



**COMMONWEALTH of VIRGINIA**  
*Office of the Governor*

John Littel  
Secretary of Health and Human Resources

January 11, 2023

The Honorable Janet D. Howell  
Co-Chair, Senate Finance and Appropriations Committee

The Honorable George L. Barker  
Co-Chair, Senate Finance and Appropriations Committee

The Honorable Barry D. Knight  
Chair, House Appropriations Committee

Dear Chairmen Howell, Barker, and Knight:

Thank you for your past and current leadership and support of efforts to transform the Commonwealth's behavioral health system. This Session presents an opportunity to dramatically transform the Behavioral Health System in Virginia to better serve our citizens.

We are pleased to submit the Final Behavioral Health Plan. This report is submitted pursuant to Item 283 F. 1 of the 2022 Appropriations Act:

F.1. The Secretary of Health and Human Resources shall establish a workgroup to review the current structure of the Department of Behavioral Health and Developmental Services (DBHDS) and make recommendations on modifications to the department's structure that improves the delivery of behavioral health and developmental disability services to the citizens of the Commonwealth. The workgroup shall include representatives of DBHDS, the Department of Medical Assistance Services, the Department of Planning and Budget, the Behavioral Health Commission and other entities as deemed necessary by the Secretary to complete the tasks of the workgroup. Specifically, the workgroup shall evaluate: (i) whether responsibility for developmental disability services is more appropriate in another state agency or a new state agency; (ii) whether community-based behavioral health services and the operations of the state mental health hospitals should be divided into separate entities; (iii) whether a different structure or model, such as public-private partnerships, is appropriate for the operation of state mental health hospitals; and (iv) whether the current structure for community-based services can be enhanced to better deliver services.

The **Behavioral Health Transformation Plan, *Right Help, Right Now***, is intended to address in a more holistic and comprehensive way the continuum of care and services provided to Virginians with mental health and substance use issues. While much of our focus this year is to improve crisis care for behavioral health, it will also expand prevention and intervention services to keep people from entering crisis and to improve re-entry and stabilization post-crisis. This will be the first phase of a three-year commitment by Governor Youngkin to address an issue that is so critical to so many.

This report takes the PowerPoint Report provided in December and puts it into prose with detailed explanations. Many of the charts and graphics from the PowerPoints are included to provide added clarity and description.

While our workgroups did address the specific questions posed in the budget language above, more complete answers require implementation of numerous components of the *Right Help, Right Now* plan. Specifically, the organization of the Department of Behavioral Health and Developmental Services (DBHDS), including responsibility of development disability services and the operation of state behavioral health facilities, needs further study in light of the transformational changes envisioned in our plan. As part of the implementation of this Plan, further work will be undertaken to address these questions and implement the conclusions:

- i. *Whether responsibility for developmental disability services is more appropriate in another state agency or a new state agency:* At this point, it was not determined that there would be significant benefits to allocating responsibility for developmental disability services to a different or new agency, when compared to the potential benefits of implementing other initiatives focused on this population as laid out in this Plan. We will work with organizational and peer advocates to consider additional potential reforms of this system and agency responsibilities.
- ii. *Whether community-based behavioral health services and the operations of the state behavioral health hospitals should be divided into separate entities:* the Joint Legislative Audit and Review Commission (JLARC) reviewed the operations of CSBs and will examine state hospitals. We support both of these reviews and endorse many of the findings of the CSB review.<sup>1</sup>
- iii. *Whether a different structure or model, such as public-private partnerships, is appropriate for the operation of state behavioral health hospitals:* Given the potential positive impact on our in-patient system with the deployment of the CrisisNow model, we did not yet thoroughly evaluate a public-private partnership model for state hospitals; this review is planned in the future. The Catawba study provides findings on this issue and recommends cases where they may be useful. It was determined for the purposes of this Plan that a built-out crisis care continuum will likely have significant impact on state hospital utilization, addressing the structural challenges that they face before addressing the governance model.

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<sup>1</sup> JLARC: Report to the Governor and the General Assembly of Virginia," December 12, 2022.

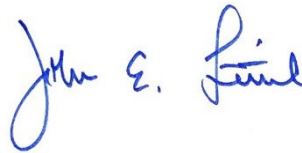
- iv. *Whether the current structure for community-based services can be enhanced to better deliver services:* We recognize the critical importance of community-based services. The JLARC report investigated extensively the various CSB structures and any relationships between those structures and various care outcomes. Several of the changes recommended by JLARC will help in these areas. Further, our Plan recommends implementing the Certified Community Behavioral Health Clinic program, among other changes, to enhance community-based services.

*Right Help, Right Now* clearly articulates a comprehensive, system-wide Plan that will improve the behavioral health system and better develop the continuum of behavioral health care, fundamentally addressing the underlying conditions in which these questions were posed.

We look forward to discussing this with you and your colleagues further. As always, my team and I are available to answer any questions from you or your staff.

Best wishes for a successful Session,

Sincerely,



John E. Littel

cc: Mike Tweedy, Senate Finance and Appropriations Committee  
Susan Massart, House Appropriations Committee  
Amy Cochran, House Appropriations Committee



# RIGHT HELP. RIGHT NOW.

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Transforming Behavioral Health Care for Virginians

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Governor Glenn Youngkin

[Virginia.gov](http://Virginia.gov)

# Contents

|    |   |
|----|---|
| i  | Executive summary   |
| 1  | Introduction  |
| 6  | Approach  |
| 12 | Pillar 1: We must strive to ensure same-day care for individuals experiencing behavioral health crises  |
| 15 | Pillar 2: We must relieve the law enforcement communities' burden while providing care and reducing the criminalization of behavioral health  |
| 20 | Pillar 3: We must develop more capacity throughout the system, going beyond hospitals, especially to enhance community-based services   |
| 24 | Pillar 4: We must provide targeted support for substance use disorder and efforts to prevent overdose   |
| 26 | Pillar 5: We must make the behavioral health workforce a priority, particularly in underserved communities  |
| 30 | Pillar 6: We must identify service innovations and best practices in pre-crisis prevention services, crisis care, post-crisis recovery and support and develop tangible and achievable means to close capacity gaps |
| 33 | Budget  |
| 35 | Conclusion  |
| 36 | Appendix  |

# Executive summary

The Commonwealth of Virginia and the United States are facing a behavioral health crisis. To address this crisis, a transformational approach to behavioral health is needed to support all Virginians and their families. Ensuring timely access to care and supporting needs related to mental health, substance use, and developmental disabilities is critical. These challenges in access and support are distributed inequitably across the Commonwealth—disproportionately impacting the most vulnerable Virginians—and occur across the full continuum of care.

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*This Behavioral Health Plan addresses these challenges and aims to achieve, by 2025, the goal that all Virginians will:*

*... be able to access behavioral health care when they need it;*

*... have prevention and management services personalized to their needs, particularly for children, youth, and families;*

*... know who to call, who will help, and where to go when in crisis; and*

*... have paths to reentry and stabilization when transitioning from crisis.*

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To achieve these goals, the multi-year “Right Help, Right Now” Behavioral Health Plan was developed through extensive stakeholder engagement, which included over 40 listening and engagement sessions with stakeholder organizations and five population-specific surveys.<sup>1</sup> More than 2,800 responses were submitted to the surveys. In addition, the Plan is built on analysis of the current behavioral health system and a review of best practices in other US states. The Plan scales what has been proven to work and reflects a bold approach to addressing Virginia’s behavioral health challenges.

The Plan focuses on pre-crisis prevention services for behavioral health conditions to provide help for Virginians as early as possible. In doing so, the Commonwealth will reduce the strain on individuals, families, law enforcement, communities, and the behavioral health system itself. Pre-crisis prevention will create greater upstream capacity, allowing the public behavioral health system to better support the needs of all Virginians—including those in need of acute care and support.

Within pre-crisis prevention services, the Plan focuses on youth mental health through promotion, prevention, school-based service delivery, and tele-behavioral health in K-12 and higher education settings. In addition, it ensures all Virginians know “who to call” by investing in 988 crisis call centers, “who will help” if in crisis by scaling crisis care response services, and “where to go” so there is “no-

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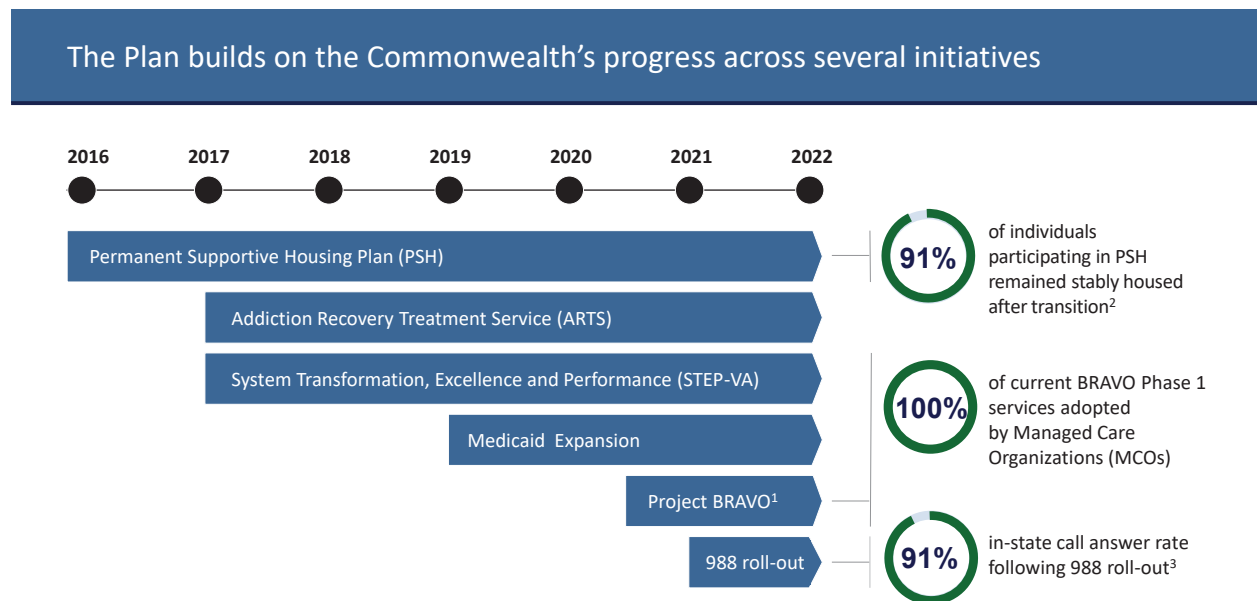
<sup>1</sup> See the Appendix for stakeholder organizations; surveys were sent to individuals who interact with adult behavioral health, child behavioral health, forensic, developmental disability, and substance use disorder services

wrong-door” to access crisis care. The Plan increases support for post-crisis recovery by helping Virginians who are transitioning out of crisis to reenter and rebuild within their communities, including through added capacity in mental health group homes. Furthermore, the Plan focuses on breaking down barriers such as stigma and workforce constraints through new roles (e.g., peer support) and engaging the broader care ecosystem, including faith-based organizations. These efforts will help deliver community-based, prevention-focused behavioral health care for all Virginians in a way that best matches their individual needs.

# Introduction

Multiple recent efforts to improve the Commonwealth's behavioral health system (e.g., 988 implementation) have resulted in several bright spots (Exhibit 1).<sup>2</sup> Relative to other states, Mental Health America ranks Virginia 14th in Adult Mental Health in its 2023 ranking, representing an improvement from the Commonwealth's 20th rank in 2022 (Exhibit 2).<sup>3</sup>

## Exhibit 1: Select recent initiatives in the Commonwealth



1. Consists of the implementation of fully integrated behavioral health services that provide a full continuum of care to Medicaid members; DMAS Virginia.gov  
2. Referring to the population served by PSH: Permanent Supportive Housing: Outcomes and Impact – November 2022 (virginia.gov)  
3. DBHDS data, received November 28, 2022

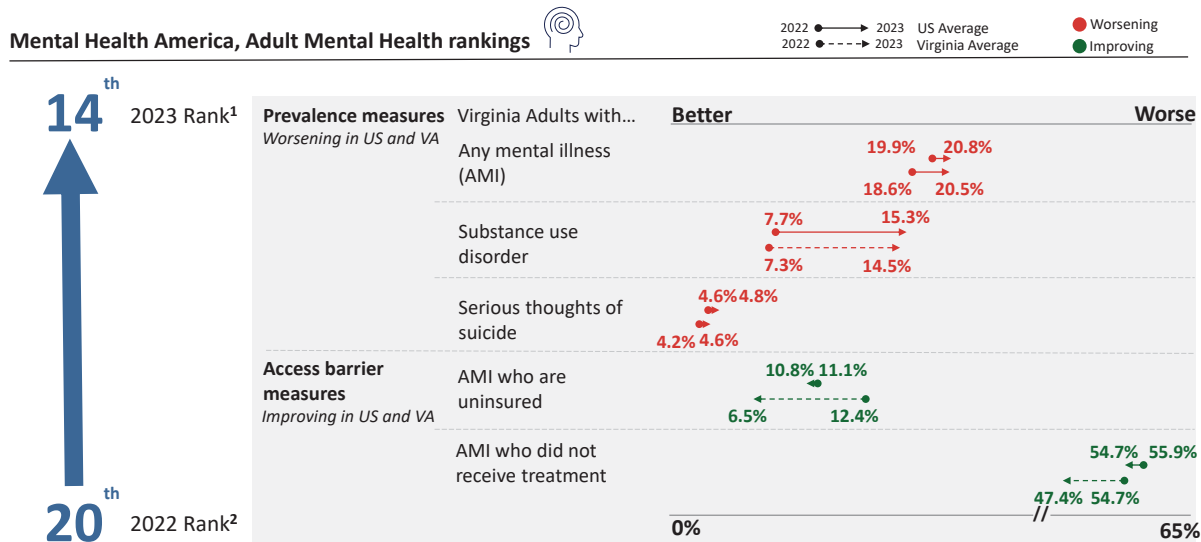
2 DBHDS data: HHR Top Accomplishments, November 8, 2022 .

3 Mental Health America: Adult Mental Health Ranking 2023, based on 2019-2020 data (<https://mhanational.org/issues/2022/ranking-states>).



