

Report to the Governor and the General Assembly of Virginia

CSB Behavioral Health Services

2022



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Contents

Summary	i
Recommendations	ix
Chapters	
1. Virginia’s Community Services Boards System	1
2. Behavioral Health Trends and CSB Outcomes	13
3. Staffing for CSB Behavioral Health Services	25
4. Emergency and Discharge Planning Services	39
5. Medicaid Funding for CSB Behavioral Health Services	59
6. State Oversight of CSB Performance	69
Appendixes	
A: Study resolution	81
B: Research activities and methods	82
C: Agency response	92
D: Community-based behavioral health service delivery system structures and approaches to service delivery	96
E: CSB behavioral health crisis facilities and services	104
F: CSB behavioral health service locations	110
G: CSB service definitions	118

Summary: CSB Behavioral Health Services

WHAT WE FOUND

Fundamental restructuring of CSB system is not needed

CSBs face numerous challenges to providing behavioral health services to their communities, including staff shortages, a growing demand for more intensive services, and an increasing administrative workload, which detracts from direct consumer care. Despite these challenges, it was clear in conducting the research for this study that CSB leaders and their staff are highly committed to effectively serving Virginians and fulfilling their role as the primary provider of behavioral health services to individuals with the most significant and urgent behavioral health needs. There is no compelling evidence that adopting an entirely different structure for community-based behavioral health service delivery would result in an inherently more efficient and effective system for Virginia; nor is there evidence that another structure is fundamentally superior to Virginia's. However, improvements should be made in the current CSB system to ensure that it functions as efficiently and effectively as possible and that CSBs are held accountable for their performance. These changes would not hinder implementation of executive branch officials' vision for the delivery and funding of behavioral health care in Virginia, but would instead better enable future system improvements.

CSBs are serving an increasing number of Virginians with serious mental illness

In Virginia and nationally, the number of individuals with a mental illness is increasing, particularly serious mental illness. CSBs' priority consumers for mental health services are those with a *serious* mental illness, and CSBs served 20 percent more consumers with a serious mental illness in FY22 than compared with a decade ago. Meeting the needs of consumers with a serious mental illness requires CSBs to provide more services per individual and more intensive services. CSBs play a larger role in the provision of services to individuals with a serious mental illness in rural areas where there are often fewer private providers of mental health services.

WHY WE DID THIS STUDY

In December 2021, the Joint Legislative Audit and Review Commission (JLARC) directed staff to conduct a review of Virginia's community services boards (CSBs). JLARC staff were directed to review CSB behavioral health funding, staffing, and outcomes as well as CSB services for individuals experiencing behavioral health emergencies. Staff were also directed to review the structure of the CSB system to identify any possible opportunities to strengthen the effectiveness and efficiency of service delivery.

ABOUT CSBs

Virginia's CSB system is the state's primary approach to providing publicly funded behavioral health services in local communities. These services include mental health and substance abuse services. CSBs provide both emergency and non-emergency behavioral health services to individuals. They are designated as the "single point of entry" into Virginia's publicly funded system of behavioral health services. State law requires every city or county to establish or join a community services board. Virginia currently has 40 CSBs, each serving between one and 10 localities. Across the 40 boards, behavioral health services are delivered at over 500 offices, with each CSB operating between two and 34 service locations.

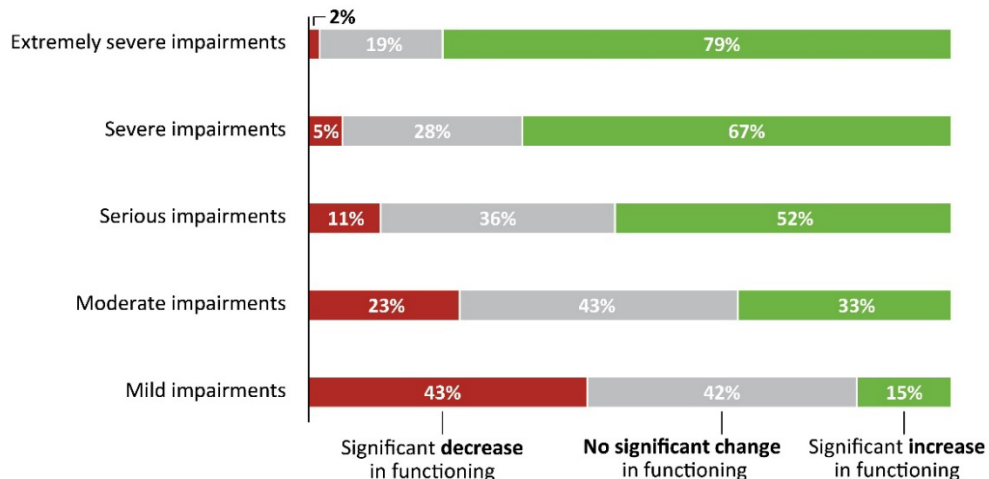
Virginians with significant impairments due to mental illness tend to improve their functioning while receiving CSB services

The majority of CSB consumers who are severely affected by their mental illness generally experienced significant improvements after receiving CSB services. These consumers are the most likely to require inpatient psychiatric hospitalization if they do not receive adequate treatment and are the priority population for CSB services.

Forty-one percent of consumers experienced declines in functioning while receiving CSB services. These consumers typically had higher levels of functioning when they began receiving CSB services despite their mental illness. The reasons for their declines in functioning are unknown, but the Department of Behavioral Health and Developmental Services (DBHDS) should examine why these declines are happening and what improvements to CSB services could be made to help these consumers.

Majority of CSB consumers with most impaired functioning improved while receiving CSB services (FY19–FY22)

After at least six months, proportion of CSB consumers in each functioning group experiencing...



SOURCE: JLARC analysis of DLA-20 data maintained in DBHDS's CCS3 system, FYs 2019–2022.

NOTE: A significant change in functioning is a score change ± 0.4 points. Figure excludes about 6% of CSB consumers who had no significant impairments when their first DLA-20 assessment was completed.

CSBs struggle to hire and retain staff, especially for emergency and crisis services, and turnover among CSB staff is high and increasing

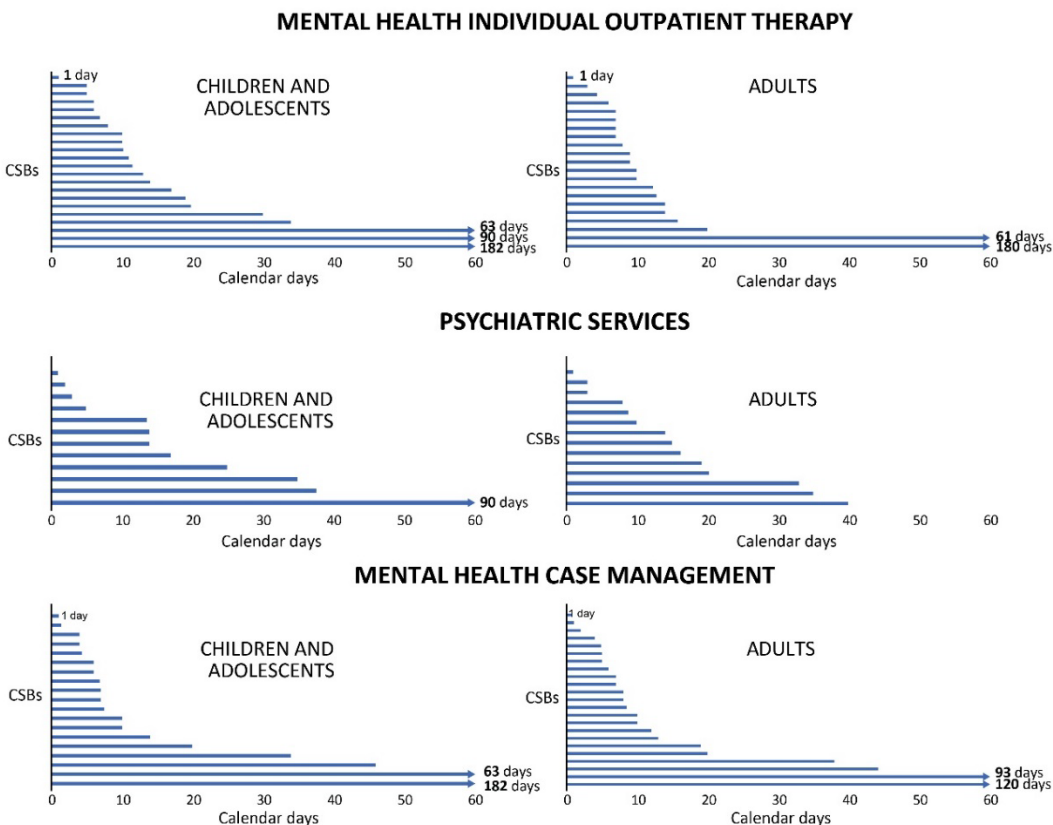
CSBs need sufficient numbers of qualified staff to provide timely and effective behavioral health services, to meet state requirements, and to implement statewide initiatives like STEP-VA and the development of the crisis services continuum. However, most of the 40 CSB directors reported having experienced difficulty hiring and retaining qualified staff to deliver behavioral health services over the past 12 months. Directors experienced the greatest challenges hiring and retaining emergency services staff, followed by crisis services staff. Both of these types of staff deliver core CSB services.

One-third of surveyed emergency services staff reported that they are considering leaving their jobs in the next 12 months. In addition, the average turnover rate among the 23 CSBs for which data was available increased from 15 percent in FY13 to nearly 27 percent in FY22, and vacancy rates average more than 20 percent among direct care staff.

Staffing challenges are affecting consumers, key CSB partners, and state initiatives. Staffing shortages are contributing to long wait times for behavioral health services at some CSBs. Self-reported data from the CSBs indicates particularly long waits for psychiatric services and mental health outpatient therapy, especially for children and adolescents, and outpatient therapy for substance use disorders. In addition, because of CSBs' staffing challenges, only four of the 40 CSBs reported typically being able to conduct "same day assessments" for all consumers on the same day they are sought. Nine CSBs reported that they were typically able to conduct same day assessments for only half or fewer of the consumers who sought one.

Some CSBs reported particularly long waits for mental health outpatient therapy and psychiatric services, especially for children and adolescents (Consumers referred to services in June 2022)

Average wait between referral for service and first offered appointment (June 2022)



SOURCE: Responses to JLARC staff data request to CSBs, September 2022.

NOTE: Figure includes only those CSBs that maintain wait times information for these services and responded to the data request.

Compensation and administrative burdens are key reasons CSBs are having trouble recruiting and maintaining staff. CSBs must increasingly compete with the private sector for behavioral health staff, and data shows that comparable jobs at other behavioral health establishments pay higher salaries and require less administrative work. Licensed clinical social workers and licensed professional counselors at a majority of CSBs are paid salaries at least 10 percent less than the same types of professionals working for other behavioral health employers in Virginia, according to March 2022 data. Most CSB executive directors reported that compensation was one of the top three factors that made it difficult for their CSB to *recruit and hire* qualified staff for behavioral health services. The most commonly reported reason that CSB directors gave for staff *turn-over* was “burdensome administrative requirements,” and CSB staff most commonly recommended reducing administrative burdens on direct care staff as a solution to staffing challenges. CSB direct care staff generally report spending (1) less time with patients and (2) more time on administrative tasks than the same types of professionals working for other behavioral health employers in Virginia.

CSBs recommend state hospital admissions for some individuals who do not need that level or type of care and do not consistently fulfill their discharge planning responsibilities

State psychiatric hospital admissions increased 68 percent between FY12 and FY21, and state hospitals have been operating at or near capacity with waitlists. An increase in civil temporary detention order (TDO) admissions to state psychiatric hospitals has been a major factor contributing to the increase in state hospital admissions. CSB emergency services staff, called “preadmission screening clinicians,” are responsible for determining whether an individual—who has been placed under an emergency custody order by a magistrate or law enforcement officer—meets the criteria to be placed under a TDO. These CSB staff are also responsible for finding a placement for the person to receive treatment while under a TDO.

Some of the pressure on state hospitals’ capacity may be relieved by providing CSBs with better and more frequent training to ensure that they make appropriate TDO and state hospital placement recommendations. Wide variation in TDO rates across CSBs indicates inconsistencies in preadmission screening practices and recommendations. In FY21, the proportion of CSB evaluations that resulted in a TDO ranged from 11 to 71 percent across CSBs. Additionally, state hospital staff indicated that many individuals under TDOs who were admitted to their facilities did not require the level or type of care provided there. CSB preadmission screening clinicians reported that some adults and children they have recommended be placed in a psychiatric hospital could have been better served in an alternative setting if one were available.

CSBs could also help reduce pressure on state psychiatric hospital capacity by improving their efforts to safely discharge state hospital patients. Not all CSBs are consistently creating quality discharge plans for state hospital patients or doing so in a timely manner. In April 2022, 10 percent of individuals in psychiatric hospitals who had been

waiting more than seven days for their discharge were waiting on a CSB to finish certain tasks. At that time, these individuals had remained in the hospital an average of 79 days after they were determined to be eligible for discharge.

State’s psychiatric bed registry wastes limited time and staff resources

CSB staff need to be able to locate a TDO placement for individuals efficiently, because they have limited time to identify the most appropriate placement. If an appropriate placement cannot be found in a timely manner and no state psychiatric hospital beds are available (sidebar), the individual may either be released from custody without being placed under a TDO or spend their TDO in a hospital emergency room. In either scenario, the individual may not receive the behavioral health services they need.

The state’s psychiatric bed registry is intended to make CSBs’ search for a psychiatric hospital bed efficient, but it lacks real-time, useful information about the psychiatric beds available. Ninety-two percent of surveyed CSB staff with bed search responsibilities indicated that the bed registry was either not at all useful or not being used as part of their bed search process. A JLARC staff review of the DBHDS bed registry in June 2022 showed that 13 of the 25 facilities listed had not updated their availability in at least two days, and some had not updated their availability in months.

Expanding residential crisis stabilization units would help reduce inappropriate psychiatric hospital placements and help with patient discharge

Residential crisis stabilization units (RCSUs) are a type of treatment facility, usually managed and staffed by CSBs, where individuals in crisis may stay temporarily to receive behavioral health services to help stabilize their condition. CSB executive directors and preadmission screening clinicians reported that additional RCSU beds would help avoid the need to place some individuals in state psychiatric hospitals. RCSUs would more directly help alleviate state psychiatric hospital admission pressures than other types of crisis services, such as mobile crisis services and 23-hour crisis stabilization services, because they can be equipped to treat individuals under a TDO. They can also provide an appropriate placement for individuals who are released from a state psychiatric hospital but who need additional residential treatment.

There are only three RCSUs for children and adolescents in Virginia, which operate only 25 beds in total. Additionally, not all licensed beds for adults are staffed because of CSBs’ current recruitment and retention challenges, and a large portion of Southside Virginia’s population does not have an adult RCSU within a one-hour drive. CSBs that serve these areas have state psychiatric hospital admission rates significantly higher than the statewide rate. Additional state resources could be devoted to fully staffing the state’s existing RCSUs and to developing additional RCSUs, particularly for children and adolescents and in underserved areas of the state.

CSBs' Medicaid funding has declined; some CSBs are not consistently billing Medicaid or receiving reimbursements from MCOs

Total behavioral health funding for the CSB system increased from \$941 million to \$1.09 billion (16 percent) adjusted for inflation, between FY12 and FY22, and additional non-Medicaid state general funds and local funding drove most of this growth. In contrast, even though the proportion of CSB consumers covered by Medicaid has increased, Medicaid funding for CSB behavioral health services has decreased 15 percent over the past decade. A majority of CSBs received less Medicaid funding in FY22 than in FY12. This trend is concerning because Medicaid reimbursements account for about 20 percent of all CSB funding.

Maximizing Medicaid reimbursement helps ensure non-Medicaid state general funds and local funds are used most efficiently, but CSBs are not receiving as much Medicaid funding as they could be. Some CSBs are reportedly not billing Medicaid because of the complexity of billing procedures or requirements for reimbursement, and they are reportedly using state general funds to cover costs of serving Medicaid enrollees. CSBs are also reportedly not receiving timely and accurate Medicaid payments.

CSBs attribute billing and reimbursement issues to the increased complexity of the claiming and billing process associated with integrating behavioral health services into Medicaid managed care contracts (MCOs), which requires more staff time and makes it difficult to collect Medicaid reimbursements in a timely manner. Commonly reported concerns include duplicative training requirements; delays in approving providers to bill for services; differences in authorization and billing processes and requirements across MCOs; frequent changes to MCO billing systems; and increased rates of reimbursement denials by MCOs.

State does not adequately oversee performance of CSBs

JLARC reports, legislative commissions, and studies from subject-matter experts have concluded that Virginia's CSB system has not been held accountable for delivering high quality services that produce positive outcomes for consumers. Three key deficiencies prevent adequate state oversight of CSBs: the lack of an explicit, overarching purpose and goals that establish guiding expectations for the system; inadequate data systems to document and evaluate CSB consumers' outcomes and CSB operations; and insufficient state resources dedicated to overseeing, evaluating, and improving CSB performance. There has been a lack of state direction or guidance to CSBs regarding the performance of their behavioral health service responsibilities and no meaningful effort to ensure that their responsibilities are fulfilled.

DBHDS should devote more attention to designing effective performance measures for key CSB responsibilities and collecting relevant performance information from CSBs. This improved insight will allow the agency, other executive branch stakeholders, the General Assembly, and local governments that establish and help fund the CSBs to better understand how CSBs are performing and what steps can be taken to

improve performance. DBHDS has no formal processes or data to understand critical aspects of CSBs' service delivery and consumer outcomes, such as preadmission screening or discharge planning. No DBHDS staff have been dedicated to monitoring the quality of behavioral health services at CSBs. The performance contracts themselves are insufficient to allow the state to assess CSB performance, provide targeted technical assistance, or hold CSBs' accountable for fulfilling their behavioral health services responsibilities. State law provides DBHDS with mechanisms to hold CSBs accountable for meeting performance expectations, but, in practice, DBHDS rarely uses them. This is at least partially because the agency lacks good information on CSB performance.

WHAT WE RECOMMEND

Legislative action

- Require DBHDS to report annually to the State Board of Behavioral Health and Developmental Services and the Behavioral Health Commission on CSBs' performance in improving the functioning of consumers receiving behavioral health services.
- Appropriate funding for salary increases for all CSB direct care staff.
- Direct DBHDS to eliminate documenting and reporting requirements for CSBs that are not essential to ensuring that CSB consumers receive effective and timely services.
- Direct DBHDS to review a sample of CSB preadmission screenings for quality on an ongoing basis and to contract with higher education institutions to deliver training on preadmission screening and provide technical assistance to CSB staff.
- Repeal the requirement in §37.2-308.1 of the Code of Virginia that every state facility, community services board, behavioral health authority, and private in-patient provider licensed by DBHDS participate in the acute psychiatric bed registry.
- Appropriate funding to support the development and operations of additional residential crisis stabilization facilities in underserved areas of the state and for children and youth.
- Direct DBHDS and DMAS to ensure that CSBs are billing for all Medicaid-eligible CSB services.
- Direct DMAS to work with the six Medicaid MCOs to adopt standard requirements and procedures for billing and reimbursement.
- Amend the Code of Virginia to clearly articulate the purpose of CSB behavioral health services and require DBHDS to develop clear goals and objectives

for CSBs that align with and advance those purposes and include them in CSBs' performance contracts.

- Direct DBHDS to develop clear and comprehensive requirements and processes for monitoring CSBs' performance and to report CSB-level performance information to each local CSB governing board, the Behavioral Health Commission, and the State Board of Behavioral Health and Developmental Services.
- Direct DBHDS to regularly monitor CSB compliance in meeting performance contract requirements and use available enforcement mechanisms, as necessary, to ensure CSB are in substantial compliance with these requirements.

Executive action

- DBHDS to contract as soon as practicable with a vendor to implement a secure online portal for CSBs to upload and share patient documents with inpatient psychiatric facilities to help find an inpatient placement for consumers who are under a TDO.
- DBHDS to oversee CSBs' discharge planning efforts and develop mechanisms for corrective action, technical assistance, and guidance to use with noncompliant or underperforming CSBs.
- DBHDS to complete a comprehensive review of all CSB performance contracts and revise all performance measures to include measurable goals, benchmarks, and specific monitoring activities to hold CSBs accountable for performance.
- DBHDS to provide status updates on its initiative to improve the exchange of consumer and service data between CSBs and DBHDS to the Behavioral Health Commission and the State Board of Behavioral Health and Developmental Services at least every three months until the project is complete.

The complete list of recommendations is available on page ix.

Recommendations: CSB Behavioral Health Services

RECOMMENDATION 1

The Department of Behavioral Health and Developmental Services should develop a process for receiving DLA-20 composite and individual item scores from all community services boards (CSBs) at least quarterly, and this process should use data in CSB electronic health records systems and not require separate data entry by CSB direct care staff. (Chapter 2)

RECOMMENDATION 2

The General Assembly may wish to consider including language in the Appropriation Act requiring the Department of Behavioral Health and Developmental Services (DBHDS) to report annually on (i) community service board (CSB) performance in improving the functioning levels of its consumers based on composite and individual item scores from the DLA-20 assessment, or results from another comparable assessment, by CSB, (ii) changes in CSB performance in improving consumer functioning levels over time, by CSB, and (iii) the use of functional assessment data by DBHDS to improve CSB performance to the State Board of Behavioral Health and Developmental Services and the Behavioral Health Commission. (Chapter 2)

RECOMMENDATION 3

The General Assembly may wish to consider including funding in the Appropriation Act to fund a salary increase for direct care staff at community services boards. (Chapter 3)

RECOMMENDATION 4

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Behavioral Health and Developmental Services to report annually to the State Board of Behavioral Health and Developmental Services and the Behavioral Health Commission on average salaries, turnover, and vacancy rates, by position type, across community services boards. (Chapter 3)

RECOMMENDATION 5

The General Assembly may wish to include language in the Appropriation Act directing the Department of Behavioral Health and Developmental Services (DBHDS) to amend community services board (CSB) performance contracts to require that (i) any funding appropriated by the General Assembly to CSBs for staff compensation only be used for staff compensation and (ii) CSBs report annually on any staff compensation actions taken during the prior fiscal year to DBHDS. (Chapter 3)

RECOMMENDATION 6

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Behavioral Health and Developmental Services (DBHDS) to (i) identify all current DBHDS requirements related to documentation and reporting of community services board (CSB) behavioral health services; (ii) identify which of these requirements currently apply to work by CSB direct care staff; (iii) identify any DBHDS requirements of direct care staff that are duplicative of or conflict with other DBHDS requirements; (iv) eliminate any requirements that are not essential to ensuring consumers receive effective and timely services or are duplicative or conflicting; and (v) report to the State Board of Behavioral Health and Developmental Services and the Behavioral Health Commission on progress made toward eliminating administrative requirements that are not essential, are duplicative, or are conflicting. (Chapter 3)

RECOMMENDATION 7

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Behavioral Health and Developmental Services (DBHDS) to contract with one or more higher education institutions to establish training and technical assistance centers to (i) deliver standardized training for preadmission screening clinicians on developing appropriate preadmission screening recommendations (including those related to the temporary detention of individuals and admission to psychiatric hospitals), interpreting lab results, and understanding basic medical conditions and (ii) provide technical assistance to preadmission screening clinicians, particularly when quality improvement is deemed necessary by DBHDS. (Chapter 4)

RECOMMENDATION 8

The Department of Behavioral Health and Developmental Services should develop and implement (i) a comprehensive and structured process to review a sample of preadmission screening forms from each community services board on an ongoing basis to ensure sufficient information is collected during preadmission screenings and that the resulting recommendations, including those related to the temporary detention of individuals and admission to psychiatric hospitals, are well supported; and (ii) an actionable quality improvement process to address identified shortcomings with CSB preadmission screenings and recommendations. (Chapter 4)

RECOMMENDATION 9

The General Assembly may wish to consider including funding in the Appropriation Act for the Department of Behavioral Health and Developmental Services to help community services boards hire additional staff for residential crisis stabilization units whose bed capacity is not fully utilized because of a lack of staff. (Chapter 4)

RECOMMENDATION 10

The General Assembly may wish to consider including language and funding in the Appropriation Act to support the development and ongoing operations of additional residential crisis stabilization units for children and adolescents, the Southside area, and any other underserved areas of the state, and to direct that the Department of Behavioral Health and Developmental Services provide detailed information on the following before such funding is provided for a new unit to ensure the most strategic deployment of limited resources: (i) the unmet needs the new unit will address, (ii) the capacity of community service boards or private providers to staff the proposed unit, (iii) the unit's ability to serve individuals under a temporary detention order, (iv) expected initial and ongoing costs of the proposed unit, and (v) the planned timeframe for when the unit would become operational. (Chapter 4)

RECOMMENDATION 11

The Department of Behavioral Health and Developmental Services (DBHDS) should contract as soon as practicable with a vendor to implement a secure online portal, which is compliant with the Health Insurance Portability and Accountability Act (HIPAA), for community services boards to upload and share patient documents with inpatient psychiatric facilities. (Chapter 4)

RECOMMENDATION 12

The General Assembly may wish to consider amending §37.2-308.1 of the Code of Virginia to repeal the requirement that every state facility, community services board, behavioral health authority, and private inpatient provider licensed by the Department of Behavioral Health and Developmental Services participate in the acute psychiatric bed registry. (Chapter 4)

RECOMMENDATION 13

The Department of Behavioral Health and Developmental Services (DBHDS) should develop and implement (i) a comprehensive and structured process to oversee the practices of community services boards (CSBs) related to discharge planning from psychiatric hospitals, particularly compliance with and effectiveness of their discharge planning responsibilities, and (ii) mechanisms for corrective action, technical assistance, and guidance when shortcomings are identified with CSBs' discharge planning efforts. (Chapter 4)

RECOMMENDATION 14

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Behavioral Health and Developmental Services to work with the Department of Medical Assistance Services to (i) develop and implement a targeted review process to assess the extent to which community services boards (CSBs) are billing for Medicaid-eligible services they provide, (ii) provide technical assistance and training, in coordination with Medicaid managed care organizations, on appropriate Medicaid billing and claiming practices to relevant CSB staff, and (iii) report the results of these targeted reviews, and any technical assistance or training provided in response, to the House Appropriations and Senate Finance and Appropriations committees no later than December 1, 2023, and annually thereafter. (Chapter 5)

RECOMMENDATION 15

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services to (i) work with the managed care organizations (MCOs) to standardize, to the maximum extent practicable, policies, procedures, and requirements that CSBs must follow to receive reimbursement for the cost of Medicaid services they provide, including documentation, training, and credentialing requirements; and (ii) report on the improvements made to MCO policies, procedures, and requirements to the Behavioral Health Commission no later than December 1, 2023. (Chapter 5)

RECOMMENDATION 16

The Department of Medical Assistance Services should work with managed care organizations (MCOs) to ensure that comprehensive information about all available MCO preferred provider programs is provided to all community services boards (CSBs), including (i) which behavioral health services are included in the preferred provider programs and (ii) the requirements CSBs must meet to participate in the programs. (Chapter 5)

RECOMMENDATION 17

The General Assembly may wish to consider amending §37.2 of the Code of Virginia to (i) clearly articulate the purpose of community services boards (CSBs) services within the state's system of community-based behavioral health services and (ii) require the Department of Behavioral Health and Developmental Services to develop clear goals and objectives for CSBs that align with and advance the articulated purpose and include them in the performance contracts. (Chapter 6)

RECOMMENDATION 18

The Department of Behavioral Health and Developmental Services (DBHDS) should complete a comprehensive review of the performance contracts with community services boards and revise all performance measures in the base performance contracts and addendums to ensure that, at a minimum, (i) the performance measures are designed to measure relevant consumer experiences and outcomes; (ii) each performance measure includes a relevant benchmark, and (iii) DBHDS has given clear direction on how it will monitor performance and enforce compliance with performance requirements. DBHDS should complete the contract revisions and report on the improvements made to the Behavioral Health Commission by December 1, 2023, and implement changes before the finalization of the fiscal year 2025 performance contracts. (Chapter 6)

RECOMMENDATION 19

The Department of Behavioral Health and Developmental Services, in consultation with the Virginia Information Technologies Agency, should provide status updates on the data exchange initiative to the Behavioral Health Commission and State Board of Behavioral Health and Developmental Services at least every three months until the project is complete. These reports should report on project status, funding, risks that could prevent the project from being completed on time and on budget, and plans to mitigate those risks. (Chapter 6)

RECOMMENDATION 20

The General Assembly may wish to include language in the Appropriation Act directing the Department of Behavioral Health and Developmental Services (DBHDS) to develop and implement clear and comprehensive requirements and processes for monitoring community services boards' (CSBs) performance with respect to the provision of behavioral health services. At a minimum, DBHDS's monitoring requirements and processes should (i) evaluate CSB performance on key consumer outcome measures, including measures of functional impairments, and compliance with performance contract requirements on an ongoing basis; (ii) use existing data and information it collects to analyze performance of CSBs and facilitate needed improvements; (iii) integrate the monitoring efforts and reporting requirements across all offices involved in CSB funding and oversight; (iv) establish a process for communicating the results of performance monitoring to CSBs; (v) develop expectations for the content and outcomes of quality improvement plans; and (vi) clearly articulate the enforcement mechanisms that will be used to address substantial underperformance or non-compliance. (Chapter 6)

RECOMMENDATION 21

The General Assembly may wish to consider amending § 37.2-508 of the Code of Virginia to require the Department of Behavioral Health and Developmental Services to (i) regularly monitor community services boards' (CSB) compliance in meeting performance contract requirements; and (ii) use available enforcement mechanisms, as necessary, to ensure CSBs are in substantial compliance with the requirements established in their performance contracts. (Chapter 6)

RECOMMENDATION 22

The General Assembly may wish to include language in the Appropriation Act directing the Department of Behavioral Health and Developmental Services (DBHDS) to report community services board (CSB)-level performance information, including any substantial underperformance or non-compliance and associated enforcement actions, annually to (1) each CSB governing board, (2) the Behavioral Health Commission, and (3) the State Board of Behavioral Health and Developmental Services. (Chapter 6)

1 Virginia's Community Services Boards System

In December 2021, the Joint Legislative Audit and Review Commission (JLARC) directed its staff to review Virginia's community services boards (CSB) system. JLARC staff were directed to review CSB behavioral health funding, staffing, and outcomes as well as CSB services for individuals experiencing behavioral health emergencies. Staff were also directed to review the structure of the CSB system to identify any possible opportunities to strengthen the effectiveness and efficiency of service delivery. (See Appendix A for the study resolution.)

