreadsheet quarterly report that shows amounts spent and in categories. These are all submitted to required parties via secure email. There is also a requirement to report partial data via CCS3 (Community Consumer Submission) quarterly to DBHDS; this is the mechanism that is used for all CSBs to report services and consumer data to DBHDS. DBHDS manually collects and aggregates data from the regions. Data is required to support the program and effective use of the DAP funds. As the system of DAP has grown the need to track and report has grown which has added administrative burden on both CSB level as well as DBHDS level. An IT solution would greatly reduce this burden.

Recommendations to Improve DAP

The workgroup made several recommendations to address the current challenges outlined in this report. These challenges address both the spending of DAP funds, as well as the gaps in services and housing for those leaving state psychiatric hospitals. These recommendations should be viewed through the lens of use of DAP's goal to promote least restrictive, highly integrated community-based services and supports.

1. After a review of the current allocation of DAP funding, there was shared agreement across the workgroup that the majority of DAP funds should continue to provide supportive residential services, to include assisted living facilities, nursing facility placements, and specialized group homes. DBHDS recommends developing processes with state facilities and CSB's to ensure placement in least restrictive and highly integrated residential services is consistent across state facilities. This would begin with training opportunities to shift culture toward integrated setting and least restrictive alternatives. Additionally, the process would include justification of why less restrictive alternatives were ruled out.

2. To address the ongoing housing needs of individuals leaving state psychiatric facilities, it is imperative to seek consultation to conduct a statewide housing and

services needs assessment, to include patient input. While the workgroup recommended some specific ongoing service needs, this assessment would help more precisely identify the full scope of needs of those leaving state facilities. This assessment would need to provide clear definitions of housing and services, with an emphasis on least restrictive community-based options. Additional administrative DAP resources would be required for DBHDS Central Office to complete this assessment.

3. To better manage the consistency of funding use for individuals being discharged to assisted living facilities, it is recommended that DBHDS seek consultation to assist in developing a tiered rate and services structure. Within Virginia, sub-region 3b has begun a pilot of such a project. The consistency in rates statewide will allow for a minimum set of standard services to be provided by ALFs. This partnership has been discussed with the Department of Social Services, the licensing entity for assisted living facilities. This rate structure would allow DBHDS to incentivize the use of smaller, more integrated settings. These integrated settings could include an expansion of adult foster care homes funded by the Auxiliary Grant in Virginia. This rate structure should also include alignment in values and payments for housing, similar to PSH. This recommendation includes the need for regularly updated assessments of an individual's housing needs in order to facilitate movement to least restrictive settings.

4. There are gaps in services for individuals who do not have a diagnosis of a serious mental illness but have either major neurocognitive disorder or TBI with behavioral disturbances. Recommendations to address this challenge include working with DARS to develop services specific to those with these disorders with behavioral disturbances. This partnership should include DMAS. Development of services should include specialized prevention or crisis intervention to decrease hospitalization of this population in state facilities.
    a. DBHDS and DARS should work together to develop a process to connect patients to appropriate TBI services at discharge. This process should include educating hospital staff on available resources and developing a contact for each state facility to connect them to TBI services.
    b. For individuals in the community utilizing DAP for TBI services, DBHDS will work to create a process that includes DARS and TBI service providers in planning to move people from intensive DAP-funded TBI services to more integrated services and to decrease dependence on DAP.
    c. Finally, the workgroup recommended funding to support a partnership with DARS to implement training for community-based facilities, caregivers, emergency departments, and CSB emergency services regarding dementia and TBI. This should include interventions at the point of crisis to avert from state hospitals.

5. The workgroup recommended DBHDS and DMAS work together with Virginia's managed care organizations (MCOs) to determine the most appropriate discharge options based on each individual's needs and the covered services in the MCO's

network. Integration of the MCOs as part of the discharge planning process would assist in determining the specific covered services for each DAP-covered individual as well as gaps in needed services. Over time, this could assist in the preservation of DAP funds.

6. DBHDS has begun collaborating with nursing facilities to serve individuals from state psychiatric facilities who require this level of care, including investigating the possibility of funding mental health behavioral analyst positions in these facilities. Currently regulations and insurance prohibits billing for most mental health services in nursing facilities. These partnerships, however, could help alleviate the perceived barriers in serving individuals leaving state facilities and make nursing facilities more comfortable accepting these patients.