## Exhibit 2: Mental Health America, Adult Mental Health rankings 2022-23, Virginia

Mental Health America ranks Virginia 14<sup>th</sup> out of 50 states for Adult Mental Health



1. Adult Ranking 2023, Mental Health America based on 2019-2020 data
2. Adult Ranking 2022, Mental Health America based on 2018-2019 data

However, Virginians still experience challenges accessing behavioral health care. They often wait hours, if not days, for inpatient psychiatric beds for voluntary and involuntary treatment. In addition, Mental Health America ranks Virginia 34<sup>th</sup> in overall mental health access, and most counties—106 of 133—are classified in full as mental health professional shortage areas.<sup>4,5</sup> Nearly one third of Virginia’s population lives in these counties. In addition, Virginia saw a decline in mental health among youth, dropping from 21<sup>st</sup> to 48<sup>th</sup> in Mental Health America’s ranking of states on Youth Mental Health.<sup>6</sup>

# 80%

106 of 133 counties are classified in full as a mental health professional shortage area. **33% of the Virginia population** lives in these counties (2.8 Million out of 8.6 Million)

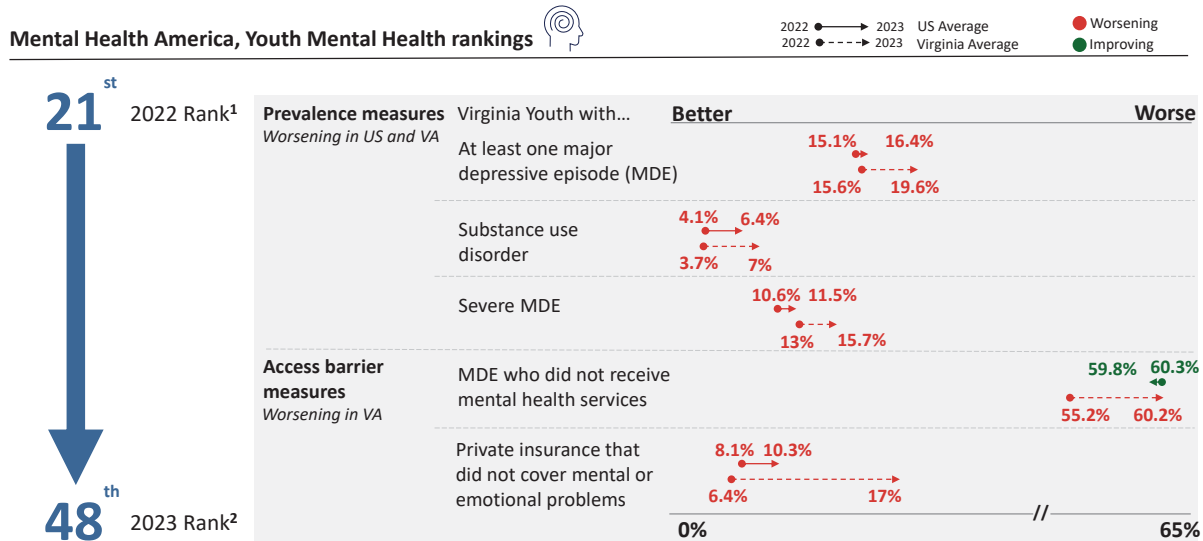
4 Mental Health America: Access to Care Ranking 2023, based on 2019-2020 data (<https://mhanational.org/issues/2023/mental-health-america-access-care-data>).

5 data.HRSA.gov: Health Resources and Services Administration Mental Health Care Professional Shortage Areas, by State, as of September 30, 2022 (<https://data.hrsa.gov/tools/shortage-area/hpsa-find>).

6 Mental Health America: Youth Ranking 2023, based on 2019-2020 data (<https://mhanational.org/issues/2023/mental-health-america-youth-data>).

### Exhibit 3: Mental Health America, Youth Mental Health rankings 2022-2023, Virginia

## Mental Health America ranks Virginia 48<sup>th</sup> out of 50 states for Youth Mental Health

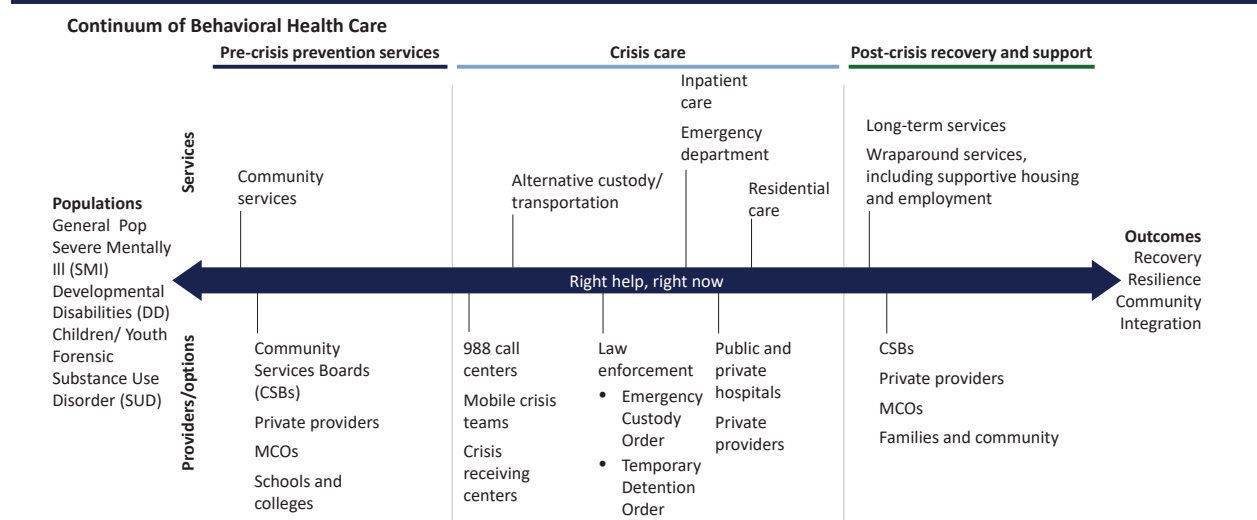


1. Youth Ranking 2022, Mental Health America based on 2018-2019 data  
2. Youth Ranking 2023, Mental Health America based on 2019-2020 data

These challenges in access are distributed across the continuum of care: from pre-crisis prevention services to crisis care to post-crisis recovery and support (see Exhibit 4).

### Exhibit 4: Continuum of Behavioral Health Care in Virginia

## Solutions to the Commonwealth's Behavioral Health crisis benefit from a system-wide perspective



Source: VA HHR: DBHDS



limited capacity means approximately 200 individuals remain on the “extraordinary barriers to discharge” list in state hospitals for an average of 230 days despite being ready for re-entry.<sup>9,10</sup> Several programs, such as Permanent Supportive Housing (PSH), have demonstrated meaningful outcomes—91% of individuals in PSH are stably housed after one year.<sup>11</sup> However, the program is limited in scale and capable of providing only 35% of the slots needed relative to demand.<sup>12</sup> A range of step-down care settings (e.g., residential, partial hospitalization, intensive outpatient) lack the needed capacity to provide sufficient options for those who seek recovery and support.

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*The “Right Help, Right Now” Behavioral Health Plan addresses these challenges through actions to be implemented through 2025.*

*Through this Plan, the goal is for all Virginians to:*

*... be able to access behavioral health care when they need it;*

*... have prevention and management services personalized to their needs, particularly for children and youth;*

*... know who to call, who will help, and where to go when in crisis; and*

*... have paths to reentry and stabilization when transitioning from crisis.*

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9 DBHDS data: EBL and LOS data for BH commission, November 2022 .

10 Ibid

11 Permanent Supportive Housing: Outcomes and Impact – December 3, 2020 (virginia.gov).

12 2016 assessment. DBHDS, Health and Housing Strategy for Virginians with Serious Mental Illness: A Report to the General Assembly, January 2022.

# Approach

This plan has been developed through extensive stakeholder engagement, quantitative and qualitative analysis to establish the current-state fact base, and a review of best practices across US states. The Office of the Secretary of Health and Human Resources (HHR) developed, deployed, and analyzed over 2,800 responses to surveys on the citizen experience with the behavioral health system. HHR also facilitated regional meetings with ~40 stakeholder groups across Virginia to understand the experiences of individuals who interact with the behavioral health system across various stakeholder groups (see Appendix). These groups included family, caretaker, school-based, law enforcement, and nonprofit groups as well as payers across the public and private sectors.

Further sources of insight included expert interviews; analyses of behavioral health access, outcomes, and resources data from Virginia and across the U.S.; review of other state best practices (e.g., Arizona's CrisisNow model); and other quantitative and qualitative analyses.

This fact base analysis informed design workshops, in which leaders from the Department of Behavioral Health and Developmental Services (DBHDS), Department of Medical Assistance Services (DMAS), and other state agencies co-developed initiatives, year-by-year activities, and impact goals across topical areas. These sessions used the fact base, best practices from other U.S. states, and syndication with HHR, DBHDS, DMAS, and Transformation Office leadership to refine and prioritize six strategic pillars.

## **Virginia Office of the Secretary of Health and Human Resources surveys on the Commonwealth Behavioral Health experience**

- Recognizing the diversity of experiences across populations, the agency developed five surveys to understand citizen experience. In November 2022, HHR launched surveys across respondent categories, including individuals who interact with adult behavioral health, child behavioral health, forensic, developmental disability, and substance use disorder services. The survey gathered quantitative and qualitative input across eight questions on Virginia's behavioral health system. Two questions captured quantitative measures of stakeholder experience:
- How satisfied are you with the overall availability of services in your community or geographic area?
- How easy is it to “navigate” the system or learn how to access the services you need?

**Six questions welcomed free form responses:**

- “Barriers” may be issues or problems that prevent you from using a service or using it fully. What are the barriers to your community receiving high-quality, effective, and accessible services?
- A service gap exists when there is a difference between what you expect from the system and what services are actually provided. What are the gaps in services (e.g., workforce challenges, quality of services, limited number of providers) in your community or geographic area for services?
- How can services be improved in your community?
- What does your community have that is working well and could be replicated in other areas?
- Share a first-hand account of when the system worked well.
- Share a first-hand account of when the system did not work well.

The survey was open November 9–30, 2022 and was distributed (1) in listening and engagement sessions to DBHDS and CSB staff, (2) to a broad range of stakeholder groups, and (3) through DBDHS social media channels. The survey received 2,830 responses across the five respondent categories.

Beginning with the quantitative measures of stakeholder experience (Exhibit 6), respondents were universally dissatisfied and expressed access challenges across surveys. Adult BH survey respondents expressed the greatest dissatisfaction, with 75% extremely or somewhat dissatisfied with the services available in their community.<sup>13</sup> Child BH survey respondents relayed the greatest access challenges, as 71% find it extremely or somewhat difficult to navigate or learn how to access the services they need.<sup>14</sup> Both providers of behavioral health services and other stakeholders (e.g., individuals receiving services, caregivers) expressed similar levels of dissatisfaction with available behavioral health services.

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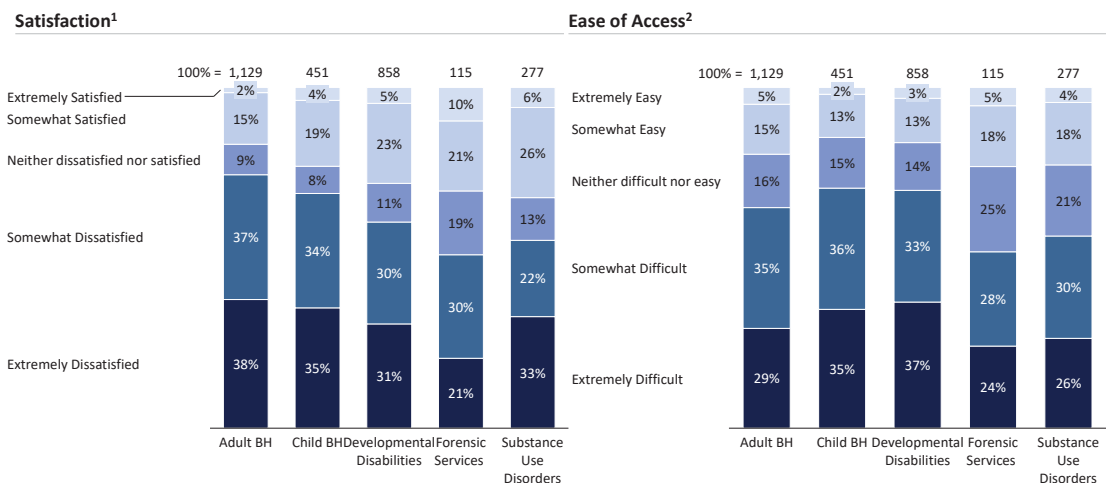
<sup>13</sup> Virginia HHR BH Services Survey, launched November 8, 2022, results as of November 30, 2022

<sup>14</sup> Ibid

## Exhibit 6: Satisfaction and Ease across survey respondents

The majority of respondents across surveys are dissatisfied with BH services available in their area and experience access challenges

PRELIMINARY DRAFT AS OF DECEMBER 2, 2022



1. Full question: How satisfied are you with the overall availability of services in your community or geographic area?

2. Full question: How easy is it to "navigate" the system or learn how to access the services you need?

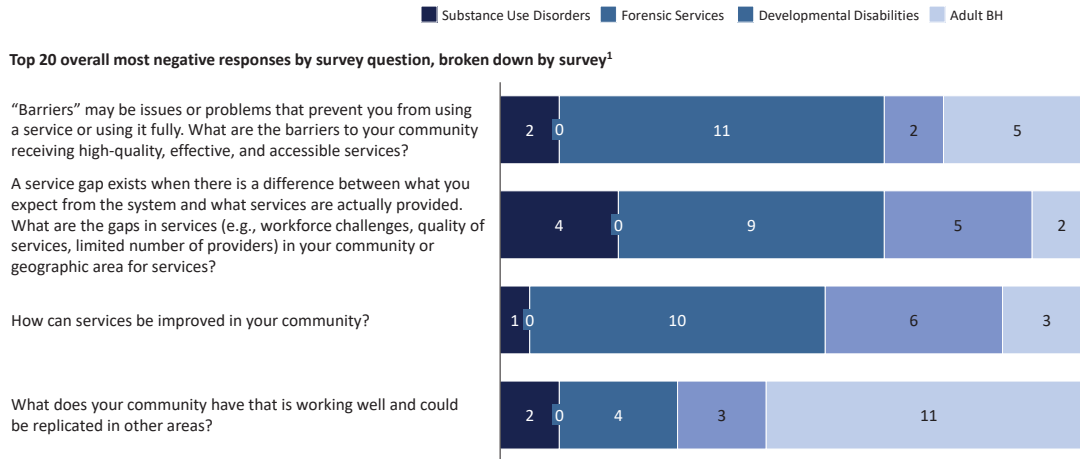
Source: Virginia HHR BHJ Services Survey, launched November 9, 2022, results as of November 30, 2022

Though all respondent groups expressed some extent of dissatisfaction and access challenges, there was variation in the intensity of their dissatisfaction. The intensity of sentiment of survey responses across all surveys were analyzed using Natural Language Processing capabilities and used four of the six free response survey questions. Each response was assigned a negativity score. Developmental Disabilities Survey respondents expressed the greatest negativity across the first three questions on barriers to services, service gaps, and ways for services to be improved (Exhibit 7). This group represented approximately 50% of the most negative responses across questions.<sup>15</sup> Adult BH respondents expressed the greatest negativity for the last question. Negativity scores of only the Top 20 responses are represented to mitigate the bias of different survey response numbers.

