Virginia Department of Behavioral Health & Developmental Services

Annual Report on the Implementation of Chapter 683 of the 2017 Acts of Assembly and Item 322.S of the 2020 Appropriation Act.

December 3, 2020

DBHDS Vision: A Life of Possibilities for All Virginians

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Preface

The Department of Behavioral Health and Developmental Services (DBHDS) is submitting this report in response to the requirements in Senate Bill 1005 and House Bill 1549 (2017) which amended and added to sections to the *Code of Virginia* related to services to be provided by the community services boards (CSBs) and behavioral health authority. The fourth enactment clause of this legislation reads as follows for both SB1005 and HB1549:

> *4. That the Department of Behavioral Health and Developmental Services shall report by December 1 of each year to the General Assembly regarding progress in the implementation of the provisions of this act.*

Additionally, in Appendix A of this report, there is information in response to Item 322.S of the 2020 Appropriations Act that requires DBHDS to report on the use of funds allocated to provide child psychiatry and children's crisis response services:

> *S. Out of this appropriation, $8,400,000 the first year and $8,400,000 the second year from the general fund shall be used to provide child psychiatry and children's crisis response services for children with mental health and behavioral disorders. These funds, divided among the health planning regions based on the current availability of the services, shall be used to hire or contract with child psychiatrists who can provide direct clinical services, including crisis response services, as well as training and consultation with other children's health care providers in the health planning region such as general practitioners, pediatricians, nurse practitioners, and community service boards staff, to increase their expertise in the prevention, diagnosis, and treatment of children with mental health disorders. Funds may also be used to create new or enhance existing community-based crisis response services in a health planning region, including mobile crisis teams and crisis stabilization services, with the goal of diverting children from inpatient psychiatric hospitalization to less restrictive services in or near their communities. The Department of Behavioral Health and Developmental Services shall include details on the use of these funds in its annual report on the System Transformation, Excellence and Performance in Virginia (STEP-VA) process.*

As of December 1, 2020, Same Day Access and Primary Care Screening are the only services that are required STEP-VA services. Additionally, funds have been appropriated for Outpatient Services and partial funding of Crisis Services (which must be implemented by July 1, 2021). For that reason, a report on the implementation of STEP-VA is a report on the implementation of the Same Day Access funds and Primary Care Screening, as well as funds appropriated to Outpatient Services and Crisis Services.

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Executive Summary

The System Transformation Excellence and Performance (STEP-VA) initiative is Virginia's concentrated effort to reform the public mental health system by improving access, quality, consistency, and accountability in public mental health services across the Commonwealth. It requires that all 40 community services boards (CSBs) implement nine essential services, referred to as steps, and requires consistent quality measures and oversight. After full implementation of STEP-VA, DBHDS anticipates fewer admissions to state and private hospitals, decreased emergency room visits, and reduced involvement of individuals with behavioral health disorders in the criminal justice system.

In the past year, despite the COVID-19 pandemic, STEP-VA implementation and planning have continued. Key progress and learnings from FY20 include:

- Primary care screening and same day access continue to be provided across Virginia's 40 CSBs, with CSBs providing telehealth or telephonic services as needed to prevent the spread of the virus.
- During FY20, over 55,000 individuals received same day assessments
- In FY20, a total of 34,534 metabolic screens were conducted for 17,113 individuals using the primary care screening process.
- Mobile crisis services and outpatient services have been partially implemented, though full funding of resources is necessary to complete implementation across Virginia.
- Planning is nearly complete for military and veteran's services and peer and recovery services, and planning continues the final three steps: case management, care coordination, and psychiatric rehabilitation.
- There continues to be a critical need for Central Office staff to provide the centralized planning and coordination necessary for effective STEP-VA implementation that has been noted in the Joint Legislative Audit and Review Commission (JLARC) report from 2019 and the 2020 Comprehensive Needs Assessment.
- There continues to be a need for critical data infrastructure to ease the administrative reporting burden on CSBs and provide DBHDS with the timely metrics necessary to gauge quality of services and institute performance improvement goals.

DBHDS continues to work with DMAS partners to align STEP-VA with Behavioral Health Enhancement and works to implement the Behavioral Health Equity Index to identify a pathway to more equitable allocation of funding across CSBs. This report concludes with future directions and an overview of activities for SFY21.

Introduction

Over the past several years, Virginia has been making concentrated and meaningful efforts to reform its strained public mental health system. In an effort to improve the system, the Department of Behavioral Health and Developmental Services (DBHDS) worked with the McAuliffe and Northam Administrations, the General Assembly, and stakeholders and drew from national best practices to design System Transformation Excellence and Performance (STEP-VA). STEP-VA focuses on improving access, quality, consistency, and accountability in public mental health services across Virginia. STEP-VA requires all community services boards (CSBs) to provide the same services, commonly referred to as "STEPs", including same day access, primary care screening, outpatient services for mental health and substance use disorders, targeted case management, crisis services, and other critical services; shifting from a system of two mandated services to nine mandated services, which represents a broader array of behavioral health services. These essential services will be available consistently across all 40 CSBs.

In addition to requiring a uniform set of services across all 40 CSBs, STEP-VA also requires consistent quality measures and improved oversight in all Virginia communities through investment in CSB and DBHDS infrastructure. STEP-VA services are intended to foster wellness among children and adults with behavioral health disorders and prevent crises before they arise. STEP-VA is also intended to provide critical support for individuals at risk of incarceration, those in crisis, and those in need of stable housing. Statewide impact following full implementation is expected to be impressive: fewer admissions to state and private hospitals, decreased emergency room visits, and reduced involvement of individuals with behavioral health disorders in the criminal justice system.

In 2018, the General Assembly provided funding for all 40 CSBs to implement the first STEP-VA service, Same Day Access, which had been funded for 18 CSBs the prior year. Then, Primary Care Screening received funding in FY19, and Outpatient Services, Detox Services, and Mobile Crisis Services received funding in FY20. Governor Northam's budget for the FY2021-2022 biennium as well as the budget passed by the General Assembly during 2020 Session also included significant investments in STEP-VA: additional outpatient and crisis funding, funding for peer recovery services and military and veterans' services STEPs, and funding for critical infrastructure at the CSBs (e.g., billing staff) and Central Office (5 positions to oversee these state general funded services in the community). Due to COVID-19 budget impacts, these funds were unallotted. Table 1 below shows the funding and implementation status for each step as November 1, 2020.

Table 1: STEP-VA funding by "step"

STEP-VA "step"	Status	Existing Funding (prior to 2020)	GA 2020 Appropriated	Unallotted	Remaining	General Assembly 2020 Special Session	Additional STEP-VA Costs for Future steps
Same Day Access	Implemented	$10,795,651	$10,795,651	$0	$10,795,651	$10,795,651	$0
Primary Care Screening	Implemented	$7,440,000	$7,440,000	$0	$7,440,000	$7,440,000	$0
Detoxification (Crisis Services)	Implemented	$2,000,000	$2,000,000	$0	$2,000,000	$2,000,000	$0
Outpatient	Jul-20	$15,000,000	$21,924,980	($6,924,980)	$15,000,000	$21,924,980	$0
Mobile Crisis	Apr-21	$7,800,000	$13,954,924	($6,154,924)	$7,800,000	$13,954,924	$0
Crisis Dispatch	Jul-21		$4,697,020	($4,697,020)	$0	$4,697,020	$0
Veterans Services	Jul-21		$3,840,490	($3,840,490)	$0	$3,840,490	$0
Peer Support & Recovery Services	Jul-21		$5,334,000	($5,334,000)	$0	$5,334,000	$0
Psychological Rehab/Skills	TBD		$0	$0	$0	$0	$6,048,797
Care Coordination	TBD		$0	$0	$0	$0	$15,779,846
Case Management	TBD		$0	$0	$0	$0	$8,417,000
Cross-Step Infrastructure*	ongoing		$3,200,000	($3,200,000)	$0	$3,200,000	$0

Primary activities during FY20 related to implementation process improvements in response to a study by the Joint Legislative Audit and Review Commission (JLARC); receiving and analyzing the results of the Comprehensive Needs Assessment; plan approval and disbursement of Outpatient Services funding, including regional training; planning, plan approval, and disbursement of Crisis Services funding; ongoing implementation and data quality review for Same Day Access and Primary Care Screening; and workgroup management for planning for remaining STEPs. Additional activities included working with DMAS partners to align STEP-VA with Behavioral Health Enhancements and working to implement the Behavioral Health Equity Index. This report concludes with future directions and an overview of activities for SFY21.

Results of the JLARC Report

In June of 2019, the Joint Legislative Audit and Review Commission (JLARC) the made a report to the Governor and General Assembly of Virginia regarding the Implementation of STEP-VA. The report detailed the status of the first two steps – same day access and primary care – and made note that sufficient oversight and coordination by DBHDS was critical to effective implementation and that effectively planning for and implementing the remaining seven steps requires more than the original four-year implementation timeline. JLARC's recommendations included an emphasis central oversight and coordination of STEP-VA implementation as well as on the development of requirements and performance metrics, which have become key focuses of STEP-VA at DBHDS.

Results of Comprehensive Needs Assessment

To understand the current capacity and needs in the public mental health system, a comprehensive needs assessment was required. This was an 18-month process beginning in 2018 and concluding at the end of calendar year 2019. Final reports were received in March 2020.

The purpose of the Virginia Behavioral Health System Needs Assessment was to assess the behavioral health system strengths, needs, and capacity across the continuum of community services. This robust statewide system includes prevention, treatment, and recovery; crisis response; and access and care coordination for patients requiring public hospital care. The assessment includes analysis of funding sources, allocations, and the processes by which allocations may be determined.