7. Finally, the workgroup recommended investment in a centralized reporting system would increase the effective use of funding and decrease the burden on local resources. A centralized system would allow for more real-time access to data, which is important for effective decision-making. Ideally, the solution would allow for connection to the databases used by regions to reduce duplication of data entry and allows for real time data reporting and understanding of funding availability.

Sustainability

Continued investment in DAP is foundational to a longer-term plan to better assist individuals with serious mental illness through potential Section 1115 Medicaid Demonstration Waiver initiatives. . Specifically, two possible waivers were discussed, including the High Needs Support Benefit and SMI/SED 1115 Demonstration. The High Needs Support Benefit would include individual housing and pre-tenancy sustaining services, community transition services, pre-employment, and employment sustaining services. These services are centered on independent housing, which is needed by a smaller portion of DAP individuals than those that require supervised living arrangements. Still, the benefit could help to transition individuals from more intensive housing options to independent housing options over time as well as support increased employment. The SMI/SED 1115 Demonstration would provide payment for mental health residential treatment options, which could significantly reduce DAP spending over time and ensure it is only used for unique services and supports that are not available under the Medicaid waiver program. This type of waiver and the treatment it offers, coupled with continuity of care in the community, could decrease the dependence on assisted living and supervised residential options for current patients.

In addition to the Medicaid waivers described above, the full implementation of Behavioral Health Enhancement opportunities may decrease the use of DAP dollars, again reserving it for only those with critical and unique needs. The extension of benefits available in the community may decrease the need and length of stay for supervised housing/residential services. Full implementation of STEP-VA, together with Behavioral Health Enhancement, will also allow for more robust community services in areas such as crisis services, assertive community treatment, outpatient services, and psychosocial rehabilitation, that would over time decrease the reliance

on state hospital beds/inpatient treatment and reduce the dependence on DAP funds for ongoing residential supports.

DBHDS and the DAP workgroup plan to continue conversations around the recommendations described above through sub-workgroups. These sub-workgroups will focus on:

- Development of a needs assessment for better understanding of service needs
- Establishment of a rate and services structure for better utilization of funds
- Partnering with other agencies to fill the gaps in services for individuals diagnosed with major neurocognitive disorder or TBI
- Exploring opportunities to incorporate mental health services in nursing facilities

In addition, DBHDS will continue to work with DMAS on the implementation of 1115 Medicaid waiver initiatives, Behavioral Health Enhancement, and STEP-VA, as well to ensure that DAP funds are being utilized for the most necessary services. DAP funds will continue to primarily support residential services for individuals discharged from state facilities, while the remaining funds provide other community support services through one-time and ongoing plans. This approach will allow for long-term sustainability of this unique and important program.

Appendices

Appendix A: Workgroup Participants

Co-Chairs: Heather Rupe, DBHDS DAP Specialist; and Shannon Wilson, DBHDS Financial and Policy Analyst

Community Services Boards:

Region 1- Hannah Jilg- DAP Coordinator and Liaison

Region 2- Mark Doering- Aftercare manager

Region 3a-Adrian Monti- BH Director

Region 3b-Mary Beth Clement- Financial Director

Region 3c-Denise Chapman- DAP Coordinator

Region 4- Daniel Rigsby- MH Director

Region 5- Carmen Keziah - Regional Manager

Executive Director Representative - Jim Bebeau

VACSB- Jennifer Faison

State Psychiatric Facilities:

Mark Morin- SWVMHI

Terry Pope- PGH

Steve O'Brien- ESH

Department of Aging and Rehabilitative Services (DARS)
Tishawn Ugworji; Christaine Miller

Virginia Department of Social Services
Marina Siynard

Department of Medicaid Assistance Services
Brian Cambell; Tammy Whitlock; Cleo Booker; Laura Reed; Alyssa ward

Department of Behavioral Health and Development Services
Kristin Yvarosky; Margaret Steele; Alex Harris; Heidi Dix, Suzanne Mayo, Emily Lowrie

Appendix B: Residential Services Taxonomy

Residential Services provide overnight care with an intensive treatment or training program in a setting other than a hospital or training center, overnight care with supervised living, or other supportive residential services.