<sup>15</sup> Ibid

## Exhibit 7: Negativity of responses by question, broken down by survey - not in PPT

Developmental Disabilities respondents expressed the greatest negativity across most questions



1. Intensity analysis NLP methodology: preexisting trained model which was trained on Amazon reviews using keras library in python
2. Selected Top 20 responses to mitigate bias of response # (e.g., Adult BH had 1,129 respondents while Forensic Services had 115 respondents)

Across the six free-response questions, two consistent themes recurred across surveys: (1) limited transportation options contribute to access challenges, and (2) workforce shortages contribute to poor service. In describing transportation challenges, respondents highlighted the challenge that rural communities face in reaching services in distant hubs and the lack of reliable public transport. Within workforce challenges, respondents noted that current staffing levels are unable to meet the extensive need as well as a lack of specialized providers (e.g., child BH or SUD experts). Exhibit 8 provides a snapshot of the recurring themes from the Adult Behavioral Health survey.



## Exhibit 8: Adult BH services: Recurring themes in qualitative responses

### Adult BH Survey Deep Dive: Word Clouds

**Q1:** “Barriers” may be issues or problems that prevent you from using a service or using it fully. What are the barriers to your community receiving high quality, effective and accessible developmental disability services?

services offered  
lack providers  
access services  
insurance companies lack knowledge  
lack services  
need services high quality  
services available  
low pay lack transportation  
bed space law enforcement long wait  
community services

**Q2:** A service gap exists when there is a difference between what you expect from the system and what services are actually provided. What are the gaps in services (e.g., workforce challenges, quality of services, limited number of providers) in your community or geographic area for developmental disability services?

service limited  
limited providers  
providers area  
providers quality  
workforce challenges  
providers accept  
quality service  
long wait

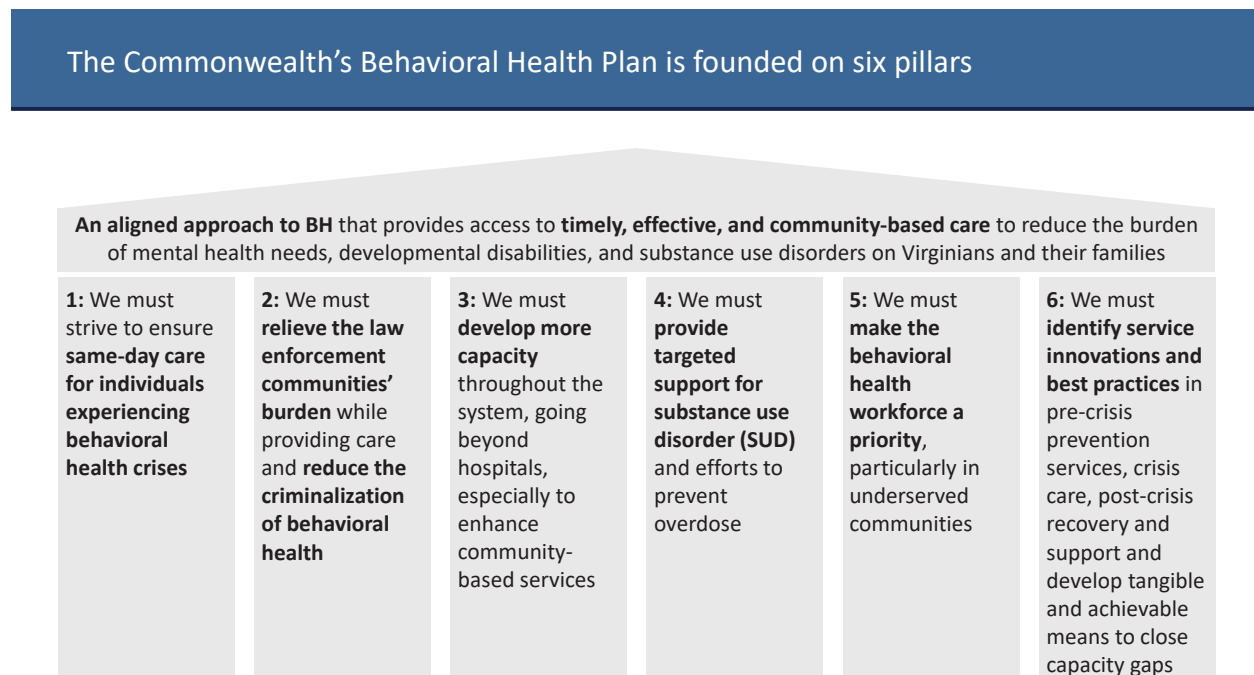
Source: Virginia HHR Adult BH Services Survey, launched November 9, 2022, results as of November 30, 2022

The themes extracted here are representative of many comments collected in the free-response portion of the survey. One respondent attributed long waitlists on “(employee) burnout, dissatisfaction with pay, and (the facility’s) difficulty finding qualified providers for the intensity of service needed.” Another described the “extreme overload (caused) by ‘accountability’ paperwork’ that has little or nothing to do with (the) clinical value of services.” Finally, one provider said, “I have given up on my Medicaid clients making it to appointments due to a lack of consistency with transportation. I have had many clients call me after they had been discharged due to missed [appointments] when the reason they missed was unreliable transportation.” The survey analyses above show that these experiences, spelled out in the free-response section, are all too common in Virginia today.

# Strategic Pillars

The Commonwealth’s Right Help, Right Now Behavioral Health Plan is founded on six pillars. Together, they form the core of the effort to transform behavioral health care for Virginians. “These pillars collectively address all aspects of the care continuum as well as critical cross-cutting enablers needed to support stakeholders across the system They support the Plan and anchor the initiatives that address them (Exhibit 9).

## Exhibit 9: Six Pillars of the Behavioral Health Plan



Source: VA HHR

Several themes emerge across these six pillars and will be a focus of implementation:

- Engagement across stakeholders, including local communities, public and private providers, caretaker groups, law enforcement, and all payers (e.g., Medicaid, commercial insurers, other public and private sources)
- Alignment of incentive structures and funding sources, including expanding near-term funding while identifying sustainable sources across the public and private sectors (including strategies to maximize the impact of state dollars)
- Enhancement of technology and systems to support improved quality and outcomes, decision-making across stakeholders in the system, and effectiveness of the overall behavioral health system.

The following sections explore each of these six pillars in depth.

# Pillar 1: We must strive to ensure same-day care for individuals experiencing behavioral health crises

Virginians in need of crisis care struggle to get the care they need in a timely fashion. The lack of community-based sites of care provides Virginians with limited options for where to go when experiencing a behavioral health crisis and result in law enforcement frequently being the de facto response. Virginia's crisis care capacity is insufficient, lagging estimated required capacity for mobile crisis teams by about 50%, crisis receiving center slots by about 60%, and short-term crisis beds by about 40%.<sup>16</sup> Closing these gaps will bring Virginia into alignment with the best-in-class CrisisNow model implemented in Maricopa County, Arizona. With the proposed funding for SFY2024, Virginia would begin to close these gaps (Exhibit 10).

## Exhibit 10: Estimated current, planned, and target state capacity for crisis response and stabilization<sup>17</sup>

Pillar 1: Planned infrastructure development across the crisis system builds towards estimated required capacity to respond to and stabilize BH crises

|   | Based on estimates of the current and planned crisis care infrastructure in VA <sup>1</sup> |   | Estimates of potential future crisis care infrastructure in VA (to build to the Arizona CrisisNow model) <sup>2</sup> |                |  |
|---|---|---|---|----------------|--|
|   | Current State (% of target <sup>2</sup> )   | Year 1 <sup>3</sup> (% of target <sup>2</sup> ) | Year 2 <sup>4</sup>   | Year 3         | Target state <sup>5</sup>                |
| Mobile crisis teams (MCT)                           | 36 <sup>1</sup> (~50%)  | 70 (100%)                                       | 70 (100%)   | 70 (100%)      | 70                                       |
| Crisis receiving center slots (<23 hours)           | 186 <sup>6</sup> (~40%)   | 290 (~60%)                                      | 360-380 (~80%)  | 450-500 (100%) | 500                                      |
| Short-term crisis beds (1-5 days)                   | 252 (~60%)  | 324 (~80%)                                      | 350-360 (~90%)  | 380-400 (100%) | 400                                      |
| Comprehensive Psychiatric Emergency Programs (CPEP) | 1   | 4+  | TBD   | TBD            | Expansion determined by success of pilot |
| Acute psychiatric inpatient beds                    | ~3,200 <sup>7</sup>   | TBD   | TBD   | TBD            | Dependent on buildout of CrisisNow VA    |

Near-term one-time investments to build infrastructure and capacity may be offset in the long-run with sustainable funding sources, including reimbursement of behavioral health services across payor sources (e.g., Medicaid, commercial health plans)

- Current and planned crisis care infrastructure estimates are based on November 2022, estimates, DBHDS
- Estimates of potential future crisis care infrastructure in VA are based on estimates from the Crisis Resource Needs Calculator's assumptions of:
  - 230 crisis episodes requiring in-person response per 100,000 population on average
  - National average rates of length of stay, occupancy rates, and utilization rates
  - Initial triage rates of 32% to mobile crisis teams (MCTs), 54% to crisis receiving facilities (CRFs), 14% to EDs
  - Referral rates of 30% from MCTs to CRFs, 35% from crisis receiving facilities to short-term crisis beds, 25% from short-term crisis beds to inpatient care, 100% from ED to inpatient care
  - Based on Arizona's 2014 implementation of its crisis system
- Includes Governor's amended budget proposals, across 23 CSUs, 37 CITACs, and 27 Crisis receiving centers
- Assumes Year 2 investment for 50% additional capacity to build on Year 1 capacity towards target state
- Target state is based on estimates from the Crisis Resource Need Calculator of minimum capacity required across settings to manage estimated number of crisis episodes requiring in-person response across the state population (based on observed average of 230 crisis episodes per 100,000 population)
- Estimate as of November 2022 based on initial Chapter 2 budget
- Includes psychiatric bed capacity across state and private hospitals (does not reflect staffing levels)

<sup>16</sup> Figures derived from the CrisisNow model calculator, which aligns with the National Guidelines for Behavioral Health Crisis Care, CrisisNow: Crisis Resource Need Calculator, 2022 ([https://calculator.crisisnow.com/#/data-insights?chart=SC&geo=State&lob=All&location\\_key=VA&metric1=bh\\_high\\_needs&tab=Map](https://calculator.crisisnow.com/#/data-insights?chart=SC&geo=State&lob=All&location_key=VA&metric1=bh_high_needs&tab=Map)).

<sup>17</sup> Current and planned crisis care infrastructure estimates are based on November 2022, estimates, DBHDS. Estimates of potential future crisis care infrastructure in VA are based on estimates from the Crisis Resource Needs Calculator's assumptions of a. 230 crisis episodes requiring in-person response per 100,000 population on average, b. National average rates of length of stay, occupancy rates, and utilization rates, c. Initial triage rates of 32% to mobile crisis teams (MCTs), 54% to crisis receiving facilities (CRFs), 14% to EDs, and d. Referral rates of 30% from MCTs to CRFs, 35% from crisis receiving facilities to short-term crisis beds, 25% from short-term crisis beds to inpatient care, 100% from ED to inpatient care. Year 2 infrastructure estimates assume investment for 50% additional capacity to build on Year 1 capacity towards target state.

Virginia supported a successful launch of the 988 Suicide and Crisis Lifeline, where the in-state response rate of 91% exceeds the national target.<sup>18</sup> Virginia was the first state to enact 988 legislation with a sustainable funding model.<sup>19</sup>

The program goal is to ensure that all Virginians who experience a crisis know who to call, who will help, and where to go when they need help. Knowing these resources will enable them to get the right help at the right time. The pillar workgroup identified five initiatives to accomplish this goal over three years (Exhibit 11):

- 1. Launch statewide 988 promotion.** The Commonwealth has been ahead of the national curve in implementing 988 as a result of General Assembly action and crisis system transformation efforts. As call center capacity expands, Virginia can build on a successful 988 launch by messaging 988 as a resource across behavioral health needs, including substance use disorder. This initiative will continue to deploy messaging campaigns consistent with the Substance Abuse and Mental Health Services Administration (SAMHSA) 988 efforts and Virginia's call capacity, including messaging that can occur before and after the July 2023 federal messaging campaign (e.g., social media, billboards).
- 2. Enhance mobile crisis team capacity.** Mobile crisis teams are one of the key components of a crisis care system (See Appendix C). Only 36% of Virginia's 70 planned mobile crisis teams (MCTs) are staffed.<sup>20</sup> Building up resources and capacity building for the remaining MCTs will help Virginia provide adequate coverage across the Commonwealth. MCTs will provide rapid response and help reduce the burden on law enforcement.
- 3. Enhance crisis receiving and stabilization capacity.** Virginia currently has 186 crisis receiving center slots and 252 short-term crisis beds. This initiative will help Virginia achieve the target crisis receiving and stabilization capacity of 500 slots and 400 beds.<sup>21</sup> This community-based crisis care will support timely care for individuals and allow law enforcement to relinquish custody on a shorter timeline at a Crisis Receiving Center (CRC).<sup>22</sup> Within this initiative, a "model" CRC will be built with a peer living room, 23-hour crisis receiving slots, short-term crisis stabilization beds, and a separate law enforcement entrance. This format aligns with best-in-class models, such as Arizona's model.<sup>23</sup> This initiative will also determine the balance of crisis receiving and stabilization centers and comprehensive psychiatric emergency program (CPEP) facilities at emergency departments. It will be based on existing resources, geographic coverage, and need; it will also provide other innovative psychiatric emergency alternatives.
- 4. Develop outcomes-based payment approach.** An outcomes-based payment approach for crisis services could incentivize outcomes-oriented, cost-effective, and holistic crisis care. This initiative will link provider payment to patient outcomes and ensure that both Medicaid and commercial payers participate in the value-based prospective payment approach.