Key Findings of the Virginia Behavioral Health System Needs Assessment

1) STEP-VA has been successful in increasing access to behavioral health services; however, the degree of service penetration and fidelity to models must be considered in the implementation of STEP-VA services and evidence-based practices (EBPs).
2) Managed care has had a significant impact on service provision in Virginia and will require the CSBs to adopt new business acumen and, in some cases, new capacities and expertise to be successful.
3) Communication between CSBs and DBHDS has been identified by all parties as an area in need of improvement.
4) Strong leadership and collaboration between DBHDS and CSBs is a critical facilitator for STEP-VA implementation and fully maximizing the Medicaid benefit.
5) CSBs lack sufficient workforce capacity to address challenges in workforce recruitment and retention and the delivery of EBPs with fidelity.
6) Funding is not adequate for STEP-VA service implementation and delivery. Although CSBs clearly value the intent of STEP-VA, funding to deliver the required services is insufficient at levels of penetration that are responsive to demand.
7) Virginia's prevention system has moved to a data-driven planning model that follows current national best practices in prevention science.

Key Recommendations of Virginia Behavioral Health Needs Assessment

1) DBHDS is encouraged to draft a communication plan supporting the timely sharing of accurate information and decisions to all CSB leaders. This communication plan should identify opportunities to improve internal communication among divisions to better align efforts and decisions and communication with CSBs and provide timely, consistent, information and guidance.
2) DBHDS is encouraged to draft a plan for information technology to identify what data are necessary for the department to monitor, plan, make programmatic decisions, and allocate resources; reduce redundancy in data collection; improve data quality; define the

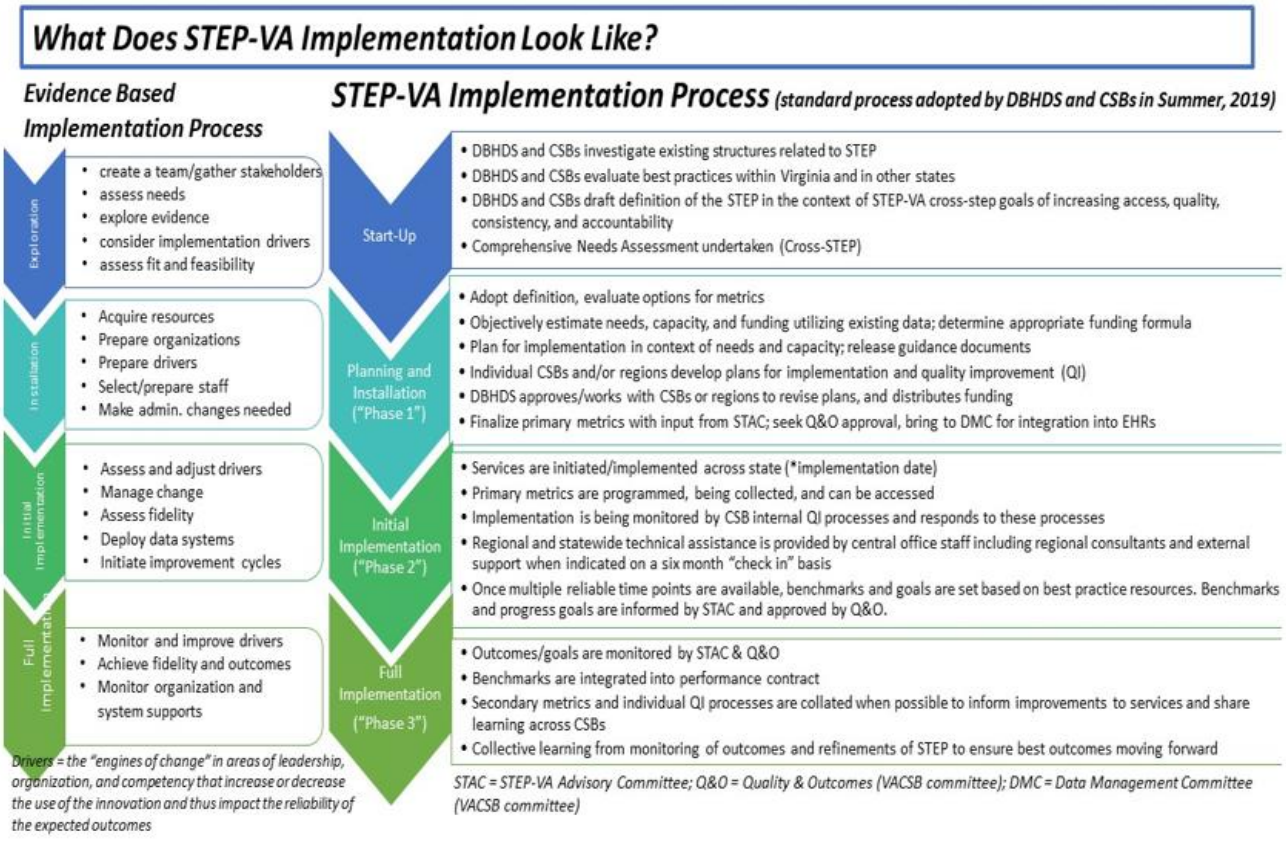
data and reporting timeline that are required from the CSBs; reduce the burden of data collection on the CSBs; define the technology needs of the department and the CSBs.

3) DBHDS is encouraged to fund a statewide contractor that operates under DBHDS's guidance to develop statewide and CSB-specific plans for systems capacity building.
4) DBDHS is encouraged to work collaboratively with key state and community stakeholders to establish consistent and enforceable requirements, expectations, and practices for managed care. The objectives of this collaboration would include: minimizing patients being adversely impacted by managed care; building systems capacity to reduce hospitalizations and re-hospitalizations; improving operations between MCOs and community providers.
5) The CSBs, DMAS, and DBHDS should agree on one set of nationally recognized or local performance measures that indicate quality and outcomes and can be used for quality improvement. High-priority technology capacity and infrastructure needs within CSBs fall into three main categories: financial information systems, an EHR, and quality management plans with a robust data analytics capacity.
6) DBHDS is encouraged to invest in CSB adoption and utilization of IT and quality management systems to conduct business and track the delivery and quality of services. Given the complexity arising from the presence of multiple payers with different requirements and payment structures, plus the need to share clinical or billing information in a more interoperable manner that allows for access across multiple entities, information and system technology is critical.
7) DBHDS is encouraged to support workforce development efforts to improve CSB recruitment and training of additional personnel with the needed skill sets and competencies.
8) DBHDS is encouraged to develop a workforce development committee made up of CSB representatives who make recommendations to address the unique needs of CSB staff. DBHDS should consider conducting a salary study.
9) DBHDS, DMAS, and the MCOs are encouraged to better align their respective goals and objectives. As STEP-VA is a signature initiative of the Virginia legislature intended to transform the Commonwealth's behavioral health system, the alignment of goals and efforts of DBHDS, DMAS, and MCOs is critical to STEP-VA's success.
10) CSBs, in collaboration with DBHDS, should undertake a dedicated and perhaps independently facilitated process to determine the true costs for essential services so that rates for services are informed by current facts.
11) DBHDS is strongly encouraged to shift or align its funding to support robust community options that can increase access to care while reducing the trauma and high costs associated with hospitalization.

STEP-VA Implementation Process Improvements

In response to the JLARC report as well as initial findings of the Needs Assessment, DBHDS took steps to clearly articulate the STEP-VA expectations and improve communication regarding STEP-VA. A primary step included the development and agreement between DBHDS and the CSBs regarding definitions of implementation phases. These are based on best practices from the field of implementation science. By clearly defining Phase 1, 2, and 3 of implementation and applying this across STEPs, we are building a common vocabulary and shared expectations about progress, metrics, data quality, and outcomes. Figure 1 below provides a visual depiction of this process.

Figure 1: STEP-VA Implementation Process



Same Day Access

Disbursement of Funds

Total same day access (SDA) funding for FY 2020 was $10,795,651. Allocations for FY20 were stable and consistent with allocations from FY19.