To address the study mandate, JLARC staff used a variety of methods, including data analysis, site visits, interviews, surveys, and reviews of other states' system structures. JLARC staff analyzed data on CSB consumers, services, funding, staffing, and outcomes, and data on the prevalence of behavioral health conditions in Virginia. JLARC staff interviewed CSB staff; staff from the Department of Behavioral Health and Developmental Services (DBHDS), state psychiatric hospitals, and other relevant state agencies; state and national subject-matter experts; and representatives of consumers, private providers, and other stakeholders. JLARC staff also conducted two statewide surveys and reviewed relevant documentation, including CSB performance contracts, pre-admission screenings, existing reports on the CSB system, and publications on other states' public behavioral health service systems. (See Appendix B for a detailed description of research methods.)

CSBs are the public provider of community-based behavioral health services

Virginia's CSB system is the state's primary mechanism for providing publicly funded behavioral health services in local communities (sidebar). CSBs provide both emergency and non-emergency behavioral health services to individuals. They are designated as the "single point of entry" into Virginia's publicly funded system of behavioral health services.

CSBs provide behavioral health services to help individuals with serious behavioral health conditions remain in their communities

Generally, CSBs exist to help individuals with serious behavioral health conditions, including individuals in crisis, remain in the community to the maximum extent possible and to prevent the need for in-patient psychiatric hospitalization (sidebar). CSBs are primarily intended to serve (1) individuals experiencing severe functional impair-

The term "community services board" most commonly refers to the entity that provides or facilitates the provision of behavioral health services, rather than the actual board of directors for the community services board. In this report, "CSB" or "community services board" refers to the entity providing the service, not the board, unless otherwise specified.

The term "behavioral health services" refers to mental health and substance abuse services.

CSBs also provide services to individuals with developmental disabilities to help them increase their independence. The focus of this report is on CSBs' behavioral health services.

ments due to a mental illness or substance use disorder and (2) individuals whose behavioral health condition presents an imminent risk to their own safety or the safety of others.

CSB emergency and crisis services are intended to provide assessments and short-term treatment for individuals at risk of placement in an in-patient psychiatric facility, including a state psychiatric hospital. CSBs are required by state law to conduct pre-admission screenings of individuals who may be a threat to themselves or others because of their behavioral health condition. An individual must receive a pre-admission screening through a CSB before they can be placed at one of Virginia's nine state psychiatric hospitals. State law also requires CSBs to facilitate the discharge of individuals from state psychiatric hospitals through discharge planning. (See Chapter 4 for more discussion on CSBs' emergency services and discharge planning.)

CSBs provide crisis services on a short-term basis to help stabilize individuals experiencing behavioral health emergencies and reduce the need for hospitalization. They operate crisis services directly, on a regional basis in partnership with other CSBs, or through a contract with a private provider. (See Chapter 4 and Appendix E for more discussion on CSB crisis services.)

CSBs also provide non-emergency assessment, treatment, and monitoring services for individuals with a mental illness or substance use disorder that significantly impairs their functioning. Since 2019, state law has required CSBs to provide "same-day mental health screening services" to individuals who request these services. Additionally, CSBs provide outpatient mental health and substance abuse treatment to individuals with significant functional impairments, and these services may be provided directly by CSB staff or by private providers. The three CSB behavioral health services with the highest number of consumers in FY22—medical services, outpatient services, and case management—were all non-emergency services (Figure 1-1). (See Chapter 2 for more discussion on trends in functional impairments among CSB consumers and preliminary data on outcomes of non-emergency CSB services. See Appendix G for service definitions.)

The 2017 General Assembly passed the System Transformation Excellence and Performance (STEP-VA) initiative to ensure all CSBs provide access to certain community-based behavioral health services. STEP-VA includes nine core services: same-day assessments, primary care screenings, outpatient services, crisis services, peer and family support, psychiatric rehabilitation, veterans' services, case management, and care coordination.

Historically, CSBs have had discretion to provide the services they think are most needed in their communities (Figure 1-2). Prior to 2017, CSBs were only required to provide emergency services, and, subject to available funding, case management. In 2017, the legislature required CSBs to provide nine additional services, for which the General Assembly has provided specific funding (sidebar).

CSBs are only one provider in Virginia's publicly funded behavioral health system, which is increasingly reliant on private providers. Eighty-two percent of Medicaid payments for behavioral health services went to private providers in FY21. CSBs also contract with private providers to deliver several types of behavioral health services. (See Appendix D for more information on private providers and their role in the CSB system.)

FIGURE 1-1

CSBs’ most used behavioral health services in FY22 were medical services, outpatient services, case management, and emergency and crisis services

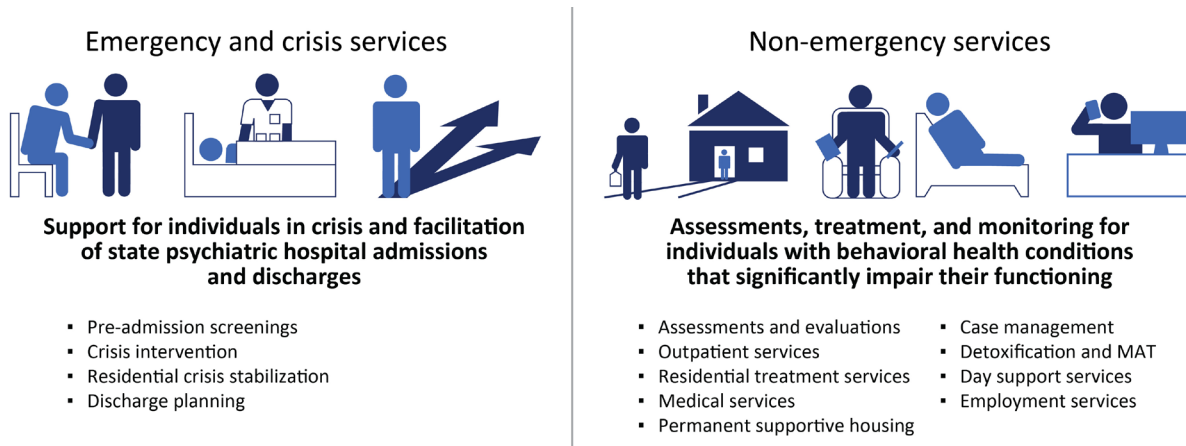


SOURCE: JLARC analysis of DBHDS FY22 CCS3 Services data.

NOTE: All other behavioral health services were provided to fewer than 5,000 consumers statewide. The total number of consumers receiving behavioral health services from CSBs is smaller than the sum of the number of consumers of each service because some consumers receive multiple services. This figure excludes behavioral health assessments and evaluations as consumer numbers for these services could not be separated from developmental disability assessments and evaluations. See Appendix G for service definitions.

FIGURE 1-2

CSBs provide various services to Virginians with a mental illness or substance use disorder



SOURCE: JLARC analysis of DBHDS FY22 CCS3 Services data.

NOTE: “MAT” = medication assisted treatment. Figure shows examples of the types of behavioral health services that CSBs offer and is not comprehensive. Some of these services (e.g., detoxification and MAT, day support services, residential treatment services, employment services, and permanent supportive housing) are not provided by all CSBs. See Appendix G for service definitions.

CSBs are local entities, and most are multi-jurisdictional

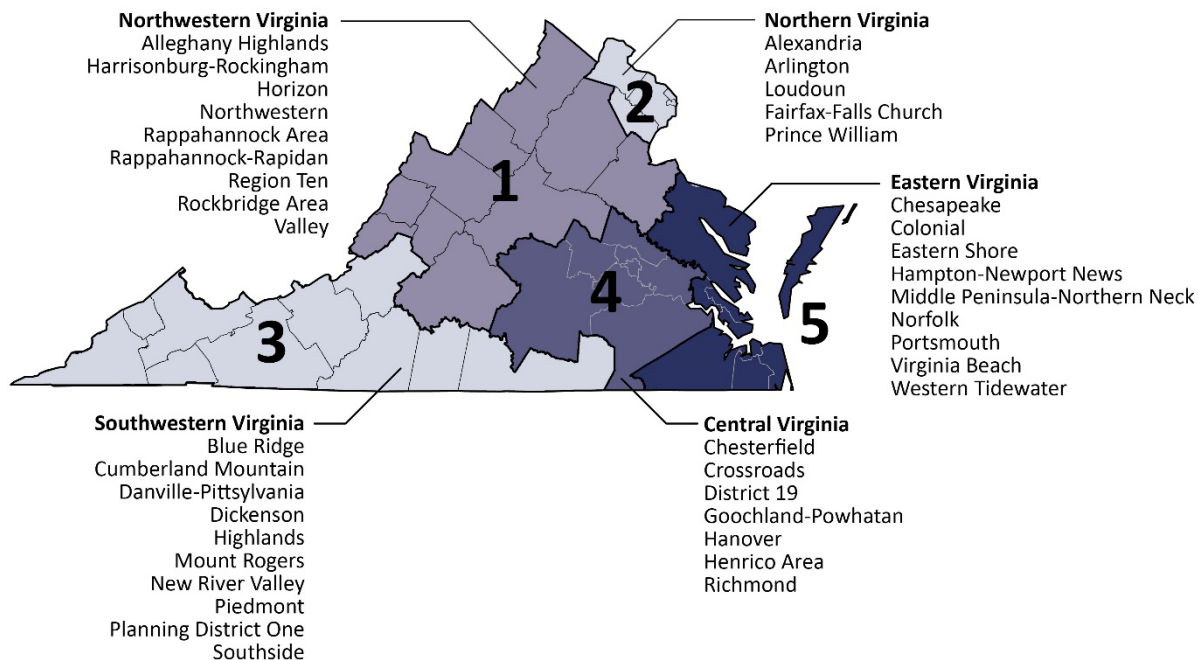
State law requires every city or county to establish or join a CSB. Virginia currently has 40 CSBs, each serving between one and 10 localities (Figure 1-3). Across the 40 boards, behavioral health services are delivered at over 500 offices, with each CSB operating between two and 34 service locations. (See Appendix F for more information on CSB service locations.)

All CSBs are agents of the local governments that established them, and many are also accountable to their appointed governing boards. Localities can make policies and regulations about their CSB’s service provision and facilities, set the size of the governing

boards, and appoint members of the governing boards and the CSB's executive director, depending on the type of board.

CSBs are grouped into five regions across Virginia to coordinate the provision of and funding for some services. All CSBs participate in at least some regional programs and services, but participation and the formality of the relationships among CSBs in each region varies substantially. (See Appendix D for more information on the structure of the CSB system and regional programs.)

FIGURE 1-3
Virginia has 40 community services boards that are separated into five regions



SOURCE: DBHDS documentation.

DBHDS is the primary state entity overseeing CSBs, but other entities also regulate and fund CSBs

CSBs are funded by and accountable to numerous entities, including their respective local governments and boards of directors, DBHDS, the Department of Medical Assistance Services (DMAS), DMAS's six managed care organizations, the Department of Health Professions, and two federal agencies.

Initially implemented in the early 1980s, performance contracts were intended to improve accountability in the CSB system.

At the state level, CSBs are primarily overseen and funded by DBHDS. DBHDS is required by state law to develop and negotiate a "performance contract" with each CSB. Through these contracts, DBHDS provides state general funds and federal funds to CSBs for the provision of mental health, developmental, and substance abuse services (sidebar).

CSBs must also follow regulations established by the State Board of Behavioral Health and Developmental Services, and DBHDS licensing staff are responsible for monitoring CSB compliance with behavioral health program and service licensing requirements. The board, which is a policy board, develops regulations and policies related to the provision of behavioral health services that CSBs, and other behavioral health service providers, must follow. State law also requires the board to review and evaluate the performance of DBHDS and CSBs in implementing its policies.

Additionally, DMAS determines the specific behavioral health services that are eligible for Medicaid reimbursement in Virginia and, as a key funder of CSB services, plays a major role in influencing CSB service delivery. DMAS contracts with six managed care organizations (MCOs) to manage health plans for Medicaid-enrolled individuals. Because each MCO operates statewide, CSBs must work with each MCO, and each MCO develops its own training, credentialing, and reimbursement policies and processes that CSBs must follow to receive reimbursement.

CSBs must also be responsive to the requirements of several other entities at the state and federal level, including the Virginia Department of Health Professions, the Substance Abuse and Mental Health Services Administration, and the Centers for Medicare and Medicaid Services.

About 165,000 Virginians received behavioral health services through CSBs in FY22

In FY22, about 210,000 Virginians received mental health, substance abuse, developmental, or other services through CSBs (sidebar). Of these individuals, around 165,000 (79 percent) received behavioral health services. The remaining 21 percent of individuals received only developmental or other services. The number of consumers receiving behavioral health services at each CSB annually varies widely, ranging from about 900 (Goochland-Powhatan) to about 11,000 (Fairfax-Falls Church) in FY22.

Over the last decade, the number of CSB consumers receiving behavioral health services increased 3 percent statewide, up from 161,000 in FY12. The number of consumers increased 7 percent between FY12 and FY19, but has declined since, which may be partially attributable to the pandemic. The growth in the number of behavioral health consumers is primarily due to an increase in consumers receiving mental health services, rather than substance abuse services, generally following trends in the prevalence of mental illness and substance use disorders in Virginia. (See Chapter 2 for more information on the prevalence of behavioral health conditions in Virginia.)

CSBs play a large and growing role in the provision of behavioral health services to consumers in rural areas

CSBs in rural areas tend to serve fewer consumers than CSBs in more urban areas, but rural CSBs play a larger (and growing) role in the provision of behavioral health services in their communities (sidebar). Rural CSBs on average provide behavioral health

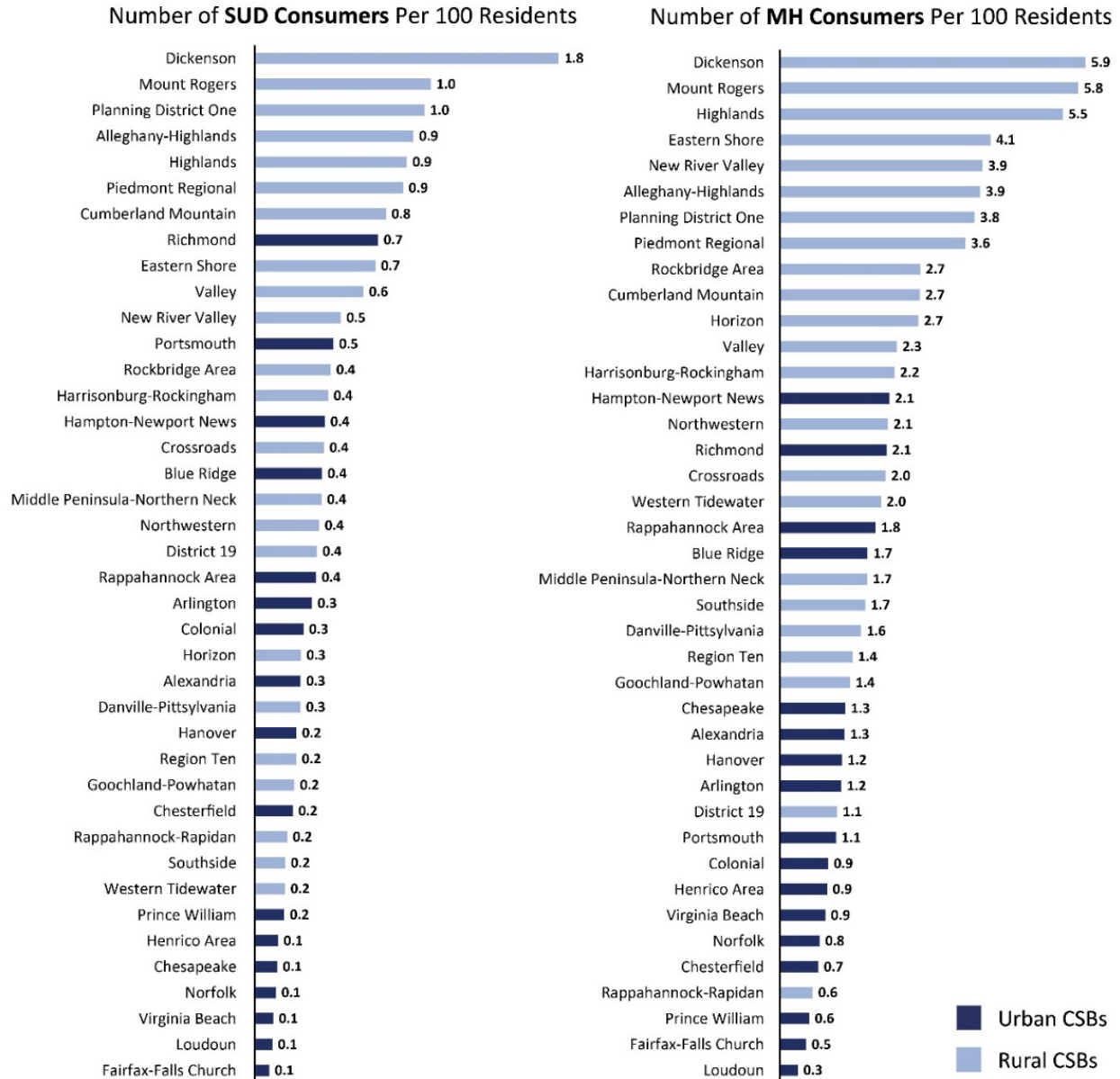
Other services include short-term or low-intensity services that do not fall within a specific treatment area, such as assessments and evaluations, motivational treatment services, consumer monitoring, and early intervention.

Rural CSBs have a population density of less than 200 people per square mile.

Urban CSBs have a population density of 200 or more people per square mile.

services to twice as many consumers annually per 100 residents in their services areas (3.6 consumers) as urban CSBs (1.8 consumers) (Figure 1-4). The relatively high utilization of CSB services in rural areas is likely due in part to a lack of available alternative providers. More densely populated areas often have more private providers.

FIGURE 1-4
Rural CSBs tended to serve a greater share of the population in their catchment areas than urban CSBs in FY22



SOURCE: JLARC analysis of DBHDS's FY22 CCS3 Consumer and Services data and DBHDS's 2020 Overview of Community Services in Virginia.

NOTE: "MH Consumers" = Consumers receiving mental health services. "SUD Consumers" = Consumers receiving substance abuse services. Some consumers may receive services from more than one CSB in a given year and/or may receive both mental health and substance abuse services, in which case they would be counted once for each CSB and for each respective service they received at that CSB.

Between FY12 and FY22, the number of CSB consumers receiving behavioral health services increased nearly 20 percent in Northwestern Virginia, nearly 10 percent in Southwestern Virginia, and 5 percent in Central Virginia. In Northern and Eastern Virginia, however, the number of CSB consumers has declined slightly over the last decade (sidebar).

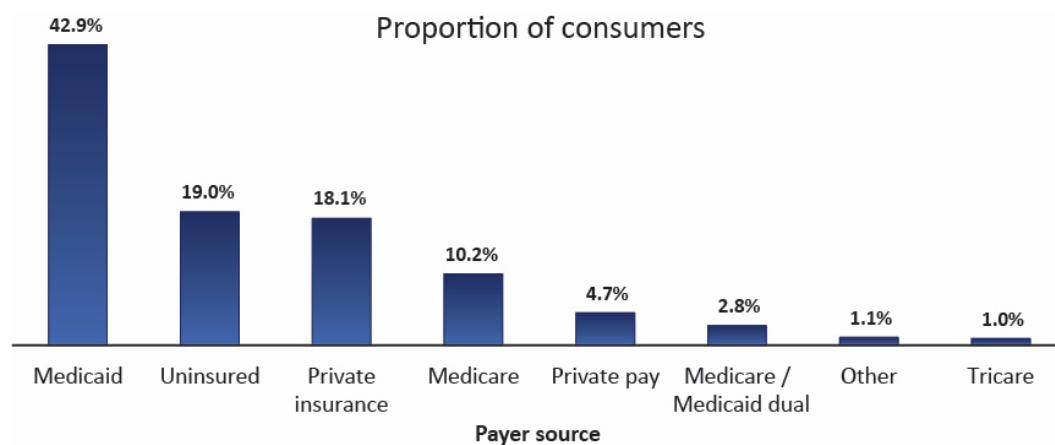
Majority of CSB behavioral health consumers are either enrolled in Medicaid or are uninsured

In FY22, an estimated 43 percent of consumers who received behavioral health services at CSBs were enrolled in Medicaid, and 19 percent were uninsured (Figure 1-5). State law and regulations do not limit CSB services to consumers who are uninsured or have low incomes, though some CSBs prioritize these consumer groups, especially because of staffing shortages. Uninsured consumers may pay for services out of pocket, depending on individual CSBs' fee policies.

Between FY12 and FY22, both the number and proportion of CSB consumers receiving behavioral health services who were enrolled in Medicaid more than doubled, while the number of consumers who were uninsured or paying privately decreased (Figure 1-6). This increase is likely due in part to the expansion in Medicaid eligibility that began January 1, 2019. The proportion of consumers enrolled in Medicaid increased from 24 percent in FY18 to 43 percent in FY22 (a 76 percent increase). In contrast, the proportion of uninsured consumers decreased from 34 percent in FY12 to 19 percent in FY22.

Regional differences in the change in the number of consumers served may be partially attributable to the expansion of Medicaid coverage, differences in the number of private provider alternatives, and variations in the prevalence of behavioral health conditions. (See Chapter 2 for more information on behavioral health and consumer trends in and across Virginia.)

FIGURE 1-5
Medicaid is the payer source for the largest proportion of consumers, FY22

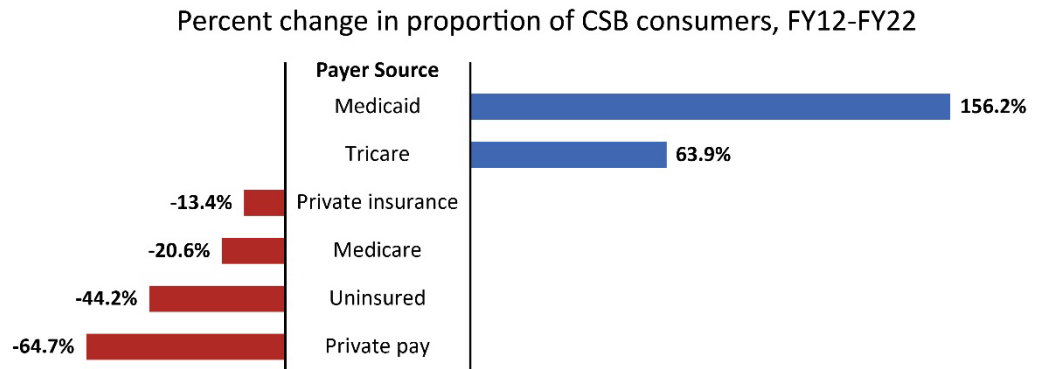


SOURCE: JLARC analysis of DBHDS's CCS3 Consumer and Services data, FY22.

NOTE: Includes only CSB consumers receiving behavioral health services. In FY22, 4 percent of consumers receiving behavioral health services used multiple payment sources, in which case they were counted once for each payment source used. Tricare is a health insurance program for uniformed service members, military retirees, and their dependents.

FIGURE 1-6

Since FY12, the proportion of consumers enrolled in Medicaid has increased, while the proportion who are uninsured or paying privately has fallen



SOURCE: JLARC analysis of DBHDS’s CCS3 Consumer and Services data, FY12–FY22.

NOTE: Includes only CSB consumers receiving behavioral health services. Payer sources were not included in this graphic if fewer than 100 consumers had used a given method of payment in FY12 or FY22 or if the payer source did not exist in FY12. “Other” was also not included. Tricare is a health-care program for uniformed service members, military retirees, and their dependents.

Total funding for the CSB system has increased since FY12, when adjusting for inflation

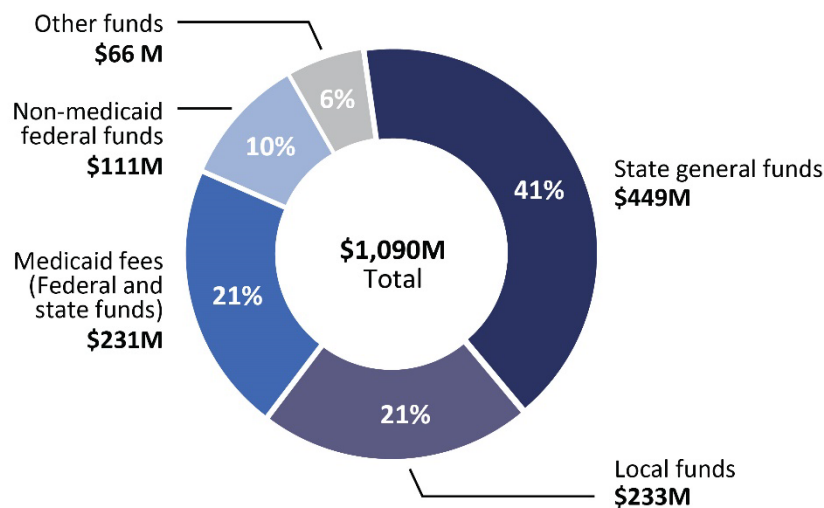
CSBs receive funding from various sources to support their operations and service delivery. The General Assembly appropriates general funds to CSBs (sometimes referred to as “non-Medicaid state funds”), which are used to support the delivery of behavioral health services and operations costs, such as staffing. CSBs are required to obtain local funding from the localities they serve and may also receive non-Medicaid federal funding to support service delivery.

CSBs also bill Medicaid managed care organizations and may bill private insurance providers for eligible services. CSBs are expected through the Appropriations Act and CSB performance contracts to maximize the collection of Medicaid payments for eligible services. If a consumer is uninsured or if services are not reimbursed through Medicaid or private insurers, CSBs may bill consumers or use general funds received from federal, state, and local sources to cover the outstanding costs.

Each CSB is required by state law to obtain a local match equating to at least 10 percent of total state and local funding.

The CSB system received \$1.09 billion for behavioral health services in FY22, with non-Medicaid state general funds, local contributions, and Medicaid fees making up the majority of funding (Figure 1-7). (Funding for Medicaid fees comes from both federal and state general funds—federal funds for Medicaid are matched by state general funds.) A majority of CSB behavioral health funding is allocated for mental health services (\$864 million), but funding is also provided for substance use disorder services (\$226 million) (sidebar).

FIGURE 1-7
State general funds are largest source of funding for behavioral health services through the CSB system (FY22)



SOURCE: JLARC analysis of CSB funding data collected through Little CARS by DBHDS.