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18 DBHDS data: HHR Top Accomplishments, November 8<sup>th</sup>, 2022

19 National Association of State Mental Health Program Directors: Paper No. 5, September 2022 ([https://www.nasmhpd.org/sites/default/files/2022-11/Three-States-Comprehensive-Coordinated-and-Sustainable-Behavioral-Health-Crisis-Systems\\_NASMHPD-5.pdf](https://www.nasmhpd.org/sites/default/files/2022-11/Three-States-Comprehensive-Coordinated-and-Sustainable-Behavioral-Health-Crisis-Systems_NASMHPD-5.pdf)).

20 DBHDS discussions, December 2022

21 Based on the CrisisNow model. CrisisNow: Crisis Resource Need Calculator, 2022 ([https://calculator.crisisnow.com/#/data-insights?chart=SC&geo=State&lob=All&location\\_key=VA&metric1=bh\\_high\\_needs&tab=Map](https://calculator.crisisnow.com/#/data-insights?chart=SC&geo=State&lob=All&location_key=VA&metric1=bh_high_needs&tab=Map)). The calculator estimates a target of 70 mobile crisis teams, whereas Virginia has identified and begun to support a state target of 90.

22 DBHDS: Report on Item 310 CC.2 Of the 2019 Appropriations Act, November 22, 2019 (<https://rga.lis.virginia.gov/Published/2020/RD4/PDF>).

23 SAMHSA: "National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit," 2020.

**5. Develop technology infrastructure to enable crisis systems.** The continued buildout of technology infrastructure for crisis services will equip stakeholders—such as emergency services providers—with real-time data on availability of services and placement options. This technology infrastructure will also help track the key performance indicators necessary to support ongoing improvement across the crisis system and an outcomes-based prospective payment system. Key components of this initiative include a transformed, real-time bed registry, a mobile dispatch dashboard, and an interface with emergency department data. This system will help connect people to care faster and reduce the burden on stakeholders involved in the process (e.g., CSB pre-screeners). This technology infrastructure could be modeled off Arizona’s CrisisNow model<sup>24</sup>

These initiatives, when implemented together, will improve the timeliness and effectiveness of crisis care, including “no wrong door” crisis care across geographies. In addition, the initiatives are anticipated to increase utilization of 988 across crisis needs from the ~6,000 calls per month currently received and increase the appropriate utilization of crisis services outside inpatient settings.<sup>25</sup>

**Exhibit 11: Pillar 1 initiatives**

| Pillar 1: We must strive to ensure same-day care for individuals experiencing behavioral health crises |   |   |   |  |
|--|---|---|---|--|
| Initiatives  | Year 1  | Year 2  | Year 3  | Potential impact   |
| <b>1. Launch statewide 988 promotion</b>   | Message emergency department alternative, including across all VA law enforcement   | Promote 988 given geolocation and routing capabilities  | Complete linkages to all relevant BH services through 988 and other crisis entry points | Increase in utilization of 988 across crisis needs including SUD and other behavioral health crises in addition to suicide prevention (from 6k calls per month received to date)<br><br>Increase in appropriate utilization of crisis services (e.g., Mobile Crisis Teams) outside of inpatient settings<br><br>Realize “no wrong door” care across settings and geographies |
| <b>2. Build up Mobile Crisis Team (MCT) capacity</b>   | Deploy regional MCT model with flexible central design based on funding provided  | Ensure adequate staffing and resourcing, including training and technology (e.g., satellite phones for rural teams) | Evaluate and refine approach based on regional models (e.g., by subpopulation)          |  |
| <b>3. Enhance crisis receiving and stabilization capacity</b>  | Build out infrastructure based on funding provided<br>Establish “CrisisNow VA” model CRC  | Identify additional system-wide capacity needed and build out infrastructure  | Complete build of infrastructure to address estimated required capacity                 |  |
| <b>4. Develop outcomes-based payment approach</b>  | Define outcomes-based payment model and metrics (including within MCO procurement)  | Ensure a meaningful portion of Medicaid reimbursement is tied to outcomes   | Ensure commercial payor participation in outcomes-based approach                        |  |
| <b>5. Develop technology infrastructure to enable crisis system</b>                                    | Develop Public Health Information Exchange with referral capability (e.g., automatic bed registry, mobile dispatch dashboard, ED interface) | Link crisis data platform to all relevant providers/MCOs and plan for linkage to 911                                | Integrate technology platform to enable outcomes reporting                              |  |
| <b>Change management</b>   | Engage stakeholders on crisis resources   | Continue to engage stakeholders on crisis resources   |   |  |

Source: VA HHR, DBHDS data

24 Ibid

25 DBHDS discussions, December 2022.

## **Pillar 2: We must relieve the law enforcement communities' burden while providing care and reducing the criminalization of behavioral health**

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Law enforcement plays a significant role in Virginia's crisis care system. This role occurs due to limited community-based alternatives for behavioral health crisis care, and it results in directing law enforcement resources away from other critical roles in the community.

Currently in Virginia, when law enforcement officers are dispatched to support an individual in crisis, they begin a journey that averages 51 hours.<sup>26</sup> Arriving on scene, the law enforcement officer will determine if an 8-hour Emergency Custody Order (ECO) is needed for the individual in crisis. If needed, law enforcement officers transport the individual to an emergency department. Of the 17 other states with defined ECO periods, 16 have longer ECOs than Virginia's window, averaging 25 hours in length.<sup>27</sup> The individual is then assessed by a CSB-certified pre-screener. If the CSB pre-screener determines a TDO is required for involuntary inpatient care, the law enforcement officer faces an additional 43 hours, on average, of waiting in the emergency department with the individual in crisis. Meanwhile, that individual is not receiving treatment during this time despite experiencing a behavioral health crisis.

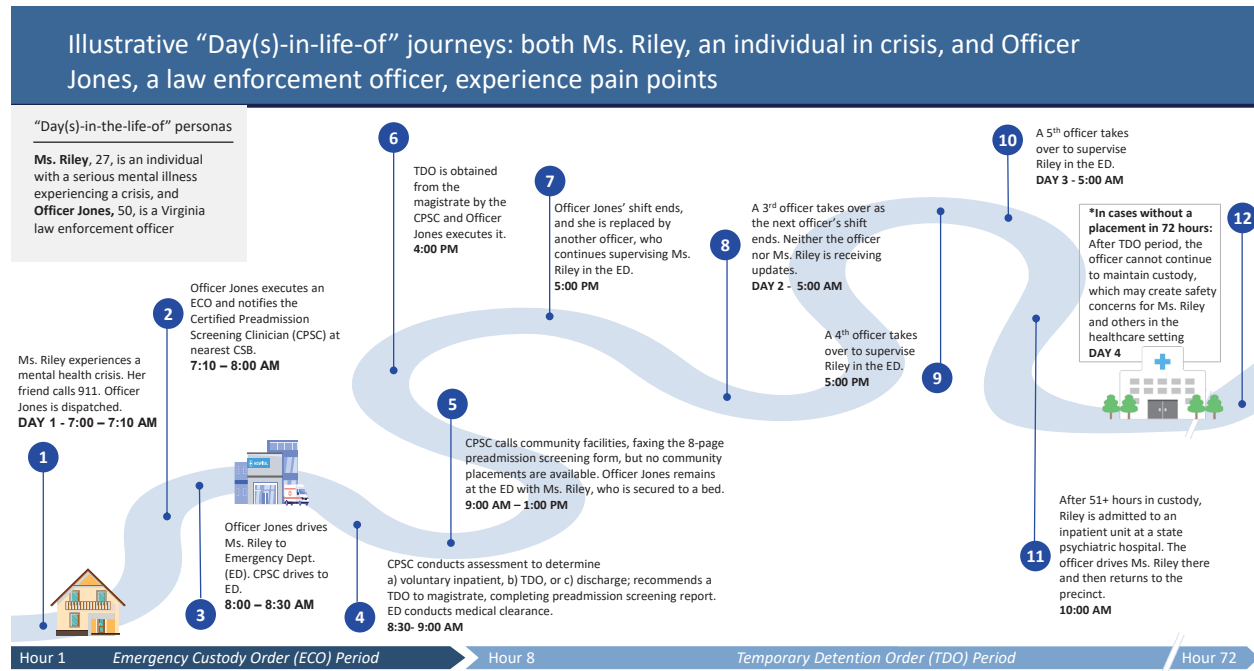
User "day(s)-in-the-life-of journey map" charts illustrate potential paths through the system for individuals in crisis and law enforcement officers (Exhibit 12). These journey maps are based on interviews and data collected and allow for a person-centric understanding of the implications of wait times and other pain points throughout the system

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<sup>26</sup> DBHDS discussions, November 2022

<sup>27</sup> DBHDS data: Comparison of state ECO-TDO laws and practices 2022, November 21, 2022

## Exhibit 12: Law enforcement and crisis “day(s)-in-the-life-of” journey



Source: DBHDS Report on Item 320.II of the 2021 Appropriations Act; DBHDS discussions and data

The long wait time that individuals in crisis experience in law enforcement custody is driven by several factors. These factors often adversely impact both individuals in crisis—who are not receiving care while waiting—and the law enforcement officers accompanying those individuals. The lack of real-time data on bed availability is a key factor, resulting in CSB pre-screeners spending an average of 4 hours searching for available beds. These pre-screeners repeatedly call—and fax—multiple private and state psychiatric hospitals in search of available beds.<sup>28</sup> In addition, 33% of all individuals in crisis who are screened by a CSB pre-screener end up in TDO.<sup>29</sup> However, TDO determinations vary significantly across CSBs, from 11% to 71%, due to resource constraints, turnover in tenured clinical positions, and training inconsistencies.<sup>30</sup>

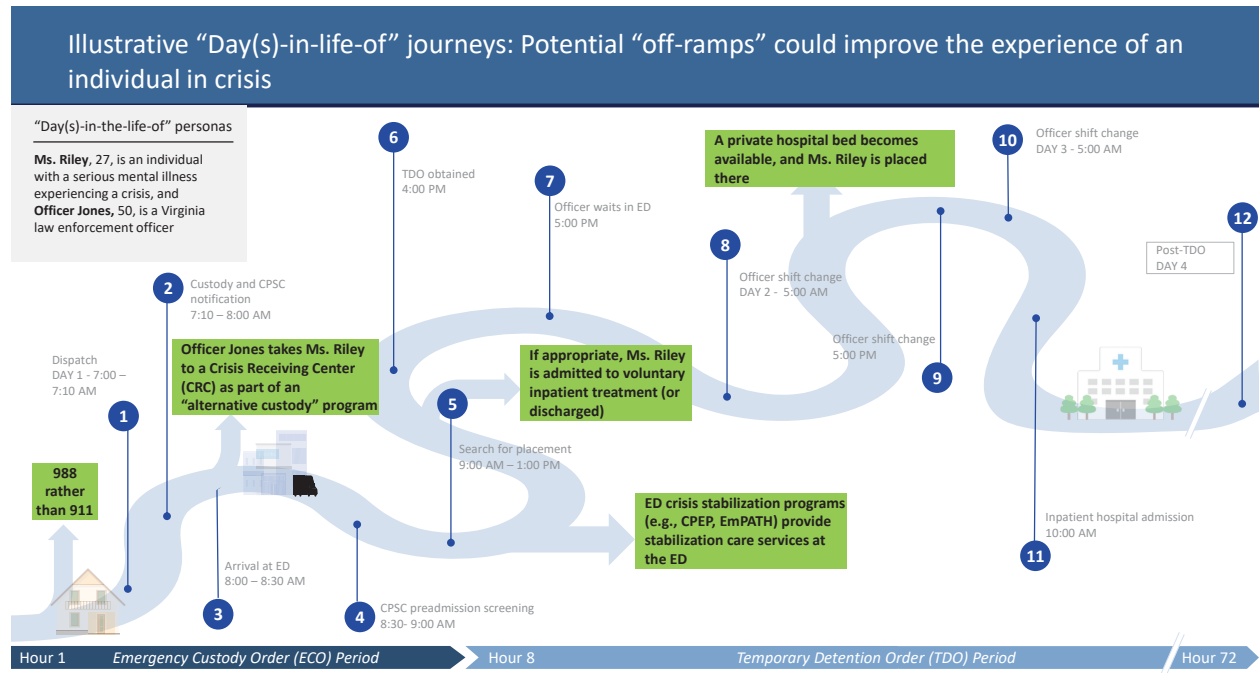
28 Report on Item 320.II of the 2021 Appropriations Act, December 29, 2021.

29 DBHDS discussions, November 2022

30 JLARC: Report to the Governor and the General Assembly of Virginia," December 12, 2022.

Addressing these journey painpoints includes creating “off-ramps” throughout the journey to provide more timely and appropriate care for individuals in crisis (Exhibit 13).