Table 2: Allocations of FY20 SDA State General Funds

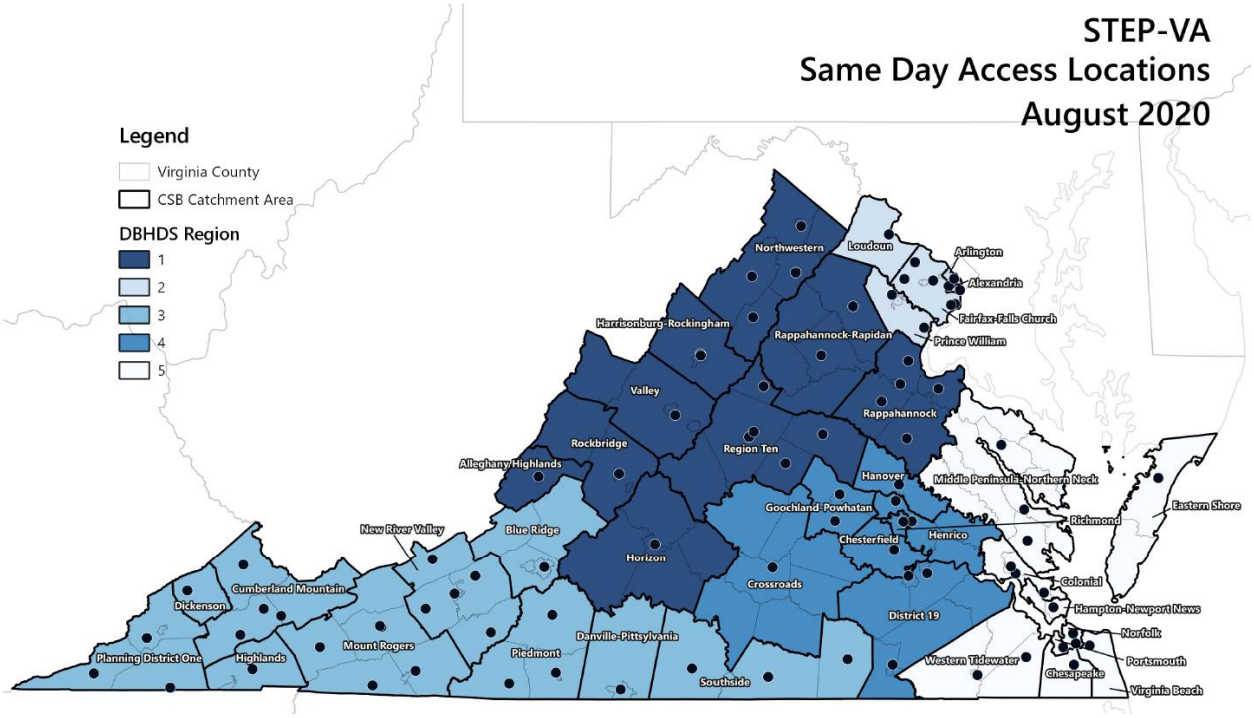
CSB	Same Day Access Allocation FY 20
Alexandria	$269,891
Alleghany	$269,891
Arlington	$269,891
Blue Ridge	$269,891
Chesapeake	$269,891
Chesterfield	$269,891
Colonial	$269,891
Crossroads	$269,891
Cumberland	$269,891
Danville Pittsylvania	$269,891
Dickenson	$269,891
District 19	$269,891
Eastern Shore	$269,891
Fairfax Falls Church	$269,891
Goochland	$269,891
Hampton NN	$269,891
Hanover	$269,891
Harrisonburg-Rock	$269,891
Henrico	$269,891
Highlands	$269,891
Horizon	$269,891
Loudoun	$269,891
Mid Peninsula NN	$269,891
Mt. Rogers	$269,891
New River Valley	$269,891
Norfolk	$269,891
Northwestern	$269,891
PD1	$269,891
Piedmont	$269,891
Portsmouth	$269,891
Prince William	$269,891
Rapp Area	$269,891
Rapp-Rapidan	$269,891
Region Ten	$269,891
Richmond	$269,891
Rockbridge	$269,891
Southside	$269,891

Valley	$269,891
Virginia Beach	$269,891
Western Tidewater	$269,891

Implementation

All 40 CSBs have successfully implemented SDA. Currently, there are 76 SDA locations across Virginia. Impressively, these services have been adapted but still maintained during COVID-19 by shifting to telehealth services as well as in-person services when needed (and hybrid services; for example, telehealth between two rooms at the CSB to follow COVID-19 protocols). Below is a map of SDA locations across Virginia.

Figure 2: SDA Locations



Outcome Measures and Continuous Quality Improvement

Quality oversight and outcome measures and processes include the following. The first three have been implemented and the last two are partially implemented at the time of this report:

1) Qualitative 6 month implementation report-outs (collected during Phase 2 only; February 2020 and August 2020)
2) Internal CSB continuous quality improvement processes (documented in CSB policies and procedures)
3) Primary metrics (collected during Phase 2; considered reliable and valid by Phase 3)

4) Statewide data review via VACSB/DBHDS Data Management Committee (for data quality, reliability, and validity) and Quality and Outcomes Committee (for benchmarking and quality improvement)
5) Performance contract modifications and enforcement (use of peer to peer support, corrective action plans, and other means of escalating enforcement)

Six month Qualitative Implementation Report-Outs

Due to the lag between implementation date and expectation of high quality, reliable and valid data regarding performance, CSBs and DBHDS agreed to a qualitative report-out on six month intervals to occur each February and August when a STEP is in Phase 2 of implementation.

Table 3: Strengths and Concerns with SDA Implementation

Top Statewide Strengths
Increased access to CSB services
Transitioned operations to telehealth/hybrid assessment offerings within 2 weeks of COVID-19 state of emergency
Utilization of QI processes and data-driven decision making to tailor staffing models and clinic flow
Stakeholder and client satisfaction; low turnover of staff in this service (although core workforce issues exist across the system)
Use of peer support specialists throughout process
Local innovations and COVID-19 solutions

Top Statewide Concerns
Length of assessment and overall assessment time
lack of coordination between DMAS and DBHDS requirements
Wait times for referral services high or rising (psychiatric services, outpatient, case management)
Need for quicker access and improvements for statewide reporting
Ensuring COVID-19 pivots remain consistent with SDA model overall (e.g., scheduling appointments via telehealth)

In addition to these statewide strengths and concerns, the check-in identified some regional differences. Primarily, Region 2 (and a minimal number of sites outside of Region 2) is experiencing high demand during SDA hours which can result in individuals presenting on that day not receiving the assessment on that day (i.e., may be invited to return for the first slot of the following day). Other areas are managing demand on the day of the assessment, but, as described above, statewide there are issues with managing demand for follow-up services such as outpatient services.

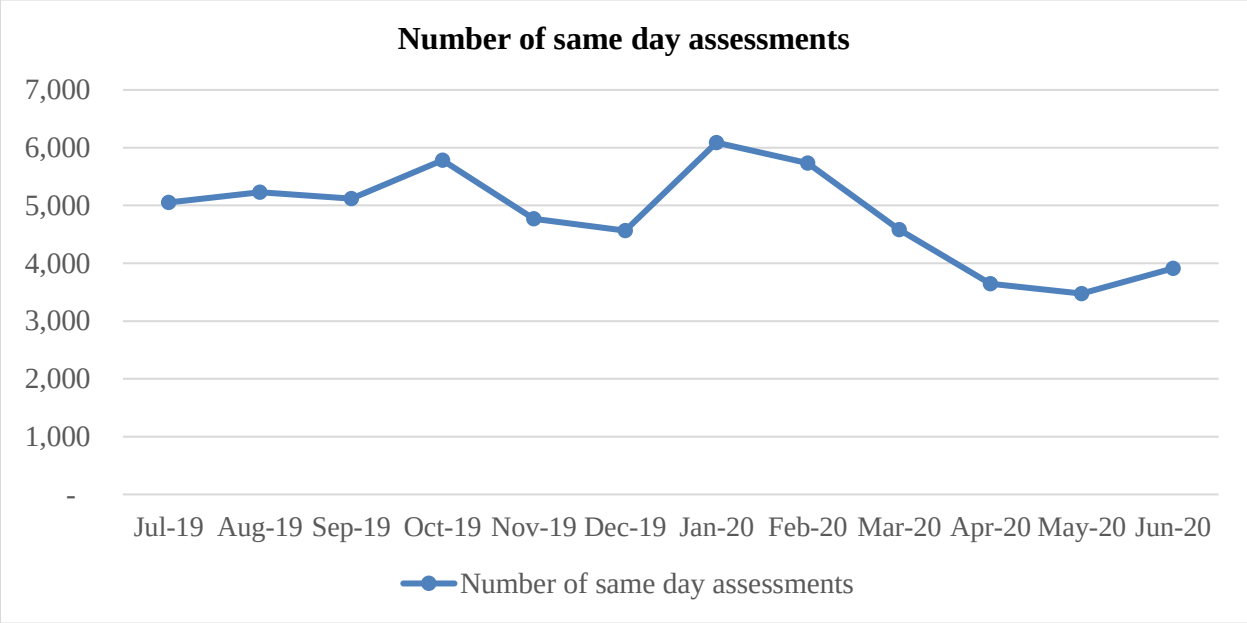
Primary Metrics

Data elements collected and reported by the CSBs as primary data elements include: (1.) The date each SDA comprehensive assessment; (2.) Whether the assessment determined the individual needs services offered by the CSB; and (3.) The date of the first service offered at the CSB for all individuals seeking mental health or substance use disorder services from the CSB.

Then, existing data elements collect additional appointments at the CSB, thus, we are able to track whether the individual attended their scheduled follow-up session.

The primary metrics include the number of individuals served by SDA; the average and range of wait times experienced by SDA consumers between initial assessment and first appointment offered; and percentage of individuals returning for a scheduled follow-up appointment. Benchmarks set prior to implementation focused on an appointment being offered within 10 business days for 90% of consumers in need of services, and that 75% of individuals would attend the scheduled follow-up appointment. These elements are captured in Community Consumer Submission 3 (CCS3) exports, which is the system which was found to be significantly inadequate in the needs assessment findings and JLARC study. Thus, there remain some data quality, reliability, and validity issues due to the lack of transactional data. Preliminary data indicate a high number of SDA assessments being conducted system-wide. During fiscal year 20, a total of 60,070 same day assessments were conducted. Assessments were conducted with 55,483 unique individuals. Patterns across months can be seen in Figure 3.

Figure 3: SDA Volume, July 2019-June2020



Preliminary data also indicate high rates of consumers attending their scheduled follow-up appointments, but, unfortunately, DBHDS cannot calculate reliable rates at this time. DBHDS and CSBs continue to work to resolve data quality, reliability, and validity issues as it is pertinent that these issues are resolved by July 1, 2021 (Phase 3 start date).