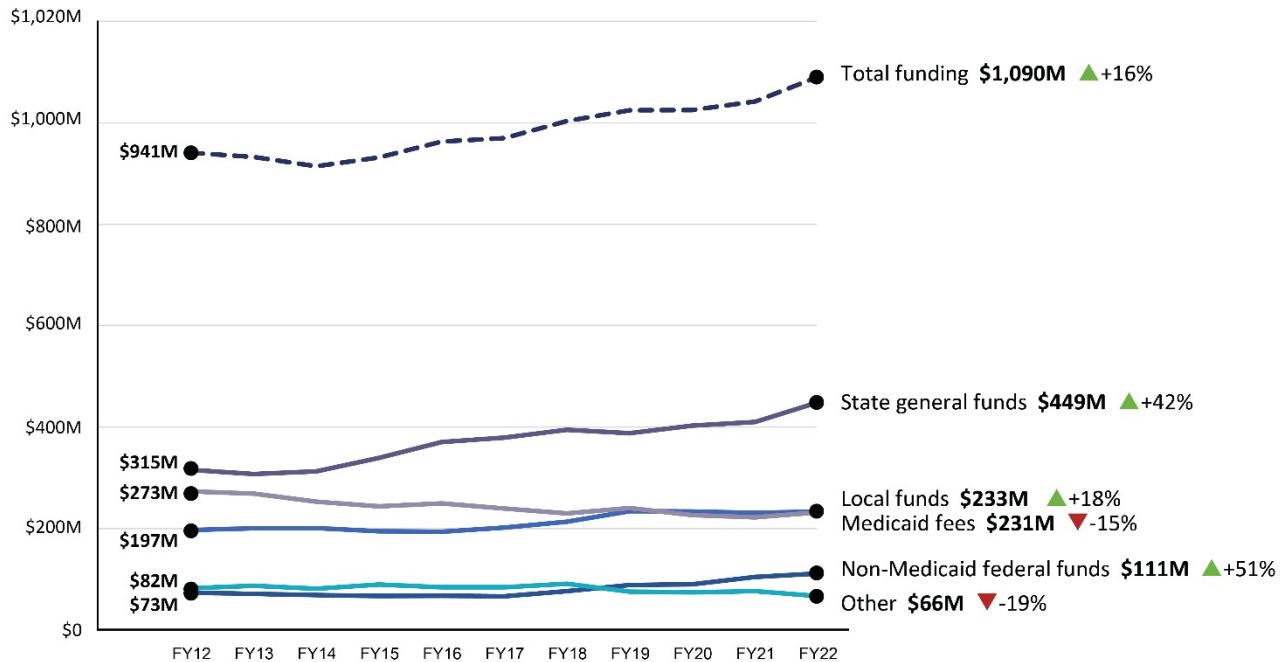
NOTE: Includes only funding for behavioral health services. The majority of state general funds were allocated to mental health services (\$383 million). Non-Medicaid federal funds made up 33 percent (~\$75 million) of substance use disorder services funding but only 4 percent (~\$36 million) of mental health services funding. "State general funds" also include unused state funds from previous years that were retained by CSBs. "Other funds" include other unused funds from previous years that were retained, and consumer and private insurance payments.

Total behavioral health funding for the CSB system increased from \$941 million to \$1.09 billion (16 percent) adjusted for inflation, between FY12 and FY22 (Figure 1-8). Per consumer funding also increased over this period, although at a slower rate, from \$5,488 to \$6,104 (11 percent).

State general funds were a primary driver of increased CSB funding over the period, and funding increases were generally provided to support the development of new services. For example, CSBs received \$77 million to develop and fund STEP-VA services in FY22, an initiative that began in FY17. However, unrestricted state funds, which are used to support operational costs and the delivery of some services mandated by state law (e.g., preadmission screenings and discharge planning), decreased 21 percent over this period.

FIGURE 1-8

CSB behavioral health funding has increased overall because of growth in state general funds, non-Medicaid federal funds, and local contributions (FY12–FY22)



SOURCE: JLARC analysis of CSB funding data collected through Little CARS by DBHDS.

NOTE: "Other funds" include other unused funds from previous years that were retained by CSBs, and consumer and private insurance payments. Figure is adjusted for inflation using medical care consumer price index (CPI).

Total Medicaid reimbursements to *all* community-based behavioral health providers in Virginia increased 32 percent between FY12 and FY21, but this was driven by an increase in reimbursements to *non-CSB* behavioral health providers. Total Medicaid reimbursements for CSB behavioral health services *declined* 15 percent over this period, and the proportion of all Medicaid reimbursements for community behavioral health services paid to CSBs declined from 29 percent to 18 percent. This is contrary to expectations as the proportion of CSB consumers covered by Medicaid has increased over the period.

Various factors may contribute to the decline in Medicaid reimbursements to CSBs, including the extent to which CSBs (1) bill for Medicaid eligible services and (2) receive Medicaid reimbursement for services they bill for. (See Chapter 5 for more information on CSB Medicaid reimbursements.)

CSBs provide a variety of crisis services, and services have expanded in recent years

CSBs provide a range of crisis services that vary in intensity, from crisis hotlines to residential crisis stabilization services, and the availability of specific types of crisis

services varies across the state. State general fund spending specifically on crisis services increased 48 percent between FY12 and FY21, adjusted for inflation. The General Assembly has provided funding primarily to expand crisis assessment facilities (“Crisis Intervention Team Assessment Centers”), mobile crisis teams, and 23-hour crisis stabilization services.

Some types of crisis services, including mobile crisis, 23-hour crisis stabilization services (sidebar), and residential crisis stabilization services, require similar types of behavioral health staff to become (and remain) fully operational. Depending on the type of service, staff may include licensed mental health professionals, such as clinical social workers and professional counselors, psychiatrists, psychiatric nurse practitioners, and peer recovery specialists. (See Appendix E for further discussion of crisis services.)

Twenty-three hour crisis stabilization services are non-residential crisis stabilization services that are delivered to individuals in a home-like setting for less than 24 hours. These services generally involve more intensive services than individuals would receive from a mobile crisis team, but less intensive services than they would receive at a residential crisis stabilization unit.

Fundamental restructuring of CSB system is not needed

There is no compelling evidence that adopting an entirely different structure for community-based behavioral health service delivery would result in an inherently more efficient and effective system; nor is there evidence that another structure is fundamentally superior to Virginia's. However, as described in this report, there are changes that should be made in the current system to ensure the CSB system functions as efficiently and effectively as possible, and that CSBs are held accountable for their performance.

States' approaches to structuring their community-based behavioral health services can generally be grouped into *centralized* systems, in which the state directly funds and provides all public behavioral health services, and *decentralized* systems, in which the state provides some funding and oversight, but community-based behavioral health services are delivered by non-state entities.

Forty-eight states, including Virginia, use a decentralized model of community-based behavioral health service delivery, but Virginia is one of only 12 states that involve local governments in service delivery. The other 36 states primarily contract with private providers to deliver community-based behavioral health services without local government involvement.

According to national subject-matter experts, no one service delivery system structure is inherently the most effective or efficient, but there are tradeoffs with use of each service delivery model. For example, decentralized systems are generally more flexible and responsive to local needs than centralized systems, but they sometimes have difficulty holding providers accountable and enacting consistent, statewide changes.

The total number of local entities (CSBs) in Virginia is comparable to the number of local entities in other states with similar systems and populations. Like in other states,

CSBs deliver some services on a regional basis or through contracts with private providers, although some states provide services on a more regional basis or are more reliant on contracts with private providers. About half of Virginia's CSBs contract out at least some of their services to private providers. Additionally, the structure of the state level administrative entity (DBHDS) is similar to other states, but some states have integrated additional functions into their state behavioral health agency, like the administration of Medicaid or physical health services. (See Appendix D for more information on how the CSB system structure compares to other states' systems and Appendix F for a discussion and maps of CSBs' service locations.)

2 Behavioral Health Trends and CSB Consumer Outcomes

Within behavioral health, community services boards (CSBs) are primarily intended to serve individuals experiencing a mental illness or a substance use disorder that significantly impairs their functioning (sidebar). These conditions can affect an individual's ability to work, maintain healthy relationships, care for themselves and others, and otherwise function.

The prevalence of serious behavioral health conditions statewide in Virginia as well as by region drives demand for CSB services. CSBs are not the only providers of community-based behavioral health services in Virginia, so their role in providing mental health and substance abuse services depends partially on the availability of other service providers.

By receiving appropriate services, particularly early and consistent professional treatment, individuals can effectively manage their conditions and function as well as possible in daily life. CSBs have recently begun using a behavioral health assessment instrument to assess how well their consumers function in their daily lives. The data from this assessment can be used by CSBs and the state to understand how CSB consumers are affected by their behavioral health conditions, how their functioning changes after receiving CSB services, and how effective CSB services are at assisting behavioral health consumers.

Prevalence of mental illness has been rising

In Virginia and nationally, the proportion of individuals with a mental illness has been increasing, particularly among youth and young adults. Research on why mental illnesses are increasing is inconclusive.

The term "mental illness" includes a diagnosable mental, behavioral, or emotional disorder, such as a mood, anxiety, personality, or psychotic disorder. When a mental illness significantly impairs an individual's functioning, it is considered a "serious mental illness." CSBs primarily provide mental health services to individuals who have a serious mental illness.

About one in 20 adults in Virginia and in the U.S. have a mental illness that significantly impairs functioning

An estimated 21 percent of adults in Virginia have a mental illness, and 5 percent have a mental illness that substantially impairs their functioning. Rates are highest among young adults aged 18 to 25, among whom an estimated 32 percent have a mental illness, and 9 percent have a serious mental illness. The estimated prevalence rates of

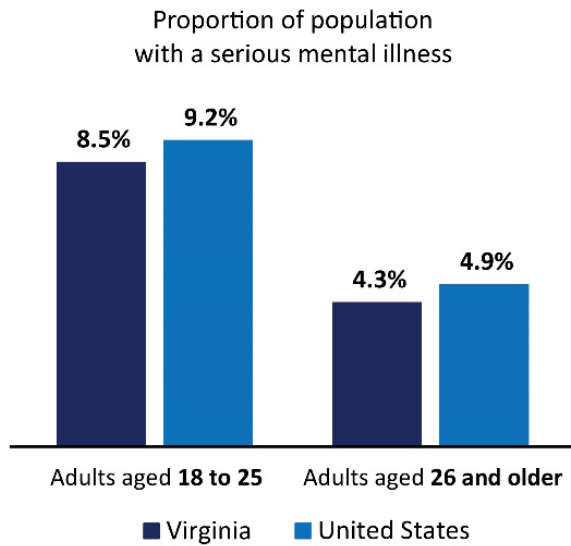
CSBs also provide services to individuals with developmental disabilities to help them increase their independence. The focus of this report is on behavioral health services provided through CSBs.

Functional impairment includes significantly impaired "judgment, behavior, capacity to recognize reality, or ability to address basic life necessities and requires care and treatment" for the well-being of the individual or others, according to the Code of Virginia.

mental illness among both younger and older adults in Virginia are generally similar to national rates (Figure 2-1).

The estimated prevalence of serious mental illness among adults varies somewhat across Virginia—ranging from 3.5 percent (Northern Virginia) to 5.4 percent (Southwestern Virginia). However, nearly half of Virginia adults with a serious mental illness live in Eastern Virginia and Northern Virginia, the most populated areas of the state.

FIGURE 2-1
Virginia’s prevalence rates of serious mental illness among adults are similar to national rates

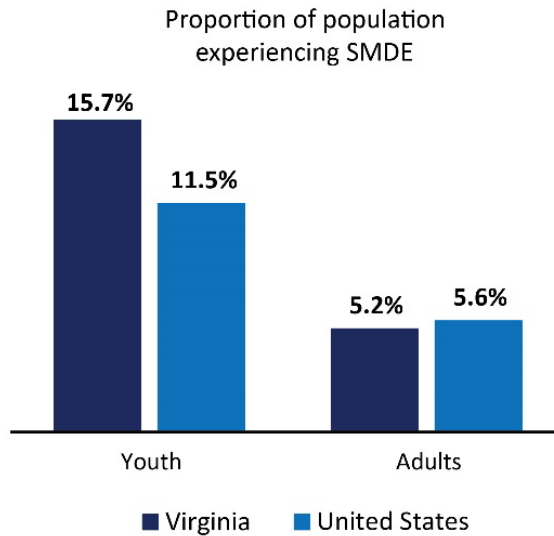


Severe major depressive episodes are periods of two weeks or longer during which an individual experiences a depressed mood or loss of interest or pleasure in daily activities, has a majority of specified depression symptoms, and experiences severe functional impairment. Major depression is one of the most common types of serious mental illness among youth.

SOURCE: JLARC analysis of NSDUH data, 2019 and 2020.

Less data is available about the prevalence of serious mental illness among children, but indicators show rates may be higher than among adults. An estimated 19 percent of children aged three to 17 in Virginia had one or more emotional or behavioral disorders in 2020. The only widely available measure of *serious mental illness* among children is the percentage of *youth* (ages 12 to 17) who experienced a severe major depressive episode in the last year (sidebar). In 2020, an estimated 16 percent of Virginia youth experienced a severe major depressive episode, which is significantly higher than the adult rate (Figure 2-2).

FIGURE 2-2
Virginia youth are more likely to experience severe major depressive episodes than adults



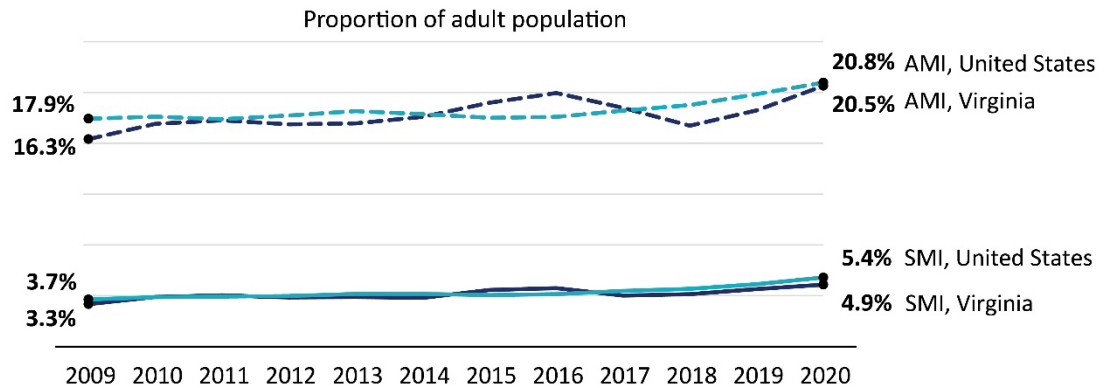
SOURCE: JLARC analysis of NSDUH data, 2019 and 2020.

NOTE: "SMDE" = Severe major depressive episodes. "Youth" = Children aged 12 to 17. SMDE is a symptom of only one form of mental illness that causes functional impairment (major depression), but it is the only widely available data point for the prevalence of serious mental illness among youth.

Prevalence of serious mental illness has been increasing, particularly among youth and young adults

Following national trends, the prevalence of mental illness among adults has been increasing in Virginia (Figure 2-3). Between 2009 and 2020, the estimated prevalence of mental illness increased from 16 percent to 21 percent (a 26 percent increase), and the prevalence of serious mental illness increased from 3 percent to 5 percent (a 46 percent increase).

FIGURE 2-3
Prevalence of mental illness has been increasing in Virginia and nationally



SOURCE: JLARC analysis of NSDUH data, 2008-2020.

NOTE: "AMI" = Any mental illness. "SMI" = Serious mental illness. SMI is a sub-category of AMI. In 2020, the pandemic necessitated slight changes to survey data collection, though survey questions remained the same.

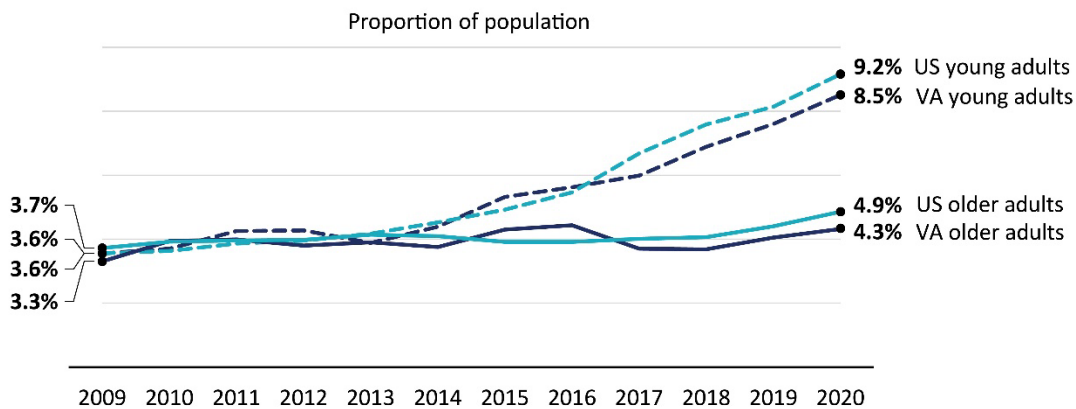
Suicide death rates in Virginia increased 81 percent among youth and 12 percent among adults between 2010 and 2020. While not all suicide victims have a mental illness, a large proportion do. DBHDS, in collaboration with CSBs, the Virginia Department of Health, and other state agencies, is charged by the Code of Virginia with developing and carrying out a statewide suicide prevention plan and receives \$500,000 annually in general funds for this effort.

Most of the increased prevalence in serious mental illness was due to increases among *young adults* (ages 18 to 25), which grew from an estimated 4 percent to 9 percent (a 140 percent increase) between 2009 and 2020 (Figure 2-4).

The prevalence of serious mental illness among youth has also grown in Virginia and at a faster rate than nationally. The estimated prevalence of severe major depressive episodes among youth increased from 7 percent to 16 percent (a 140 percent increase) in Virginia between 2011 and 2020. In comparison, the estimated prevalence doubled from 6 percent to 12 percent nationally over that time period.

Some of the increase in the reported prevalence of mental illness might be explained by a growing willingness to seek mental health services because of better societal understanding and awareness of mental illness. However, there is some evidence that the actual prevalence is increasing. For example, increased suicide death rates among youth and adults over the past decade suggest at least some actual increase in the prevalence of mental illness (sidebar).

FIGURE 2-4
Most of the growth in the prevalence of serious mental illness is due to growth in serious mental illness among adults aged 18 to 25, following national trends



SOURCE: JLARC analysis of NSDUH data, 2008-2020.

NOTE: "Young Adults" = Adults aged 18 to 25. "Older Adults" = Adults aged 26 and older. In 2020, the pandemic necessitated slight changes to survey data collection, though survey questions remained the same.

CSBs are generally serving more consumers with a serious mental illness than they were a decade ago, particularly in rural areas

CSBs are serving an increased number of both adults and children with a serious mental illness (sidebar). CSBs provided mental health services to about 87,000 individuals with a serious mental illness in FY22, a 20 percent increase from the 73,000 served in FY12. The number of adults in Virginia with a serious mental illness grew 35 percent between 2012 and 2020, a much higher increase than the 5 percent population growth in Virginia over that time.

The number of CSB consumers with a serious mental illness increased at the greatest rate in Northwestern Virginia (around 40 percent) and at the slowest rate in Northern and Eastern Virginia (around 5 percent each). CSBs also serve a greater proportion of adults with a serious mental illness who reside in Southwestern and Northwestern Virginia than in other areas of the state.

Additionally, a greater proportion of CSB consumers receiving mental health services have a serious mental illness than a decade ago, likely requiring CSBs to provide more intensive services. In FY22, 27 CSBs provided mental health services mostly to consumers with a serious mental illness (at least 75 percent of consumers) compared to 16 CSBs in FY12. The full effects on CSBs of serving a greater proportion of consumers with a serious mental illness are unclear, but CSBs tend to provide more services and more intensive services to consumers with lower functional levels.

The total number of individuals who received behavioral health services, including mental health and substance abuse services, through CSBs increased between FY12 and FY22. The growth was driven by an increase in the number of individuals receiving mental health services.

One exception to the growth in consumers served was Black children. While the number of consumers with a serious mental illness who received mental health services increased—or declined by less than 10 individuals—for all other racial and age groups between FY12 and FY22, the number of Black children receiving services fell by 1,400 (or 18 percent).

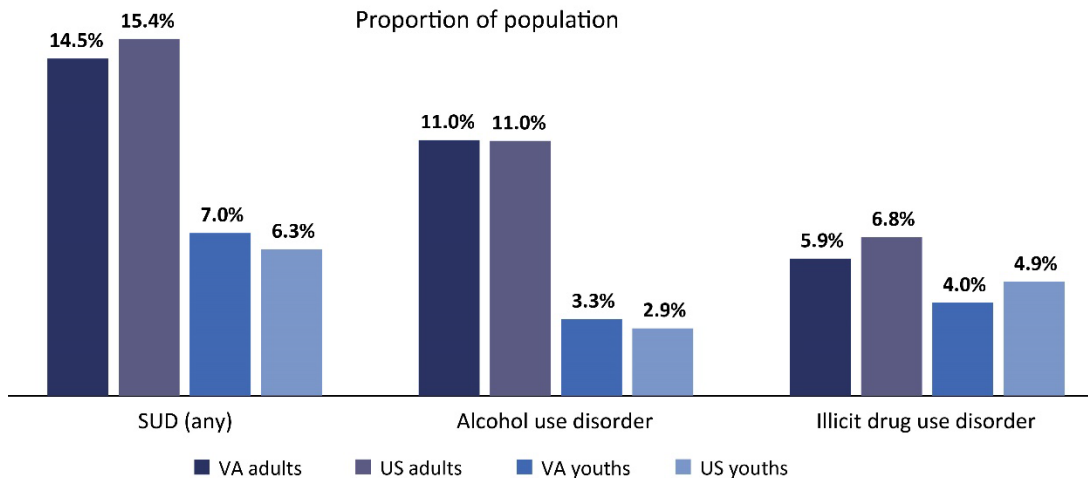
CSBs are providing substance abuse services to fewer consumers than in FY12

Illicit drugs include marijuana, cocaine, heroin, hallucinogens, inhalants, and methamphetamine as well as prescription psychotherapeutic drugs, such as pain relievers and sedatives, if misused.

CSBs are also required to provide services to individuals whose substance use affects their functioning. Substance use disorders may include an alcohol use disorder, an illicit drug use disorder, or both (sidebar).

Virginia's prevalence rates of substance use disorders among adults and youth are generally similar to national rates (Figure 2-5). An estimated 15 percent of adults in Virginia had a substance use disorder in 2020, and alcohol use disorders were the most common, affecting 11 percent of adults in Virginia. An estimated 7 percent of Virginia youth had a substance use disorder in 2020.

FIGURE 2-5
In 2020, about one in seven Virginians had a substance use disorder



SOURCE: JLARC analysis of NSDUH data, 2020.

NOTE: "SUD" = Substance use disorder. "Youths" = Children aged 12 to 17. Individuals with a SUD may have an alcohol and/or illicit drug use disorder.

There is no available data on the regional prevalence of substance use disorders, but data on substance use and fatal drug overdoses suggests that prevalence varies across Virginia. Rates of substance use are generally highest in Central Virginia, but the number of users is highest in Northern Virginia for most substances, following population patterns. The number of fatal drug overdoses was highest in Northwestern and Southwestern Virginia in 2021.

In FY22, CSBs provided substance abuse services to nearly 25,000 individuals statewide, which is a 30 percent decrease from FY12, when 35,000 consumers were served (sidebar). The decrease in consumers was notable in Northern and Eastern Virginia (a decline of around 50 percent each) and slight in Southwestern and Northwestern Virginia (declines of 1 percent and 12 percent, respectively). Moreover, the

Virginians with Medicaid may receive treatment outside of CSBs through the Addiction and Recovery Treatment program, which DMAS launched in 2017.

decrease in the number of CSB consumers receiving substance abuse services is primarily driven by a decrease in younger consumers. While the number of consumers over the age of 54 rose 37 percent, the number of consumers under the age of 25 declined 71 percent, and the number of consumers aged 25 to 54 declined 22 percent.

There is limited data on trends in the prevalence of substance use disorders, but between 2016 and 2019, the estimated overall prevalence of substance use disorders in Virginia decreased 5 percent among adults. Over that period, the prevalence of alcohol use disorders declined while illicit drug use disorders increased among adults. The estimated prevalence of substance use disorders among youth remained stable.

Individuals with significant impairments tend to improve functioning while receiving CSB services

In 2019, the Department of Behavioral Health and Developmental Services (DBHDS) began requiring CSBs to report data on consumers' functioning levels. This data, which is based on a functional assessment known as the Daily Living Activities-20 (DLA-20), indicates how well people are able to function in different areas of their life, such as nutrition, hygiene, social connections, and employment (sidebar). The DLA-20 measures individuals' functioning levels on a scale from one to seven (Table 2-1). All CSB consumers who receive ongoing behavioral health services (e.g., outpatient therapy, not a one-time service like a preadmission screening) at a CSB are given this assessment at intake and at least once every six months while they continue to receive CSB services.

Initial data indicates CSB consumers with the most severe functional impairments improve while receiving CSB behavioral health services

Across all CSB consumers who had more than one DLA-20 assessment, 53 percent improved significantly after at least six months of receiving CSB services (sidebar). The majority of consumers with "extremely severe," "severe," and "serious" impairments—CSBs' priority population—experienced significant improvements in functioning (Figure 2-6), according to their composite DLA-20 scores.

Individuals with mild impairments were more likely to experience a decline in their functioning levels. However, the functioning levels of a majority of individuals with mild impairments (57 percent) either improved or remained stable while receiving CSB services (sidebar, next page).

Over 300 public and private providers of behavioral health services in 43 states use the DLA-20 assessment, according to the developers of the instrument.

JLARC staff consulted with the developers of the DLA-20 assessment to ensure Virginia data, including initial composite scores across different diagnoses types, were generally consistent with what they would expect to see.

JLARC staff used **composite DLA-20 scores** for this analysis. Composite scores are an average of all 20 items on the DLA-20 assessment. Individual item scores were not available for CSB consumers because DBHDS does not collect this information.

TABLE 2-1
DLA-20 measures consumers' level of functional impairment on scale of 1 to 7

CSB consumers may still require services, even when their functional level improves. Ongoing services can help consumers with a serious mental illness or substance use disorder remain at higher functional levels and manage their behavioral health symptoms. As a result, CSBs may serve consumers with DLA-20 scores that indicate no or only mild functional impairments.

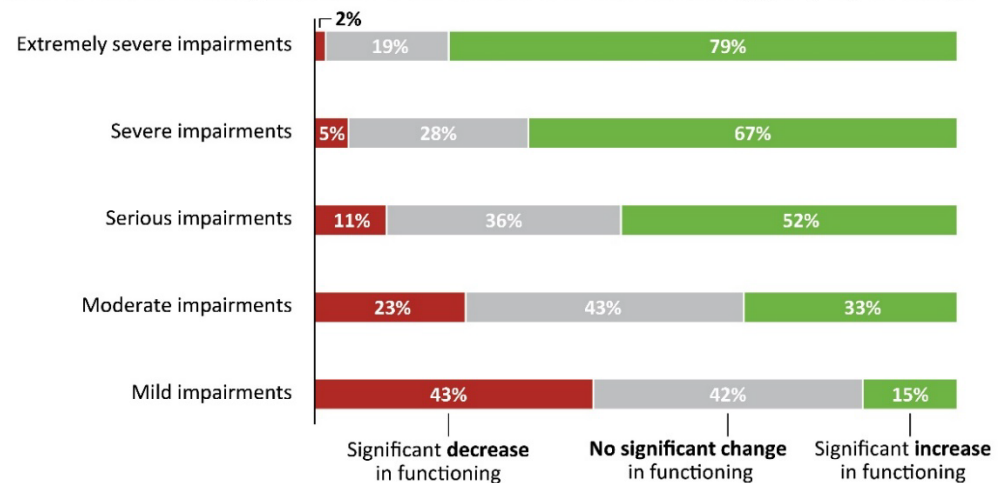
Functioning level (DLA-20 score)	Description of functioning level	% of CSB consumers (FY19 to FY22)
Extremely severe impairments (1 to 1.99)	Problems are present <u>almost all of the time</u> and disrupt a person's life <u>every day</u> .	0.4%
Severe impairments (2 to 2.99)	Problems are present <u>most of the time</u> and disrupt a person's life <u>most days</u> .	6%
Serious impairments (3 to 3.99)	Problems are present <u>at least half the time</u> and disrupt a person's life <u>frequently</u> .	25%
Moderate impairments (4 to 4.99)	Problems are present <u>less than half the time</u> and disrupt a person's life <u>occasionally</u> .	40%
Mild impairments (5 to 5.99)	Problems are present <u>a little of the time</u> and <u>rarely</u> disrupt a person's life.	25%
No significant impairments (6 to 7)	No significant or only slight impairments in functioning.	6%
Total consumers with at least one DLA-20 score		130,976

SOURCE: JLARC analysis of DLA-20 composite scores in DBHDS's CCS3 system, FYs19–22, and DLA-20 documents.

FIGURE 2-6
Majority of CSB consumers with most impaired functioning improved while receiving CSB services (FY19–FY22)

Although there is not a benchmark for an expected change in DLA-20 scores over time, the developers of the assessment say that a change of more than 0.4 points in either direction indicates a significant change in functioning.

After at least six months, proportion of CSB consumers in each functioning group experiencing...



SOURCE: JLARC analysis of DLA-20 composite scores maintained in DBHDS's CCS3 system, FYs 2019–2022.