### Exhibit 13: “Day(s)-in-the-life-of” journey off-ramps



Source: DBHDS Report on Item 320.II of the 2021 Appropriations Act; DBHDS discussions



The workgroup identified four initiatives that could reduce the burden on law enforcement in the behavioral health system over three years (Exhibit 14):

### Exhibit 14: Pillar 2 initiatives

## Pillar 2: We must relieve the law enforcement communities' burden while providing care and reduce the criminalization of behavioral health

| Initiatives  | Year 1  | Year 2  | Year 3  | Potential impact  |
|--|---|---|---|---|
| <b>1. Promote co-responder models</b>                                    | Survey CSBs to establish fact base on co-response models across law enforcement (LE) departments in VA (e.g., current build-out and funding models)<br>Identify potential reimbursement options                 | Scale co-responder model to additional LE departments<br>Integrate co-responder strategy with the build-out of overall mobile crisis team as part of the broader crisis system infrastructure |   | Reduce TDOs (from 21,104 in SFY2022)<br><br>Increase consistency across CSBs in issuance of TDOs (e.g., reduce variation across pre-screeners from ~10-70% across CSBs) |
| <b>2. Provide training and support to CSBs (e.g., pre-screener role)</b> | Understand variation in TDO issuance across CSBs including pre-screener role<br>Conduct state-wide training and oversight across CSBs and pre-screeners   | Review pre-screening role, including professional requirements  | Address pre-screening role, including licensure / certification                           | Reduce time that law enforcement is involved in BH response from average ~51 hours to time of transport   |
| <b>3. Reduce administrative burden for pre-screeners</b>                 | Establish Public Health Information Exchange (in coordination with crisis pillar)<br>Create transparency through real-time TDO data (e.g., dashboard for the TDO task force)                                    | Add private provider information to Public Health Information Exchange  |   |   |
| <b>4. Scale alternative transport, custody, and treatment services</b>   | Develop change management plan for DBHDS and CRCs to enable "no wrong door"<br>Launch mental health transportation pilot<br>Support off-duty officer program<br>Implement alternative custody where appropriate | Coordinate with crisis pillar to scale CRC model and conduct LE and other stakeholder site visits<br>Scale alternative transport programs   |   |   |
| <b>Change management</b>   | <i>Engage law enforcement on crisis resources</i>   |   | <i>Continue to engage law enforcement and additional stakeholders on crisis resources</i> |   |

Source: VA HHR, DBHDS data

- 1. Promote co-responder models.** Co-responder models dispatch behavioral health specialists alongside law enforcement officers to behavioral health-related crisis calls. Together, they work to de-escalate the situation and get the individual in crisis the care required for their specific situation. This initiative will establish the current state on co-responder models in Virginia (e.g., Fauquier County), including mapping capacity, service area, and funding model(s). The initiative will support scaling this model and support law enforcement when responding to behavioral health crises.
- 2. Provide training and support to CSBs (e.g., pre-screener role).** There is high variation in TDO rates across CSBs, ranging from 11% to 71%<sup>31</sup>. This initiative will determine the drivers of variation in TDO rates and support statewide training for CSB pre-screeners. This initiative will also explore licensure and certification requirements for CSB pre-screeners.
- 3. Reduce administrative burden for pre-screeners.** CSB pre-screeners currently must fill out a 9-page report and engage in time-consuming placement search processes that, on average, total 4 hours; the process includes using outdated technology such as faxes.<sup>32</sup> This initiative will focus on reducing the administrative burden for pre-screeners to reduce the wait time for law enforcement officers.
- 4. Scale alternative transport, custody, and treatment services.** In coordination with Pillar 1, this initiative will enable law enforcement to relinquish custody within crisis care settings and establish "no wrong door" crisis care. These changes will help reduce the 51-hour average wait time for law

31 JLARC: Report to the Governor and the General Assembly of Virginia," December 12, 2022

32 Report on Item 320.II of the 2021 Appropriations Act, December 29, 2021

enforcement.<sup>33</sup> They will also reduce on-duty law enforcement transportation times with individuals in crisis. Solutions will leverage existing capabilities in new ways, such as off-duty and alternative-transport programs and by scaling existing programs (e.g., Mt. Rogers CSB pilot) with greater funding to incentivize sufficient workforce mobilization.

Once implemented, these initiatives will help reduce the number of TDOs (from 21,104 in SFY 2022), increase consistency in the issuance of TDOs, and reduce the time that law enforcement is involved in behavioral health response—from ~51 hours to the time it takes to transport a person in crisis to a CSB.<sup>34,35</sup> In addition, these initiatives will make strides toward reducing the criminalization of behavioral health. Too many Virginians end up in the criminal justice system because of untreated mental illness and substance use. By integrating appropriately trained professionals that can aid in de-escalation, and by connecting individuals to the appropriate services in a “no wrong door” system, Virginians can get the help they need in their communities, addressing their health care needs rather than criminalizing them.

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33 DBHDS discussions, November 2022

34 DBHDS discussions, November 2022

35 Ibid

## **Pillar 3: We must develop more capacity throughout the system, going beyond hospitals, especially to enhance community-based services**

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Capacity is constrained across the Commonwealth's continuum of behavioral health care. The 40 CSBs play a critical role in delivering community-based behavioral health services and are the primary source of delivering publicly funded behavioral health care in Virginia.<sup>36</sup> Together with Medicaid's behavioral health providers, they deliver publicly funded behavioral health care in Virginia. However, funding across CSBs varies in terms of per capita funding and sources of funds (e.g., Medicaid, federal, state, local). Furthermore, funding levels are not correlated to behavioral health needs, services provided, or outcomes achieved.<sup>37</sup>

Virginia's twelve state psychiatric hospitals, of which nine support the general population, are also capacity constrained. These nine hospitals sustain an average utilization of about 95%, higher than the state's 85% target utilization rate (Appendix D).<sup>38</sup>

For post-crisis recovery and support, limited community re-entry services result in ~200 individuals remaining on the extraordinary barriers to discharge list in state hospitals, despite being ready for re-entry.<sup>39</sup> Individuals ready for discharge wait 230 days on average.<sup>40</sup> While Virginia's Permanent Supportive Housing program is an important building block of post-crisis re-entry and recovery measures, a range of step-down care settings (e.g., residential, partial hospitalization, intensive outpatient) lack capacity to provide sufficient options for those seeking recovery and support.

Initiatives in Pillar 3 focus on increasing capacity throughout the continuum of behavioral health care (Exhibit 15). Through the implementation of these initiatives, Virginia could strengthen system capacity so all Virginians can access care when and where they need it.

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36 DBHDS discussions, November 2022

37 DBHDS: Funding by CSB FY2022 and Virginia Census data

38 DBHDS data: Bed Utilization Percentage of Total Capacity, November 2022; DBHDS data: DBHDS Capacity and Resources, November 2022.

39 DBHDS data: EBL and LOS data for BH commission, November 2022

40 Ibid

## Exhibit 15: Pillar 3 initiatives

### Pillar 3: We must develop more capacity throughout the system, going beyond hospitals, especially to enhance community-based services

| Initiatives   | Year 1  | Year 2  | Year 3   | Potential impact  |
|---|---|---|--|---|
| <b>1. Expand community-based models</b>                                   | Plan for CCBHC <sup>1</sup> Demonstration Program (e.g., data infrastructure, payment system)   | Train 12 CSBs (e.g., CCBHC)<br>Establish data-sharing approach<br>Assess CSB shared savings<br>Ease CSB billing                                     | Train 28 CSBs (e.g., CCBHC)<br>Ensure DD, emergency, other services continue across CSBs | Decrease in wait times for BH care<br><br>Decrease in adults with any mental illness (AMI) who did not receive treatment                |
| <b>2. Expand care integration</b>   | Assess landscape of non-BH providers<br>Expand BH supports in specialty provider settings   | Build on Virginia Mental Health Access Program<br>Support inclusion of primary care supports in BH settings<br>Explore creation of BH reserve corps |  | Increase in individuals receiving BH care at parity, regardless of insurance status   |
| <b>3. Expand tele-behavioral health access</b>                            | Determine need for broadband to support telehealth objectives<br>Launch telehealth strategy across behavioral health continuum                              | Address broadband needs identified to support telehealth<br>Assess telehealth access for tiered services in schools                                 |  | Increase in access to BH screening, early intervention, and referral at specialty provider setting                                      |
| <b>4. Increase youth BH support</b>                                       | Scale school-based mental health trainings and services<br>Expand Medicaid funded school-based services and support Phase II of BRAVO on children and youth |   |  | Increase in integrated care (BH/physical health integration)<br>Increase in children, youth that need treatment, getting access to care |
| <b>5. Expand services for individuals with developmental disabilities</b> | Increase rates for waiver services<br>Reduce priority 1 waitlist  | Assess performance and address opportunity improvement areas<br>Continue to reduce priority 1 waitlist  |  | Decrease in state psychiatric hospital readmissions and utilization (from current utilization rate of 95% to state target of 85%)       |
| <b>6. Enhance re-entry and stabilization services</b>                     | Scale Permanent Supportive Housing and Mental Health Group Homes<br>Identify additional programs / services to potentially scale                            | Expand and support additional community reintegration needs (e.g., employment, care coordination, group homes)                                      |  | Shift to sustainable funding sources over time  |

1. Certified Community Behavioral Health Clinics (CCBHCs)

Source: VA HHR, DBHDS data

- 1. Expand community-based models.** This initiative will focus on implementing the Certified Community Behavioral Health Clinic (CCBHC) model. CCBHCs are a federally supported model – by SAMHSA and the Centers for Medicare and Medicaid Services (CMS) – for delivering community-based behavioral health services. The ten US states that have implemented the CCBHC demonstration program have increased access to behavioral health services, reduced emergency department and hospital visits, improved integration of physical care, and enhanced SUD service capacity.<sup>41</sup> If Virginia is selected for the CMS demonstration program, all 40 CSBs would have the opportunity to participate over the next 3 years and would represent an opportunity to create increased accountability for CSBs.
- 2. Expand care integration.** Integration of behavioral health with primary care and specialty providers (e.g., OBGYN) can help positively impact behavioral health outcomes. For example, 66% of youth have better outcomes when receiving integrated care.<sup>42</sup> This initiative will focus on improving the integration of behavioral health into other provider settings.
- 3. Expand tele-behavioral health access.** Tele-behavioral health can provide behavioral health supports and service and decrease wait times to seek care. This initiative will assess the geographic need and broadband capabilities of communities to access tele-behavioral health. It will also assess where and how tele-behavioral health capabilities can be provided across the continuum and expand school-based tele-health services for K-12 and higher education students.
- 4. Increase youth BH support.** National data show that ~45% of students who receive behavioral health treatment do so in schools<sup>43</sup>. Through school-based behavioral health trainings and resources, school-based services and support to youth could be expanded. The illustrative user journey maps (Exhibits 16 and 17) chart the current state for youth and their families, highlighting pain points and

41 National Council for Behavioral Health and Well-Being, CCBHC Impact Report, 2022 (<https://www.thenationalcouncil.org/wp-content/uploads/2022/10/2022-CCBHC-Impact-Report.pdf>).

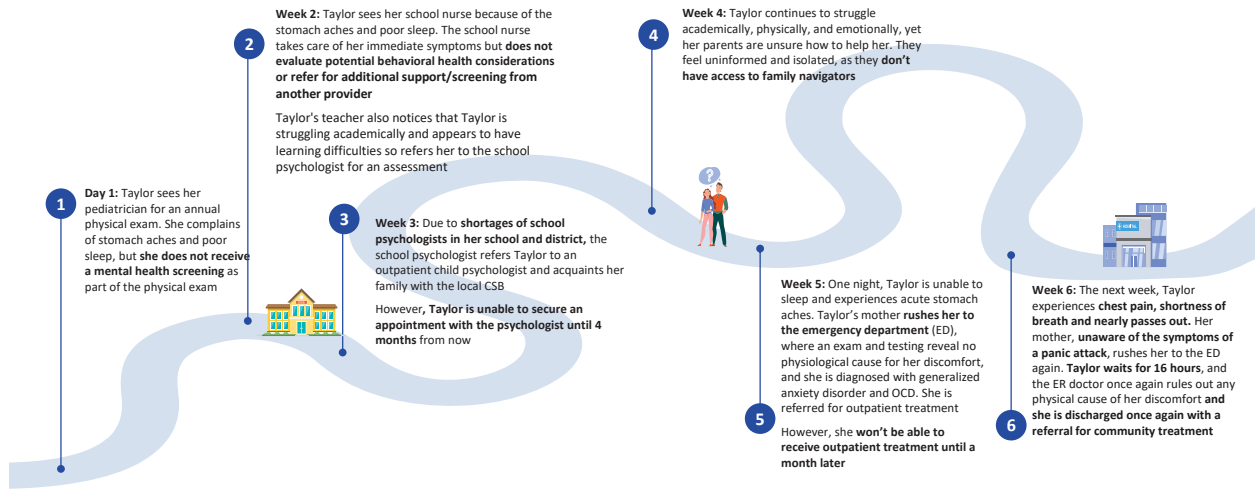
42 DMAS: Virginia Medicaid Continuum of Behavioral Health Services Report, December 2018 (<https://www.dmas.virginia.gov/media/1414/2019-continuum-proposal-report.pdf>).

43 SAMHSA: National Survey on Drug Use and Health, 2019 (<https://www.samhsa.gov/data/release/2019-national-survey-drug-use-and-health-nsduh-releases>).

potential junctures throughout the journey where behavioral health support for youth can be increased, as well as the off-ramps that can exist when that support is provided.

### Exhibit 16: “Day(s)-in-the-life-of” journey for children in school settings

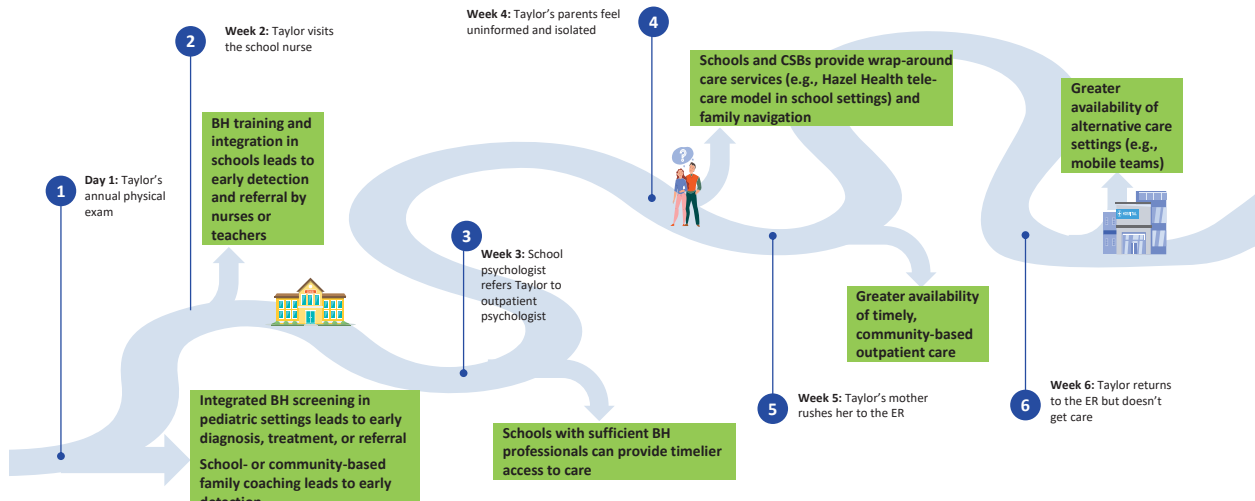
#### Illustrative “Day(s)-in-life-of” journey: Children in school settings experience painpoints in the prevention and management of BH challenges



Source: DBHDS and expert interviews, November 2022

### Exhibit 17: “Day(s)-in-the-life-if” journey off-ramps for children in school settings

#### Illustrative “Day(s)-in-life-of” journey: Potential “off-ramps” could improve children’s experience and access to prevention and management care



Source: DBHDS and expert interviews, November 2022

- 5. Expand services for the DD population.** Individuals with developmental disabilities (DDs) and their families have had to navigate a complex system and long waiting lists to access the care they need to live independently (e.g., ~3,000 Virginians are on the priority one waitlist for DD Waiver services). This initiative will fund additional waiver slots and enhance rates for waiver providers to improve access to care and quality of life for individuals with developmental disabilities and the families who support them.
- 6. Enhance re-entry and stabilization services.** This initiative aims to support individuals' re-entry into their communities post-hospitalization or long-term inpatient care. It will help with permanent or temporary housing support, care coordination and wraparound community supports, transition planning pre-discharge, and employment support.