Quality Improvement Process

As described, the SDA process is complex, and CSBs worked throughout the year with consultant services of MTM, Inc. as well as using their own internal Quality Improvement (QI) processes to improve the process. Examples of QI improvements undertaken at CSBs during FY 2019 included efficiencies during intake interviews, with average clinician time per SDA client served decreasing, on average, from 5.6 hours to 4.5 hours (20% decrease). CSBs continue work to provide direct assessment for under 90 minutes, a benchmark which multiple CSBs are

reaching on average based on their 6-month check-ins. Processes such as collaborative note writing have been implemented to continue to decrease the length of the initial assessment. The majority of CSBs have not had difficulty managing demand, and individuals who present for an assessment are able to be seen that day (sometimes individuals choose to leave and come back), yet, in Northern Virginia, there is demand that is significantly higher than capacity, which can lead to clients not being seen on the same day.

Primary Care Screening

$7.4 million dollars was appropriated towards primary care screening for CSBs in FY 20. Primary Care Screening was implemented among the CSBs by July 1, 2019.

This STEP was fully defined in a committee made of DBHDS and CSB staff. Individuals with serious mental illness (SMI), a population primarily served by the CSBs, are known to be at higher risk for poor physical health outcomes largely due to unidentified chronic conditions. Therefore it is important for behavioral health staff to provide primary care screening to identify and provide related care coordination to ensure access to needed physical health care. The objectives of the STEP that were implemented during SFY 19 are as follows:

> Objective 1: Any child diagnosed with a serious emotional disturbance and receiving ongoing CSB behavioral health service or any adult diagnosed with a serious mental illness and receiving ongoing CSB behavioral health service (defined as targeted case management services) will be provided or referred for a primary care screening on a yearly basis.
>
> Objective 2: Screen and monitor any individual over age 3 being prescribed an antipsychotic medication by a CSB prescriber for metabolic syndrome following the American Diabetes Association guidelines.

These clients are required to be provided with a yearly primary care screening to include, at minimum, height, weight, blood pressure, and BMI. This screening may be done by the CSB or the individual may be referred to a primary care provider to have this screening completed. If the screening is done by a primary care provider, the CSB is responsible for the screening results to be entered in the patient's CSB electronic health record. The CSB will actively support this connection and coordinate care with physical health care providers for all service recipients.

Table 4: Disbursement of Funds, FY20

CSB	Primary Care Screening Funds
Alexandria	$130,197
Alleghany	$60,729
Arlington	$164,095
Blue Ridge	$348,270
Chesapeake	$119,428
Chesterfield	$113,325
Colonial	$80,397

Crossroads	$238,025
Cumberland	$158,168
Danville Pittsylvania	$148,765
Dickenson	$69,110
District 19	$161,776
Eastern Shore	$99,269
Fairfax Falls Church	$406,181
Goochland	$52,325
Hampton NN	$329,681
Hanover	$41,318
Harrisonburg-Rock	$99,608
Henrico	$205,902
Highlands	$138,605
Horizon	$453,970
Loudoun	$48,971
Mid Peninsula NN	$221,818
Mt. Rogers	$365,762
New River Valley	$265,333
Norfolk	$282,806
Northwestern	$222,852
PD1	$192,464
Piedmont	$268,467
Portsmouth	$113,272
Prince William	$130,307
Rapp Area	$253,049
Rapp-Rapidan	$82,584
Region Ten	$284,871
Richmond	$359,812
Rockbridge	$99,941
Southside	$156,638
Valley	$91,558
Virginia Beach	$197,238
Western Tidewater	$183,111
TOTAL	**$7,440,000**

The funding formula was determined representing 50% of funding based on demand (using information about meeting needs of uninsured population), 25% based on community needs (using Health Opportunity Index information as a proxy), and 25% based on needs associated with provider shortages (using Health Provider Shortage Areas as a proxy). This formula yielded the amounts reported above.

This funding was used to fund nurse practitioner positions, nurse positions, and other necessary aspects of beginning or expanding primary care screening offerings for each CSB. All CSBs were offering primary care screening beginning July 1, 2019.

Primary Care Screening Outcome Measures and Continuous Quality Improvement

Outcome measures and quality improvement processes are the same as SDA, with the specific outcome measures varying for each STEP.

The first goal of this step is that any child with serious emotion disturbance (SED) or adult with serious mental illness (SMI) receiving ongoing behavioral health services (defined as targeted case management services) will receive a yearly primary care screen, completed at the CSB or through a primary care provider to include at minimum: height, weight, blood pressure, and body mass index (BMI). The associated metrics will be the receipt of this screen, as well as follow-up when BMI is outside of range.

During FY20, a total of 77,795 screens were conducted for unique 36,156 individuals. Due to COVID-19, the time frame for 2019-2020 physical screens was extended to 18 months (i.e., through December, 2020). A statewide estimate of how many individuals would need a screen based on the definition is approximately 50,000, thus, for only two-thirds of the year being pre-COVID, these data are promising.

The second goal of this STEP is to ensure that individuals over the age of three on an antipsychotic medication will receive screening, monitoring and referral to the appropriate provider for treatment of metabolic syndrome according to guidelines of the American Diabetes Association.

Indicators of the screening include: Glucose Hemoglobin A1c Lipid profile, blood pressure, weight, and waist circumference to determine abdominal obesity BMI. The associated metric will be whether the metabolic screen is conducted, and whether it is out of range.

Across FY 2020, a total of 34,534 metabolic screens were conducted across 17,113 individuals. Thus, on average, individuals screened were receiving two screens per year. Due to COVID-19, metabolic screens are conducted when clinically indicated. A statewide estimate of how many individuals would need a screen based on the definition is approximately 26,000, thus, given the context of COVID-19, these data are promising.

Six Month Qualitative Report Outs

After 6 months of implementation, reports during February implementation check-ins indicated overall success in designing and utilizing procedures to ensure that all individuals in the target populations receive the appropriate screenings. The primary variation in success seemed to tie specifically to the infrastructure for primary care screenings at each CSB. In other words, the more infrastructure (i.e., on site primary care services; on site blood draw; streamlined contracts for processing) at a CSB, the more successful. CSBs relying on ad hoc referrals and working individually with community providers to seek records, labs, etc. were spending more time to complete these tasks and felt they were less successful (e.g., difficult to get paperwork back from outside providers).

The August 2020 check-in primarily centered on COVID-19 pivots. Due to the in-person nature of primary care screenings, DBHDS supported CSBs to guide decision-making with clinical

expertise and person-centered planning. Concerns included consideration for clients who are uncomfortable coming in person, consideration for whether an in-person screen is indicated if there is not another reason for the client to come in-person and the screen is not clinically indicated (e.g., the individual has had a primary care comprehensive evaluation in the last 12 months). For this reason, DBHDS indicated that a window of 18 months will be evaluated regarding conducting primary care screens. Across the system, in-person screens are still being conducted in the following circumstances: if the client is presenting in-person for any reason; if the client does not have a primary care physician; or if the client is at high clinical or physical risk (primarily for the metabolic screenings). For example, psychiatric yearly evaluations are being conducted in person at many sites. Additionally, case managers and nurses are gathering height and weight to calculate BMI via telehealth appointments and are continuing discussions and motivational interviewing regarding the importance of primary care appointments and physical health.

Outpatient Services

Outpatient services received $15 million in state general funds for FY 20. Fifty-two percent was distributed as base funding and 37% was distributed as needs based funding, with the remaining 10% ($1.5 million) distributed regionally for outpatient training in evidence-based and trauma-informed practices.

A needs-based funding formula was developed specific to outpatient services. Needs were considered across the system by comparing CSBs to one another. In other words, needs identified do not indicate an absolute level of need, rather, it indicates a relative level of need as compared to other CSBs.

Table 5: Disbursement of Funds for Outpatient Services

CSB	Outpatient Base Funding	Outpatient Needs Based Funding
Alexandria	$198,656	$54,735
Alleghany	$198,656	$133,315
Arlington	$198,656	$54,735
Blue Ridge	$198,656	$192,380
Chesapeake	$198,656	$152,895
Chesterfield	$198,656	$89,035
Colonial	$198,656	$89,035
Crossroads	$198,656	$152,895
Cumberland	$198,656	$133,315
Danville Pittsylvania	$198,656	$152,895
Dickenson	$198,656	$133,315
District 19	$198,656	$192,380
Eastern Shore	$198,656	$152,895
Fairfax Falls Church	$198,656	$89,035

Goochland	$198,656	$192,380
Hampton NN	$198,656	$89,035
Hanover	$198,656	$133,315
Harrisonburg-Rock	$198,656	$152,895
Henrico	$198,656	$133,315
Highlands	$198,656	$89,035
Horizon	$198,656	$152,895
Loudoun	$198,656	$89,035
Mid Peninsula NN	$198,656	$192,380
Mt. Rogers	$198,656	$152,895
New River Valley	$198,656	$152,895
Norfolk	$198,656	$152,895
Northwestern	$198,656	$192,380
PD1	$198,656	$152,895
Piedmont	$198,656	$133,315
Portsmouth	$198,656	$152,895
Prince William	$198,656	$133,315
Rapp Area	$198,656	$192,380
Rapp-Rapidan	$198,656	$152,895
Region Ten	$198,656	$152,895
Richmond	$198,656	$133,315
Rockbridge	$198,656	$152,895
Southside	$198,656	$133,315
Valley	$198,656	$89,035
Virginia Beach	$198,656	$152,895
Western Tidewater	$198,656	$133,315
TOTAL	**$7,946,240**	**$ 5,513,570**

Remaining $1,500,000 was distributed to the 5 regions to fund their regional training plans in evidence based practices and trauma informed care.