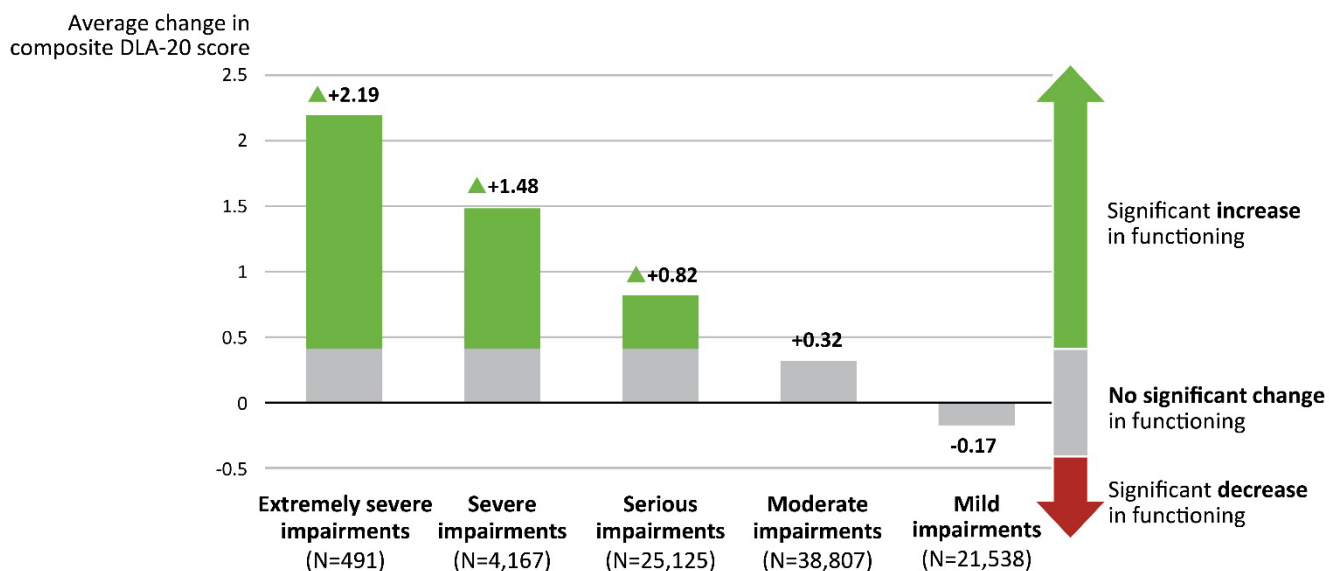
NOTE: A significant change in functioning is a score change ± 0.4 points. Figure excludes about 6% of CSB consumers who had no significant impairments when their first DLA-20 assessment was completed.

Furthermore, DLA-20 scores indicate that CSB consumers with the *most* severe functional impairments generally experienced greater improvements than consumers with less severe impairments (Figure 2-7). On average, CSB consumers with the *least* severe impairments saw no change (positive or negative) in their DLA-20 scores. These trends were similar across CSBs, race, gender, and age.

Forty-one percent of CSB consumers had a significant decline (at least 0.4 points) in their functioning while they were receiving CSB services. These declines were most common for consumers who started at a higher functional level, and these consumers typically receive lower intensity services at CSBs, such as case management or less frequent outpatient counseling. Declines in DLA-20 scores were not concentrated in any area of the state, within any demographic group, or at any CSBs. Still, DBHDS should examine why these declines are happening and what improvements to CSB services could be made to help these consumers.

Data limitations prevent determining with certainty whether CSB services alone are responsible for changes in consumers' functioning. In addition, some score changes, both positive and negative, are likely attributable to the cyclical nature of behavioral health issues, as people's functioning may improve or decline regardless of any treatment they are receiving.

FIGURE 2-7
CSB behavioral health consumers with most significant impairments experience the largest improvements in functioning, on average, after at least 6 months



SOURCE: JLARC analysis of DLA-20 composite scores maintained in DBHDS's CCS3 system, FYs 2019–2022.
 NOTE: Results are for behavioral health consumers with more than one DLA-20 score at least six months apart. Percentages do not sum to 100 because consumers with no significant impairments (about 6 percent) are not included in the figure.

DLA-20 data could be used more effectively to monitor CSB performance

DBHDS currently collects data on CSB consumers' composite DLA-20 scores and conducts some analyses of these scores. However, the agency could better monitor CSB performance and consumer outcomes and appropriately intervene to improve outcomes, if it collected and analyzed the DLA-20's individual item scores in addition to the composite scores. The individual item scores would provide more information to understand the outcomes of particular services or programs, and analysis of them would more clearly demonstrate specific shortcomings or successes in the provision of such services. With this more detailed data, needed adjustments could be better identified and made to strengthen the effectiveness of services being provided. For instance, a large number of consumers at a CSB with persistently low scores on the alcohol and drug use item of the DLA-20 could indicate that this CSB needs additional substance use disorder expertise and resources. Alternatively, if an analysis of individual DLA-20 item scores showed that individuals receiving outpatient therapy generally were not improving their social functioning as expected, DBHDS could work with relevant CSBs to improve the provision of this service.

Access to individual item scores would also allow DBHDS to provide up-to-date information about changing consumer or community needs to policymakers. For example, with individual item scores, policymakers can better understand the extent to which CSBs are helping improve consumers' ability to

One potential approach to transfer individual item scores from CSBs to DBHDS on a regular basis is a data system called **SPQM**, which was created by the developers of the DLA-20 assessment and is used by public and private providers in other states.

- control their use of alcohol or illicit drugs;
- cope with various stressful situations independently;
- maintain positive relationships with family or community members (e.g., not isolating themselves or exhibiting physical aggression towards others); and/or
- maintain their personal safety.

DBHDS initially contracted with the developers of the DLA-20 to implement SPQM in conjunction with the introduction of the DLA-20 assessment. However, according to DBHDS staff, the SPQM system was not fully implemented and the contract was allowed to expire in 2019.

Currently, DBHDS does not have a way to collect individual item scores from DLA-20 assessments, and collecting this data through existing DBHDS data systems would likely be administratively burdensome for CSB staff. DBHDS staff have indicated that CSBs will eventually be able to report individual DLA-20 item scores through the planned data exchange platform. However, the data exchange platform is currently in the very early stages of development. (Additional discussion about DBHDS's data exchange platform initiative is included in Chapter 6.)

In the near term, DBHDS should develop a process receive DLA-20 composite *and* individual item scores from all CSBs on a regular basis. To minimize the administrative burden on CSB staff, DBHDS should ensure the process uses existing data in CSB electronic health records systems and does not require separate data entry by CSB direct care staff (sidebar).

DBHDS should analyze and report on trends in composite DLA-20 scores, as well as individual item scores, annually. At a minimum, these reports should highlight CSB performance in improving functioning levels of individuals beginning and continuing to receive behavioral health services during the prior fiscal year and changes in CSB performance over time. If DBHDS discontinues use of the DLA-20 and requires CSBs to complete another type of assessment, DBHDS should analyze and report on results from that assessment. Improvements to DBHDS's use of DLA-20 data or data from a comparable functional assessment should be included as part of the recommended changes to the agency's broader CSB performance monitoring processes (Chapter 6, Recommendation 22).

RECOMMENDATION 1

The Department of Behavioral Health and Developmental Services should develop a process for receiving DLA-20 composite and individual item scores from all community services boards (CSBs) at least quarterly, and this process should use data in CSB electronic health records systems and not require separate data entry by CSB direct care staff.

RECOMMENDATION 2

The General Assembly may wish to consider including language in the Appropriation Act requiring the Department of Behavioral Health and Developmental Services (DBHDS) to report annually on (i) community services board (CSB) performance in improving the functioning levels of their consumers based on composite and individual item scores from the DLA-20 assessment, or results from another comparable assessment, by CSB, (ii) changes in CSB performance in improving consumer functioning levels over time, by CSB, and (iii) the use of functional assessment data by DBHDS to improve CSB performance to the State Board of Behavioral Health and Developmental Services and the Behavioral Health Commission.

3 Staffing for CSB Behavioral Health Services

To provide timely and effective behavioral health services and to meet requirements in state law and performance contracts with the state, CSBs need sufficient numbers of qualified staff. Sufficient staff capacity is also critical for the successful implementation of statewide initiatives, including STEP-VA and the development of a crisis services continuum.

In FY21, about 71 percent of CSB staff (9,450 full-time equivalent employees) provided or supported behavioral health services (sidebar). These staff include licensed clinical social workers (LCSWs), licensed professional counselors (LPCs), licensed clinical psychologists (LCPs), psychiatrists, psychiatric nurse practitioners, and qualified mental health professionals. The number of behavioral health employees at each CSB varied from about 36 FTEs (Goochland-Powhatan CSB, which served the fewest consumers in FY21) to about 943 FTEs (Fairfax-Falls Church CSB, which provides many different types of behavioral health services directly to consumers) (sidebar).

CSBs struggle to hire and retain behavioral health staff, especially for emergency and crisis services

Recruiting and retaining sufficient numbers of qualified behavioral health staff is a challenge facing behavioral health providers nationwide, and CSBs in all five regions of the state report struggling to hire and retain qualified staff for behavioral health services. Available data on turnover and vacancies confirm these staffing difficulties. Staffing challenges appear to be affecting CSBs' ability to follow certain requirements in state law and provide timely services.

CSBs report substantial difficulties hiring and retaining qualified staff for core services, and many CSB staff are considering leaving

In interviews and in survey responses, CSB executive directors reported experiencing difficulties recruiting and retaining qualified staff for behavioral health services (sidebar). In JLARC's survey, 36 of 40 CSB executive directors reported that their CSB has experienced substantial difficulty *recruiting/hiring* qualified staff for behavioral health services during the past 12 months. Nineteen of 40 CSB executive directors reported substantial difficulties *retaining* qualified staff for behavioral health services (Figure 3-1).

CSB executive directors reported struggling the most to recruit and retain staff for emergency and crisis services (Figure 3-2). Emergency services staff conduct preadmission screenings to determine whether an individual is an imminent threat to themselves or others and needs inpatient treatment, such as at a state psychiatric hospital.

Staff in the developmental disability service area comprise the remaining 29 percent of the statewide CSB workforce. For this analysis, the CSB behavioral health workforce includes direct care staff and administrative staff.

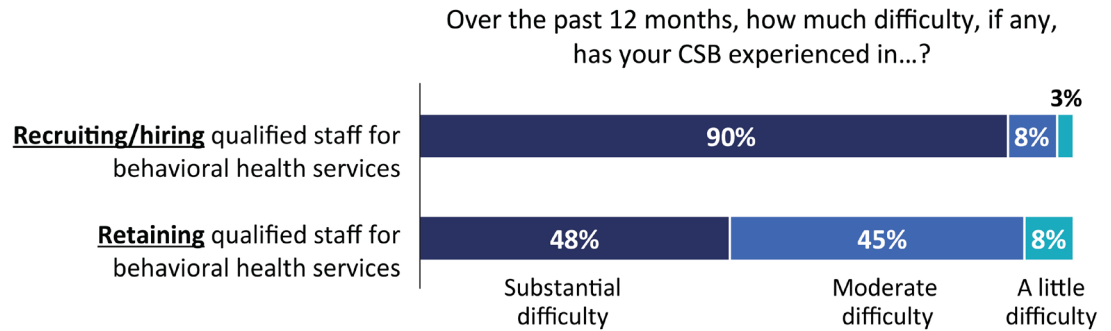
Planning District 1 CSB, which serves several localities in far Southwest Virginia, has the fewest employees (four FTEs in FY21), and all of its staff are administrative. Planning District 1 CSB contracts with a 501(c)3 entity to provide all behavioral health services to consumers.

JLARC staff conducted a survey of the executive directors of all 40 CSBs. The survey response rate was 100%. (See Appendix B for more information.)

In practice, the same licensed clinician may perform a variety of tasks for the CSB, such as emergency services, crisis intervention services, non-emergency assessments, and therapy, depending on CSB staff capacity, demand for services at any given time, and the clinician's qualifications.

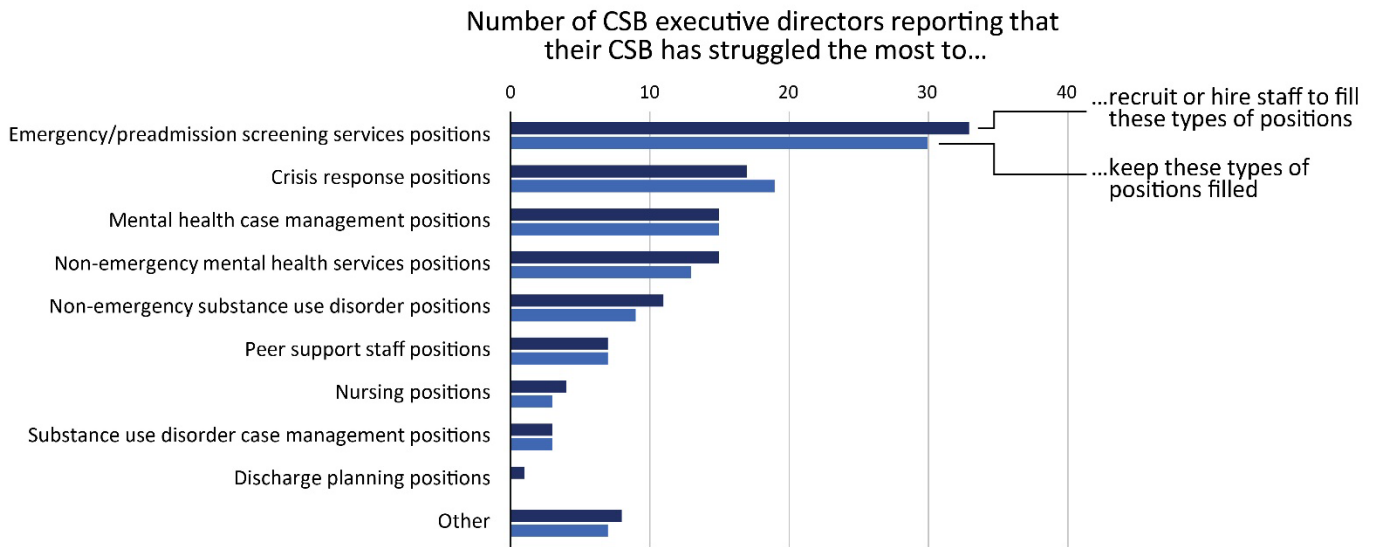
Crisis services staff provide short-term support to individuals experiencing psychiatric or substance abuse crises (sidebar).

FIGURE 3-1
Almost all CSB directors reported substantial difficulties recruiting qualified behavioral health staff, and half report substantial difficulties retaining them



SOURCE: Responses to JLARC survey of CSB executive directors, 2022.
 NOTE: Includes responses from executive directors of all 40 CSBs.

FIGURE 3-2
CSBs generally report struggling to recruit and retain emergency and crisis staff



SOURCE: Responses to JLARC survey of CSB executive directors, 2022. Includes responses from executive directors of all 40 CSBs.

A substantial portion of surveyed CSB staff also reported that they were considering leaving in the next 12 months. In response to JLARC's survey, 91 of 283 emergency services staff (32 percent) reported they were considering leaving their current job within the next 12 months. Of the 91 staff who were considering leaving, 73 (80 per-

cent) reported they were considering leaving to take another job (sidebar). (More discussion about the reasons they were considering leaving is provided later in this chapter.)

Some CSBs recently lost an average of 20 to 30 percent of their staff per year, and turnover has been increasing

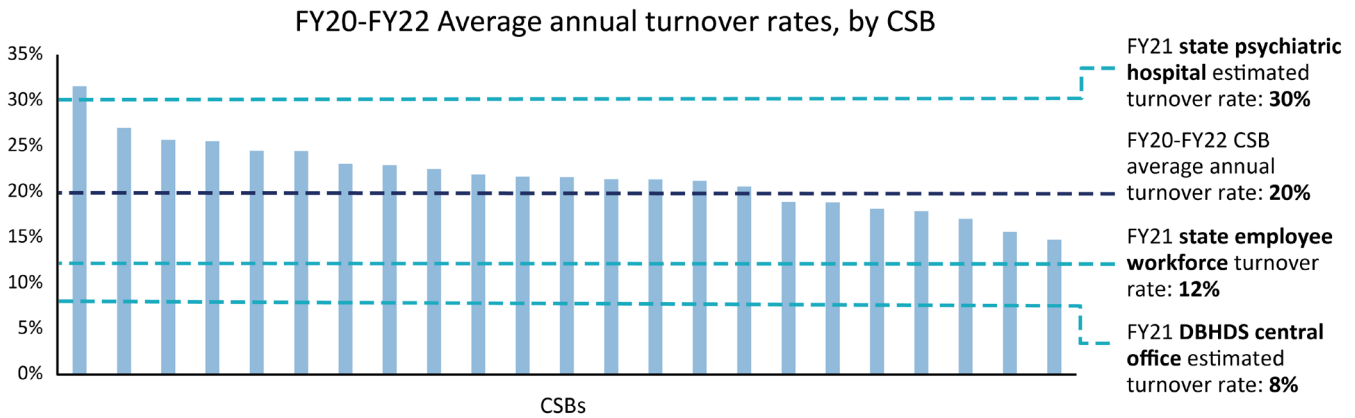
Available data indicates some CSBs have recently experienced relatively high staff turnover. The 23 CSBs for which data is available lost between 15 and 32 percent of their staff, on average, per year between FY20 and FY22 (Figure 3-3) (sidebar). Sixteen of those 23 CSBs experienced three-year average turnover rates of 20 percent or more. For comparison, these turnover rates were substantially higher than the FY21 turnover rates among state employees and DBHDS’s central office staff.

Turnover rates among CSBs have increased over the past decade, and most experienced particularly high turnover in FY22 (Figure 3-4). Turnover exceeded 25 percent for 14 of 23 CSBs in FY22 and was 30 percent or more at five CSBs. The increase in turnover in FY22 follows a national pattern of higher turnover compared with previous years.

JLARC staff conducted a survey of the CSB emergency services leadership and staff. The estimated survey response rate was 65%. (See Appendix B for more information.)

There is no historical and statewide turnover data for all CSBs. However, JLARC staff were able to calculate turnover rates among all full-time staff for 23 of 40 CSBs using VRS data. Turnover calculations include all CSB full-time staff, including staff who provide developmental disability services. (See Appendix B for more information.)

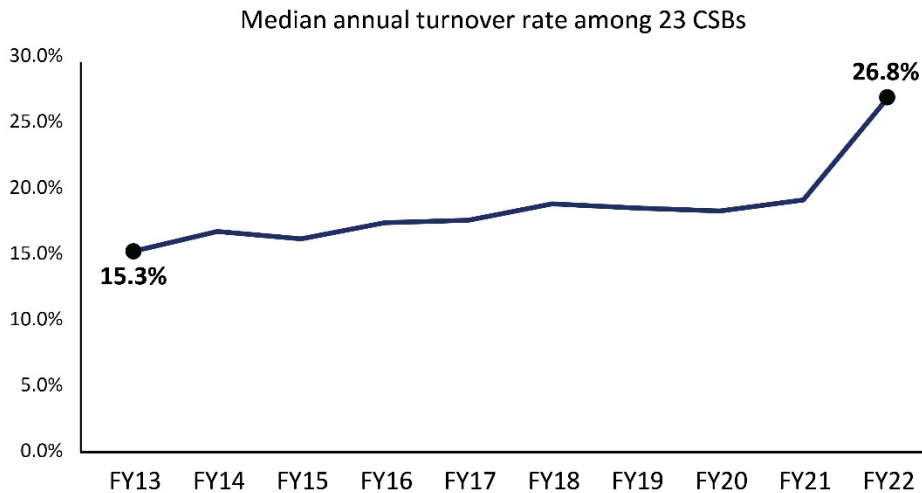
FIGURE 3-3
Average annual turnover among CSBs is higher than state employee and DBHDS central office turnover, but is generally lower than state psychiatric hospitals (FY20–FY22)



SOURCE: JLARC analyses of VRS and DHRM data.

NOTE: Turnover rates include all full-time staff at 23 CSBs for which data is available, which include some developmental disability and administrative staff, and exclude part-time staff. CSB turnover represents the proportion of employees who were no longer employed by the CSB the subsequent fiscal year. Turnover data from Planning District 1 CSB is excluded from this graphic because it employs only four full-time staff and contracts with private providers for all behavioral health services. Estimated turnover rates for DBHDS central office and state psychiatric hospitals were calculated using DHRM data and by dividing the total reported separations during FY21 by initial FY21 staffing levels. DBHDS central office staff turnover rates exclude staff of state psychiatric hospitals, training centers, and the Virginia Center for Behavioral Rehabilitation. (See Appendix B for more information on turnover calculations and estimates.)

FIGURE 3-4
CSB turnover rate has increased steadily since FY13 and increased substantially in FY22



SOURCE: JLARC analyses of VRS data.

NOTE: Turnover rates include all full-time staff at 23 CSBs for which data is available, which include some developmental disability and administrative staff, and exclude part-time staff. Turnover represents the proportion of employees who were no longer employed by the CSB the subsequent fiscal year. Turnover data from Planning District 1 CSB is excluded from this graphic because it employs only four full-time staff and contracts with private providers for all behavioral health services. (See Appendix B for more information on turnover calculations and estimates.)

High turnover is primarily concentrated among direct care staff, rather than administrative staff. The term “CSB direct care staff” includes staff who provide direct services to consumers, including licensed mental health professionals, qualified mental health professionals, peer specialists, registered nurses, and psychiatrists.

According to a recent DBHDS survey, the average turnover rate among CSB direct care staff at 30 CSBs in FY22 was 25.2 percent, compared with 9.7 percent among administrative staff.

Vacancy rates at CSBs are particularly high for direct care behavioral health staff

Less data is available on vacancy rates than turnover rates, but recent survey data indicates that CSBs are also experiencing difficulties filling vacant direct care staff positions. Among the 30 CSBs that responded to DBHDS’s survey, vacancy rates in September 2022 were higher among direct care staff (21.4 percent) than administrative positions (6.4 percent). Among the 30 CSBs that responded to DBHDS’s survey, 14 CSBs reported vacancy rates among licensed mental health professional positions of at least 20 percent, and seven of these CSBs reported vacancy rates that exceeded 30 percent.

Staffing challenges are affecting CSBs' ability to provide timely assessments and services and implement statewide initiatives

CSBs and other stakeholders reported several operational impacts related to CSBs' recruitment and retention challenges. JLARC staff identified several examples where staffing challenges appear to be affecting consumers, key CSB partners, and statewide initiatives.

Few CSBs report being able to provide "same day assessments" on the same day they are sought

Since 2019, CSBs have been required by state law to provide "same-day mental health screening services" to individuals who request these services. These comprehensive assessments are intended to help determine whether individuals need behavioral health services and the specific behavioral health services these individuals need.

Same day assessments must be provided by licensed or licensed-eligible clinicians, and CSBs previously reported difficulties recruiting sufficient staff to provide them. In response to a 2019 JLARC survey, almost all CSB executive directors (95 percent) reported needing to hire additional staff to implement same day assessments, and 19 CSBs reported that staffing challenges were making it difficult to implement same day assessments at that time.

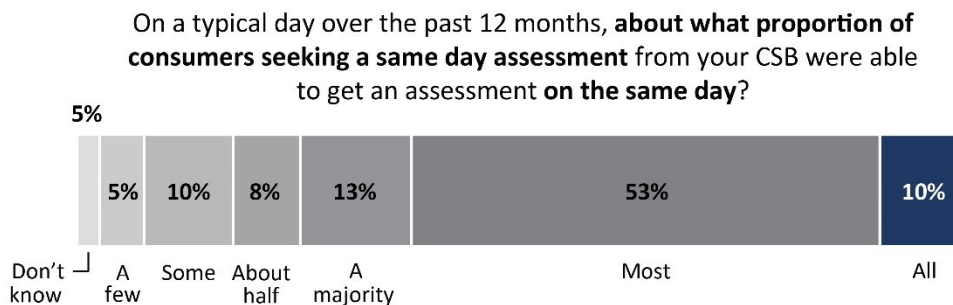
Staffing challenges continue to inhibit most CSBs from providing same day assessments as intended, as only a small proportion of CSBs reported being able to provide same day assessments to all consumers. Only four of 40 CSB executive directors (10 percent) reported in the 2022 JLARC survey that, on a typical day over the past 12 months, *all* consumers seeking a same day behavioral health assessment from their CSB were able to get an assessment on the same day (Figure 3-5). Nine CSBs, including two serving very large localities, reported they were typically able to provide assessments *to half or fewer* of the consumers who sought them.

DBHDS does not maintain data on the proportion of consumers who are able to receive same day assessments, so it is not possible to determine the extent to which this statutory requirement has not been met. Nevertheless, in its December 2021 report on the implementation of STEP-VA, DBHDS reported that "all 40 CSBs have successfully implemented [same day assessments]."

An individual's access to same day assessments may also be limited by geographic availability and when the service is offered. DBHDS does not require that same day assessments be offered every day of the week, and some CSBs do not offer the service every day of the week or for the entire day. Some CSBs also offer same day assessments only to certain populations or geographic areas on specific days of the week.

In FY21, a total of 44,305 assessments were conducted through the same day access process, according to DBHDS. It is unclear, however, how many of these assessments were conducted on the day consumers initially sought them.

FIGURE 3-5
Only 10 percent of CSBs reported typically being able to provide same day assessments to all consumers requesting them, as required by state law



SOURCE: Responses to JLARC survey of CSB executive directors.

NOTE: In the survey, "All" was 100 percent, "Most" was 76 percent to 99 percent, "A majority" was 56 percent to 75 percent, "About half" was 45 percent to 55 percent, "Some" was 26 percent to 44 percent, and "A few" was 1 percent to 25 percent. Includes responses from executive directors of all 40 CSBs.

Consumers, particularly children and adolescents, experience long wait times at some CSBs before receiving needed behavioral health treatment

In response to JLARC's 2019 survey, 26 CSBs ranked "more or different staff" as the most important thing they needed to meet STEP-VA outpatient behavioral health services expectations. An additional 12 CSBs ranked it as the second most important thing they needed.

Staffing shortages appear to be contributing to long wait times for behavioral health services at some CSBs, especially services for children and adolescents. In interviews and survey responses, CSB executive directors and staff reported that they are unable to provide services to some consumers in a timely manner because they do not have enough qualified staff. For example, in their survey response, one CSB executive director reported that their CSB was at 30 percent of staffing capacity for children's outpatient therapy, which was causing significant delays in providing this service to consumers. Similarly, another CSB reported that six of their 12 substance use disorder outpatient therapist positions were vacant, and that consumers were experiencing substantial delays as a result (sidebar).

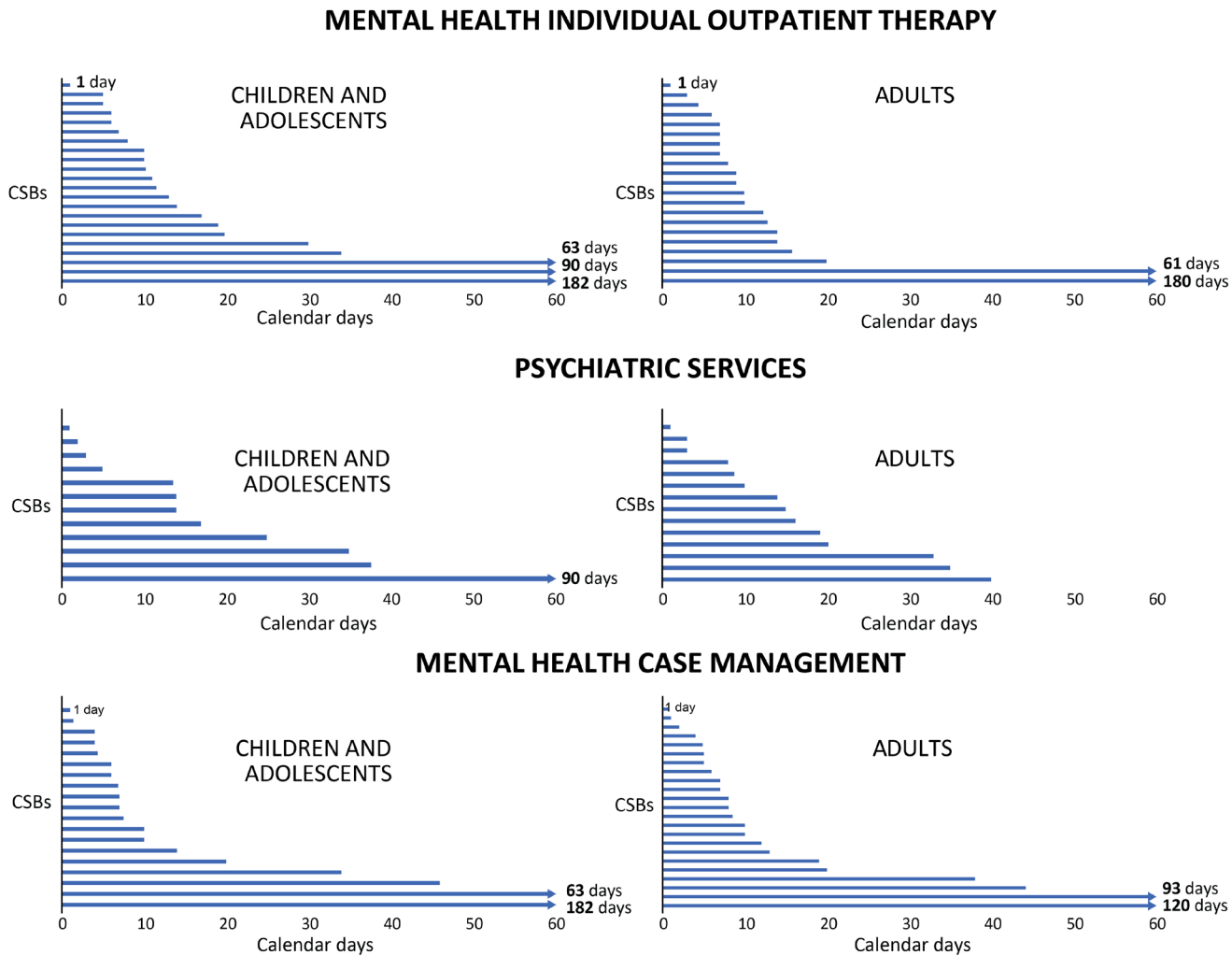
DBHDS data and reports imply that consumers who receive same day assessments are typically able to access treatment within 10 days. However, there are substantial issues with this data, including a broad definition of "outpatient services."