These initiatives have the potential to collectively improve Virginians' ability to access behavioral health care, including early treatment in the least restrictive setting. In particular, wait times could decrease for adults with any mental illness (AMI) to receive treatment. Furthermore, increases in access to BH care could be measured.<sup>44</sup> Finally, a decrease in state psychiatric hospital readmissions and utilization (from 95% today to the state target of 85%) could occur. In addition to achieving these outcomes, funding could be shifted to more sustainable sources over time, including Medicaid and commercial health insurance.

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<sup>44</sup> For example, the number of individuals receiving behavioral health care regardless of insurance status, access to behavioral health screening, early intervention, and referral at specialty provider setting can be measured and benchmarked across the system

## Pillar 4: We must provide targeted support for substance use disorder and efforts to prevent overdose

A substance use crisis is unfolding nationally, and communities across the country are struggling with addiction and overdose. In Virginia, the prevalence of substance use disorder (SUD) diagnoses doubled for both adults and youth in one year – for adults increasing from 7.3% to 14.5% and for youth from 3.7% to 7.0%.<sup>45 46</sup> Overall, the state saw a 35% increase in overdose deaths between June 2021 and June 2022.<sup>47</sup>

The landscape of substance use prevention, treatment and recovery programs includes federally and state funded initiatives (e.g., Addiction and Recovery Treatment Services Program [ARTS]) and partnerships with educational institutions (e.g., Virginia Commonwealth University) and community-based organizations (e.g., Community Coalitions of Virginia). This pillar builds on the progress of these prior efforts to support substance use prevention, treatment, and recovery (Exhibit 18).

### Exhibit 18: Pillar 4 initiatives

#### Pillar 4: We must provide targeted support for substance use disorder (SUD) and efforts to prevent overdose

| Initiatives   | Year 1   | Year 2  | Year 3  | Potential impact  |
|---|--|---|---|---|
| <b>1. Develop mobile treatment and crisis response specific for SUD</b>                       | Develop substance use journeys to pressure test against crisis system design<br>Develop strategy for mobile crisis response for SUD      | Expand to additional pilot geographies<br>Develop and incorporate substance use specific metrics into crisis system | Launch model statewide<br>Support integration of SUD into crisis delivery | Increase access to timely care for individuals seeking treatment for substance use in prevention and management settings  |
| <b>2. Empower communities in addressing the SUD crisis</b>                                    | Support communities (including Community Coalitions) in prevention-focused efforts<br>Launch wellness and resiliency campaign            | Define and begin tracking specific impact measures<br>Expand wellness and resiliency campaign                       | Build in accountability mechanisms  | Increase access for individuals experiencing substance use-related crises<br><br>Reduce rates of relapse through improved peer support resources and housing supports for individuals in recovery |
| <b>3. Target programs with the greatest potential to prevent adverse outcomes</b>             | Assess potential for harm reduction<br>Expand Naloxone access and training   | Build capacity to link state social and health services for harm reduction  | Align incentives across state entities to support standards               |   |
| <b>4. Expand innovative programs for proven and effective treatments across the continuum</b> | Convene cross-agency planning for evidence-based treatment pilots<br>Expand delivery of evidence-based treatments                        | Expand pilots by archetype (e.g., rural, families) for programs (e.g., Peer Mentor Program with Child Welfare)      | Scale programs statewide  |   |
| <b>5. Reduce barriers to recovery</b>   | Assess current policies and levers to reduce barriers to recovery (e.g., peer roles, transition programs) and expand or pilot approaches | Expand pilots for specific subpopulations (e.g., non-traditional supports)  | Scale programs statewide  |   |

Source: VA HHR

**1. Develop mobile treatment and crisis response specific for SUD.** Given both the severity of the substance use crisis and the high rates of co-occurrence between mental health and SUD, a well-designed crisis response system cannot be diagnosis dependent. In 2020, emergency department (ED) visits increased 28% for SUD-related events, even while overall ED visits declined by 2.3%.<sup>48</sup> To ensure that individuals experiencing crises involving substance use get the appropriate in-person

<sup>45</sup> Mental Health America: Youth Ranking 2023, based on 2019-2020 data

<sup>46</sup> Mental Health America 2022, 2023 Reports: Adult Ranking 2022, 2023, based on 2018/2019 – 2019-2020 data

<sup>47</sup> CDC: Provisional Drug Overdose Death Counts., 2022

<sup>48</sup> VCU School of Medicine: Addiction and Recovery Treatment Services (ARTS) Evaluation Report for State Fiscal Years 2019 and 2020

response, the Commonwealth's mobile crisis team roll-out will include SUD specific capabilities and trained staff.<sup>49</sup> This process will begin with articulating the mobile crisis strategy with specific considerations for substance-use-related crises in Year 1 and scale statewide in Years 2 and 3, including integration with the broader crisis and behavioral health ecosystem.

- 2. Empower communities to address the substance use crisis.** Addressing the substance use crisis requires education and awareness initiatives focused on primary prevention and stigma reduction, including efforts led by the broader community. These efforts include schools, faith-based organizations, and community-based organizations. For example, Community Coalitions of Virginia and Peer/Parent Mentor programs support people who are struggling with substance use by enabling family togetherness, creating safe spaces, and offering prevention and recovery tools. Over three years, opportunities will be identified to enable organizations to provide these services sustainably and at-scale.
- 3. Target programs with the greatest potential to prevent adverse outcomes.** This initiative aims to scale evidence-based practices that have been demonstrated to be effective in the fight against the substance use crisis, which include Naloxone distribution (e.g., by mail, in specific community settings, to law enforcement officers) and scaling the presence of harm-reduction programs across the state. This initiative will identify additional evidence-based practices to scale and then expand those practices statewide over the coming three years. Included in this initiative are efforts to address the high fatality rate of overdoses involving fentanyl, which represented 71.8% of all fatal overdoses in Virginia in 2020 (through either prescription, illicit, and/or analogs).<sup>50</sup>
- 4. Expand innovative programs for proven and effective treatments across the continuum.** This initiative aims to continue to support and expand ongoing SUD programs (e.g., ARTS). Additionally, the initiative will scale innovative and effective SUD treatments (e.g., peer mentorship, therapies that drive reduction in substance use) to enable holistic support across the care continuum.
- 5. Reduce barriers to recovery.** This initiative will support individuals in recovery as they transition from residential or detox facilities, long-term inpatient care, and jails/prisons. Individuals will be supported in their prevention and ongoing recovery efforts through programs like Bridge Clinics and employment and housing supports. The initiative will assess current programs and policies for opportunities to expand or pilot approaches in Year 1 and scale programs in Years 2 and 3.

The potential impact of these initiatives includes increased access to timely care, reduced adverse outcomes—including fatal overdoses—and stronger pathways to recovery for all Virginians.

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49 National Institute on Drug Abuse: The Connection between Substance Use Disorders and Mental Illness (Research Report), April 2020.

50 Virginia Department of Health: Office of the Chief Medical Examiner, Q3 Report, 2021

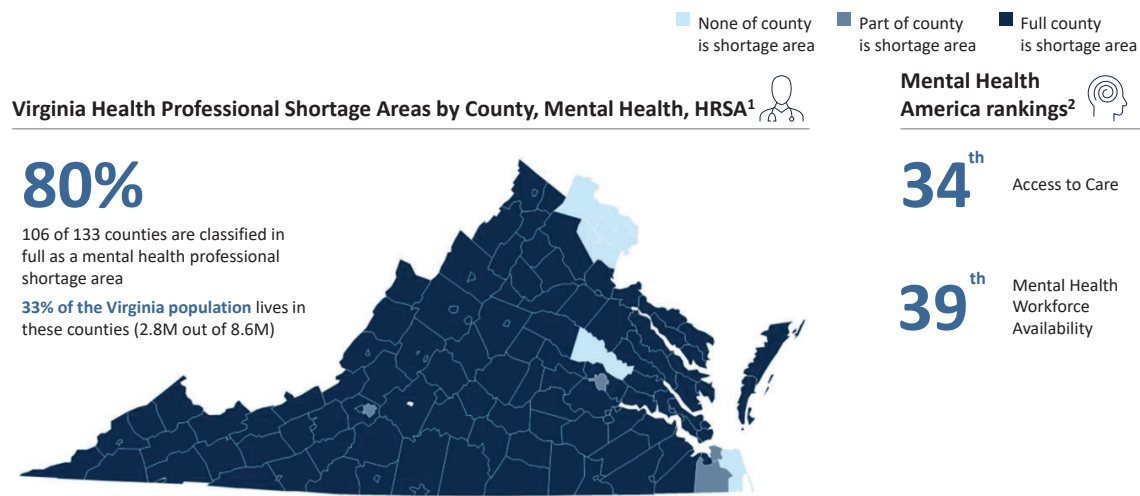


## Pillar 5: We must make the behavioral health workforce a priority, particularly in underserved communities

The Commonwealth, and the US more broadly, is experiencing a shortage of behavioral health providers at the same time as a historically high need for behavioral health care. More individuals seek treatment for mental illness and substance use disorders which places additional demand on the system.<sup>51</sup> In Virginia, the majority of counties (106 of 133) are classified in full as Mental Health Professional Shortage Areas and cover 33% of the population (~2.8M people affected) (Exhibit 19).<sup>52</sup>

### Exhibit 19: HRSA Mental Health Professional Shortage Areas by County in Virginia

Across the Commonwealth, access to Behavioral Health care remains a challenge



1. Health Resources and Services Administration Mental Health Care Health Professional Shortage Areas, by State, as of September 30, 2022, data.HRSA.gov  
 2. State of Mental Health America, Access to Care Ranking 2023

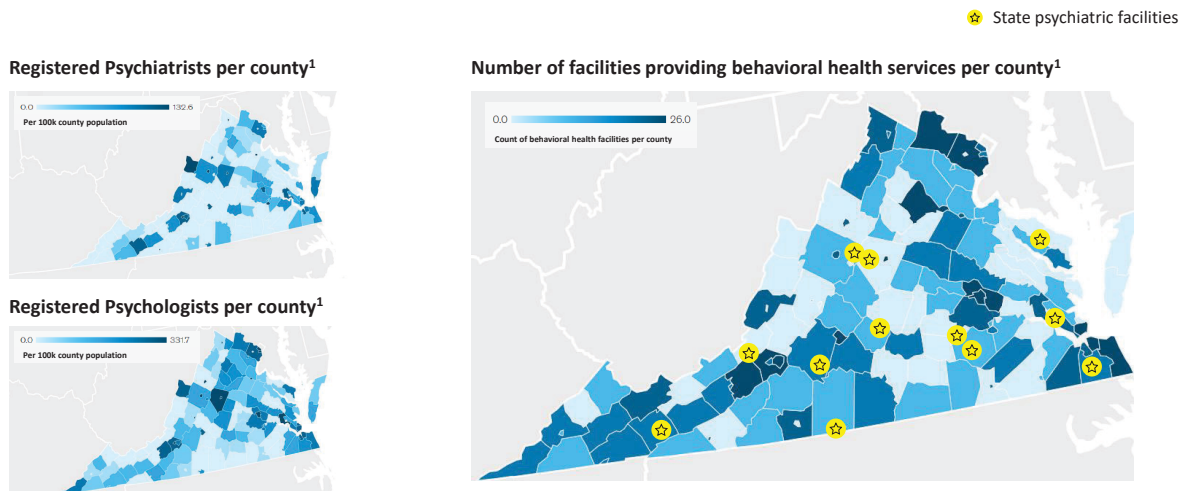
51 Claude Moore Charitable Foundation: Virginia's Human Services Workforce, Strategic Investment Initiatives Report, August 19, 2022

52 Data.HRSA.gov: Health Resources and Services Administration Mental Health Care Professional Shortage Areas, by State, as of September 30, 2022

The shortage of behavioral health providers is predominantly in rural areas as current supply of psychologists, psychiatrists, and facilities is concentrated around urban areas (Exhibit 20).<sup>53</sup>

### Exhibit 20: Number of BH providers and facilities in the Commonwealth

Behavioral health provider availability is concentrated in metro areas



1. Provider types as defined by the Health Care Provider Taxonomy code set (<https://taxonomy.nucc.org/>) used in the NPPES NPI to classify registered providers; psychologists and psychiatrists refer to individual type providers and are required to have appropriate licenses to practice Psychology and Psychiatry, respectively; public and private facilities providing mental health services refers to Non-Individual (Organization) provider types associated with providing Mental Health services  
Source: NPPES NPI Registry via McKinsey Vulnerable Populations Dashboard, April 2021

A large and disproportionate number of Virginia’s licensed behavioral health professionals are nearing retirement age, with 61% of all psychiatrists in the state at age 55 or older.<sup>54</sup> Furthermore, there is no evident increase in the pipeline of incoming providers. Virginia ranks 34<sup>th</sup> in Mental Health America’s “Access to Care” rankings and 39<sup>th</sup> in Mental Health Workforce Availability.<sup>55</sup>

Four main challenges are impacting workforce availability: (1) existing constraints limiting the opportunity to expand the workforce through recruitment; (2) compensation differences between public and private providers; (3) administrative burden impacting retention of current BH providers; and (4) the underutilization of non-behavioral health providers to extend behavioral health capabilities.<sup>56</sup> Bold and immediate action is needed to address the current workforce shortage. The initiatives below (Exhibit 21) have been identified to address current challenges to the behavioral health workforce across recruitment, retention, and expansion opportunities.