At the time of this report, over 100 new positions for licensed clinicians or license-eligible clinicians have been supported in the CSB system. Funds were further used for salary alignment within CSBs and across CSBs; recruitment bonuses and performance bonuses; and other investments in outpatient services. For CSB with high needs, DBHDS allowed for critical infrastructure purchases as well that supported outpatient services (e.g., EHR add-ons to be able to analyze outcomes for outpatient services). It is expected that the July 1, 2021 implementation deadline will be met for this STEP.

Outpatient Services Outcome Measures and Continuous Quality Improvement

Six Month Qualitative Report Out

The initial qualitative report-out for outpatient services occurred in August 2020. Strengths included that the majority of CSBs had implemented their STEP-VA outpatient plans and also transitioned to a primarily telehealth environment for outpatient services. It is important to note that CSBs each have internal procedures to identify when clients may benefit from in-person services vs. telehealth; further, some CSBs are beginning to offer both as customary options as of September 2020 to ensure that client needs are met in the context of COVID-19 safety requirements. Additionally, the majority of trainings in evidence-based practices were able to successfully transition to telehealth and are currently continuing via telehealth.

Primary difficulties with the implementation of outpatient STEP are as follows:

1) Workforce difficulties. It remains difficult for CSBs to compete with private providers for highly qualified clinicians
2) Paperwork. Clinicians continue to report that paperwork is a deterrent to working at the CSB and inhibits outpatient caseloads (which are already higher than in the private sector). For outpatient services, private providers tend to practice under Department of Health Professions licenses, whereas CSBs and some private providers must meet DBHDS Outpatient license criteria as well. Additionally, there is not full alignment between DMAS and DBHDS paperwork.
3) Access. Due to workforce shortages, limited funding (i.e., this STEP has only been partially funded), and increasing demand and access via SDA, caseloads are rising and there is concern that wait times will move to an average outside of the 10-day window.

A primary investment across STEP-VA has been the implementation of the Daily Living Assessment 20 (DLA-20) which is a validated measure of functional impairment. DBHDS continues to invest federal resources, and CSBs have invested additional state resources into ongoing DLA-20 training. It is expected that primary outcomes for outpatient services will include DLA-20 change scores (i.e., did the client demonstrate improvement or stabilization, as compared to worsening status) as well as engagement measures. The measurement of engagement in treatment services can be calculated based on national standards provided through Health Plan Employer Data and Information Set (HEDIS). These metrics have been collected for substance use treatment, and we will expand them to capture engagement in mental health treatment services as well (national benchmarks exist only for substance use engagement).

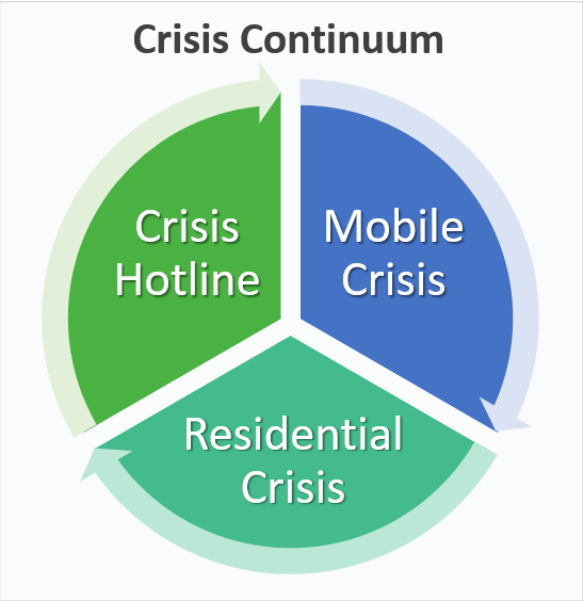
Regarding training in evidence-based practices and trauma-informed care, it will be necessary for DBHDS to collect yearly training data regarding CSB trainings and credentials, beginning in July 2021. This will be added to existing year-end reporting requirements. This will be an attestation which would then be reviewed when site visits or audits occur.

STEP-VA Crisis Services

As one of the nine required services for System Transformation Excellence and Performance (STEP-VA), behavioral health crisis services are intended to reduce use of hospital emergency departments, limit hospitalizations, decrease unnecessary incarcerations, and help ensure people with behavioral health services can live successfully and productively in their own communities. DBHDS envisions a robust crisis system for all Virginians that does not discriminate based on age, disability, or support need. The purpose of a crisis continuum of services is to ensure the availability of care to meet people where they are (literally and figuratively) when they are experiencing a crisis because of an acute mental health or behavioral emergency. It is expected that implementation deadline of July 1, 2021 will be met, although mobile crisis teams will not provide statewide capacity and minimal STEP-VA funds for adult mobile crisis will have been realized by that deadline.

According to the National Association of State Mental Health Program Directors, a comprehensive cross-disability life span crisis service system contains three major components based on national best practice. These crisis services include:

1) A crisis hotline that is available 24/7, 365 days/year to dispatch a mobile crisis response, link to community services or connect to urgent response (police, ambulance);
2) Mobile crisis services that respond to people in the community wherever they are and provide crisis intervention and stabilization supports in the community; and
3) Residential crisis stabilization for those who need more targeted support to allow the person to receive services in an alternative community location to a hospital.



DBHDS Current Crisis Services

Currently, Virginia has crisis services managed by DBHDS in each of the three major NASMHPD areas. However, in order to adopt a comprehensive crisis system based on best practices, DBHDS would need to build on existing services in each of the three major areas. The current system and vision for the future system are demonstrated below:

	Current Crisis System		Future System
Crisis Hotline	Virginia's crisis hotline system is bifurcated, confusing to consumers and not universally available 24/7. There is the traditional emergency services system operated by local CSBs. There is also a developmental disability-specific crisis hotline encompassed in the Regional Education Assessment and Crisis Habilitation (REACH) program. This developmental disability-specific crisis hotline is housed in five regions, meaning citizens in Virginia only need to call one of five crisis lines. To access emergency services, citizens in Virginia would need to call roughly 40 different phone numbers, one covering each CSB catchment area.		Regional or statewide crisis hotline for all citizens to access.
Mobile Crisis	There are major gaps in Virginia's mobile crisis services. For DD population they are offered through regional REACH programs. Some regions have children's behavioral health mobile crisis services in region 4 (CREST) and region 2 (CR2) and six other CSBs have a limited behavioral health mobile crisis capability. There is not sufficient adult behavioral health mobile crisis available in Virginia.		Statewide 24/7 mobile response and supports in the community regardless of disability type or age.
Residential Crisis/Crisis Stabilization Services	For adults, there 5 crisis therapeutic homes for individuals with DD. For individuals with BH needs, there are 14 residential crisis stabilization programs (CSUs) across the state, some of which provide medically managed withdrawal services (detox). Additionally, there are over 40 Crisis Intervention Assessment Centers (CITAC) and 20 CSBs provide 23-hour crisis stabilization services. For children, there are CSUs in Region 3 (6 beds), Region 4 (8 beds) and Region 5 (6 beds). DD services will also be opening 2 CTHCs for children. However, there is not a statewide network of universally available and consistent CSU and detox services for all individuals across the lifespan.		Statewide availability of 23-hour crisis stab; statewide capacity and availability of CSU child and adult; and statewide availability of detox beds as part of the CSU structure.

Building STEP-VA Crisis Services

For the build-out of all STEP-VA, the initial timeline projected that major funding will be secured for fiscal years 2021 and 2022. With the initial appropriation for crisis services of $7.8 million during the 2019 General Assembly Session, DBHDS applied the funds as follows:

- **$5.8M** to establish or expand mobile crisis assessment and stabilization teams for children and youth with behavioral health challenges; and

- **$2.0M** to establish or expand mobile crisis assessment and stabilization services for adults with mental illness who have cognitive impairments due to the severity of their illness and present with functional support needs.

DBHDS is currently in Phase One of building the new STEP-VA crisis services. Phase One has included a process of identifying how the current appropriation will be utilized and seeking input from stakeholders on how mobile crisis links with other key services in a comprehensive crisis system. During FY 20, the focus was on strengthening mobile crisis assessment and crisis stabilization services to children with behavioral health disorders. These mobile crisis services build on existing behavioral health and developmental services with a focus on community-based mobile assessment and supports statewide. An explanation of the existing child psychiatry and other services are in Appendix A. Additionally, a portion of the funds would be delineated for adults with behavioral health support needs who present as with a cognitive disability but do not meet the diagnostic criteria for developmental services. Services include mobile crisis assessment and crisis stabilization services in the community. Mobile crisis assessment services include responding to individuals at their residences or wherever in their community they are experiencing the crisis. Mobile crisis supports include stabilizing the crisis and working with the individual and their support system around skills that prevent future crises.