Systematic data is not available to fully understand which regions and services have the longest wait times for consumers. However, self-reported data from the CSBs that collect this information indicate particularly long waits for psychiatric services and mental health outpatient therapy, especially for children and adolescents, and outpatient therapy for substance use disorders (Figure 3-6). Long waits for services were reported at CSBs serving both rural and urban areas and CSBs serving both a relatively high and relatively low number of consumers.

FIGURE 3-6

Some CSBs reported particularly long waits for mental health outpatient therapy and psychiatric services, especially for children and adolescents (Consumers referred to services in June 2022)

Average wait between referral for service and first offered appointment (June 2022)



SOURCE: Responses to JLARC staff data request to CSBs, September 2022.

NOTE: Figure includes only CSBs that maintain wait times information for each of these services and responded to the data request. Mental health individual outpatient therapy wait time data was received from 18 CSBs for adults and 19 CSBs for children. Psychiatric services wait time data was received from 11 CSBs for adults and nine CSBs for children. Mental health case management wait time data was received from 21 CSBs for adults and 17 CSBs for children. For each type of service, several CSBs reported wait times that exceeded 60 days. These are indicated on the graphic.

Lack of CSB capacity to staff crisis services will likely hamper implementation of planned comprehensive crisis system

Over the past several fiscal years, DBHDS has allocated funding for CSBs to support the development of regional mobile crisis services. As of August 2022, 32 CSBs reported that consumers in their catchment area had access to at least one mobile crisis team.

As of November 2022, there were 15 CSB residential crisis stabilization facilities and three CSB 23-hour observation and treatment facilities in operation. An additional 10 23-hour observation and treatment facilities and four residential crisis stabilization facilities were at various stages of development.

The General Assembly has provided funding to support the development of additional crisis services across CSBs and has directed DBHDS to lead the development of a comprehensive crisis system. Several types of CSB crisis services are in the process of being developed or expanded, including mobile crisis units, 23-hour crisis observation and treatment facilities, and residential crisis stabilization units (sidebars). Each will require additional staff to become operational, and they will compete with one another for already-scarce staff, particularly licensed clinicians. (See Appendix E for more information about the different types of crisis services offered by CSBs.)

CSBs will face challenges staffing these additional crisis services, considering the current difficulties they report in staffing existing crisis services (Figure 3-2). Open-ended comments in JLARC's survey of CSB executive directors illustrate concerns about CSBs' ability to staff crisis services:

The biggest challenge with the implementation of the new crisis services has been the workforce shortage. The crisis system has true potential to impact significant changes. However, the qualified workforce is not there to allow for the services to align with the design.

DBHDS moved too quickly in rolling out the new crisis system. The technology was not ready, and there is currently inadequate staffing.

Thirty-five of 40 CSB executive directors reported that DBHDS had not assessed whether their CSB had sufficient staffing capacity to meet state expectations for the crisis services system.

Stakeholders report some CSBs are not providing services required in state law

Some CSBs are not providing services required in state law consistently or at all, according to interviews with leadership in state psychiatric hospitals, DBHDS central office staff, representatives of regional jails, and representatives of private hospitals. These services include preadmission screenings and psychiatric hospital discharge planning. For example, several state hospitals have assumed CSB responsibilities for discharge planning because it was reportedly not occurring. Additionally, representatives of several regional jails expressed frustration with the services provided by their local CSBs. For example, some CSBs were not consistently able or willing to conduct a preadmission screening for an inmate when requested by the jail. These representatives noted that CSB workforce shortages were the primary reason for the lack of responsiveness but expressed a desire for more accountability.

The full extent and causes of the shortcomings are unknown, because DBHDS generally lacks information on the performance of CSB core services, including preadmission screening and discharge planning. However, staffing challenges are clearly a contributing factor. (See Chapter 4 for more information on CSB preadmission screening and discharge planning.)

Increasing salaries and eliminating unnecessary administrative tasks would help CSBs staff core services

Data indicates there are not enough behavioral health providers in Virginia—and the U.S.—and CSB recruitment and retention challenges are driven partially by these broader shortages. However, CSBs appear to face certain challenges that make it particularly difficult to maintain an adequate workforce. The state could adopt certain near- and longer-term strategies to help CSBs mitigate these staffing challenges.

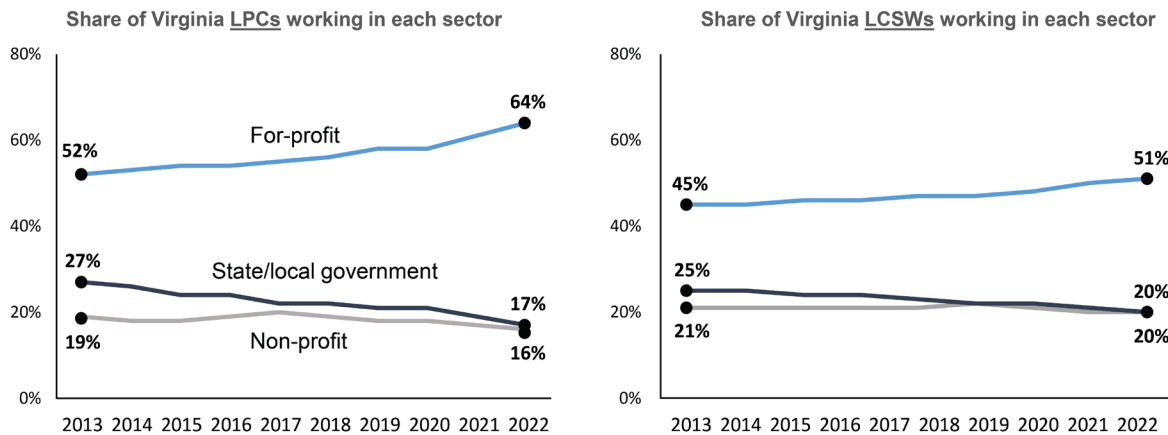
CSBs increasingly compete with private sector establishments to recruit and retain qualified behavioral health staff. The overall behavioral health workforce in Virginia is increasing, based on available licensing data and trends in the number of individuals graduating from post-secondary behavioral health programs in Virginia (sidebar). However, the proportion of licensed behavioral health providers working in state and local government has steadily declined since at least 2014, while the proportion working in the private sector has increased, according to data from the Department of Health Professions (DHP) (Figure 3-7) (sidebar).

Survey responses also indicate some current CSB staff are seeking private sector jobs. Half of the emergency services staff who reported they were considering leaving the CSB for another job intended to look for a job with another type of behavioral health provider.

JLARC staff used data from the Department of Health Professions (DHP) and Virginia Health Care Foundation to assess trends in Virginia's broader behavioral health workforce. (See Appendix B for more information.)

Several factors may be contributing to the shift in the broader behavioral health workforce toward the private sector. National reports indicate that administrative challenges dealing with insurance (including Medicaid), low reimbursement rates, and the corresponding ability of private behavioral health providers to receive payment for services directly from individuals at least partially explain it.

FIGURE 3-7
A smaller proportion of behavioral health professionals are working for state and local governments, while the share working in the private sector has grown



SOURCE: JLARC analyses of data from the DHP Healthcare Workforce Data Center.

NOTE: Figure includes share of all licensed professional counselors (LPCs) and licensed clinical social workers (LCSWs) in Virginia. Figure does not include several other types of behavioral health professionals, including psychiatrists and qualified mental health professionals, who may also work at CSBs, because similar data does not exist. LCSW data is not available for 2016.

Uncompetitive salaries are a key reason for CSB staffing challenges

Survey responses from CSB executive directors indicate compensation is a key factor driving their recruitment and retention challenges. More than 80 percent of CSB executive directors reported that compensation was one of the top three factors that made it difficult for their CSB to *recruit and hire* qualified staff for behavioral health services. Similarly, a majority of CSB directors reported that higher pay offered by private providers (58 percent of directors) and inadequate compensation (55 percent of directors) were among the top three factors that have made it difficult for their CSB to *retain* qualified staff for behavioral health services.

Survey responses from CSB staff also indicate that compensation is a top reason staff are planning to leave their jobs. Fifty-nine percent of CSB emergency services staff who responded to JLARC’s survey and who were considering leaving their job to take another job indicated they were planning to leave because they believed “other employers offered better compensation.” This was the second most commonly cited reason for considering leaving, just behind “the stress and workload are too much for me” (62 percent of respondents).

Some direct care staff of CSBs are paid substantially less than similar staff working elsewhere, based on available data, and a majority of CSBs do not offer competitive salaries for these positions. In a statewide 2022 Department of Health Professions survey, Virginia LCSWs and LPCs reported median incomes of between \$70,000 and \$79,999 (sidebar). In contrast, comparable positions at a majority of CSBs were paid average annual wages that were at least 10 percent lower as of March 2022 (Figure 3-8). The CSBs that paid higher average salaries were in Northern Virginia, where the cost of living is higher.

Virginia LCSWs and LPCs have experienced considerable growth in their reported incomes since 2014, according to DHP surveys. In 2014, LPCs reported median incomes of between \$50,000 and \$59,999, and LCSWs reported median incomes of \$55,001 and \$60,000.

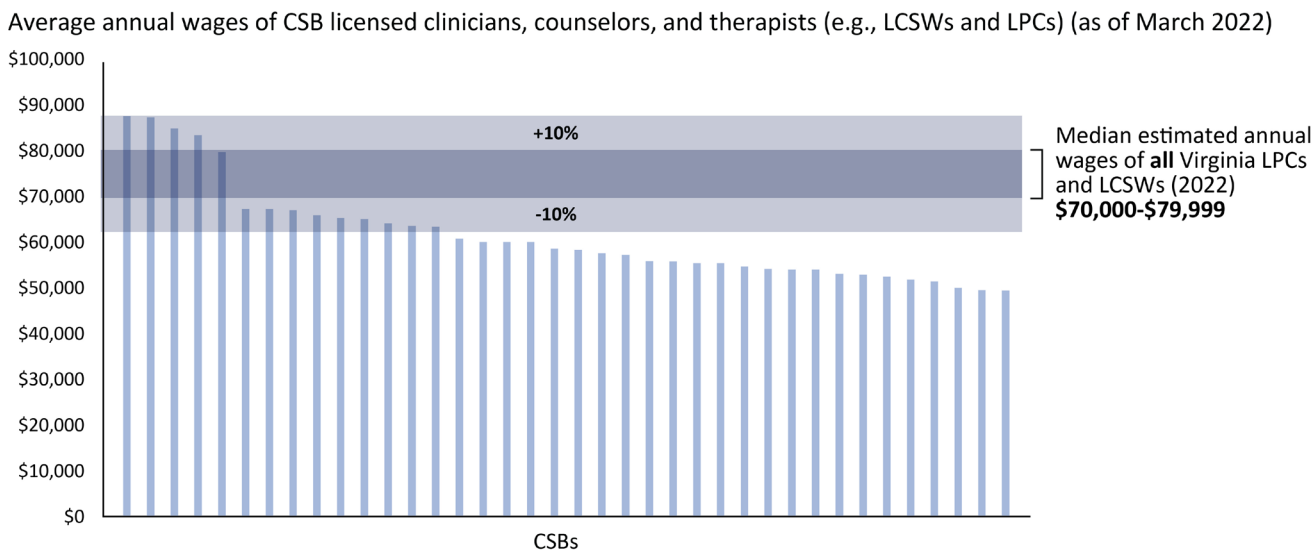
The General Assembly should appropriate funds for regular salary increases to CSB staff and require DBHDS to report annually on turnover, vacancy rates, and salaries across CSBs to monitor their workforce challenges. Salary increases should be prioritized for direct care staff, rather than administrative staff.

State costs to provide salary increases will vary depending on the (1) positions covered by the increases, (2) amount of the increases, and (3) proportion of the total cost of salary increases the General Assembly funds. For example, the estimated state cost of a 5 percent salary increase in FY24 to all CSB staff would range from about \$11 million (if the General Assembly covered 30 percent of the total cost of the increase) to about \$37 million (if the General Assembly covered 100 percent of the total cost of the increase). The estimated state cost of a 5 percent salary increase in FY24 targeted for CSB behavioral health direct care staff, who comprise about 60 percent of the CSB workforce, would range from about \$6.7 million (if 30 percent of the total costs were covered) to \$22.3 million (if 100 percent of the total costs were covered).

Given the particularly high turnover in emergency and crisis services, the General Assembly could also consider providing funding retention bonuses for these positions. Executive directors of 24 CSBs reported providing a retention bonus to at least some

behavioral health staff within the last 12 months. However, there has been no state funding allocated specifically for this purpose.

FIGURE 3-8
Majority of CSBs pay licensed behavioral health clinicians less than competitive salaries



SOURCE: JLARC analysis of (1) CSB reported wages of licensed clinicians, therapists, and counselors as of March 2022 and (2) 2022 DHP surveys of LCSWs and LPCs in Virginia.

NOTE: LCSW = licensed clinical social workers. LPCs = licensed professional counselors. One CSB (Piedmont CSB) did not report any wage data for licensed clinicians, therapists, and counselors. Figure does not include 5 percent increase that was appropriated to CSBs in FY23. There is no statutory or policy guidance about what Virginia considers “comparable” compensation, but JLARC staff considered between 90 percent and 110 percent of the market median to be a competitive range.

RECOMMENDATION 3

The General Assembly may wish to consider including funding in the Appropriation Act to fund a salary increase for direct care staff at community services boards.

RECOMMENDATION 4

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Behavioral Health and Developmental Services to report annually to the State Board of Behavioral Health and Developmental Services and the Behavioral Health Commission on average salaries, turnover, and vacancy rates, by position type, across community services boards.

Recent broader General Assembly behavioral health workforce programs, including a program to pay for clinical supervision of LCSWs and LPCs and a behavioral health loan forgiveness program that does not require a local match, will also likely help with CSB recruitment and retention.

Some CSBs have not increased employee salaries even though state funding was appropriated for that purpose

The General Assembly has appropriated funded salary increases for full-time CSB staff several times over the past decade, but some CSBs have not provided the salary increases to their employees (sidebar). One reason is that this funding has covered only

The General Assembly appropriated salary increases for full-time CSB staff four times between FY13 and FY22.

between 25 and 31 percent of the cost of the salary increases, which has been the proportion of total salary costs appropriated by the General Assembly in recent years. CSBs must find other sources of funding, such as local funding, to pay the remainder of the full salary increase. Some CSBs that did not have access to this additional funding chose not to increase salaries rather than increasing them by what could be viewed by employees as an immaterial amount.

The funding CSBs receive for salary increases is included with other state funding provided to CSBs, and no CSBs have returned funds because they decided not to provide salary increases. It is unclear how CSBs used these funds, but the Appropriation Act is clear that a portion of the state funding CSBs receive should be used for salary increases. CSBs should be held accountable for using state funds as intended by the General Assembly through their performance contracts with DBHDS.

CSB staff are local employees or, in the case of multi-jurisdictional CSBs, employees of entities controlled by local governments.

RECOMMENDATION 5

The General Assembly may wish to include language in the Appropriation Act directing the Department of Behavioral Health and Developmental Services (DBHDS) to amend community services board (CSB) performance contracts to require that (i) any funding appropriated by the General Assembly to CSBs for staff compensation only be used for staff compensation and (ii) CSBs report annually on any staff compensation actions taken during the prior fiscal year to DBHDS.

Burdensome administrative requirements contribute to direct care staff turnover and less time to provide patient care

“CSB workload is much different than the licensing and reimbursement requirements expected of private providers. Data collection, outcomes measures, additional documentation, and other reporting requirements shift the provider’s focus from high-need consumers to state-required compliance—not what they entered the field to do.”

— CSB executive director

Given staff shortages and apparent delays in consumers’ access to services, existing direct care staff need to be able to maximize their work time devoted to consumer care. CSB direct care providers, including licensed professional counselors, licensed clinical social workers, and licensed clinical psychologists, spend a significant amount of time on administrative work, which reduces time available to provide care to patients. Extensive time spent on administrative work not only reduces the care that can be provided but also contributes to staff turnover.

According to CSB directors, a major reason why CSB direct care staff are leaving their jobs is the required administrative work. In response to JLARC’s survey, 34 of 40 CSB executive directors cited “burdensome administrative requirements” among the top three factors that have made it difficult for their CSB to retain qualified staff for behavioral health services. This was the most commonly reported factor cited.

In survey responses, CSB staff also reported that heavy workloads were a key reason they were considering leaving. Among the 73 emergency services staff who were considering leaving their jobs, 45 staff (62 percent) reported, “the stress and workload associated with the job are too much for me,” as a primary reason why they were considering leaving. When asked in an open-ended question whether CSB staff had

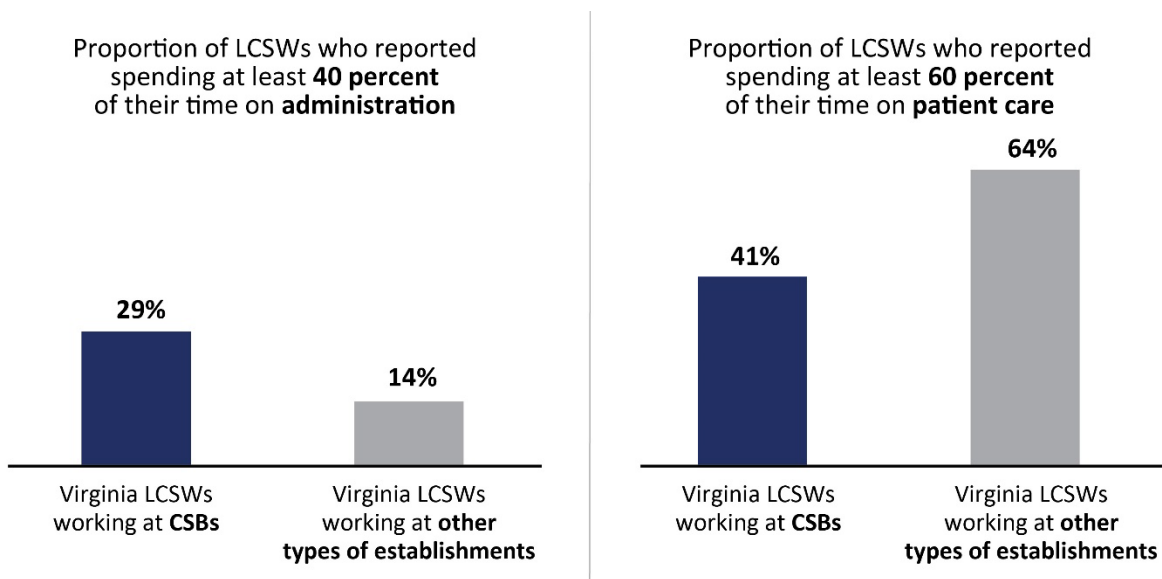
any recommendations on how the state could help CSBs address their workforce challenges, survey respondents most commonly recommended decreasing administrative burdens on CSB direct care staff. Although emergency services work is inherently difficult, eliminating burdensome administrative work could make workloads more manageable.

Statewide data on the workloads of CSB and non-CSB direct care staff supports concerns about the administrative burden on CSB staff. LCSWs, LCPs, and LPCs working at CSBs generally report spending (1) less time with patients and (2) more time on administrative tasks than the same types of professionals working for other behavioral health employers in Virginia, according to DHP data (sidebar). For example,

- 29 percent of LCSWs working at CSBs reported spending at least 40 percent of their time on administration in 2021, while only 14 percent of LCSWs for other behavioral health employers in Virginia reported spending this much time on administration.
- 41 percent of LCSWs working at CSBs reported spending at least 60 percent of their time on patient care—compared with 64 percent of LCSWs working elsewhere (Figure 3-9).

JLARC staff used data from Department of Health Professions 2021 surveys of licensed clinical psychologists, licensed clinical social workers, and licensed professional counselors to analyze time allocation patterns between CSBs and non-CSB establishments. (See Appendix B for more information.)

FIGURE 3-9
Virginia LCSWs working at CSBs report spending less time with patients and more time on administrative work compared with LCSWs working at other types of establishments (2021)



SOURCE: JLARC analysis of responses to DHP’s 2021 statewide survey of LCSWs in Virginia.
 NOTE: LCSW = licensed clinical social workers (LCSWs). N (CSBs) = 375; N (Others) = 4,361. Survey response rate among all current LCSWs in Virginia = 80%.

CSB staff’s administrative burden is at least partially attributable to the fact that CSBs are among the most regulated organizations in Virginia. They are funded by and accountable to numerous entities, including three divisions at DBHDS, the Department of Medical Assistance Services, six managed care organizations (MCOs), the Department of Health Professions (DHP), their respective board of directors, and their respective local government(s). In contrast, some private providers, such as outpatient providers that accept only cash for services, need only be licensed by and accountable to DHP.

“An intake in private outpatient mental health or substance use disorder practice takes just over an hour. In a CSB it takes almost three hours because of excessive documentation and data collection requirements.”

– CSB executive director

While multiple entities contribute to the administrative burden, DBHDS should start the process of determining how to reduce administrative burden because it is the state agency primarily responsible for overseeing and funding CSBs. DBHDS staff have acknowledged that their agency is contributing to the administrative burden, and that some of this burden is the result of conflicting or duplicative documentation and reporting requirements across various DBHDS offices and divisions. Additionally, DBHDS staff do not use some of the information reported to them for any meaningful purposes. However, no agency-wide efforts have been taken to reduce unnecessary requirements. In 2018, several workgroups comprising CSB staff identified specific administrative tasks that could be consolidated, eliminated, or reduced, and presented a list of these tasks for DBHDS to consider. According to DBHDS staff, “minimal progress” has been made toward addressing the administrative burden.

The General Assembly should direct DBHDS to conduct a focused effort to reduce the administrative burden on CSBs’ direct care staff with the goal of freeing up more of their time to provide patient care. DBHDS staff should ensure existing administrative documentation and reporting requirements for CSB direct care staff are necessary, and streamline them as much as possible. DBHDS could use existing recommendations presented by CSBs in 2018 as a starting point for its review. DBHDS should also identify any documentation or reporting requirements that conflict with those of other agencies, and work with these other agencies to align these requirements to the greatest extent possible.

None of the recommendations in this report are expected to increase administrative burdens on CSB direct care staff.

Several other recommendations, including recommendations to standardize managed care process and requirements to the maximum extent practicable (Chapter 5) and to improve the performance contract (Chapter 6), would also help reduce administrative burdens on CSB direct care staff.

RECOMMENDATION 6

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Behavioral Health and Developmental Services (DBHDS) to (i) identify all current DBHDS requirements related to documentation and reporting of community services board (CSB) behavioral health services; (ii) identify which of these requirements currently apply to work by CSB direct care staff; (iii) identify any DBHDS requirements of direct care staff that are duplicative of or conflict with other DBHDS requirements; (iv) eliminate any requirements that are not essential to ensuring consumers receive effective and timely services or are duplicative or conflicting; and (v) report to the State Board of Behavioral Health and Developmental Services and the Behavioral Health Commission on progress made toward eliminating administrative requirements that are not essential, are duplicative, or are conflicting.

4 Emergency and Discharge Planning Services

Community services boards (CSBs) are required by state law to evaluate whether individuals who are, or who are reported to be, experiencing a behavioral health crisis should be admitted to an inpatient psychiatric facility (sidebar). This evaluation is called a “preadmission screening.” When inpatient psychiatric treatment is deemed necessary, CSBs are also required to locate an appropriate facility for individuals. These responsibilities, commonly referred to as “emergency services,” are an essential component of the involuntary commitment process and contribute to state hospital bed utilization.

For individuals placed in state psychiatric hospitals, CSBs are also required by state law to develop discharge plans, which identify the services an individual will need upon release and the entities that will provide those services. Discharge plans need to be completed before an individual can be released. The timeliness and effectiveness of discharge plans can affect when an individual is released and the likelihood that they will require future psychiatric hospitalization.

The utilization of the state’s nine psychiatric hospitals has been a major concern for behavioral health professionals, legislators, and executive branch officials, because the reduced capacity of and high demand for state hospital beds has created an urgent public behavioral health situation (sidebar). The high demand for state hospital beds is due to numerous factors, many of which are not related to CSBs, such as the growing demand for state hospital beds needed for individuals in the criminal justice system. Still, to help avoid inappropriate use of limited state hospital capacity, CSB emergency services and discharge planning efforts need to be carried out effectively and efficiently. Alternative services and facilities—especially the crisis services that the state and CSBs have funded—need to also be sufficiently available statewide to ensure that CSB staff have alternatives to inpatient psychiatric hospital placements when appropriate.

CSB TDO recommendations have contributed to increase in state psychiatric hospital admissions

During a preadmission screening, a CSB clinician determines whether an individual who has been placed under an emergency custody order by a magistrate or law enforcement officer meets the criteria for a temporary detention order (TDO) (Figure 4-1). CSB staff are also required to identify the facility at which the individual will be placed for further assessment and treatment during the TDO period. If an individual needs to be placed under a TDO, but a bed at a private psychiatric hospital or other

Preadmission screenings may result in recommendations other than involuntary inpatient psychiatric treatment.

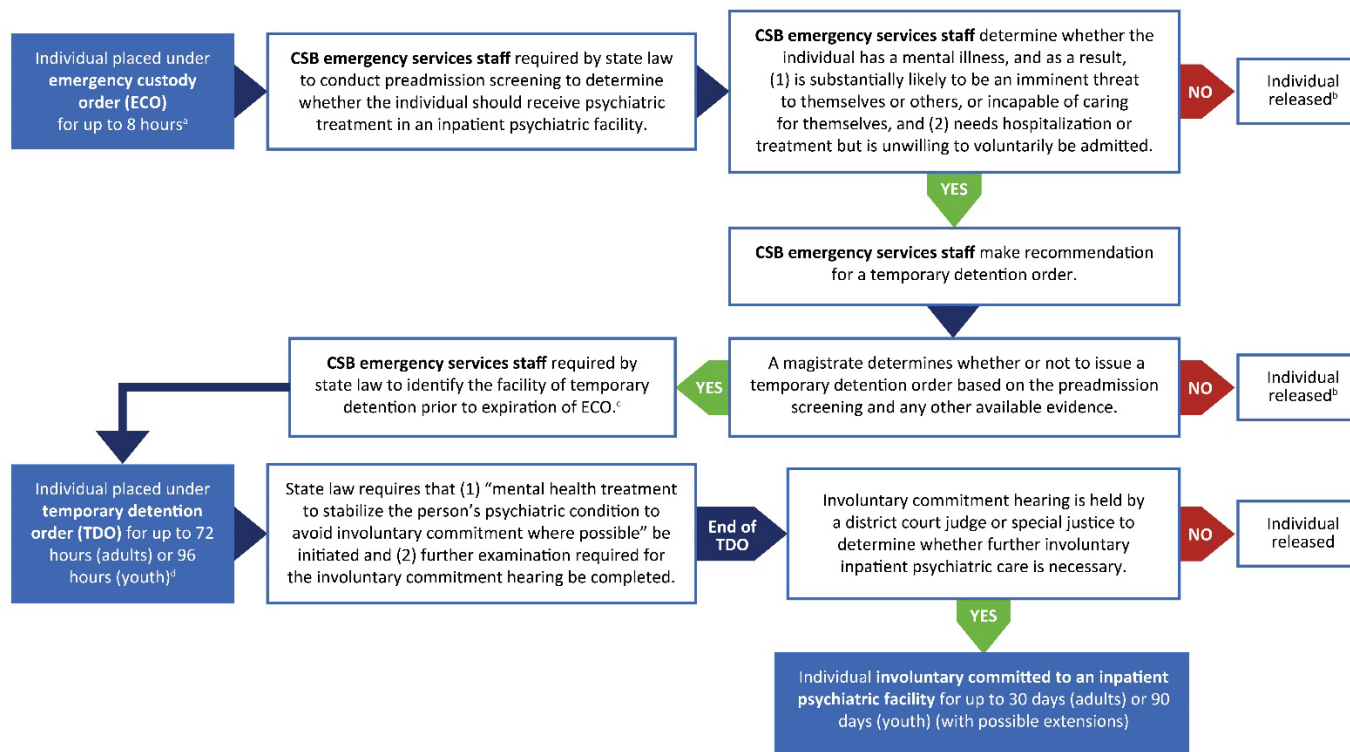
Examples of these recommendations include voluntary inpatient psychiatric treatment, outpatient treatment, and no further intervention.