a. *Highly Intensive Residential Services (501) provide overnight care with intensive treatment or training services. These services include: Mental Health Residential Treatment Centers such as short term intermediate care, residential alternatives to hospitalization such as community gero-psychiatric residential services, and residential services for individuals with co-occurring diagnoses (e.g., mental health and substance use disorders, intellectual disability and mental health disorders) where intensive treatment rather than just supervision occurs; Community Intermediate Care Facilities for Individuals With Intellectual Disability (ICF/ID) that provide care to individuals who have intellectual disability and need more intensive training and supervision than may be available in an assisted living facility or group home, comply with Title XIX of the Social Security Act standards and federal certification requirements, provide health and habilitation services, and provide active treatment to individuals receiving services toward the achievement of a more independent level of functioning or an improved quality of life; and Substance Abuse Medically Managed Withdrawal Services that provide detoxification services with physician services available when required to eliminate or reduce the effects of alcohol or other drugs in the individual's body and that normally last up to seven days, but this does not include medical detoxification services provided in community-based substance abuse medical detoxification inpatient services (260) or social detoxification services.*

b. *Residential Crisis Stabilization Services (510) provide direct care and treatment to nonhospitalized individuals experiencing an acute crisis related to mental health, substance use, or co-occurring disorders that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization, provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in crisis, and mobilize the resources of the community support system, family members, and others for ongoing rehabilitation and recovery. Residential crisis stabilization services are provided in a community-based program licensed by the Department. These services are planned for and provide overnight care; the service unit is a bed day. Services that are integral to and provided in residential crisis stabilization programs, such as outpatient and case management services, should not be reported separately in those core services since they are included in the bed day.*

c. *Intensive Residential Services (521) provide overnight care with treatment or training that is less intense than highly intensive residential services. It includes the following services and Medicaid ID HCB waiver congregate residential support services. Group homes or halfway houses provide identified beds and 24 hour supervision for individuals who require training and assistance in basic daily living functions such as meal preparation, personal hygiene, transportation, recreation, laundry, and*

budgeting. The expected length of stay normally exceeds 30 days. Primary care offers substance abuse rehabilitation services that normally last no more than 30 days. Services include intensive stabilization, daily group therapy and psychoeducational services, consumer monitoring, case management, individual and family therapy, and discharge planning. Intermediate rehabilitation is a substance abuse psychosocial therapeutic milieu with an expected length of stay up to 90 days. Services include supportive group therapy, psychoeducation, consumer monitoring, case management, individual and family therapy, employment services, and community preparation services. Long-term habilitation is a substance abuse psychosocial therapeutic milieu with an expected length of stay of 90 or more days that provides a highly structured environment where residents, under staff supervision, are responsible for daily operations of the facility. Services include intensive daily group and individual therapy, family counseling, and psycho-education. Daily living skills and employment opportunities are integral components of the treatment program. Jail-based habilitation services, previously reported here, should be reported in outpatient services (310).

d. *Supervised Residential Services (551) offer overnight care with supervision and services. This subcategory includes the following services and Medicaid ID HCB waiver congregate residential support services. Supervised apartments are directly-operated or contracted, licensed residential programs that place and provide services to individuals in apartments or other residential settings. The expected length of stay normally exceeds 30 days. Domiciliary care provides food, shelter, and assistance in routine daily living but not treatment or training in facilities of five or more beds. This is primarily a long-term setting with an expected length of stay exceeding 30 days. Domiciliary care is less intensive than a group home or supervised apartment; an example would be a licensed assisted living facility (ALF) operated, funded, or contracted by a CSB. Emergency shelter or residential respite programs provide identified beds, supported or controlled by a CSB, in a variety of settings reserved for short term stays, usually several days to no more than 21 consecutive days. Sponsored placements place individuals in residential settings and provide substantial amounts of financial, programmatic, or service support. Examples include individualized therapeutic homes, specialized foster care, family sponsor homes, and residential services contracts for specified individuals. The focus is on individual residential placements with expected lengths of stay exceeding 30 days rather than on organizations with structured staff support and set numbers of beds.*

e. *Supportive Residential Services (581) are unstructured services that support individuals in their own housing arrangements. These services normally do not involve overnight care delivered by a program. However, due to the flexible nature of these services, overnight care may be provided on an hourly basis. It includes the following services and Medicaid ID HCB waiver supported living/in-home supports, respite (agency and consumer-directed) services, companion services (agency and consumer-directed), and personal assistance services (agency and consumer-directed).*