Below are the detailed allocations for FY 2020 crisis services:

1. Children Cross-Disability Crisis Services:
    - Assumes a base budget for all programs of $250,000 to address infrastructure-and operational base ($1.25million)
    - Additional $4,550,000 to be allocated as to the portion of dollars on a needs base on Crisis Assessments
    - This year's allocation driven by the regional percentage of crisis assessments provided in a year which range from 11% to 24% from data submitted to the Department
    - These funds are expected to be rolled into the balance of how current funds allocated per region are being utilized to address children's BH and DD crisis needs

Table 6: Children's Crisis, proposed $5.9 million

Region	% of Face to Face Assessment	Base Allocation	Additional Allocation above Base	Total Allocation
Region I	23%	$250,000	$1,046,500	$1,296,500
Region II	24%	$250,000	$1,092,000	$1,342,000
Region III	23%	$250,000	$1,046,500	$1,296,500
Region IV	11%	$250,000	$ 500,500	$750,500
Region V	19%	$250,000	$ 864,500	$1,164,500
Total	100%	$1,250,000	$4,550,000	$5,800,000

2. To serve adults in Crisis who have a primary MH diagnosis/crisis but also present with cognitive support needs but do not have a qualifying DD diagnosis.
    - Allocate $2 million of the $7.8 million to adult mobile crisis

    - Each program receives a base of $250,000 ($1.25million) to provide base operational
- Budget Allocations are based on percentage of individuals referred to REACH who did not meet diagnostic criteria in FY 18 with the rationale being based on the data these are individuals with behavioral health crisis needs who typically end up defaulting to state hospitals under ECO/TDO process

Table 7: Adult Crisis, $2 million

Region	% of Crisis Assessment	Base Allocation	Additional Allocation above Base	Total Allocation
Region I	13%	$250,000	$91,126	$341,126
Region II	19%	$250,000	$144,529	$394,529
Region III	18%	$250,000	$137,508	$387,508
Region IV	20%	$250,000	$ 150,245	$400,425
Region V	30%	$250,000	$ 226,590	$476,590
Total	100%	$1,250,000	$750,000	$2,000,000

Process to Date

- In November 2018, DBHDS developed an internal group of subject matter experts who reviewed best practice models of crisis services in other states. In January 2019, this group was expanded to include additional subject matter experts and DMAS.
- In November 2019, DBHDS, in concert with the VACSB, formulated the STEP-VA Advisory Council (STAC), including 19 CSB executive directors and DBHDS staff. The STAC meets regularly (initially monthly) since its inception. DBHDS involved the leadership from the CSB via the STAC including presenting information regarding the process and best practice strategies, receiving feedback and vetting proposals.
- On 2/27/19 and 4/4/19, DBHDS brought together stakeholders from emergency services, crisis programs, and children's program involved with the CSB through two stakeholder meetings (one in person and one via webinar) discussing the best practice models, implementation considerations for Virginia, and pros and cons of the same.

Service Implementation

Proposals were submitted by each of the Regions on the proposed implementation of mobile crisis supports by 10/1/2019. DBHDS reviewed all the plans submitted and followed up with each of the regions to assure the plans moved the Commonwealth further in alignment with the best practice model of crisis support services.

Funding was allocated to all of the regions in the last two quarters of FY 20 to allow the regions to start the process of implementing the services.

Service implementation has been compromised as a result of the impact of COVID-19. COVID-19 has impacted the ability to provide face-to-face supports as well as hiring staff for the mobile crisis programs. A review of the programs that occurred as part of the most recent STAC meeting prior to the end of the fiscal year in May. In Regions 2 and 4, where a regional child

crisis system was already operational, these additional funds added more staffing capacity to be able to increase availability of mobile crisis response for children in the region. For the remaining regions, planning identified a regional “hub” or “hubs” as well as additional locations for the dispatch of child crisis services (i.e., co-located staff at additional CSBs). Regions formed steering committees to engage in this planning, which will continue to guide the implementation of the regional child crisis services throughout the implementation. All regions have advertised for positions, and most regions have begun to fill these positions. Currently, regions are utilizing existing call lines to ensure that there are not duplicate investments in call lines, as there is planning for statewide infrastructure for call center and regional dispatch.

Community detoxification funding provided in FY 20 was provided to the detox services built last year in Regions 2 and 3. This builds on the investments made in FY 2018 that supported substance use disorder liaison positions and funding for substance use services (in all regions) with an additional focus on state hospital diversion and crisis stabilization unit (CSU) support in two regions.

Status of Planning for Additional Steps

Peer and Recovery Services and Military and Veterans’ Services STEPs are nearly fully planned and ready for implementation, as a funding date of July 1, 2020 was expected prior to COVID-19. Further, additional planning for the remaining outpatient funds, crisis call center staff, and adult mobile crisis had been conducted. Additionally, planning for the infrastructure funding at the CSBs indicated a need for billing staff as well as data/analytics staff.

Central office positions were funded as critical infrastructure to the STEP-VA project. These positions would allow for capacity in the community behavioral health division for data analysis, child and family services program manager, quality improvement staff, and staff specific to STEPs being implemented. The employee work profiles and job advertisements for these positions were in development at the time that the funds were unallotted due to the onset of the COVID-19 pandemic. The resources for FY 2022 were reallotted during the 2020 special session, and will be available for distribution July 1, 2021.

The final three STEPs (Case Management, Care Coordination, Psychiatric Rehabilitation) were not funded for the upcoming (2021-2022) biennium. Thus, planning on these STEPs continues but at a slower rate due to ongoing implementation of funded STEPs as well as COVID-19 impacts on CSB capacity for planning. Nevertheless, workgroups have been formed, and DBHDS seeking a process for the remaining three STEPs that works closely with DMAS in the implementation of these services, in line with the findings and recommendations of the Virginia Needs Assessment results.

Implementation Barriers and Expected Upcoming Activities for FY 2021

STEP-VA’s efficacy is largely contingent on increasing service capacity at CSBs for each of the 9 required services and also having sufficient DBHDS resources for leadership, implementation, and oversight. These findings were in the JLARC report on STEP-VA implementation and

echoed in the Virginia Comprehensive Needs Assessment. Community Behavioral Health has devoted a significant portion of the Deputy Director position to the implementation of STEP-VA, as well as the support of the Chief Deputy Commissioner. STEP-VA had a devoted project manager from January 2019 until August 2020, which helped greatly with communication and organization. Additionally, other staff members with subject matter expertise in specific STEPS provide some staffing support to the STEP implementation. STEP-VA implementation also requires effort from internal program, IT, and budget staff, as well as IT systems and data infrastructure. DBHDS has not received specific resources for staff and infrastructure to effectively implement STEP-VA for the long term, and existing staff and existing data systems cannot absorb or provide the quality required of these responsibilities.

Although CSBs have demonstrated success thus far in implementing services with the funding provided, there is significant unmet need and ongoing demand for behavioral health services across Virginia. As SDA has increased access, there is concern that demand will continue to grow and wait times will rise again if capacity for outpatient and other follow up services is not increased. Further, CSBs have struggled to meet the demands of the MCOs and the transition to a healthcare billing framework as opposed to local authority has been difficult, which ultimately could compromise the success of STEP-VA. Table 8 shows the funding status for current and future steps. The table does not reflect infrastructure and other costs that are required to effectively oversee and monitor these programs. It also does not show or reflect any growth in demand for behavioral health services that may occur over time.

Table 8: STEP-VA funding status by "step"

STEP-VA "step"	Status	Existing Funding (prior to 2020)	GA 2020 Appropriated	Unallotted	Remaining	General Assembly 2020 Special Session	Additional STEP-VA Costs for Future steps
Same Day Access	Implemented	$10,795,651	$10,795,651	$0	$10,795,651	$10,795,651	$0
Primary Care Screening	Implemented	$7,440,000	$7,440,000	$0	$7,440,000	$7,440,000	$0
Detoxification (Crisis Services)	Implemented	$2,000,000	$2,000,000	$0	$2,000,000	$2,000,000	$0
Outpatient	Jul-20	$15,000,000	$21,924,980	($6,924,980)	$15,000,000	$21,924,980	$0
Mobile Crisis	Apr-21	$7,800,000	$13,954,924	($6,154,924)	$7,800,000	$13,954,924	$0
Crisis Dispatch	Jul-21		$4,697,020	($4,697,020)	$0	$4,697,020	$0
Veterans Services	Jul-21		$3,840,490	($3,840,490)	$0	$3,840,490	$0
Peer Support & Recovery Services	Jul-21		$5,334,000	($5,334,000)	$0	$5,334,000	$0
Psychological Rehab/Skills	TBD		$0	$0	$0	$0	$6,048,797
Care Coordination	TBD		$0	$0	$0	$0	$15,779,846
Case Management	TBD		$0	$0	$0	$0	$8,417,000
Cross-Step Infrastructure*	ongoing		$3,200,000	($3,200,000)	$0	$3,200,000	$0

The COVID-19 pandemic and associated economic downturn has already begun to increase mental health demand in the community, and this is expected to rise further. Without ongoing support for the behavioral health system in Virginia, demand may quickly outpace capacity.

Nevertheless, STEP-VA implementation activities during FY 2021 are planned and will be continued as previously unalloted funding comes back online. These include implementing some of the recommendations of the Virginia Comprehensive Needs Assessment, with a focus on data management/IT needs, DMAS/DBHDS alignment, and estimating the true cost of delivering services. We also have data quality improvements and ongoing committee work with VACSB to ensure that the process for statewide data reporting and quality improvement is well articulated and that the performance contract is updated to reflect any changes to processes. DBHDS will also explore additional potential activities such as a salary study and/or setting expectations for clinician salaries across the state; building a workforce development committee or taskforce; and working to decrease or consolidate reporting requirements and/or paperwork required of the CSBs.

Conclusion

In total, $10,795,651 for Same Day Access (SDA), $7,440,000 for primary care screening, $15,000,000 for outpatient services, $7,800,000 for crisis, and $2,000,000 for detoxification services was provided in full to the CSBs during FY 20. CSBs have used this funding to implement the SDA process; hire staff, including nurses and nurse practitioners; purchase equipment needed to create and sustain the SDA and primary care screening processes within their CSBs; hire outpatient clinicians; improve employee retention and recruitment with salary improvements; train in evidence-based practices; and begin to form regional hubs for mobile crisis implementation. CSBs have also engaged in the planning process for STEPS funded in FY21 (currently unallotted), including planning for individual CSB and regional activities.