As of October 2022, Virginia's state psychiatric hospitals were operating at the reduced capacity of 1,169 staffed beds. Prior to July 2021, the facilities had a total of 1,356 staffed beds in operation. This reduced capacity contributed to the unmet demand for services described in this section.

An individual can be placed under an emergency custody order (ECO) by a magistrate or law enforcement officer if there is probable cause to believe the individual, who has a mental illness, is substantially likely in the near future to physically harm themselves or others, or lacks the capacity to care for themselves.

Figure 4-1

CSBs are required to conduct preadmission screenings and bed searches as part of the involuntary commitment process



SOURCE: JLARC staff review of the Code of Virginia and interviews with CSB emergency services staff.

NOTE: Figure simplified for clarity purposes. ^a An individual may also request a preadmission screening voluntarily. ^b An individual may be released with or without a referral to other services. ^c The facility of temporary detention can be a state or licensed hospital, training center, psychiatric hospital, or other type of residential or outpatient mental health or developmental services facility that can accept custody of an individual. ^d An individual can be released prior to an involuntary commitment hearing if (1) a special justice or court judge, or (2) the director of the facility of temporary detention finds that the individual does not meet the criteria for involuntary commitment.

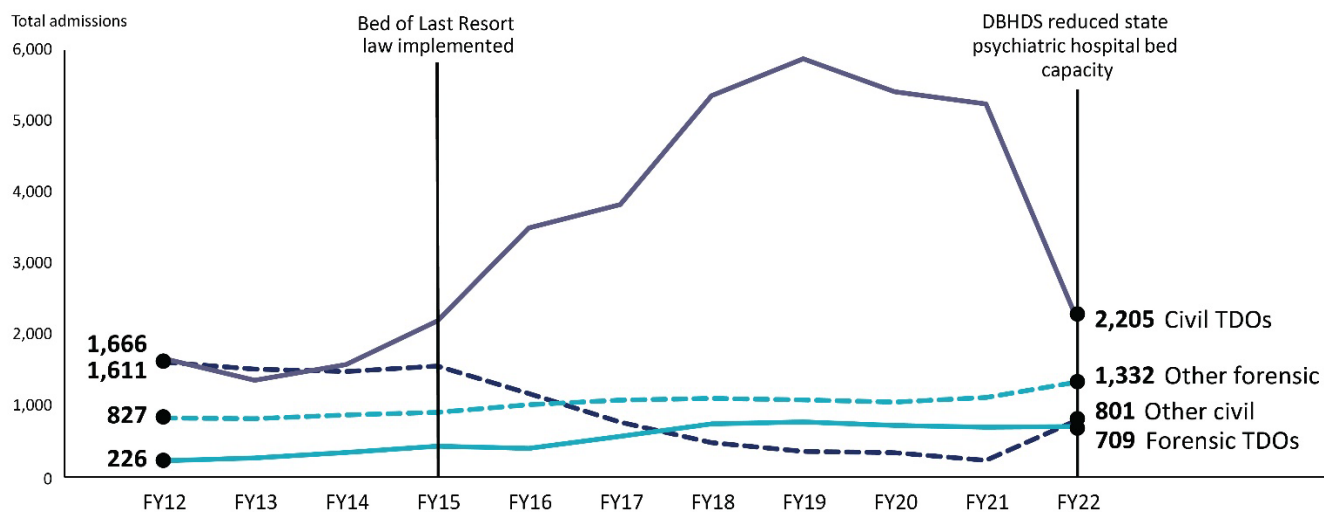
appropriate facility is not found by the time the emergency custody order expires, the *state* psychiatric hospital is required to admit the individual. This requirement is a key element of Virginia’s Bed of Last Resort law, which was implemented in FY15.

State psychiatric hospital admissions increased 68 percent between FY12 and FY21, and an increase in civil TDO admissions was a major contributing factor (Figure 4-2). Although various factors contribute to increases in state psychiatric hospital admissions, the number of civil TDO admissions to state psychiatric hospitals tripled between FY12 and FY21—from around 1,700 admissions to 5,200. Over this period, TDOs related to criminal acts or alleged criminal acts (“forensic TDOs”) also increased. Other civil admissions, including voluntary admissions, decreased.

Although civil TDO admissions steadily increased over this period, they declined significantly in FY22, when DBHDS reduced the bed capacity of state psychiatric hospitals because of staff vacancies. To achieve and maintain the reduced capacity, DBHDS limited the number of new civil TDO admissions into state psychiatric hospitals.

Unless otherwise specified, in this chapter TDOs refer to temporary detention orders issued through the civil commitment process. Individuals may also be placed under a TDO through a separate forensic process when related to criminal acts or alleged criminal acts.

Figure 4-2
Civil TDO admissions contribute to increases in state hospital admissions



SOURCE: JLARC analysis of DBHDS state psychiatric hospital admission data.

With the exception of the most recent fiscal year (FY22), state psychiatric hospitals have generally experienced an increase in civil TDO admissions because more individuals under a TDO are being placed in *state* hospitals rather than other facilities. In FY21, 25 percent of individuals under a TDO were placed in a state psychiatric hospital compared with 11 percent in FY15, though the total number of TDOs and pre-admission screenings decreased over this period. As discussed below, various factors may be contributing to the increase in civil TDO admissions.

State psychiatric hospitals have been operating at or near capacity, which requires some individuals to be placed on a waitlist for admission. Between September 2021 and July 2022, a daily average of 35 adults and nine children were on the statewide waitlist to be admitted to a state psychiatric hospital.

In some cases, the waits for admissions are extensive, particularly for children, and some individuals are unable to receive treatment in a timely manner or at all. For example, various stakeholders reported that the lack of inpatient psychiatric beds have led to

- individuals being detained in emergency departments for long periods without receiving needed psychiatric treatment. Individuals placed under a TDO should receive treatment during the TDO period to help avoid involuntary commitment to a psychiatric hospital, according to state law; and
- individuals being released from emergency departments at the expiration of their emergency custody order or TDO without receiving any psychiatric treatment, despite being determined to be an imminent threat to themselves or others. In FY21, 120 individuals were reported to have left a facility or assessment site without receiving needed treatment or assessments. The Bed of Last Resort law was designed to prevent these situations.

CSBs recommend state hospital TDO admissions for some who do not need that level or type of care

Inpatient psychiatric hospitalization is the most restrictive setting for psychiatric treatment available in the Commonwealth. Such placements should be reserved for individuals who need the most intensive psychiatric treatment and for whom no feasible alternative treatment options are available.

Placing individuals in an inpatient psychiatric hospital when they do not require the level or type of care provided can have adverse effects on both the individual and the broader behavioral health system. For example, inappropriate inpatient psychiatric hospitalizations result in

- individuals not receiving the psychiatric treatment they need;
- individuals receiving psychiatric treatment they do not need; and
- a misuse of inpatient psychiatric facilities, including state psychiatric hospitals that are already operating at or near capacity (sidebar).

Substantial portion of individuals recommended for state psychiatric hospital placement by CSBs do not need that level or type of care

Staff from each state psychiatric hospital interviewed indicated that a substantial proportion of individuals admitted to their facilities through the civil TDO process do not require the level or type of care provided. (JLARC staff interviewed leadership

As used in this chapter, the characterization of a civil TDO recommendation or placement as “inappropriate” refers to a civil TDO recommendation or placement that does not align with the individual’s needs. As discussed below, in some cases, civil TDO placements in state psychiatric hospitals may be determined necessary because of a lack of suitable alternatives, but they are still considered inappropriate because the individual does not need that level or type of care.

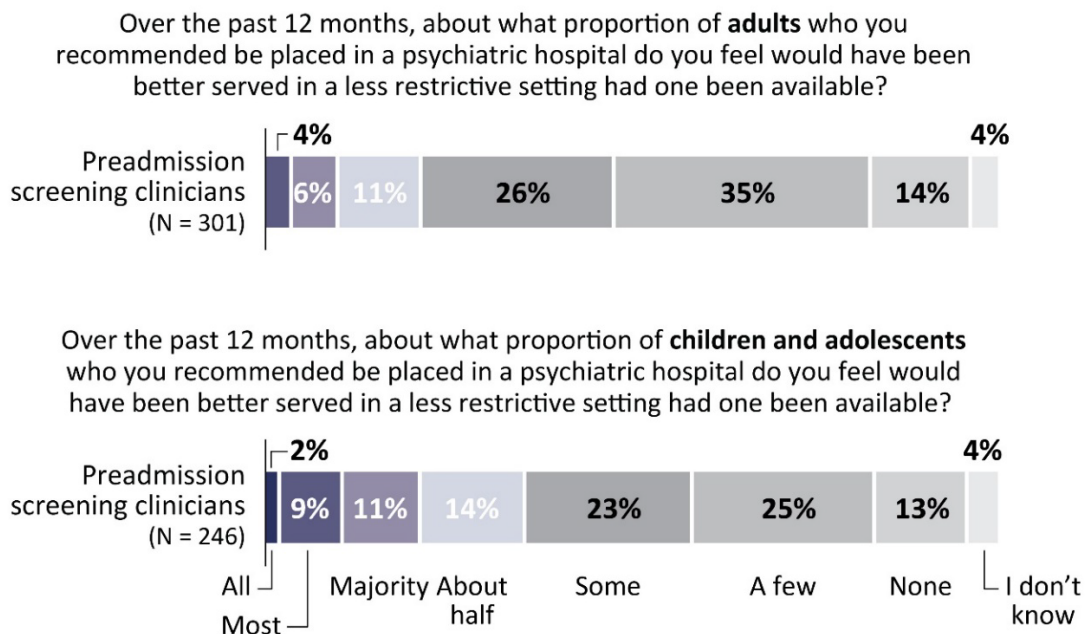
and staff of eight of Virginia’s nine state psychiatric hospitals.) Among the state psychiatric hospitals that receive civil TDO admissions regularly, staff estimated that between 20 and 50 percent of their civil admissions did not need to be placed at their facility. These individuals either

- had a mental illness but did not need the level of psychiatric treatment provided by the state psychiatric hospital or
- had conditions that did not require psychiatric treatment (e.g., their symptoms were a manifestation of an underlying physical condition, such as an infection, rather than a mental illness).

CSB preadmission screening clinicians also reported that some adults and children they have recommended be placed in a psychiatric hospital could have been better served in an alternative setting, had one been available (Figure 4-3). Around 20 percent of surveyed clinicians indicated that half or more of the *adults* they recommended for psychiatric hospitalization would have been better served in a less restrictive setting. Thirty-six percent of clinicians indicated this to be the case for *children and adolescents* for whom they had recommended psychiatric hospitalization.

Figure 4-3

A substantial portion of CSB clinicians reported that half or more of individuals for whom they recommended psychiatric hospitalization would have been better served in an alternative setting



SOURCE: Responses to JLARC survey of CSB preadmission screening clinicians and emergency services directors.

NOTE: In survey, “All” was 100 percent, “Most” was 76 percent to 99 percent, “Majority” was 56 percent to 75 percent, “About Half” was 45 percent to 55 percent, “Some” was 26 percent to 44 percent, and “A few” was 1 percent to 25 percent. The number of preadmission screening clinicians who responded to each question depended on whether or not the clinicians had conducted preadmission screening for adults, or children or adolescents over the past 12 months.

The most common conditions of individuals placed inappropriately in state psychiatric hospitals were dementia, an intellectual or developmental disability, an impairment due to substance use, or a non-psychiatric medical condition. Additionally, youth in foster care, particularly those exhibiting behavioral challenges, were frequently noted to be placed in state psychiatric hospitals inappropriately.

For individuals who do not require the type of care provided in state psychiatric hospitals, placement in these facilities can result in their underlying conditions remaining untreated and can be harmful. State psychiatric hospitals are generally not equipped to treat non-psychiatric conditions, according to state psychiatric hospital staff. For example, through its Medical TDO policy and procedures document (2020), which outlines diagnoses and conditions state psychiatric hospitals are unable to treat, DBHDS states that

[state psychiatric hospitals] are not equipped to treat individuals with dementia as a primary diagnosis. These individuals are also at increased risk of victimization.

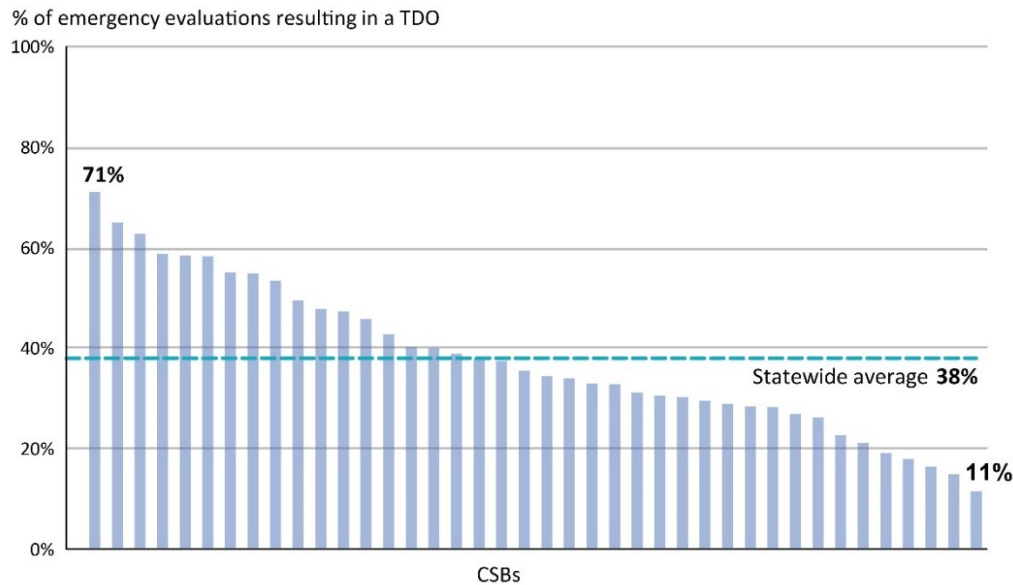
Psychiatric hospitalization can also make it difficult to get individuals the continued treatment and care they need. In a recent presentation to the Behavioral Health Commission, DBHDS estimated that at least 80 percent of individuals placed in a state psychiatric hospital lose their nursing home or assisted living facility placements after being admitted to a state psychiatric hospital. This may occur because nursing homes or assisted living facilities lack the staff or other resources to manage especially difficult behaviors, but also because of the stigma associated with state psychiatric hospitalization. This creates challenges to safely discharging individuals from the psychiatric hospitals, contributing to longer stays in these facilities.

Inappropriate placements in state hospitals also prevent individuals who do need inpatient psychiatric care from accessing it in a timely manner and can also increase the likelihood that they receive no treatment at all. This is occurring even though these individuals have been determined by CSB clinicians to be a risk to themselves or others.

Training gaps and insufficient oversight likely contribute to some inappropriate psychiatric hospitalization recommendations

Wide variation across CSBs in the proportion of preadmission screenings that lead to a TDO raises questions about the overall quality of the screenings (Figure 4-4). In FY21, the proportion of emergency evaluations that resulted in a TDO ranged from 11 percent to 71 percent across CSBs. Some variation in CSBs' TDO rates is expected, but this wide variation indicates inconsistencies in CSBs' preadmission screening efforts.

Figure 4-4
Wide variation in TDO rates across CSBs indicates inconsistencies in pre-admission screening practices and recommendations



SOURCE: JLARC analysis of DBHDS emergency services activity data (FY21).
 Note: Figure includes only civil TDOs and excludes forensic TDOs.

Ensuring CSB preadmission screening clinicians have adequate qualifications, training, support, and oversight to complete preadmission screenings can help ensure that quality preadmission screenings occur at all CSBs. Virginia’s current qualification requirements for these clinicians appear adequate, and are similar to those in other states, but additional clinician training and better oversight may improve the quality of preadmission screenings (sidebar).

Gaps in training and support likely hinder CSB preadmission screening clinicians’ ability to make appropriate recommendations

Forty percent of surveyed preadmission screening clinicians felt that additional training would be beneficial. The most common training topics these staff felt were needed included

- developing recommendations based on the preadmission screening (58 percent);
- understanding basic medical conditions (56 percent); and
- understanding how to interpret lab results (56 percent).

Additionally, around a third of preadmission screeners who responded to JLARC’s survey had not received formal training on how to conduct preadmission screenings within the last three years. Examples of clinicians’ feedback regarding training are reflected below.

To become a certified preadmission screener, CSB staff must complete online modules developed by DBHDS and orientation through their CSB. They must also conduct at least three preadmission screenings, observe 40 hours of emergency services operations, and perform 40 hours of emergency services operations under direct supervision of a certified preadmission screening clinician.

To receive recertification, preadmission screening clinicians must annually complete 16 hours of relevant continued education and receive 12 hours of clinical supervision from a certified preadmission screening clinician.

The current online modules created by DBHDS... are laughable at best in their utility. They are outdated, lacking any sense of context particular to the delivery of service.

Most of the [current training is] at the expense of more practical training [such as] practicing prescreens, using role-plays or learning how to work with community stakeholders and providers. This exceptionally important part of training is conducted [by] staff who are on-shift and juggling their [other] work responsibilities... making the training process very haphazard and disorganized.

Addressing gaps in training for preadmission screening clinicians could help reduce inappropriate psychiatric hospitalizations. For example, understanding basic medical conditions and lab results is critical to determine whether an individual's symptoms, such as aggression or hallucination, are caused by a physical condition, such as an infection, or a mental illness.

VDOE contracted with seven higher education institutions to develop **Training and Technical Assistance Centers (TTACs)**, which provide ongoing training and support for special education personnel.

Developing the additional training needed will require specialized knowledge of clinical evaluations and best practices for formulating recommendations. At least two other states (New Jersey and North Carolina) contract with universities and education centers to provide ongoing training and support for professionals providing similar evaluations to Virginia's preadmission screening clinicians.

To ensure CSB preadmission screening clinicians are equipped with training and support needed to make appropriate recommendations, DBHDS should contract with one or more higher education institutions to develop one or more training and technical assistance centers for CSB emergency services staff. Some of Virginia's higher education institutions already have the expertise needed to develop these centers, including Virginia Commonwealth University and the University of Virginia, which have departments of psychiatry with specialties in consultation-liaison psychiatry, inpatient psychiatry, and adult and child psychiatric services.

“ It is not realistic to expect [prescreening clinicians] to be experts in all things. Developing a group of experts they can consult with for specialized situations would be helpful, ”

— State psychiatric hospital director

At a minimum, these centers should develop and administer standardized training on developing preadmission screening recommendations, interpreting lab results, and understanding basic medical conditions. These trainings should be updated as needed to align with current best practices. Additionally, these centers should provide ongoing technical assistance to these clinicians, particularly when opportunities for improvement are identified by DBHDS.

RECOMMENDATION 7

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Behavioral Health and Developmental Services (DBHDS) to contract with one or more higher education institutions to establish training and technical assistance centers to (i) deliver standardized training for preadmission screening clinicians on developing appropriate preadmission screening recommendations (including those related to the temporary detention of individuals and admission to psychiatric hospitals), interpreting lab results, and understanding basic medical conditions and (ii) provide technical assistance to preadmission screening clinicians, particularly when quality improvement is deemed necessary by DBHDS.

DBHDS oversight of CSBs' preadmission screenings is insufficient to ensure clinicians make appropriate recommendations

Currently, DBHDS does not have a formalized, structured ongoing monitoring process related to CSBs' preadmission screening practices and recommendations. As a result it cannot determine

- the extent to which CSB preadmission screening clinicians are conducting effective preadmission screenings and making appropriate recommendations;
- whether additional support and training is needed to improve the quality of preadmission screening practices and appropriateness of CSB recommendations; or
- the extent to which factors outside of CSBs' control are contributing to inappropriate psychiatric hospitalizations.

The prevalence of inappropriate psychiatric hospitalizations and the wide variation in TDO rates across CSBs indicate a need for additional monitoring of CSB preadmission screening practices and recommendations. This would help DBHDS determine the extent to which CSB preadmission screenings and recommendations result in inappropriate hospitalizations and inform DBHDS about the need for additional training or targeted technical assistance.

DBHDS already has access to preadmission screening data that could be used to target more in-depth reviews of CSB preadmission screening efforts. For example, DBHDS has access to preadmission screening forms for individuals placed in state psychiatric hospitals under a TDO and collects data on emergency services activities (i.e., number of evaluations, TDOs executed, and ECOs by CSB). DBHDS could also request a random sample of additional preadmission screening forms from CSBs directly, as needed.

In July 2022, DBHDS initiated additional oversight activities related to CSB preadmission screening efforts, and these new activities appear to be an improvement. These activities have not been fully formalized but could be used as a starting point for de-

Current DBHDS oversight of CSB preadmission screening efforts is limited to collecting forms from clinicians that attest that the individual meets the certification or recertification requirements to be a preadmission screening clinician.

veloping the agency's ongoing oversight capabilities related to preadmission screenings. When fully developed, DBHDS's additional oversight activities need to be sufficient to ensure that the agency has a comprehensive understanding of the effectiveness and appropriateness of preadmission screenings and recommendations, and the extent to which factors outside of clinicians' control contribute to inappropriate recommendations. The additional oversight activities should also be accompanied by relevant technical assistance for CSB staff, as appropriate.

RECOMMENDATION 8

The Department of Behavioral Health and Developmental Services should develop and implement (i) a comprehensive and structured process to review a sample of preadmission screening forms from each community services board on an ongoing basis to ensure sufficient information is collected as part of preadmission screenings and that the resulting recommendations, including those related to the temporary detention of individuals and admission to psychiatric hospitals, are well supported; and (ii) an actionable quality improvement process to address identified shortcomings with CSB preadmission screenings and recommendations.

Lack of alternative placements contributes to inappropriate state hospital TDO admissions

While improving training and oversight for preadmission screening clinicians can help prevent inappropriate psychiatric hospitalizations, such placements appear to be driven in part by a lack of alternative placements and treatment options, circumstances which are outside of the preadmission screening clinicians' control. As previously noted, CSB preadmission screening clinicians indicated that at least some of the individuals who were placed in a psychiatric hospital after a TDO could have been better served in an alternative setting, had one been available. State psychiatric hospital staff also acknowledged that inappropriate placements in their facilities were in part driven by a lack of treatment and placement options in the community.

Ensuring adequate placement options are available is particularly critical in Virginia given the Bed of Last Resort Law. Through this law, state psychiatric hospitals are required to admit individuals placed under a TDO regardless of whether staff of these facilities agree that the individual requires the level or type of care available. For example, an individual placed under a TDO whose primary diagnosis is dementia must be admitted to a state psychiatric hospital if no alternative placement exists, but a state psychiatric hospital is generally not equipped to treat dementia.

Expanding alternative placement options could help reduce inappropriate psychiatric hospitalizations, limit the number of TDOs that result in state psychiatric hospital admissions, and provide more appropriate care for individuals. Increasing capacity in private psychiatric hospitals and residential crisis stabilization units, two key alternative placement options, would help reduce the number of individuals under a TDO who

need to be placed in a state psychiatric hospital. Additionally, expanding access to non-psychiatric placements, like memory care units for individuals with dementia, would help divert individuals from the involuntary commitment process, when psychiatric treatment is not the type of care needed.

Fewer individuals under a TDO are placed in private psychiatric hospitals

TDO admissions to private psychiatric hospitals have declined since the Bed of Last Resort legislation passed, but still represent the majority of TDO hospital admissions. Based on the best available data, between FY15 and FY22, TDO admissions to private psychiatric facilities decreased from around 22,000 admissions to 18,900 (16 percent). The proportion of all TDOs that are served in private hospitals generally declined over this period as well. However, in FY22, private hospitals admitted a higher proportion of all civil TDOs than in previous years, largely because of the substantial reduction in capacity at state psychiatric hospitals.

The reasons for the reduction in private psychiatric hospitalizations for individuals under a civil TDO are not fully understood; there are various factors that may affect whether a private hospital is able or willing to admit these individuals. However, according to DBHDS, the most common reasons for private hospitals' denials were that the acuity of the patient's needs was too high, the patient's diagnosis did not meet the facility's admissions criteria, and the facility was concerned about potential barriers to discharging the patient in the future.

The General Assembly has recently provided funding to DBHDS to expand alternative placement options to state hospitalization, including through increasing private hospital capacity to support individuals requiring psychiatric treatment. In FY22, this funding was used to develop crisis services at private facilities and expand private psychiatric hospitals' bed capacity. For example, DBHDS contracted with a private hospital to pilot a Comprehensive Psychiatric Emergency Program (CPEP), which provides crisis services in specialized units in hospital emergency departments. According to the provider, within seven months 220 individuals were diverted from a state psychiatric hospital through this program.

During the 2023 JLARC study of state psychiatric hospitals, JLARC staff will review these existing diversion programs and identify other strategies or opportunities to further reduce inappropriate state psychiatric hospitalizations.

Additional residential crisis stabilization unit bed capacity would help reduce inappropriate TDO placements in state psychiatric hospitals

As an alternative to public and private psychiatric hospitalization, individuals under a TDO may instead receive psychiatric treatment at a residential crisis stabilization unit (RCSU). RCSUs are treatment facilities where a person in crisis may stay for short

periods, such as three to seven days, to receive behavioral health services to help stabilize their condition. Most RCSUs in the state are operated by CSBs, but a small number are operated by private providers. Treatment at RCSUs may include therapy, medication, care coordination, psychiatric medication, and peer recovery support.

RCSUs would more directly help alleviate state psychiatric hospital admission pressures than other types of crisis services, such as mobile crisis services and 23-hour crisis stabilization services, because they can be equipped to treat individuals under a TDO. They can also provide individuals who need further residential treatment after their TDO expires with an appropriate placement when they are released from the state psychiatric hospital.

CSB executive directors and preadmission screening clinicians reported that additional RCSU beds would help avoid the need to place some individuals in state psychiatric hospitals after a TDO. In response to JLARC’s surveys,

- 57 percent of preadmission screening clinicians and 78 percent of CSB executive directors reported that additional RCSUs in their area would most effectively reduce the number of children and adolescents placed in inpatient psychiatric facilities, including state psychiatric hospitals.
- 50 percent of preadmission screening clinicians and 58 percent of CSB executive directors reported additional RCSU facilities would most effectively reduce the number of adults placed in inpatient psychiatric facilities.

Additional crisis services that are in various stages of implementation across Virginia are based on the **Crisis Now model**, which was developed by the National Association of State Mental Health Program Directors and is regarded as a best practice by SAMHSA.

In addition, in responses to a May 2022 survey from the Virginia Hospital and Healthcare Association, private psychiatric hospitals in several regions of the state identified additional RCSUs as a key service needed to help meet local needs.

Virginia likely needs roughly twice as many licensed RCSU beds as are currently available, which would require at least 13 new RCSUs (if every RCSU operates the maximum 16 beds). According to the national crisis model that Virginia is in the process of implementing, Virginia needs at least 4.7 RCSU beds per 100,000 residents to meet statewide need (sidebar). However, currently, the state has only 2.5 licensed RCSU beds per 100,000 residents, including both adult and youth beds (sidebar).

As of November 2022, **Virginia had a total of 185 licensed RCSU beds (160 beds for adults and 25 beds for children and adolescents)**. In 2021, DBHDS reported that 111 RCSU beds were staffed and operating.

Gaps in RCSU availability are most pronounced for certain populations and geographic regions of the state. Virginia has only three RCSUs for children and adolescents, and these facilities operate a total of 25 beds. Additionally, as of October 2022, a large portion of Southside Virginia’s population does not have an adult RCSU within a one-hour drive, and the CSBs that serve these areas have state psychiatric hospital admission rates significantly higher than the statewide rate.

Several private providers ceased RCSU operations during the COVID-19 pandemic, with an estimated loss of 24 beds for adults.

Individuals who require only short-term psychiatric residential treatment would most likely benefit from additional RCSU capacity, and a substantial portion of individuals who are placed in state psychiatric hospitals have short stays. Of all individuals released from a state psychiatric hospital in FY22, 26 percent were released within 10 days—the maximum length of stay at a RCSU.

In the near-term, the state could take a two-pronged approach to increasing access to RCSUs. First, the General Assembly should consider providing additional funding to help fully staff existing RCSUs, since not all licensed beds are staffed because of CSBs' current recruitment and retention challenges. By devoting resources to fully staffing existing RCSUs, the state could increase the availability of RCSU beds relatively quickly and help relieve pressure on state psychiatric hospitals from TDO admissions.