53 Ibid

54 Virginia Health Care Foundation: Assessment of the Capacity of Virginia’s Licensed Behavioral Health Workforce, January 2022

55 Mental Health America: Access to Care Ranking 2023, based on 2019-2020 data

56 DBHDS Discussions, Design Sprint, December 2022

## Exhibit 21: Pillar 5 initiatives

### Pillar 5: We must make the behavioral health workforce a priority, particularly in underserved communities

| Initiatives  | Year 1  | Year 2  | Year 3   | Potential impact   |
|--|---|---|--|--|
| <b>1. Increase recruiting by reducing constraints where appropriate</b>  | Define objectives (e.g., peer hiring) & review parameters for licensure requirements  | Implement changes and relaunch recruitment  |  | Enhance recruitment: Increase number of individuals in existing roles in the field providing services  |
| <b>2. Work towards parity in rates and compensation across private and public sectors</b>                        | Understand opportunity across roles and potential sources (e.g., CCBHC opportunity for CSBs) and create roadmap to parity<br>Increase funding for non-direct care staff to increase bed capacity at public facilities | Determine any required administrative changes to enable reimbursement<br>Act on roadmap created in year 1 | Implement updates to compensation structures<br>Assess early impacts and outcomes of first initiatives | Improve retention: Ensure retention across all roles and improve the attractiveness of roles<br><br>Ensure expansion: Expand the service of non-BH providers via integrated care |
| <b>3. Increase capabilities for non-BH providers to provide BH care</b>  | Prioritize target roles and initiate engagement campaign with providers and educators   | Design and launch training programs to upskill additional providers on BH care                            | Collect feedback from providers and educators and refine program                                       |  |
| <b>4. Increase pipeline of incoming BH providers through educational opportunities and “grow your own” roles</b> | Fund loan repayment programs for BH providers<br>Increase BH residency slots<br>Develop a provider training strategy  | Engage providers and educators in “grow your own” training opportunities                                  | Review, refine and expand programs as needed<br>Assess early impacts and outcomes of first initiatives |  |
| <b>5. Reduce administrative burden for providers</b>   | Establish cross-agency workgroup to identify and address key pain points  | Implement streamlined processes for priority roles in public BH system                                    | Review, refine and expand program  |  |
| <b>6. Support public campaigns to increase attractiveness of BH roles</b>  | Collaborate with state and external stakeholders on public campaigns aimed to increase attractiveness of BH provider roles  | Assess initial impact, refine and scale programs  |  |  |

Source: VA HHR, DBHDS data

21

- 1. Increase recruiting by reducing constraints where appropriate.** Constraints on job placement may include potentially onerous licensing requirements and other prerequisites that restrict an individual’s eligibility for a job based on prior personal background. While these requirements exist to safeguard patients, there is an opportunity to assess parameters for licensure requirements to determine whether there are opportunities to update the approach to expand the pipeline of incoming behavioral health providers.<sup>57</sup>
- 2. Work toward rate and compensation parity across private and public sectors.** Compensation for behavioral health providers lags that of other healthcare providers, especially in public facilities.<sup>58</sup> Addressing this reality will require first developing a detailed understanding of the disparities by role and geography. In order to address these disparities, this initiative will identify near-term opportunities for investment in specific roles and facilities (e.g., opportunities created by the rollout of the CCBHC model) as well as administrative changes that are required to enable sustainable funding to support compensation. This initiative will also build on current commitments to invest in non-direct care providers in state psychiatric facilities.<sup>59</sup>
- 3. Increase capabilities for non-BH providers to provide BH care.** Extending the capabilities of non-behavioral health providers—including primary care physicians, pediatricians, and other providers—can also expand the pipeline (e.g., through training programs to upskill behavioral health competencies). This initiative will build on and expand local and role-specific examples, including current training programs focused on nurse practitioners and registered nurses, to upskill the non-behavioral health workforce.

57 DBHDS/DHP Discussions, Design Sprint, December 2022

58 Ibid

59 Ibid

- 4. Increase pipeline of incoming BH providers through educational opportunities and “grow your own” roles.** Increasing the educational pipeline of behavioral health providers requires supplementing current opportunities offered by the higher education system. This initiative includes near-term investments to fund loan forgiveness programs and increase the number of residency positions for behavioral-health-focused medical professionals in the Commonwealth. It also includes an intention to explore the opportunity to develop “grow your own” roles where new roles are developed in-state to address a community need. The mental health crisis has massively impacted youth; yet, in Virginia, there are only 211 Child and Adolescent Psychiatrists. This initiative could leverage innovations to address these constraints (e.g., “Behavioral Health Coaches” roles) to address the BH needs of children and youth.<sup>60</sup>
- 5. Reduce the administrative burden for providers.** The administrative burden associated with clinical paperwork, billing, and other administrative tasks contributes to job dissatisfaction for providers in both the public and private sectors.<sup>61</sup> The initiative aims to reassess current requirements for clinical and billing paperwork for behavioral health providers and identify tech-enabled solutions to streamline current processes.
- 6. Support public campaigns to increase the attractiveness of BH roles.** In addition to the above initiatives that address structural challenges of the behavioral health workforce, state support of public campaigns can also increase the attractiveness of behavioral health provider roles. This initiative will focus on identifying, supporting, and scaling relevant public education campaigns aimed at promoting and valuing behavioral health provider roles.

The potential impact of this initiative includes an increased number of individuals in existing roles in the field providing services, enhanced recruitment, improved retention across all roles, and an expanded effective behavioral health workforce through integration with physical health care providers.

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60 Children and Youth Behavioral Health Initiative (CYBHI), 2022

61 DBHDS/DHP Discussions, Design Sprint, December 2022

## **Pillar 6: We must identify service innovations and best practices in pre-crisis prevention services, crisis care, post-crisis recovery and support and develop tangible and achievable means to close capacity gaps**

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While total expenditures on behavioral health in Virginia across all sources have been increasing, Medicaid is the largest and fastest growing payer for behavioral health. While total behavioral health expenditures in Virginia grew by 10% annually between 2018 and 2020, Medicaid behavioral health expenditures grew by 15% annually to nearly \$2B in 2020.<sup>62</sup> Importantly, while Medicaid spending increased over time, the contributing share of state general funds has remained relatively constant (~\$4.6B) while the federal share has increased significantly.<sup>63</sup>

Medicaid represents an opportunity to strengthen behavioral health service quality and availability using the established infrastructure of the publicly funded behavioral health system. The current Medicaid Managed Care Organization (MCO) contracts and the upcoming re-procurement provide an opportunity for improvements in several areas: enhance quality through service innovations; address and reduce network capacity gaps; enhance administrative requirements for providers; and establish outcomes-based payment incentives. Moreover, by strengthening the financing and delivery of behavioral health services through Medicaid, Virginia has an opportunity to set the standard for other payers (e.g., commercial insurers) to improve.

The establishment of Medicaid services under Phase 1 of the Behavioral Health Redesign for Access, Value & Outcomes (BRAVO) program represented a significant step forward for Virginia. However, insufficient and inconsistent provider training and public awareness regarding available services are impediments to achieving full uptake of BRAVO services. Efforts to enhance provider trainings and other administrative requirements can bolster the quality and provision of Medicaid behavioral health services through the Medicaid MCOs. These efforts can provide the necessary foundation to make progress towards parity between physical health and behavioral health care while expanding access to critical behavioral health services for all Virginians.

Several other pain points remain a challenge for Virginia, including gaps in behavioral health accessibility, adequacy in Medicaid MCO provider networks, and the variation in governance structures and service availability through the CSBs (see Pillar 3). Pillar 6 addresses these and other challenges through new approaches to measurement and monitoring in Medicaid and the Medicaid MCOs, new reimbursement models (e.g., CCBHCs and outcomes-based payment models), and exploration of specialized models to support youth with behavioral health needs through Medicaid managed care. Pillar 6 explores opportunities to expand coverage for behavioral health services by commercial insurers.

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62 Analysis of third-party claims data from: IBM's Truven Commercial Database (2018-2020); IBM's Truven Medicaid Database (2018-2020); 5% Sample CMS Medicare Limited Data Set, 2018-2020; Definitive Enrollment Data at the MSA-level 2017-19; DRG Medicaid FFS/MCO data, 2018-2020; Medicaid State Index

63 Virginia Department of Planning and Budget data. Note totals shown for 2020 reflect Medicaid Expansion and federal funding received during the Public Health Emergency is included for 2020 and 2022.

Pillar 6 initiatives (Exhibit 22) offer an approach to tackle the remaining challenges in an integrated and holistic way:

## Exhibit 22: Pillar 6 initiatives

### Pillar 6: We must identify service innovations and best practices in prevention and management, crisis services, re-entry services and develop tangible and achievable means to close capacity gaps

| Initiatives   | Year 1  | Year 2   | Year 3   | Potential impact  |
|---|---|--|--|---|
| <b>1. Enhance administrative processes and provider trainings to reduce provider burden</b> | <ul style="list-style-type: none"> <li>Convene agencies with directive to establish uniform standards for BRAVO providers, e.g., <ul style="list-style-type: none"> <li>Provider (e.g., QMHP) training curriculum</li> <li>Medicaid MCO administration practices</li> </ul> </li> <li>Develop public education campaign to build BH system awareness for individuals and providers</li> </ul> | <ul style="list-style-type: none"> <li>Work with Medicaid MCOs to coordinate delivery of common qualified mental health professionals (QMHP) training</li> <li>Work with Medicaid MCOs to improve administrative processes</li> <li>Launch BH public education campaign</li> </ul> | <ul style="list-style-type: none"> <li>Evaluate effectiveness of QMHP training</li> <li>Determine additional workforce focus for training standardization</li> <li>Determine additional administrative efficiencies for Medicaid MCOs and define timeframe for implementation</li> </ul> | <ul style="list-style-type: none"> <li>Improve service delivery quality and increase access to services</li> <li>Increase provider satisfaction by reducing administrative burden and overhead for providers</li> </ul> |
| <b>2. Assess and align BH provider network to address service gaps</b>                      | <ul style="list-style-type: none"> <li>Convene agencies to develop an analytical approach to determine BH network and workforce gaps</li> <li>Establish model to measure BH network adequacy and determine priorities</li> </ul>  | <ul style="list-style-type: none"> <li>Determine workforce network capacity priorities</li> <li>Implement MCO BH network accessibility and adequacy standards through re-procurement</li> </ul>  | <ul style="list-style-type: none"> <li>Determine workforce network capacity priorities</li> <li>Monitor MCO performance on new network adequacy contract requirements, refine over time</li> </ul>   | <ul style="list-style-type: none"> <li>Make progress towards aspirations of BH parity</li> </ul>  |
| <b>3. Develop outcomes-based payment strategies</b>   | <ul style="list-style-type: none"> <li>Design and plan for launch of CCBHC model (e.g., develop reimbursement model)</li> <li>Create an outcomes-based payment model that holds MCOs accountable for BH quality and outcomes</li> </ul>   | <ul style="list-style-type: none"> <li>Build out CCBHC reimbursement model</li> <li>Award Medicaid MCO contracts that include BH outcomes-based payment standards (e.g., that increase YOY)</li> </ul>   | <ul style="list-style-type: none"> <li>Refine and scale CCBHC reimbursement model</li> <li>Continually refine and strengthen BH outcomes-based payment model in Medicaid MCO contracts</li> </ul>  |   |
| <b>4. Increase youth BH support through specialized programs in Medicaid managed care</b>   | <ul style="list-style-type: none"> <li>Explore design options for specialized program/services for children and youth BH through Medicaid managed care</li> <li>Facilitate DSS/DMAS collaboration; focus on Model of Care for youth and notification processes</li> </ul>   | <ul style="list-style-type: none"> <li>Determine path forward for children/youth BH (e.g., Model of Care, specialized programs/services)</li> </ul>  | <ul style="list-style-type: none"> <li>Implement new programs and strategies</li> </ul>  |   |
| <b>5. Work with commercial health plans to enhance BH service coverage</b>                  | <ul style="list-style-type: none"> <li>Determine opportunities and strategies to increase coverage for BH services in commercial insurance (e.g., enhancing Essential Health Benefits)</li> </ul>   | <ul style="list-style-type: none"> <li>Implement changes to increase coverage of BH services and establish processes for managing and monitoring</li> </ul>  | <ul style="list-style-type: none"> <li>Implement management and monitoring processes</li> </ul>  |   |

Source: VA HHR, DBHDS data

- 1. Enhance administrative processes and provider trainings to reduce provider burden.** Given the recent rollout of BRAVO services and the disruptions caused by the evolving pandemic, additional effort is required to train providers (e.g., Qualified Mental Health Professionals) on service offerings and requirements. Reviewing and aligning administrative requirements across Medicaid MCOs can also enable increased uptake of services among providers and allow providers to spend more time delivering care. Finally, additional efforts to create awareness about services among Virginians would increase understanding, access, and uptake.
- 2. Assess and align BH provider network to address service gaps.** While the Medicaid MCO program includes standards for provider network accessibility and adequacy that each MCO must meet, these standards do not fully or holistically address the capacity needed in the system. Virginia would benefit from developing a deeper analytical understanding of Medicaid provider network capacity and gaps. It could benefit from exploring contract standards—including local response times and availability of behavioral health providers—while accounting for geographic variations. DMAS and licensing agencies can start by establishing a methodology to determine priority needs for specific behavioral health provider types and developing standards, measurement, and monitoring approaches to address them.

**Develop outcomes-based payment strategies.** Outcomes-based payment strategies can serve as a catalyst for driving quality within healthcare. Incorporating arrangements that support outcomes-based payment, such as the nationally recognized CCBHC model, would contribute to a growth in service standards and quality. Additional strategies to strengthen provider quality and service delivery could include efforts such as outcomes-based payment models that support Medicaid MCO accountability for BH

quality and care outcomes.

- 3. Increase youth BH support through specialized programs in Medicaid managed care.** In several other states, the unique challenges involved in caring for youth with behavioral health needs enrolled in Medicaid have been addressed through specialized managed care standards or programs (e.g., Ohio's OhioRise program). In Virginia, there are multiple entities involved in the provision of care for Virginia's youth and children. The Medicaid model of care currently used in Virginia can be reviewed to encourage further collaboration between the local departments of social services (LDSS) and the Medicaid MCOs. This effort would yield stronger partnerships that benefit Virginia's youth, children, and families. Additional consideration will be given to Medicaid managed care program design and model options for youth and children in need of behavioral health supports.
- 4. Work with commercial health plans to enhance BH service coverage.** The actions described in this plan to strengthen the behavioral health system through Medicaid can be furthered through enhanced offerings from commercial insurers and the support of large employers in the state. Increased coverage for behavioral health services through commercial insurance (e.g., refinements to Essential Health Benefits) will be considered as an important step toward realizing the aspirations of behavioral health parity.

These initiatives will deliver results in three ways: (1) improving service quality and access to services for all Virginians; (2) increasing satisfaction for behavioral health providers by reducing administrative burdens; (3) making progress towards behavioral health parity.

# Budget

Governor Youngkin will propose a series of immediate steps to bolster his three-year transformation plan, including over \$230 million in new funding for behavioral health in his proposed amendments to the 2022-2024 Biennial Budget released on December 15, 2022. The centerpiece of these proposals will include a \$20 million proposal to fully-fund 30+ new mobile crisis teams to respond to calls into Virginia's 988 hotline. With this new funding, the Governor's commitment to behavioral health will top \$660 million in additional funding in the next fiscal year.