It appears that Virginia will meet the July 1, 2021 deadline for four of the STEPs required in STEP-VA per HB1549/SB1005. It is important to note that the full crisis system will not be implemented; rather, the specialized child crisis services funded in FY 20 will be implemented, in combination with the ongoing child psychiatry and crisis implementation described in Appendix A. The other services that require funding to implement include psychiatric rehabilitation services, peer support and family support services, mental health services for members of the armed forces located 50 miles or more from a military treatment facility and veterans located 40 miles or more from a Veterans Health Administration medical facility, care coordination services, case management services, and additional crisis services. Funding and implementation of these services is a crucial step to transforming Virginia's behavioral health care system. As we continue to implement STEP-VA, we seek to be responsive and integrated with other efforts to transform Virginia's behavioral health care system and are grateful for ongoing attention and investments to these priorities.

Appendices

Appendix A: Children's Crisis Services, STEP-VA, and a Comprehensive Crisis Continuum

STEP-VA funding for crisis services builds on existing investments in specialized children's crisis services. For this year, the report to the General Assembly regarding the impact of this funding is included as part of this STEP-VA report. We first describe the impact of this investment, followed by planning and initial implementation of the new STEP-VA funds for crisis services.

The following describes the impact of funding from the General Assembly allocation for Child Psychiatry and Children's Crisis Response in three strategy areas. CSBs report data on community services in the DBHDS Community Consumer Submission (CCS) application. The data provided in this report are from the service categories in the CCS that are most frequently provided to children in crisis. Those services include:

1. Psychiatry Services,
2. Ambulatory crisis stabilization services, and
3. Residential crisis stabilization services.

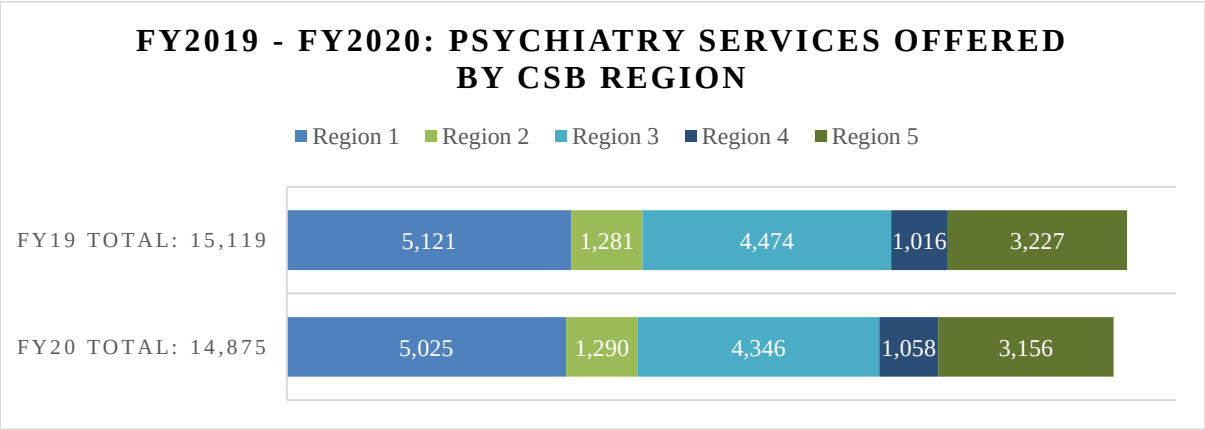
Strategy 1: Child and Adolescent Psychiatry Services

In order to extend the reach of very limited child psychiatry resources, regions were asked to provide child psychiatry in one or more of the following three venues:

- Face-to-face office visits with children;
- Tele-psychiatry services to children in remote sites; and
- Child psychiatry consultations to other providers, such as pediatricians, primary care providers and others.

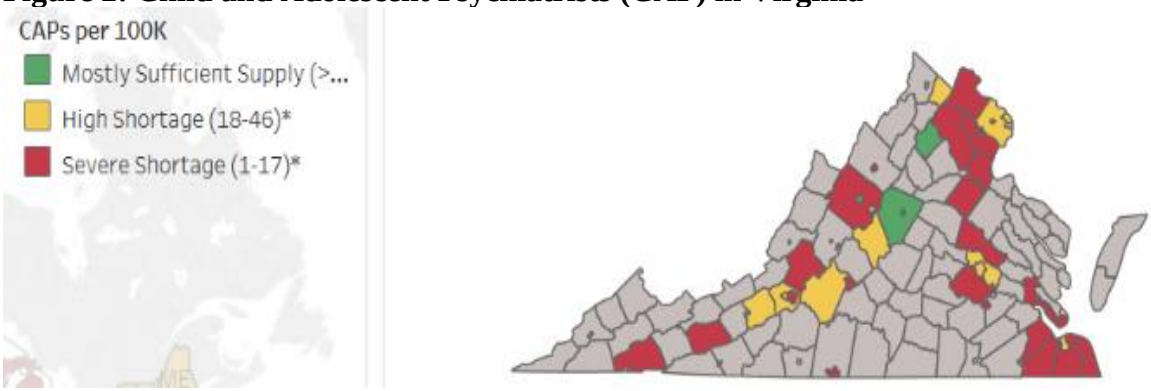
Child psychiatry services are reported in the Medical Services category in CCS. Medical Services are defined as the provision of psychiatric evaluations and psychiatric, medical, psychiatric nursing, and medical nursing services by licensed psychiatrists, physicians, psychiatric nurse practitioners, other nurse practitioners, and nurses and the cost of medications purchased by the CSB and provided to individuals. Medication services include prescribing and dispensing medications, medication management, and pharmacy services. Medication only visits are provided to individuals who receive only medication monitoring on a periodic (monthly or quarterly) basis from a psychiatrist, other physician, psychiatric nurse, or physician's assistant. Figure 4 depicts the number of children served by psychiatric services in FY 2020.

Figure 1: Unduplicated Number of Children Served through Psychiatry Services in FY2019-FY2020



Child psychiatry services continue to be a successful aspect of this initiative, adding capacity in an environment of extreme scarcity of board-certified child psychiatrists. However, some regions still experience delays with hiring because of the shortage of child psychiatrists in the Commonwealth. Regions persistently advertise and utilize different approaches, such as locum tenens (a temporary psychiatrist), to fill the need. Tele-psychiatry is used to increase access to child psychiatrists. Figure 5 below illustrates the shortage of child psychiatrists throughout the Commonwealth.

Figure 2: Child and Adolescent Psychiatrists (CAP) in Virginia



Note: The counties in gray do not have a child and adolescent psychiatrist. Source: American Academy of Child and Adolescent Psychiatry workforce map. March 2018

While the three approaches to child psychiatry have created greater flexibility and access to these critical services, there are still challenges to providing the service.

Region 1:
Funding for child psychiatry in Region 1 provides psychiatric services both through face-to-face visits and tele-psychiatry for children and youth at five CSBs with the highest need for child psychiatry. Those CSBs are: Horizon, Rappahannock Area, Rappahannock Rapidan, Region Ten, and Harrisonburg/Rockingham. The Region 1 face-to-face psychiatric services for children in crisis are provided at both Horizon and Region Ten CSBs. The Region 1 psychiatrist and nurse practitioner additionally provide tele-psychiatry for children in crisis at all 5 CSBs. The psychiatrist and nurse practitioner are consistently collaborating with primary care physicians,

crisis staff, as well as other care providers involved in a child's treatment in order to offer the highest level of care.

Region 2:
In Region 2, funding for child psychiatry provides access to a psychiatrist for children receiving mobile crisis stabilization services by the Children's Regional Crisis Response (CR2) program. All CSBs in Region 2 provide child psychiatry.

Region 3:
Region 3 has a contract with the University of Virginia's Department of Psychiatry and Neurobehavioral Sciences (UVA) to provide tele-psychiatry. In times of need, up to 42 hours per week of psychiatry care can be requested. The wait to obtain a psychiatric intake tends to be 6-12 weeks or more. Since the region has a tele-psychiatry contract with UVA, children referred for an emergency intake are scheduled within the week of request. Children that are admitted to any crisis stabilization service offered in Region 3 are seen within 72 hours, some even the same day. Region 3 has been able to increase continuity of care by having the same psychiatrist who provides medication management services in the Crisis Stabilization Unit (CSU) to follow the child back into the community post discharge.

Region 4:
While children are receiving services at St. Joseph's Villa's Crisis Stabilization Unit (CSU), Region 4 partners with InSight Physicians to provide tele-psychiatry and psychiatric consultation. The region has expanded child psychiatry to their community-based mobile crisis program, Children's Response and Stabilization Team (CReST). After several years of continuous recruiting, the program has a 20-hour per week child and adolescent psychiatrist on board serving youth referred through CReST.

Region 5:
Psychiatry services are provided by the Children's Behavioral Health Urgent Care Center. The Center provides rapid access to crisis intervention and psychiatric care to the entire region and is able to maintain cases until children are linked with long term providers. Additionally, eight out of nine CSBs in Region 5 provide outpatient child psychiatry.