Four CSBs are in the early stages of developing new RCSUs, including one in Southside Virginia, but no new state funding has been allocated specifically for developing more RCSUs. These RCSUs are not included in the current bed count.

The General Assembly should also prioritize the development of *additional* RCSUs, particularly for children and adolescents and for underserved areas of the state. Establishing each new RCSU costs from \$2 to \$5 million, according to DBHDS, depending on the size of the facility. Estimated annual operating costs for the state are \$2 million to \$3.5 million, not including reimbursements from Medicaid or commercial insurance, which would reduce the state's total share of the cost. Any RCSU operating costs not covered by state funding, Medicaid reimbursements, or other insurance would need to be covered by local funds. Total state costs to establish and operate RCSUs could be further reduced if additional private providers open RCSUs, or if the state or CSBs partner with private providers for RCSU beds. For instance, one CSB partners with a local nonprofit organization to operate an RCSU for children, which is housed at the nonprofit.

In the short term, fully staffing and developing RCSUs will require additional state investment, and the state is unlikely to realize any immediate savings on behavioral health care. However, in the long term, increased use of RCSUs is likely to reduce state spending on behavioral health care. For example, although the cost of individuals' stays in state psychiatric hospitals and an RCSU are generally comparable, state psychiatric hospital stays cannot be paid for by Medicaid, while RCSU stays can (for Medicaid enrollees) (sidebar). This would reduce the state's share of the cost in the long term.

The full cost of a stay in a state psychiatric hospital is paid for by the state, unless a patient's private insurance agrees to cover the cost, or the patient has some ability to pay.

DBHDS requests for future funding for additional RCSUs should include sufficient information to ensure the new facilities would be the most strategic use of limited resources. At a minimum, this information should include specific details on the unmet needs the new facility will address and the capacity of CSBs or private providers to staff the proposed facility and to serve individuals under a TDO. The information should also include the expected initial and ongoing costs of the proposed facility and the planned timeframe for when the facility would become operational.

RECOMMENDATION 9

The General Assembly may wish to consider including funding in the Appropriation Act for the Department of Behavioral Health and Developmental Services to help community services boards hire additional staff for residential crisis stabilization units whose bed capacity is not fully utilized because of a lack of staff.

RECOMMENDATION 10

The General Assembly may wish to consider including language and funding in the Appropriation Act to support the development and ongoing operations of additional residential crisis stabilization units for children and adolescents, the Southside area, and any other underserved areas of the state, and to direct that the Department of Behavioral Health and Developmental Services provide detailed information on the following before such funding is provided for a new unit to ensure the most strategic deployment of limited resources: (i) the unmet needs the new unit will address, (ii) the capacity of community service boards or private providers to staff the proposed unit, (iii) the unit's ability to serve individuals under a temporary detention order, (iv) expected initial and ongoing costs of the proposed unit, and (v) the planned timeframe for when the unit would become operational.

DBHDS has allocated some state funding to support alternative placements, including for individuals with dementia

Stakeholders, including preadmission screening clinicians and state psychiatric hospital staff, commonly reported that a lack of alternative placements and treatment options for certain populations were also a major contributing factor to inappropriate placements in state psychiatric hospitals. In particular, through JLARC's surveys, nearly 60 percent of surveyed preadmission screening clinicians indicated that greater availability of long-term care facilities that accepted individuals with dementia or other non-psychiatric behavioral health needs would also help reduce psychiatric hospitalizations. Examples of stakeholder feedback regarding the lack of non-psychiatric placement options are reflected below.

Dementia cases have steadily increased and often result in inpatient psychiatric admission as a "last resort" due to no appropriate community supports. The same is true for complex medical conditions. (CSB preadmission screener)

[Children with developmental disabilities] are often experiencing long-term communication struggles that have become untenable for caregivers, but are not an acute illness for which [psychiatric] hospitalization is expected to benefit them. A lack of placement options [for these individuals] is a huge reason for [psychiatric] hospitalization. (State psychiatric hospital staff)

DBHDS has recently taken steps to help divert individuals from state psychiatric hospitals by allocating funding for non-psychiatric placements, and expanding these alternative placements would likely further help reduce admissions to state psychiatric hospitals. In FY22, funding was used to increase the capacity of nursing home and memory care facilities by hiring additional staff to support individuals with extraordinary behavioral health needs and dementia—individuals whose primary ailments are not psychiatric. The funding for these programs was fully spent by the third quarter of FY22 and supported the diversion of 105 individuals.

During the 2023 JLARC study of state psychiatric hospitals, JLARC staff will review these existing diversion programs and identify other strategies or opportunities to further reduce inappropriate psychiatric hospitalizations.

State’s psychiatric bed registry wastes limited time and staff resources

CSBs need to be able to efficiently search for the most appropriate placement for individuals requiring temporary detention. CSB staff have eight hours to conduct the preadmission screening for an individual under an emergency custody order (ECO), and locate a bed when an individual has been determined to meet the criteria for a TDO. If an ECO expires before a placement for temporary detention can be identified, the individual must be released from custody. The Bed of Last Resort legislation was designed to prevent this from happening, but this requires sufficient bed availability and an efficient and reliable bed search process.

The current bed search process is unnecessarily cumbersome and could be made more efficient and useful to ensure staff find beds in a timely manner. Through the current bed search process, CSB staff notify inpatient psychiatric facilities of the need for a psychiatric bed, share the individual’s records—generally via paper-based faxes—with each facility, and conduct follow up calls until each facility determines whether the individual will be admitted. A review of a sample of documented CSB bed search efforts indicated that a median of 32 facilities were contacted through this process before an individual was referred to a state psychiatric hospital. Many CSB staff reported that this process is inefficient and time consuming:

“It takes on average over 36 hours to secure a bed for almost any consumer. Our consumers consistently sit in ERs for 1–2 days.”

“We waste hours and hours calling facilities just to tell them what is already documented in the prescreen, waiting for faxes to process, and then waiting for faxes to be reviewed, just to be declined a bed.”

DBHDS’s bed registry is intended to help improve the efficiency of the bed search process but lacks real-time, useful information about the psychiatric beds available (sidebar). Ninety-two percent of surveyed CSB staff with bed search responsibilities indicated that the bed registry was either not at all useful, or not being used as part of their bed search process. A JLARC staff review of the DBHDS bed registry in June 2022 showed that 13 of the 25 facilities listed had not updated their availability in at least two days, and some had not updated their availability in months.

Other states have established information exchange systems that, if adopted in Virginia, would support a more efficient, reliable, and transparent bed search process. At least nine other states have developed referral systems that allow authorized users to submit HIPAA-compliant electronic referrals to facilities and that allow facilities to respond to these referrals through the portal (sidebar). These systems also allow states

DBDHS is statutorily required to “develop and administer a web-based acute psychiatric care bed registry,” which collects and displays information about available acute beds in public and private inpatient psychiatric facilities.

Deficiencies with the existing bed registry are a longstanding issue. In 2016, similar findings were reported by the Office of the State Inspector General.

Nine other states developed information exchange systems, including DE, GA, IN, NC, NE, NV, NM, OH, and TN. All of these states except Georgia contracted with a vendor to build and manage these systems.

to monitor which facilities, including private inpatient psychiatric hospitals, are reviewing cases in a timely manner and accepting patients—a practice currently not possible in Virginia. Fifteen CSBs have begun using software to exchange information with some local hospitals to improve the bed search process.

Improving the efficiency of the bed search process would also increase CSB staff's capacity to provide other services, including preadmission screenings, crisis services, outpatient mental health treatment, and same day access assessments, depending on the clinician's specific credentials.

Developing a more efficient and reliable bed search process will require a phased approach. In the short term, the General Assembly should include language in the Appropriation Act directing DBHDS to purchase an online HIPAA-compliant portal that CSBs can use to upload and share documents with inpatient psychiatric facilities. To ensure the online HIPAA-compliant portal is used statewide as part of the bed search process, the General Assembly should require every CSB, state psychiatric hospital, and other inpatient psychiatric facility licensed by DBHDS to share and accept patient information exchanged through this portal until it is replaced with a fully functioning referral system.

Because the bed registry does not fulfill its intended purpose and is currently counterproductive, the General Assembly should suspend the requirement that CSBs and state and other inpatient psychiatric facilities licensed by DBHDS participate in the acute psychiatric bed registry. Funding that has been allocated for managing this bed registry (~\$147,000) could be reallocated to support the development and management of the online HIPAA-compliant portal.

RECOMMENDATION 11

The Department of Behavioral Health and Developmental Services (DBHDS) should contract as soon as practicable with a vendor to implement a secure online portal, which is compliant with the Health Insurance Portability and Accountability Act (HIPAA), for community services boards to upload and share patient documents with inpatient psychiatric facilities.

RECOMMENDATION 12

The General Assembly may wish to consider amending §37.2-308.1 of the Code of Virginia to repeal the requirement that every state facility, community services board, behavioral health authority, and private inpatient provider licensed by the Department of Behavioral Health and Developmental Services participate in the acute psychiatric bed registry.

DBHDS is reportedly developing a new approach to the bed registry, but it appears unlikely to address the inefficiencies of the bed search process. The new bed registry

is intended to allow DBHDS to track the use of the bed registry and providers' admissions decisions. However, the new bed registry will not improve the process of exchanging information between CSBs and inpatient facilities.

The new bed registry is reportedly being developed as part of DBHDS's broader crisis data platform (sidebar). However, the data platform does not yet include a bed registry component, and DBHDS has not assigned staff to implement and manage the new bed registry.

As part of JLARC's 2023 state psychiatric hospital study, JLARC staff will examine the plans for and progress made toward developing a new bed registry and further review alternative strategies to improve the bed search process.

DBHDS has contracted with an IT vendor to build a new crisis data platform that is intended to facilitate the sharing of information across various crisis services, such as the 988 crisis call centers, mobile crisis teams, and residential crisis stabilization services.

Stakeholders report various shortcomings with CSB discharge planning efforts

CSBs are required by state law to develop discharge plans for all individuals placed in state psychiatric hospitals, including individuals hospitalized for a TDO and those who have been involuntarily committed for a longer period. Each plan must identify the services the individual will need upon their discharge into the community and the entities that have agreed to provide the service(s) for the individual. These plans must be completed before an individual can be released and are expected to be developed in collaboration with patients and their treatment teams (sidebar).

Treatment team members include individuals responsible for the patient's care and treatment, including psychiatrists, psychologists, social workers, and nurses.

Like CSB emergency and crisis services, timely and effective discharge planning can help manage the use of state psychiatric hospital beds. Timely discharge planning helps ensure individuals are released from state psychiatric hospitals as soon as they are deemed ready. Additionally, effective discharge planning can reduce the likelihood that an individual will need to be readmitted to an inpatient psychiatric facility.

Based on available data, few individuals experience delayed releases from state psychiatric hospitals because of untimely CSB discharge planning efforts, but those who do experience delays remain in state hospitals for an extended period. Only 15 of 141 individuals (10 percent) placed on the extraordinary barriers to discharge list (EBL) in April 2022 were waiting for a CSB to complete discharge planning tasks so they could be released (Figure 4-5) (sidebar). However, these individuals had remained in a state psychiatric hospital for a median of 79 days after they had been determined ready for discharge.

An individual is placed on the **extraordinary barriers to discharge list (EBL)** if they have not been released within seven days of being determined ready for discharge.

The primary barriers to discharge are generally outside of CSBs' control, but staff at the state's psychiatric hospitals have observed shortcomings in CSBs' discharge planning. Staff from all the state psychiatric hospitals reported that some CSB discharge staff do not fulfill their discharge planning obligations. This has resulted in state psychiatric hospital staff taking on those responsibilities to ensure timely discharges. A consultant hired by DBHDS reported similar concerns in 2021:

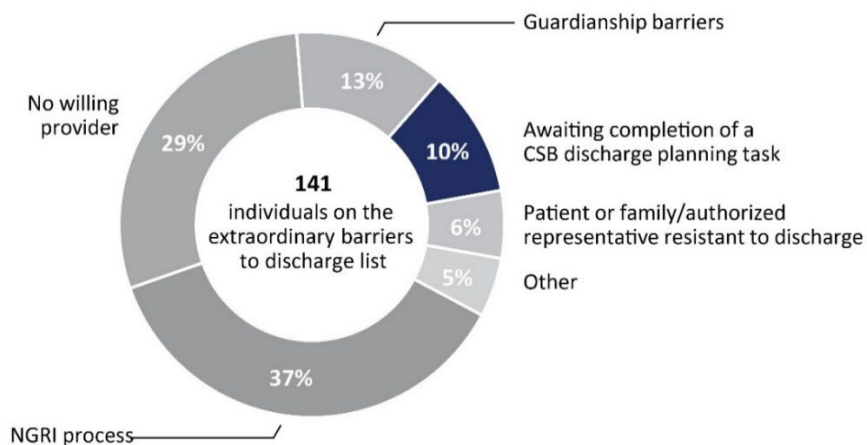
In April 2022, 141 beds were being use by individuals on the EBL—accounting for 12 percent of Virginia's state psychiatric hospital staffed capacity.

There is significant variability in the execution of the discharge planning guidelines and level of CSB compliance with contractual obligations related to discharge planning.

State psychiatric hospital staff also noted concerns with CSBs' collaboration with patients. A best practice for effective discharge planning is to develop the plan in collaboration with the patient. This helps ensure the individual is invested in their discharge plan and is more likely to adhere to it upon release. However, state psychiatric hospital staff indicated that some CSB discharge staff did not collaborate with patients as part of the discharge planning process, and that some liaisons developed discharge plans without meeting patients in their facility at all.

State psychiatric hospital staff also commonly reported concerns regarding the lag between an individual's release and their receipt of needed services after discharge. Receiving necessary services shortly after discharge, such as medication management or outpatient therapy, can help prevent the re-escalation of an individual's symptoms. DBHDS also requires CSB discharge staff to arrange therapy or psychiatric treatment services within seven days of an individual's release if the individual needs these services. However, in practice, state psychiatric hospital staff reported that sometimes individuals who are released from their hospital do not receive these treatment services within seven days. Instead, these individuals are provided an appointment at the CSB to complete intake procedures, not to receive treatment. CSB intake procedures could take place before an individual's discharge from a state psychiatric facility.

Figure 4-5: Ten percent of individuals awaiting discharge from a state psychiatric hospital were waiting for CSBs to carry out their responsibilities



SOURCE: JLARC analysis of DBHDS EBL data (April 2022 snapshot).

NOTE: These statistics are for adults and geriatric patients and do not include children and adolescents. Examples of "other" reasons include delays due to the DD waiver process and non-NGRI forensic barriers. "The not guilty by reason of insanity (NGRI) process" is the primary barrier to discharge if an individual is ready for discharge but has not had a conditional release plan approved. "No willing provider" is the primary barrier if a support or placement deemed necessary in the discharge plan has not yet been found or is not available. This was most commonly due to a lack of assisted living facility, nursing home, permanent supportive housing capacity, and ID/DD services.

DBHDS does not conduct ongoing monitoring of the discharge planning process to ensure (1) both CSBs and state psychiatric hospitals are complying with their respective responsibilities and (2) effective discharge planning is occurring.

Because discharge planning can affect whether discharges are timely and individuals successfully transition back into the community, DBHDS should develop and implement a structured process to ensure CSBs are effectively fulfilling their discharge planning responsibilities in a timely manner. The agency should also establish mechanisms for corrective action, technical assistance, and guidance to address identified problems with CSBs' discharge planning efforts.

RECOMMENDATION 13

The Department of Behavioral Health and Developmental Services (DBHDS) should develop and implement (i) a comprehensive and structured process to oversee the practices of community services boards (CSBs) related to discharge planning from psychiatric hospitals, particularly compliance with and effectiveness of their discharge planning responsibilities, and (ii) mechanisms for corrective action, technical assistance, and guidance when shortcomings are identified with CSBs' discharge planning efforts.

5 Medicaid Funding for CSB Behavioral Health Services

Funding for the CSB system comes from the federal, state, and local governments, as well as from fees that CSBs bill to Medicaid and other public and private health insurers. Major responsibility for CSB funding levels rests with the federal, state, and local governments, because more than 70 percent of CSBs' funding comes from these sources (Chapter 1). However, CSBs are also responsible for generating funding for their services and operations through accurate and effective billing practices, and Medicaid and other insurers are responsible for reimbursing CSBs accurately and in a timely manner. Medicaid and other insurance payments accounted for roughly one-quarter of CSBs' funding in FY21.

State and local funding for the CSB system has increased, but Medicaid funding has decreased

The Department of Behavioral Health and Developmental Services (DBHDS) distributes **non-Medicaid state general funds** to CSBs for various purposes, including to cover the costs of services for uninsured individuals, to support staff salaries, and to contract with private providers to provide behavioral health services. In FY22, the CSB system received \$449 million in state general funds for behavioral health services, and 20 of 40 CSBs received the largest proportion of their behavioral health funding from state general funds.

CSBs also receive funding through federal funds (10 percent) and other sources (6 percent), including private insurance payments, and consumer fees.

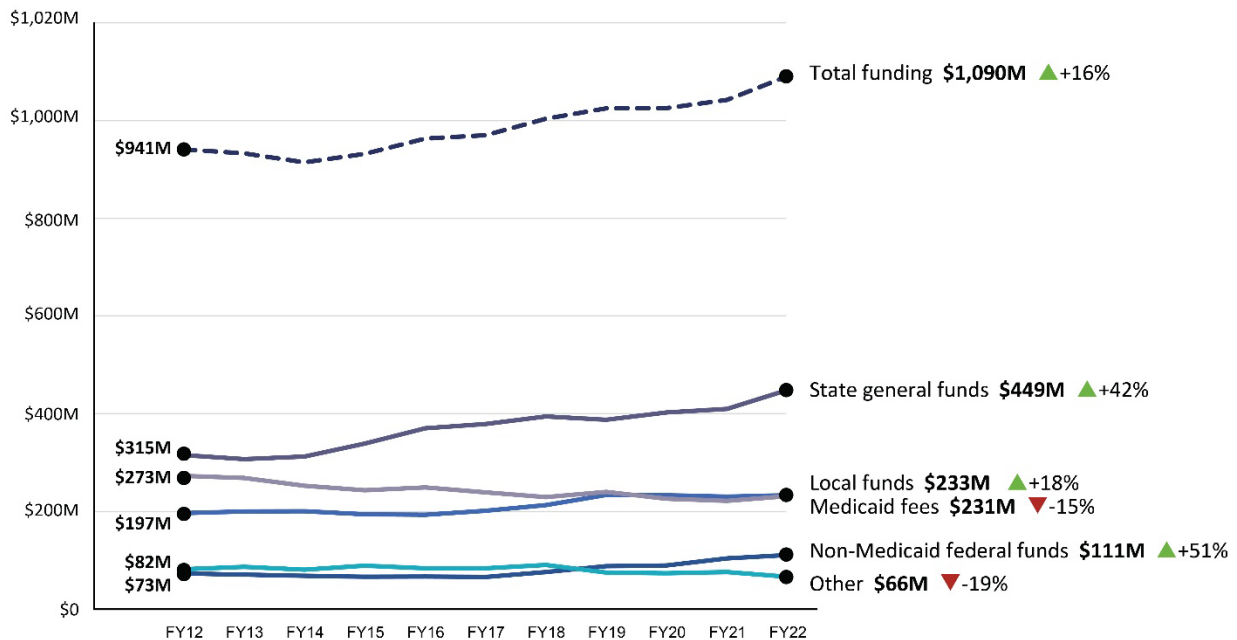
CSBs must also accept **Medicaid**. To collect reimbursement for covered services provided to Medicaid enrollees, CSBs must request reimbursements through six Medicaid managed care organizations (MCOs), which are under contract with the Department of Medical Assistance Services (DMAS). In FY22, CSBs received a total of \$231 million in Medicaid fees, and 12 of 40 CSBs received the largest proportion of their behavioral health funding from Medicaid fees. (Funding for Medicaid fees comes from both federal and state general funds—federal funds for Medicaid are matched by state general funds.)

Local funding is another important funding source for CSB behavioral health services, as CSBs are local (or multi-jurisdictional) entities. CSBs are required to provide a 10 percent match on state funds (sidebar). Total local funding for the CSB system in FY22 was about \$233 million, and seven of 40 CSBs received the largest proportion of their behavioral health funding from local funds in FY22 because they substantially exceeded local match requirements.

In FY22, only one CSB did not meet the local match requirement. This is lower than in FY18, when six CSBs did not meet the match, as reported in JLARC's 2019 CSB Funding report.

Total behavioral health funding for the CSB system increased from \$941 million to \$1.09 billion (16 percent) adjusted for inflation, between FY12 and FY22, and additional state and local funding drove most of this growth. Adjusted for inflation, state funding increased about 42 percent between FY12 and FY22, and local funding increased about 18 percent (from \$197 million to \$233 million) (Figure 5-1). A majority of CSBs experienced an increase in state general funds (38 of 40 CSBs) and local funding (28 of 40 CSBs). State and local funding increases outpaced the increase in total number of behavioral health consumers served by CSBs (about 3 percent) between FY12 and FY22.

Figure 5-1
Total funding for CSB behavioral health services has increased over the past decade, but Medicaid funding has decreased



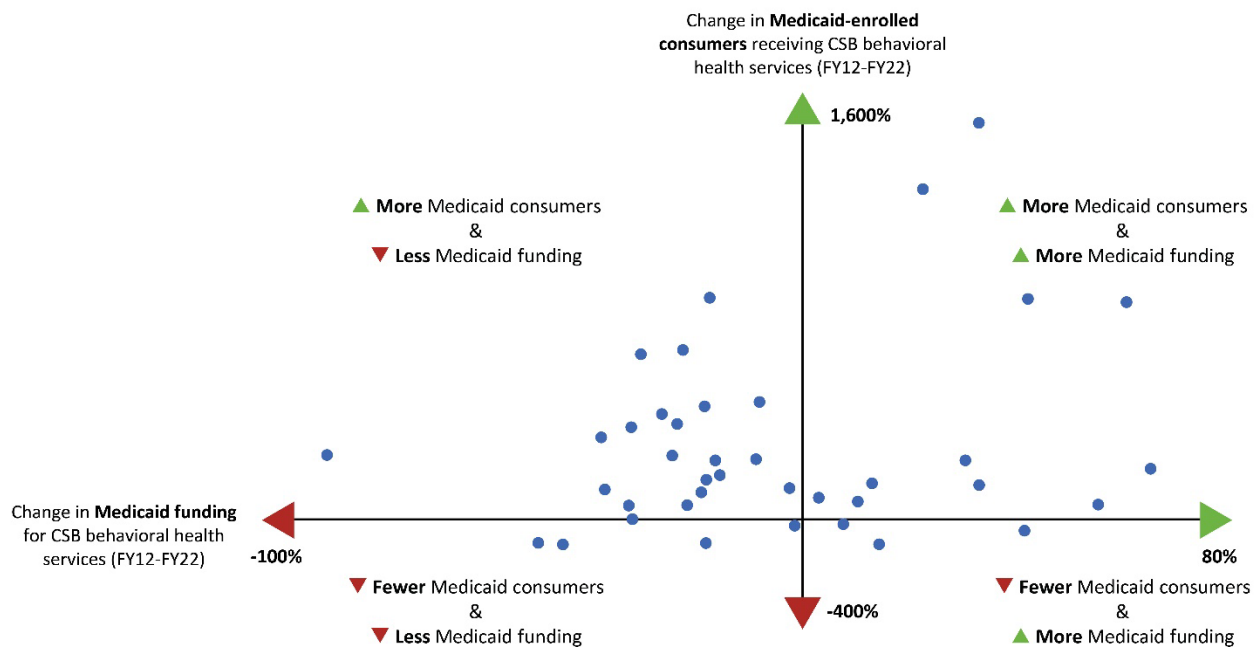
SOURCE: JLARC analysis of CSB funding data collected through Little CARS by DBHDS.
 NOTE: "Other funds" include non-state retained earnings, service fees, and private insurance payments. Figure is adjusted for inflation using medical care consumer price index (CPI).

In FY21, private providers accounted for nearly 82 percent of all Medicaid behavioral health spending in Virginia, while CSBs accounted for about 18 percent, according to DMAS data. For more information on the role of private providers, see Appendix D.

In contrast, Medicaid funding for CSB behavioral health services has decreased 15 percent over the past decade, from \$273 million in FY12 to \$231 million in FY22, adjusted for inflation. A majority of CSBs (25 of 40 CSBs) received less Medicaid funding in FY22 than in FY12, even though the proportion of CSB consumers covered by Medicaid has increased. Twenty-one CSBs provided behavioral health services to more Medicaid-enrolled consumers but received less Medicaid funding, according to DBHDS data (Figure 5-2).

The 15 percent decrease in Medicaid funding for CSB behavioral health services is counter to state expectations. When the General Assembly expanded Medicaid eligibility beginning in January 2019, the state assumed CSBs would receive Medicaid reimbursement for services delivered to consumers whose services historically had been paid for by state general funds. CSBs also were expected to receive additional Medicaid funding because consumers who had not sought services previously would be more likely to do so when enrolled in Medicaid. Based on these assumptions, the General Assembly reduced CSBs’ general fund appropriations by \$11.1 million in FY19 and \$25 million in FY20.

Figure 5-2
Over the past decade, 21 CSBs saw an increase in Medicaid consumers but a decrease in Medicaid funding (FY12 to FY22)



SOURCE: JLARC analysis of CSB funding data collected by DBHDS and CCS3 data.

NOTE: Figure is adjusted for inflation. One CSB not included in the graphic reportedly experienced growth in Medicaid consumers exceeding 1,600%.

Not all CSBs are maximizing collection of Medicaid reimbursements

Both the Appropriation Act and CSB performance contracts set the expectation that CSBs should maximize the collection of Medicaid payments for their services. Maximizing Medicaid reimbursements preserves more funds to pay for services of consumers without Medicaid coverage or private insurance, because federal funds pay for at least half—and up to 90 percent in some cases—of the cost of services for Medicaid recipients. When a CSB does not collect Medicaid payments for eligible services,

it must spend other funds to cover the cost of these services that could have been used for other consumers.

Two factors that can contribute to underutilization of Medicaid funds are (1) not billing *at all* for some Medicaid-eligible services and (2) not *successfully* billing for some Medicaid-eligible services. To receive full and timely Medicaid reimbursement for provided services, CSBs need to submit necessary information to the Medicaid MCOs within required timeframes.

CSBs are not consistently billing for all Medicaid-eligible services, which is a problem identified previously by JLARC

Credentialing is the process in which providers demonstrate they have the qualifications necessary to participate in an MCO network. Individual providers at CSBs must be credentialed by each MCO they work with.

To maximize Medicaid reimbursements, including associated federal funding, CSBs should bill MCOs for every Medicaid-eligible service they provide to Medicaid-enrolled consumers. However, no processes exist to ensure CSBs are appropriately and consistently billing Medicaid.

Available data shows that Medicaid reimbursements received per Medicaid-enrolled consumer vary significantly across CSBs, indicating possible shortcomings in CSBs' efforts to bill for Medicaid-covered services. While some of this variation may be attributable to individual consumer needs and MCO policies, some CSBs report receiving about 10 times as much Medicaid funding per Medicaid enrollee as other CSBs. Additionally, both state agency staff and CSB staff reported that some CSBs are not consistently billing for Medicaid services. These stakeholders report that CSB staff are not billing Medicaid for some services because of the complexity of the billing process, including the billing and claiming procedures and provider credentialing requirements (sidebar)—and instead are using state general funds to cover costs of serving Medicaid enrollees. The extent to which CSBs are underbilling for Medicaid-eligible services is unknown because neither DBHDS nor DMAS systematically monitors whether CSBs are billing for all eligible services.

A previous JLARC report, *CSB Funding (2019)*, identified the need for **better processes to ensure CSBs are maximizing reimbursements for Medicaid-covered services.**

To ensure CSBs are maximizing the use of Medicaid funds and using state funds as a funding source of last resort, DBHDS, with the assistance of DMAS, should develop and implement a process to conduct targeted reviews of CSBs that may be underbilling for Medicaid-eligible services. For example, DBHDS could use existing data to identify CSBs with significant discrepancies between the number of Medicaid-eligible consumers they serve and the amounts of Medicaid reimbursements they receive. DBHDS could then conduct targeted reviews of those CSBs' billing records to assess the extent to which, and reasons why, the CSBs did not bill for services provided to Medicaid-eligible consumers.

Where deficiencies are identified in CSB billing efforts, DBHDS and DMAS, in coordination with the MCOs, should provide additional training and technical assistance to appropriate CSB personnel. Training and technical assistance should be provided to both billing and clinical staff at CSBs, as needed. The training could also be made available to all CSBs. DBHDS and DMAS have previously recognized a need for this

type of technical assistance and training at CSBs and have indicated their willingness to support such activities (sidebar).