## Exhibit 22: Budget-annotated initiatives by pillar across the care continuum

### The Governor's proposed additional spend and budget language amendments for 2024 (Total over \$230M)

|  | \$xx Proposed additional budget spend (2024)   |   |  |
|--|--|---|--|
|  | Pre-crisis prevention services   | Crisis care   | Post-crisis recovery and support   |
| <b>Pillar 1:</b> We must strive to ensure same-day care for individuals experiencing behavioral health crises  |  | <ul style="list-style-type: none"> <li>Expansion of mobile crisis units: <b>\$20M<sup>1</sup></b></li> <li>Build out infrastructure for crisis receiving: <b>\$58.3M<sup>1</sup></b></li> <li>Innovative hospital-based psychiatric emergency alternatives: <b>\$20M</b></li> </ul> | <b>\$98M</b>   |
| <b>Pillar 2:</b> We must relieve law enforcement communities' burden and reduce criminalization of mental health   |  | <ul style="list-style-type: none"> <li>Mental health transportation pilot: <b>\$4.1M</b></li> <li>Support off duty officer program: <b>\$1M</b></li> <li>Flexible use of mental health pilot program funds</li> <li>Dedicated sworn officers for ECO/TDO: <b>\$4M</b></li> </ul>    | <b>\$9M</b>  |
| <b>Pillar 3:</b> We must develop more capacity throughout the system, going beyond hospitals, especially community-based services  | <ul style="list-style-type: none"> <li>Telehealth services for k-12 and higher-ed: <b>\$9M</b></li> <li>Expansion of school-based mental health services: <b>\$15M</b></li> <li>Plan for CCBHC Demo program: SAMSA grant in progress</li> <li>CSB training: <b>\$1M</b> CDC Grant</li> <li>Improvements to waiver administration system: <b>\$0.5M</b></li> <li>Fund 500 additional DD waiver slots: <b>\$15.1M</b></li> </ul> | <ul style="list-style-type: none"> <li>Increase rates for personal care, respite, and companion services: <b>\$41.6M<sup>2</sup></b></li> </ul>   | <ul style="list-style-type: none"> <li>Expand housing options for the SMI population: <b>\$8M</b></li> </ul> |
| <b>Pillar 4:</b> We must provide targeted support for substance use disorder and efforts to prevent overdose   | <ul style="list-style-type: none"> <li>Campaign to reduce fentanyl deaths: <b>\$5M</b></li> <li>Increase access to Naloxone: <b>\$3M<sup>3</sup></b></li> <li>Designate portion of opioid settlement fund for Fentanyl: <b>\$7M</b></li> </ul>   |   | <ul style="list-style-type: none"> <li>Improve access to peer recovery services in Medicaid</li> </ul>       |
| <b>Pillar 5:</b> We must make the BH workforce a priority, particularly in underserved communities   | <ul style="list-style-type: none"> <li>Additional funding for state facility staff: <b>\$9M<sup>3</sup></b></li> <li>Additional psychiatric residency slots: <b>\$1M<sup>3</sup></b></li> </ul>  | <ul style="list-style-type: none"> <li>Additional Loan repayments for psychiatric nurse and nurse practitioners: <b>\$5M</b></li> <li>Loan repayment for child and adolescent psychiatric providers: <b>\$3M<sup>3</sup></b></li> </ul>   | <b>\$18M</b>   |
| <b>Pillar 6:</b> We must identify service innovations and best practices in prevention and management, crisis services, re-entry services and develop tangible and achievable means to close capacity gaps | <ul style="list-style-type: none"> <li>Administrative costs for managed care organization re-procurement: <b>\$4.3M<sup>1</sup></b></li> <li>MCO contract changes to be proposed in 2024 General Assembly session for approval</li> </ul>  |   | <b>\$4M</b>  |

1. \$4.3M includes total funding for Medicaid procurement (and not only BH components) 2. Includes DD and CCC Plus populations 3. Amounts are incremental to existing budget  
Source: VA HHR, Governor's proposed 2024 budget



Included in the Governor's revised budget is:

- \$20 million to fund 30+ new mobile crisis teams to meet the Year 1 statewide goal of responding to 988 hotline calls
  - \$58 million to increase the number of Crisis Receiving Centers and Crisis Stabilization Units, fully funding the number of necessary centers in Southwest Virginia and Hampton Roads
  - \$15 million to expand the elementary, middle, and high school-based mental health program to dozens of new communities
  - \$9 million to expand tele-behavioral health services in public schools and on college campuses
  - \$20 million for partnerships with hospitals to create alternatives to emergency departments for those in crisis
  - \$9 million for transportation and in-hospital monitoring by law enforcement and other personnel
  - \$8 million for Serious Mental Illness housing, creating 100 new placements for SMI patients with extraordinary barriers to discharge
  - \$57 million for 500 additional Medicaid Waiver Priority 1 Waitlist Slots and increased provider rates, including respite and companion services
  - \$15 million in opioid abatement initiatives including a campaign to reduce fentanyl poisoning among youth
1. This funding will be the “down payment” on successfully transforming the behavioral health system in Virginia. These installments are the first steps in establishing the necessary program infrastructure. As the workforce increases, community-based services are anticipated to increase and diversify. Once the system and infrastructure are in place, the cost is anticipated to be reduced, especially with the increased role of Medicaid and other insurers. Also, the increase in pre-crisis prevention services should result in fewer people in crisis care and post-crisis recovery, reducing the total cost of these services. In addition, if the post-crisis recovery and support system is more robust, then not as many people will return to crisis—relieving demand and cost on the system.

# Conclusion

By executing the initiatives across the six strategic pillars over a three-year implementation horizon, Virginia can transform its behavioral health system. This transformation will expand timely, effective, outcomes-oriented care across all parts of the care continuum and improve service quality, increase capacity and access, and improve provider experience.

The first steps toward implementation have already been taken, starting with budget proposals. The Governor's revised budget includes funding for various initiatives across the Plan, as outlined in the Budget section above. For example, the budget proposed \$98M in new funding for same-day crisis services, \$57M to improve services for individuals with Intellectual and Developmental Disabilities, \$25M to fund capacity development in prevention and management, and more than \$50M in funding for other initiatives across the behavioral health care continuum. In total, more than \$230M in additional proposed funding has been submitted.

Following the launch of the Plan in December 2022, various stakeholders expressed support. One state senator said, "Building out the crisis system will ultimately help people avoid the need for involuntary treatment."<sup>64</sup> A state delegate added, "This step is deeply meaningful for Virginians who have needed a lifeline of support."<sup>65</sup> The executive director of the Virginia Association of Community Services Boards said the organization is "looking forward to working with this administration to build capacity and supports for individuals with behavioral health and developmental disability service needs and welcomes the sustained and targeted attention that the Governor can bring to bear on systemic issues."<sup>66</sup> The executive director of the Virginia Sheriffs Association said, "These efforts are long-overdue and will get law enforcement back to their public safety duties and, most importantly, enable Virginians (to) get the help they need when they are experiencing mental health struggles."<sup>67</sup>

In addition, three-year cross-agency implementation is beginning in January 2023 with the development of a comprehensive implementation plan. Pillar leads and their teams have been assigned from across agencies (e.g., DBHDS, DMAS) and will work toward developing implementation plans. Each implementation plan will include the activities required for each initiative, key metrics, stakeholder engagement plans, risks, dependencies, and other implementation considerations across the three-year time period. The overall objective of implementation will be to realize the goals set forth by each pillar by 2025. The implementation plans will be governed by best practices in transformation to ensure successful tracking of key performance indicators and achievement of the anticipated impact of each initiative.

The time to act is now. This is a truly unique moment for the Commonwealth, where the shared focus and resolve to make positive change, combined with the many opportunities for innovation in both care and funding, can enable transformation of the system for Virginians today and for generations to come. This transformation will require participation of all stakeholders and partners across the ecosystem, including state agencies, public and private providers, payers across Medicaid, commercial insurance and other segments, employer groups, and the individuals, their caregivers, families and friends who are impacted directly by behavioral health conditions. Continued engagement from all of those with a voice and a role to play will be welcomed, and they are essential for progress in the months ahead.

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64 State Senator Barbara Favola, "What They Are Saying: Governor Glenn Youngkin Announces Transformational Behavioral Health Plan," Office of the Governor, December 16, 2022

65 Delegate Emily Brewer, "What They Are Saying: Governor Glenn Youngkin Announces Transformational Behavioral Health Plan," Office of the Governor, December 16, 2022

66 Jennifer Faison, Executive Director, Virginia Association of Community Service Boards, "What They Are Saying: Governor Glenn Youngkin Announces Transformational Behavioral Health Plan," Office of the Governor, December 16, 2022

67 John Jones, Executive Director of the Virginia Sheriffs Association, "What They Are Saying: Governor Glenn Youngkin Announces Transformational Behavioral Health Plan," Office of the Governor, December 16, 2022

# Appendix

## Appendix A: Stakeholders engaged November-December 2022




The Office of the Secretary of Health and Human Resources facilitated ~40 regional stakeholder meetings between September 28, 2022, and December 2, 2022, with the following stakeholder groups:

- Behavioral Health Commission
- BHDS Board
- Board of Supervisors (Central)
- Board of Supervisors (Eastern)
- Board of Supervisors (Northern)
- Board of Supervisors (Western)
- Board of Supervisors Meeting (Southwestern)
- Central Virginia Health Services
- Chesterfield County Sheriffs
- Chesterfield Safe / Virginia Foundation for Healthy Youth
- Crossroads of Abingdon
- DBHDS Central Office Staff
- DBHDS State Facility Directors
- Endependence Center Inc.
- Hanover County Public Schools Counseling Services
- Highland Community Services
- Mental Health America Virginia
- Montgomery County Sheriffs
- National Alliance for Mental Illness – Virginia
- Opioid Abatement Authority
- The Arc of Virginia (Central)
- The Arc of Virginia (Northern)
- The Arc of Virginia (Tidewater)
- The Arc of Virginia (West)

- Virginia Association of Community Service Boards Conference
- Virginia Assn Community Based Providers
- Virginia Assn Health Plans
- Virginia Department for the Deaf and Hard of Hearing
- Virginia Foundation for Healthy Youth
- Virginia Hospital and Healthcare Association (Staff)
- Virginia Hospital and Healthcare Association (Steering Committee and other Members)
- Virginia Municipal League
- Virginia Network of Private Providers
- Virginia Municipal League - Mayors, City Managers (Central)
- Virginia Municipal League - Mayors, City Managers (Eastern)
- Virginia Municipal League - Mayors, City Managers (Western)
- VOCAL Virginia
- Warren County Community Health Coalition
- Warren High School

# Appendix B: Summary of key crisis care system components (based on SAMHSA National Guidelines for Behavioral Health Crisis Care)

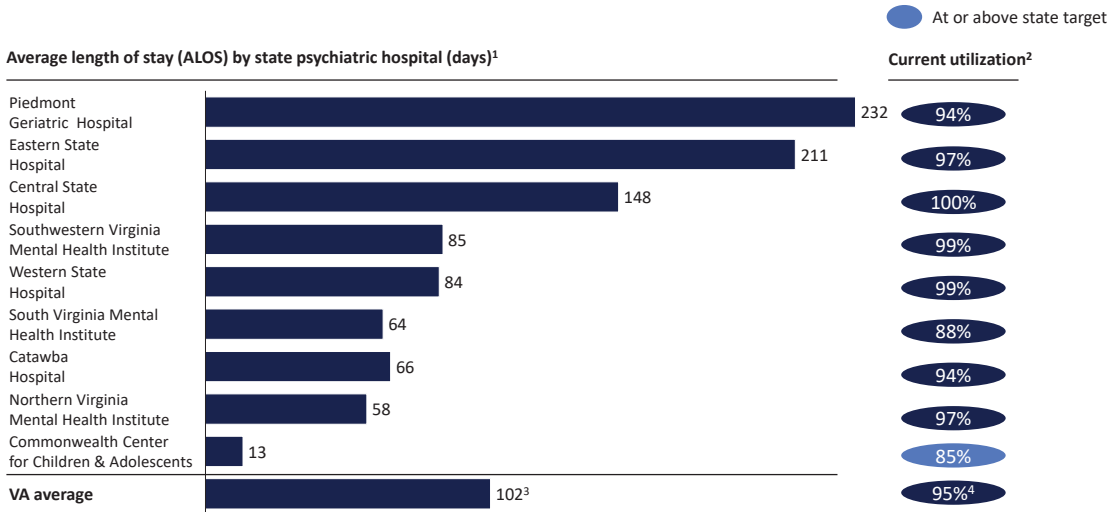
There are several core elements of a crisis care system (based on SAMHSA National Guidelines for Behavioral Health Crisis Care)

| Crisis care system components  | Virginia's current crisis care system   |
|--|---|
|  <p><b>Regional crisis call centers -- 988</b><br/> <b>"Someone to talk to"</b><br/>                     Real-time access to a live person every moment of every day for individuals in crisis</p>  | <p><b>2 regional crisis call centers</b></p> <ul style="list-style-type: none"> <li>• PRS-operated in Oakton, VA covers 4 regions</li> <li>• Frontier Health-operated in Johnson City, TN covers 1 region (southwest VA)</li> </ul>                     |
|  <p><b>Mobile crisis teams</b><br/> <b>"Someone to respond"</b><br/>                     Community-based intervention to individuals in need wherever they are; including at home, work, or anywhere else in the community</p>  | <p><b>90 mobile crisis teams</b></p> <ul style="list-style-type: none"> <li>• 36 mobile crisis team units funded and staffed</li> <li>• 54 additional units in-flight</li> </ul>  |
|  <p><b>Crisis receiving and stabilization facilities (e.g., crisis receiving chairs, short-term crisis beds)</b><br/> <b>"A place to go"</b><br/>                     No-wrong-door access to mental health and substance use care (e.g., accepts all walk-ins, police drop-offs)</p> | <p><b>170+ crisis receiving chairs</b><br/> <b>236 short-term crisis beds</b><br/>                     Provided by 17 CSBs with crisis stabilization services (2 for children only) and 25+ regional hub MOUs provide crisis stabilization services</p> |

Sources: SAMHSA, DBHDS data

# Appendix C: Average Length of Stay (ALOS) across state psychiatric hospitals, 2022

Average length of stay varies across state hospitals and utilization rates are above target levels



1. State psychiatric hospitals can serve different populations; Source: DBHDS data  
 2. Cross-sectional data from April 5, 2022; Source: DBHDS data  
 3. Weighted ALOS across 9 facilities  
 4. Average utilization across 9 facilities