Strategy 2. Ambulatory Crisis Stabilization Services

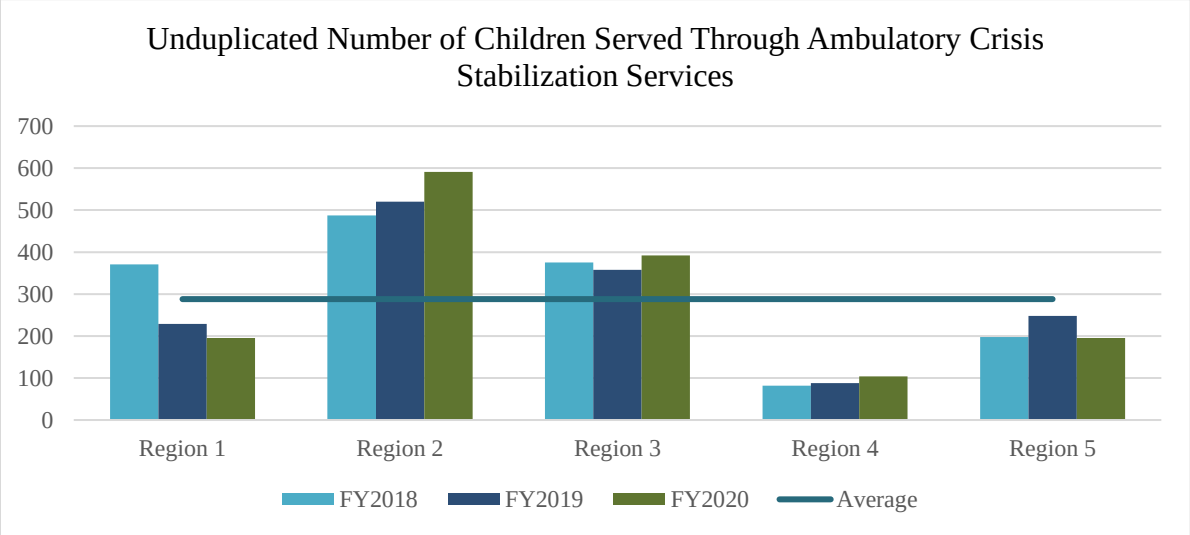
Ambulatory crisis services provide direct care and treatment to non-hospitalized children and are available 23 hours per day. The goals are to avoid unnecessary hospitalization, re-hospitalization, or disruption of living situation, assure safety and security, and stabilize children in crisis. Services may involve mobile crisis teams. Ambulatory crisis stabilization services may be provided in an individual's home or in a community-based program. The following table and figure offer data on the number of children served through ambulatory crisis stabilization.

Table 1: Unduplicated Number of Children Served through Ambulatory Crisis Stabilization Services

Region	FY2018	FY2019	FY2020	Percent Change (Since 2018)
1	371	229	195	-47%
2	487	520	591	+21%

3	375	358	392	+5%
4	82	88	104	+27%
5	198	248	195	+2%
Totals	**1,513**	**1,443**	**1,477**	**-2%**

Figure 3: Trend over Time of the Number of Children Served through Ambulatory Crisis Stabilization



Region 1:
Horizon Behavioral Health has center-based ambulatory crisis stabilization services located in Lynchburg and Campbell County. These services provide evidence based strategies and interventions in their ambulatory crisis stabilization units. For FY20, all Region 1 CSB's provided crisis intervention services in the home, school, and community settings.

While the overall percent change in the number of unduplicated children receiving ambulatory crisis stabilization services, from FY2018 to FY2020 is -47%, the percent change from FY2019 to FY2020 is -15%. Horizon Behavioral Health stopped providing center-based ambulatory crisis stabilization at one of their clinics during FY2019. This may account for the decrease in numbers of youth served through ambulatory crisis stabilization.

Region 2:
The Children's Regional Crisis Response (CR2) program provides 24 hours a day, seven days a week mobile crisis stabilization services. Staff provide short-term crisis services, linkages to new or current community providers, and tele-psychiatry, as needed. Service duration is based on time needed to resolve the existing crisis. In FY20, CR2 was able to divert 88% of children from hospitalization, and 87% of those served were able to retain their living arrangement.

Region 3:
In the region there is one ambulatory crisis stabilization program and two ambulatory crisis stabilization programs with combined mobile crisis and center-based services. These services are provided at Mt. Rogers, Cumberland Mountain, and Highlands CSBs. Geographical barriers for CSBs that cover several rural counties has been an obstacle in expanding ambulatory crisis

services. The region uses funding to expand limited crisis services to a youth specific pre-screener, community-based responders, or staff embedded in high crisis referral locations such as pediatric offices.

Region 4:
Mobile Crisis Response Services are provided through the Children's Response and Stabilization Team (CReST). The CReST team works with Pediatric Emergency Departments, schools, CSB Emergency Services, as well as acute inpatient hospitals. The team assists hospitals with children who are ready to discharge from the hospital but are at risk of re-hospitalization without active services. St. Joseph's Villa in Region 4 continues to operate two-day beds that offer center-based crisis stabilization services, enhancing the system of crisis care for youth in the region. COVID-19 has affected the operations and utilization of Region 4 child crisis services since March 2020. The child CSU has implemented COVID screening and visitation protocols and halted day-service admissions during the pandemic; CReST has implemented telehealth protocols to ensure youth and families in crisis can be served. Overall, referrals to youth crisis services have been depressed during the spring, typically a high-utilizer time of the year, given that schools and other community services have been shuttered.

Due to the way services are reported in CCS by Region 4, the numbers of children served by Region 4's ambulatory crisis services are likely underreported. It is probable that the services that are reported in Table 1 and Figure 2 are likely the children that receive center-based ambulatory crisis stabilization and not those that receive community based ambulatory crisis stabilization.

Region 5:
With the additional funding through STEP-VA for children's mobile crisis, the region has chosen to transition the current positions that provide mobile crisis with this general assembly allocation to crisis navigators. After the initial crisis intervention from the newly formed STEP-VA mobile crisis teams, the crisis navigators will provide on-going crisis stabilization for those that need additional crisis support.

Strategy 3. Residential Crisis Stabilization Services/Crisis Stabilization Units

Based on service gaps identified in their proposals, each region has different needs and resources for residential crisis stabilization services. All residential crisis stabilization services are short-term and focused on maintaining family contact and returning children to their homes and schools. Regions 3, 4, and 5 have residential crisis stabilization units. The table and figure below provide data on the number of children served through residential crisis stabilization services.

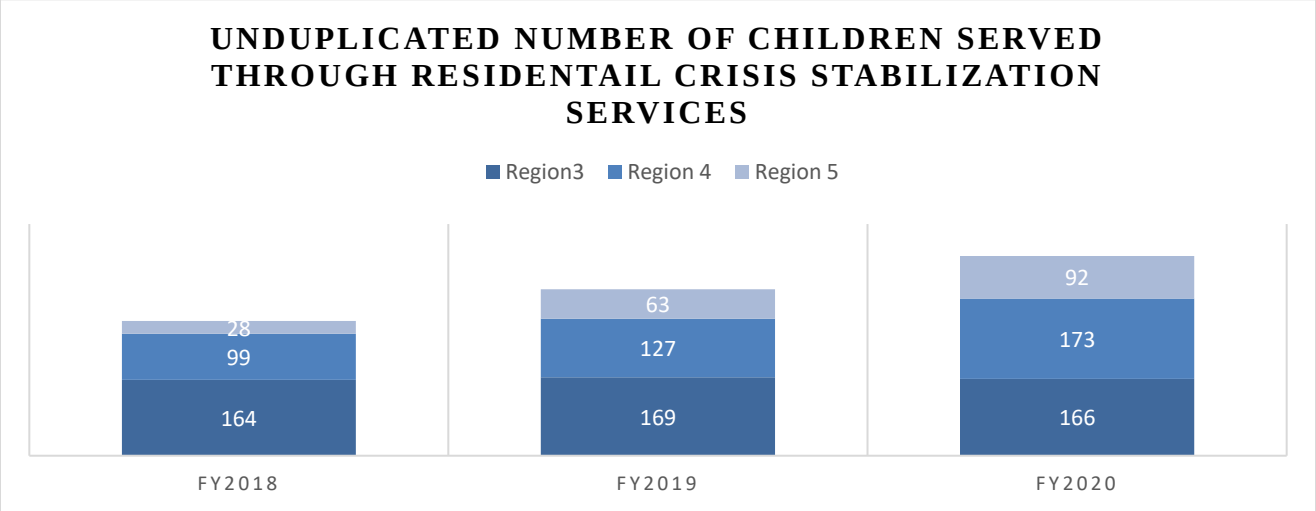
Table 2: Unduplicated Number of Children Served through Residential Crisis Stabilization Services/Crisis Stabilization Units

Region	FY2018	FY2019	FY2020	Percent Change (Since 2018)
1	NA	NA	NA	-
2	NA	NA	NA	-
3	164	169	166	+1%
4	99	127	173	+75%
5	28	63	92	+229%

Totals	**291**	**424**	**481**	**+65%**

Numbers of children are unduplicated.

Figure 4: Trend over Time of the Number of Children Served through Residential Crisis Stabilization/Crisis Stabilization Units



Region 3:
Region 3 has an eight bed crisis stabilization unit (CSU) located at the Mt. Rogers Community Services Board. When needed, the region provides transportation assistance to overcome geographic barriers. A behavior analyst is available at the CSU to provide the expertise needed to address the needs of children with developmental disabilities. Psychological testing when requested is an additional service provided by the CSU.

Region 4:
Through a public-private partnership, Region 4 has an eight-bed crisis stabilization unit at St. Joseph's Villa and the capacity for both overnight and day-only services. In order to facilitate admissions, the CSU accepts direct referrals from the community. St. Joseph's Villa works closely with both CReST and Regional Education Assessment Crisis Services Habilitation (REACH) to ensure youth are accessing the most appropriate level of crisis care at the right time.

Region 5:
Region 5 has a six-bed Crisis Stabilization Unit (CSU) located in Suffolk, Virginia. The Region collaborates with: regional emergency services departments, local inpatient and residential facilities, and other CSB departments to divert children from inpatient hospitalization. The CSU has seen a 229% increase in utilization since opening in FY 2018.