DBHDS and DMAS should conduct the first targeted reviews of CSBs’ Medicaid billing practices and report the results, including any follow-up technical assistance or training provided to CSBs, to the General Assembly by December 1, 2023, and annually thereafter.

RECOMMENDATION 14

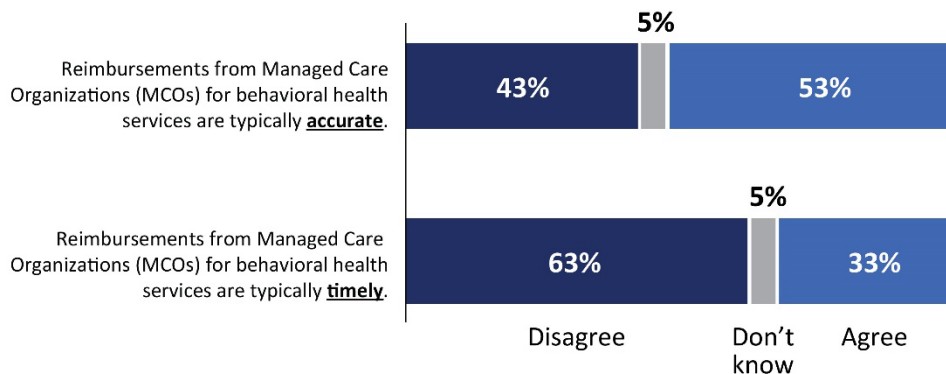
The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Behavioral Health and Developmental Services to work with the Department of Medical Assistance Services to (i) develop and implement a targeted review process to assess the extent to which community services boards (CSBs) are billing for Medicaid-eligible services they provide, (ii) provide technical assistance and training, in coordination with Medicaid managed care organizations, on appropriate Medicaid billing and claiming practices to relevant CSB staff, and (iii) report the results of these targeted reviews, and any technical assistance or training provided in response, to the House Appropriations and Senate Finance and Appropriations committees no later than December 1, 2023, and annually thereafter.

DBHDS previously submitted a budget request for state funding to expand their capacity to support CSB reimbursement collection efforts. Specifically, DBHDS requested about \$328,000 in FY23 and FY24 for three staff positions to oversee CSB reimbursement activities, coordinate with DMAS, and provide additional training and assistance to CSBs on reimbursement activities. However, this funding was not included in the introduced 2023–24 budget.

Challenges working with MCOs contribute to Medicaid collection issues

In addition to not billing for some Medicaid-eligible services, CSBs report challenges receiving timely and accurate payments for Medicaid-eligible services they do bill for. In response to JLARC’s survey, 30 percent of CSB executive directors reported their CSB was not able to maximize Medicaid revenue, and many reported issues with the timeliness and accuracy of reimbursements they did receive (Figure 5-3).

Figure 5-3
CSB executive directors report challenges with timeliness and accuracy of Medicaid reimbursements



SOURCE: Responses to JLARC’s survey of CSB executive directors.
 NOTE: Percentages may not sum to 100 percent because of rounding.

Previous DBHDS reports to the General Assembly found large differences between CSB billings and collections. In March 2021, DBHDS reported that CSBs collected only 72 percent of the Medicaid reimbursements they billed for between July 2019 and December 2019. The calculations used to determine the general fund reductions in FY19 and FY20 assumed that CSBs would collect 90 percent of all Medicaid reimbursements they billed for.

Managed care is a health-care delivery system designed to manage costs, utilization, and service quality. In Virginia, DMAS contracts with managed care organizations (MCOs) that accept a set per member payment to provide health-care services, including behavioral health services.

One reason some CSBs are not maximizing reimbursement for Medicaid-eligible services is the increased complexity of the claiming and billing process associated with integrating community behavioral health services into Medicaid managed care contracts (sidebar). Since 2018, DMAS has contracted with six different MCOs to manage community behavioral health services for the Medicaid population in Virginia. Through their contracts with the state, MCOs are required to include CSBs as part of their provider networks. Each MCO operates throughout the state, and Medicaid enrollees can choose which MCO plan to participate in. Each CSB must therefore work with up to six MCOs to receive reimbursement for services they provide to Medicaid enrollees. Prior to the integration of community behavioral health into managed care contracts, CSBs worked through DMAS for most Medicaid reimbursements.

CSB executive directors report that working with six MCOs has significantly increased the complexity of Medicaid billing, requiring additional staff and making it more challenging to collect Medicaid reimbursement in a timely manner. In response to JLARC's survey, 88 percent of CSB executive directors reported that their CSB's administrative workload has "increased substantially" because of the shift to managed care. Commonly reported issues include duplicative training requirements; delays in approving providers to bill for services (credentialing); differences in authorization and billing processes and requirements across MCOs; frequent changes to MCO billing systems; and increased rates of MCOs' reimbursement denials. Several CSB executive directors reported hiring more administrative staff to handle Medicaid claiming and billing functions with MCOs.

Additionally, DBHDS's reviews of CSB financial statements indicate that some CSBs have experienced significant adverse financial impacts as a result of the transition to managed care. Some CSBs have accrued large outstanding balances of unpaid Medicaid reimbursements and increased amounts of services billed but deemed uncollectable. For example, in FY20, one CSB could not collect over \$1 million in Medicaid funds because of issues with billing, denials, and timely filing limits associated with the transition to managed care. Another CSB could not collect approximately \$700,000 in FY20 because of credentialing and authorization issues, and a third CSB could not collect over \$850,000 in FY19 because of issues with authorizations and processing errors.

One strategy to improve CSBs' ability to collect Medicaid reimbursements is to maximize the uniformity of requirements and processes across the MCOs. There have been previous efforts to align requirements and processes across MCOs, and the Gen-

eral Assembly has also recognized the challenges associated with the moving of behavioral health to managed care. To address these challenges, the General Assembly directed DMAS to convene an advisory panel of providers to identify and address challenges with MCO processes. This panel, known as the “MCO Resolutions Panel,” continues to meet to resolve some of the issues identified by providers, and DMAS reports offering additional opportunities to coordinate with CBSs and CSB representatives to address issues with MCOs. However, key stakeholders, including CSB executive directors and front line staff, continue to report that lack of alignment across MCO requirements and processes continues to prevent them from efficiently and effectively collecting Medicaid reimbursements.

While some variation in policies and practices is unavoidable across the different MCOs, standardizing processes as much as possible would improve the efficiency and effectiveness of CSBs’ Medicaid collection efforts. For example, aligning credentialing requirements across MCOs, including the specific information providers must submit to be credentialed, and establishing a reasonable time limit for MCOs to complete provider credentialing (such as 90 days), would help CSB clinicians to become credentialed more quickly and begin collecting Medicaid reimbursements sooner. Several other states, including Mississippi, North Carolina, and Ohio, have recently centralized credentialing programs to reduce the administrative burden of provider credentialing for multiple MCOs. In these states, providers submit their information to a single, central entity to be credentialed to work with any MCO contracted by the state rather than engaging in individual processes with each MCO. Aligning and streamlining authorization and registration forms and procedures in Virginia would improve CSBs’ ability to receive reimbursements more consistently in a more timely manner for services provided.

Recent changes to the Code of Virginia allow clinicians to bill for services while awaiting credentialing; however, reimbursement for those services cannot be provided until the credentialing process is complete.

The General Assembly should direct DMAS to work with the CSBs and MCOs to align and standardize MCOs’ documentation requirements, training requirements, and procedures to the maximum extent practicable, and report to the Behavioral Health Commission on the changes made.

RECOMMENDATION 15

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services to (i) work with the managed care organizations (MCOs) to standardize, to the maximum extent practicable, policies, procedures, and requirements that CSBs must follow to receive reimbursement for the cost of Medicaid services they provide, including documentation, training, and credentialing requirements; and (ii) report on the improvements made to MCO policies, procedures, and requirements to the Behavioral Health Commission no later than December 1, 2023.

Another opportunity to reduce the administrative complexity is to encourage CSBs to pursue “preferred provider” status with MCOs whenever possible. Designation as a “preferred provider” or “gold card” provider means that the provider is not required

Prior authorization is a requirement to obtain approval from a health plan, like an MCO, before a service or product is provided to a consumer. The process typically involves the provider submitting administrative and clinical information to the health plan to determine if the plan will cover the costs of the product or service. CSBs must receive prior authorization from MCOs for many behavioral health services.

to meet prior authorization requirements for certain services. Reducing prior authorization requirements can allow consumers to receive services more quickly and require fewer administrative steps before CSBs are able to receive reimbursement for services delivered (sidebar). To qualify for this status, providers must demonstrate high prior authorization approval rates (often 90 percent or above) for the specific service over a period of time (often six to 12 months).

Currently, not all MCOs in Virginia offer a preferred provider program, and the programs that are available are not applicable to all behavioral health services. In interviews with JLARC staff, only two MCOs reported operating preferred provider programs that are available to CSBs. In addition, the extent to which CSBs participate in available programs and the types of behavioral health services the two MCOs include in their programs reportedly varies. To facilitate CSBs' participation in available preferred provider programs, DMAS should work with MCOs to ensure information is available to all CSBs regarding which MCOs offer these programs, the specific behavioral health services that are included, and the qualifications CSBs must meet to participate. CSBs should work to meet the relevant MCOs' preferred provider requirements for as many services as possible.

When the current contracts expire with the MCOs and new contracts are negotiated, DMAS could use that opportunity to require MCOs to offer preferred provider programs for behavioral health services as part of the new contracts. In the interim, DMAS should explore with the MCOs their willingness to voluntarily provide more opportunities for CSBs to participate in preferred provider programs.

RECOMMENDATION 16

The Department of Medical Assistance Services should work with managed care organizations (MCOs) to ensure that comprehensive information about all available MCO preferred provider programs is provided to all community services boards (CSBs), including (i) which behavioral health services are included in the preferred provider programs and (ii) the requirements CSBs must meet to participate in the programs.

Although improved alignment across MCOs will help reduce administrative complexity, some of the increased administrative requirements CSBs face for Medicaid billing are unavoidable. The shift from a single billing entity under the previous fee-for-service Medicaid system to six separate billing entities inevitably increased administrative complexity and workload. The managed care model of health-care delivery involves a higher level of clinical review and documentation compared with the previous fee-for-service model. In particular, stakeholders report that the implementation of managed care has resulted in increased documentation requirements for CSBs for processes like prior authorizations; higher rates of claim denials that require follow up and resubmissions; and more frequent audits conducted by each of the MCOs.

Key stakeholders, including DMAS staff, MCO staff, and CSB executive directors report that some CSBs do not have sufficient administrative resources, including staffing and IT systems, to meet the increased administrative demands of managed care. These stakeholders have also suggested that CSBs with larger budgets and more administrative resources have more easily adapted to the requirements of managed care. Several CSBs reported that they have hired additional administrative staff to help meet the requirements of managed care, but CSBs have not received any additional state funding to respond to this increased administrative demand. In the future, some CSBs may require additional state funding for administrative resources to effectively collect Medicaid reimbursement for the services they provide. Examples of stakeholders' comments regarding CSBs' current administrative capabilities are reflected below.

We have added four (4) FTEs to manage [preauthorizations], billing, chart reviews, and audits (165 audits by MCOs in the last 12 months). Almost all audits are desk audits that require us to pull, copy, and upload documents into the MCO's portal. It is a huge burden at this time. (CSB Executive Director)

I don't think they ever had strong administrative capabilities and this has made it harder...it's very different to operate with six MCOs vs. one or two entities with FFS. (MCO Staff)

6 State Oversight of CSB Performance

JLARC reports, legislative commissions, and studies from subject-matter experts have concluded that Virginia’s community services board (CSB) system has not been held accountable for efficiently and effectively delivering high quality services that produce positive outcomes for consumers. Three key deficiencies prevent adequate state oversight of CSBs:

- The state has not established or articulated the overarching purpose or goals of the CSB system, and without them the Department of Behavioral Health and Developmental Services (DBHDS) will continue to struggle to provide the needed direction and guidance to CSBs or to hold them accountable for their performance.
- The state has not invested in the necessary technology for collecting, sharing, and evaluating CSB operations or consumer outcomes data.
- DBHDS has not dedicated sufficient attention or staff resources to overseeing, evaluating, and improving CSB performance.

CSB system lacks clear performance expectations and effective accountability

State-supervised, locally administered systems, like Virginia’s CSB system, should be guided by a clearly articulated purpose and goals; useful data on CSBs’ performance; and strong accountability mechanisms. These safeguards would help balance localities’ desire for flexibility in serving its citizens with the state’s responsibility to ensure effective service delivery and efficient use of taxpayer resources.

State has not established clear purpose or goals for CSBs, which enables ineffective service delivery

State law does not articulate a clear purpose for the behavioral health services delivered through the CSB system. The statute governing CSBs includes only a broad statement that CSBs should be the single point of entry to publicly funded behavioral health services and that CSBs are to provide services and supports to persons with mental illness or substance abuse disorders. These expectations are too general to effectively guide policymaking, funding decisions, or oversight of CSBs, which are the cornerstone of Virginia’s publicly funded community-based behavioral health system. A specified purpose and goals for the system will also help the state hold CSBs accountable for their performance.

As mentioned in JLARC’s prior report, *CSB Funding (2019)*, much of CSBs’ state funding is restricted for specific purposes through separate budget items. In addition, DBHDS distributes state funding to CSBs using numerous “budget lines,” which reflect the specific purposes described in the budget. Each budget line typically carries its own reporting requirements for CSBs and monitoring by DBHDS.

Moreover, neither the State Board of Behavioral Health and Developmental Services nor DBHDS has developed basic goals that provide clear direction and guidance to CSBs in the provision of behavioral health services. Instead, CSBs have been left to implement numerous and evolving state initiatives without an overarching statement of purpose or broader goals to guide them. This lack of guidance is reflected in the performance contracts between DBHDS and each CSB, which are the primary vehicle for establishing state expectations for CSB performance. The contracts include only a vague mission statement about funding being provided to the CSB to support “individuals by promoting recovery, self-determination, and wellness in all aspects of life.”

The Code of Virginia more clearly articulates purposes of other state supervised, locally operated programs, such as Virginia’s child welfare programs that are operated by local departments of social services and early childhood education programs operated by school divisions.

In addition, several other states have specified in state law the specific purpose of their community-based behavioral health systems, thereby setting expectations for what the systems should achieve. For example, California, which has a locally administered system like Virginia, articulates in state law that the purpose of the state’s mental health system is to

enable persons experiencing severe and disabling mental illnesses and children with serious emotional disturbances to access services and programs that assist them... to better control their illness, to achieve their personal goals, and to develop skills and supports leading to their living the most constructive and satisfying lives possible in the least restrictive available settings.

Similarly, Ohio state law establishes several specific purposes for its community-based behavioral health system, including to

protect the personal liberty of mentally ill persons so that they may be treated in the least restrictive environment... foster the development of comprehensive community mental health services, based on recognized local needs, especially for severely mentally disabled children, adolescents, and adults...ensure that services provided meet minimum standards established by the director of mental health and addiction services... [and] promote the delivery of high quality and cost-effective addiction and mental health services.

The General Assembly should establish in state law a clear purpose for CSBs’ behavioral health services. Articulating the specific purpose of CSBs and their behavioral health services in state law should enable the State Board of Behavioral Health and Developmental Services and DBHDS to more easily develop appropriate goals and objectives to achieve the overall purpose, and establish a framework to guide policy and funding decisions. A clearly defined purpose will also provide stability for the CSB system, which undergoes regular changes in executive branch leadership with each new gubernatorial administration. State priorities and directives for the CSB system have changed frequently, exacerbated in recent years by turnover among senior leadership at DBHDS (sidebar).

High turnover in the DBHDS commissioner position in recent years has contributed to frequent shifts in direction provided at the state level for the CSB system. DBHDS has had six commissioners since 2014, each serving an average of 1.3 years. For comparison, between the creation of DBHDS in 1942 and 2014, the agency had a total of 12 commissioners who each served for an average of 6 years.

The General Assembly's defined purpose, or purposes, for CSB's behavioral health services should be broad enough to enable DBHDS to develop related, but more specific goals consistent with this purpose. For example, the Code of Virginia could state that the **overarching purpose** of CSBs' behavioral health services is to

enable individuals who are experiencing a mental illness or substance use disorder that significantly impairs their functioning to access effective, timely, and cost-efficient services that help them (1) overcome or manage the functional impairments caused by the mental illness or substance use disorder, and (2) remain in the community to the greatest extent possible, consistent with the consumers' well-being and public safety.

DBHDS should then be required to develop **specific goals**, which could be articulated in the performance contracts as expectations. These goals would facilitate the CSB system's achievement of that overarching purpose and should be developed in collaboration with the State Board of Behavioral Health and Developmental Services. They should include, at a minimum:

assessing consumers' behavioral health conditions and arranging for the delivery of appropriate services as expeditiously as possible;

maximizing the extent to which consumers with behavioral health conditions are served in community-based settings, consistent with each consumer's welfare and needs and the safety of the public;

ensuring that all behavioral health service plans and treatments developed for consumers are well designed, informed by their individual needs, and delivered by qualified staff; and

maximizing the use of all available non-state funding sources for CSB behavioral health services, including Medicaid reimbursements.

DBHDS should also develop **specific objectives** to measure progress toward meeting each of these articulated goals. Actionable and measurable objectives should then serve as the basis for more specific performance measures that can be used in the performance contracts. For example, objectives for the goal of maximizing the use of all available funding sources for CSB behavioral health services could include

increasing the number of Medicaid-eligible behavioral health services that CSBs bill for; and

increasing the collection rate for behavioral health services billed to Medicaid.

These goals and objectives would need to be fully developed by DBHDS with input from CSB leaders, and other stakeholders, including members and staff of the Behavioral Health Commission. DBHDS should then use these goals and objectives to develop specific, measurable performance metrics that enable state and local monitoring

of CSBs' performance. (More discussion about the CSB performance metrics is provided in the next section.)

RECOMMENDATION 17

The General Assembly may wish to consider amending §37.2 of the Code of Virginia to (i) clearly articulate the purpose of community services boards (CSBs) services within the state's system of community-based behavioral health services and (ii) require the Department of Behavioral Health and Developmental Services to develop clear goals and objectives for CSBs that align with and advance the articulated purpose and include them in the performance contracts.

DBHDS's performance contracts with CSBs are inadequate to hold CSBs accountable for their performance

§ 37.2-508 of the Code of Virginia requires that DBHDS "develop and initiate negotiation of performance contracts through which it provides funds to community services boards." While DBHDS enters into individual contracts with each CSB, the base language of the contract is the same across all 40 CSBs. Individual requirements or measures specific to individual CSBs are included in appendices to the base contract.

State law requires DBHDS to enter into a contract with each CSB to receive state funding. The contracts, known as "performance contracts," are the primary mechanism through which DBHDS can hold CSBs accountable (sidebar). State law requires the performance contract to contain meaningful performance measures and enforcement mechanisms, but DBHDS and the CSBs have not fulfilled this expectation. Performance contracts are required to

- specify conditions CSBs must meet to receive state-controlled funds;
- contain specific outcome measures for consumers, provider performance measures, satisfaction measures for consumers, and participation and involvement measures for consumers/their families;
- establish enforcement mechanisms; and
- include financial reporting mechanisms.

The contracts' performance measures and associated reporting requirements are inadequate (Table 6-1). Most of the performance measures in the contract are (1) utilization rather than consumer outcome measures; (2) irrelevant to the purpose of the service being measured; and/or (3) not focused on key aspects of the CSB system. As described by a DBHDS staff member, the current performance contracts include many things that are "easy to measure, not because they are useful" and that "we are not measuring things that give you good information on what's going on."

Poorly designed performance measures prevent the state from fully understanding CSB performance, providing targeted technical assistance, or holding CSBs accountable. Performance measures that focus on utilization rather than consumer outcomes make it difficult for DBHDS to assess if CSB services are meeting consumer needs and improving outcomes. These ineffective measures also create unnecessary work for CSBs. CSBs collect and report substantial amounts of information to DBHDS that is not used in a meaningful manner to understand and improve CSB performance, according to interviews with stakeholders and the findings of multiple previous reports.

TABLE 6-1
Examples of DBHDS performance measures that are insufficient to ensure CSB accountability

Service	Measure	Benchmark	Problem with measure	Potential additional or improved measure(s)/benchmarks
Residential crisis stabilization units (RCSU)	Percentage of RCSU beds utilized annually	Utilize at least 75% of beds	Measures utilization rather than the extent to which RCSUs reduce need for hospitalization or other more intensive, inpatient services	Percentage of individuals served by an RCSU who were (1) readmitted to the RCSU or (2) hospitalized within some period of time from RCSU discharge
Same Day Access (SDA)	Percentage of individuals receiving an SDA assessment who 1) are offered an appointment within 10 days and 2) attend an appointment within 30 days	Offer appointment: 86% Keep appointment: 70%	Measure and benchmark are not related to the goal of providing consumers access to an assessment on the same day they first visit a CSB	Percentage of individuals seeking a same day assessment who receive the assessment on that day
Outpatient services	Provide appointment within 10 days of SDA assessment	Outpatient clinicians should receive at least 8 hours of trauma-informed practice training	Measure and benchmark for performance are not related to each other, does not measure outcomes	Percentage of individuals receiving outpatient therapy who improved functioning within a defined period

SOURCE: JLARC review of FY22-23 performance contract documents.

DBHDS is currently revising the performance contracts with useful changes, but the revisions are primarily focused on streamlining the contract requirements rather than improving the quality of performance measures. These efforts have been focused on removing unnecessary material from the contract, clearly delineating responsibilities of parties to the contract, and reducing the number of amendments to the base contract (sidebar). However, DBHDS staff have recognized that further revision of the performance contract is necessary to ensure the agency is able to assess the effectiveness of CSB services and hold CSBs accountable for their performance.

JLARC previously recommended improving the same day access measure in Recommendation 1 of JLARC’s 2019 review of the implementation of STEP-VA.

DBHDS should complete a comprehensive review of the performance contracts and revise performance measures. The revised performance measures should align with and advance the articulated purpose, goals, and objectives of CSB behavioral health services (Recommendation 17). To the greatest extent practicable, performance measures should target consumer outcomes, rather than utilization or process (sidebar).

Exhibit Ds are amendments to the base performance contract that are created when additional funding is made available outside the typical contract timeline. Each Exhibit D has its own documentation and reporting requirements.

To ensure that performance contract measures adequately assess CSB performance related to system goals, DBHDS should include a directly relevant benchmark for each measure and identify specific monitoring activities for that measure. Improvements should be made to all performance measures included in the base performance contract, as well as any CSB-specific measures included in appendices or exhibits attached to the contract.

The DLA-20, as discussed in Chapter 2, is one data source available to DBHDS to better assess the impact of CSB services on consumers' ability to overcome or successfully manage functional impairments caused by behavioral health issues.

DBHDS should also review all reporting requirements in the existing performance contracts and eliminate any that are unrelated to either the revised performance measures or federal reporting requirements. DBHDS should revise the contracts by December 1, 2023, which will allow the changes to be implemented before the effective date of the FY25 performance contracts.

RECOMMENDATION 18

The Department of Behavioral Health and Developmental Services (DBHDS) should complete a comprehensive review of the performance contracts with community services boards and revise all performance measures in the base performance contracts and addendums to ensure that, at a minimum, (i) the performance measures are designed to measure relevant consumer experiences and outcomes; (ii) each performance measure includes a relevant benchmark, and (iii) DBHDS has given clear direction on how it will monitor performance and enforce compliance with performance requirements. DBHDS should complete the contract revisions and report on the improvements made to the Behavioral Health Commission by December 1, 2023, and implement changes before the finalization of the fiscal year 2025 performance contracts.

DBHDS and CSB data systems create avoidable administrative burdens and prevent thorough assessments of CSB effectiveness

Multiple previous studies and reports spanning more than 40 years have highlighted that DBHDS's and CSBs' data infrastructure is outdated, overly complex, and unreliable. DBHDS's and CSBs' behavioral health data systems are not compatible with one another, which complicates reporting and data analysis and creates issues with data reliability and validity. Systems for maintaining electronic health records are not standardized across CSBs, making it difficult to share consumer-level information among individual CSBs, DBHDS, and in-patient psychiatric facilities.

Currently, each CSB submits data to DBHDS through at least 10 different data systems. Submitting this data involves both manual and automated uploads, with some processes requiring the transfer of individual spreadsheets or faxing of information. CSB staff reported that these reporting requirements take up significant staff time and take providers' focus away from service delivery. DBHDS IT staff reported that the data reporting requirements and processes create delays in data availability, require significant DBHDS staff time, and undermine data quality.

Transactional or encounter level data indicates the consumer's clinical diagnosis and the services provided to treat the condition. This type of data is important for measuring and monitoring managed care plan quality, service utilization, finances, and compliance with contract requirements.

In addition to the heavy administrative demands required by DBHDS's IT systems, the primary data system used to collect consumer and service data, Community Consumer Submission 3 (CCS3), has several key limitations that prevent DBHDS staff from effectively monitoring CSB performance and measuring the impact of CSB services on consumer outcomes. DBHDS cannot use CCS3 to collect transactional level data (sidebar), which inhibits DBHDS from accurately assessing the impact of services. Instead, data is aggregated and submitted on a monthly basis, with little insight into the consumers' day-to-day experience. Additionally, CCS3 does not allow

DBHDS to assign a unique identifier to each CSB consumer reliably, which prevents DBHDS from assessing service utilization and consumer outcomes over time and across CSBs (sidebar).

DBHDS has begun the process to implement a new data exchange initiative to simplify reporting and improve data quality and timeliness. The goal of the data exchange initiative is to address many of the current limitations of the state's and CSBs' data systems. Most importantly, the new data exchange program should include a uniquely identifiable patient record across service providers, including CSBs and state hospitals, and should allow for the collection and analysis of transactional level data. This should allow DBHDS to better understand consumers' experiences, including the services consumers receive on a daily basis, so that DBHDS can better assess the impact of services received by CSB consumers over time. Additionally, the new data exchange program is expected to (1) streamline the reporting process by consolidating the existing reporting systems; (2) reduce the time delay between data submission and analysis; (3) provide a reporting platform to allow CSBs to access the data they submit to DBHDS; and (4) improve the reliability and quality of data and associated state and federal mandated reports.

The new data exchange initiative is a complex and expensive endeavor that warrants ongoing monitoring. DBHDS IT staff report that there are currently six defined projects that make up the overall data exchange modernization initiative, and that the total effort is expected to be completed in the next two to three years and require about \$10 to \$12 million to fully implement. DBHDS has not yet procured a vendor to provide the new data exchange system, but the department has secured federal funding that is expected to cover the initiative's implementation costs. Like other large-scale IT projects, this project carries many risks. One major risk is project delays, which could be especially problematic because some of the federal funding designated for the data exchange initiative must be used by March 2024.

Legislative oversight would help ensure that the data exchange modernization initiative remains on track. Specifically, the General Assembly should direct DBHDS and the Virginia Information Technologies Agency to provide reports on the project status to the General Assembly's Behavioral Health Commission and the State Board of Behavioral Health and Developmental Services at least every three months until the project is completed. These reports should provide an update on the project status, budget, risks that could prevent project completion on time and on budget, and plans to mitigate those risks.

DBHDS currently conducts an internal matching process using various identifying factors to attempt to monitor consumer services and outcomes. Staff report that this process is time intensive and not always successful, contributing to issues with data validity and reliability.

RECOMMENDATION 19

The Department of Behavioral Health and Developmental Services, in consultation with the Virginia Information Technologies Agency, should provide status updates on the data exchange initiative to the Behavioral Health Commission and State Board of Behavioral Health and Developmental Services at least every three months until the project is complete. These reports should report on project status, funding, risks that could prevent the project from being completed on time and on budget, and plans to mitigate those risks.

DBHDS has not devoted sufficient attention and staff resources to oversight of CSB performance

In 2021, management of performance contracts was reassigned to the agency's Office of Enterprise Management Services. Several additional staff have since been hired to assist with contract management, bringing the total to four full-time equivalent staff positions.

In addition to explicit goals, useful performance measures, and better data systems, DBHDS will also need to devote more attention to monitoring CSB performance, including in critical areas such as preadmission screening and discharge planning. Historically, DBHDS has not devoted sufficient attention and resources to ensure that CSBs are meeting performance contract requirements and delivering high quality services. Until recently, only one staff position was devoted full time to managing performance contracts for all 40 CSBs (sidebar). Similarly, no DBHDS staff have been dedicated to monitoring the quality of behavioral health services at CSBs. Previous state-level reports, dating back to the 1970s, also identified significant gaps in DBHDS's monitoring efforts, finding that DBHDS needed to dedicate more time and resources to properly monitoring system performance.

As mentioned in other chapters of this report, DBHDS has no formal processes or data to understand critical aspects CSBs' service delivery and consumer outcomes. For example, DBHDS's current processes do not allow it to answer the following questions:

- Are consumers typically able to access same day assessments on the same day at each CSB, and, if not, why not? (Chapter 3)
- How long are consumers waiting to receive needed treatment at each CSB, and are there certain CSBs or types of treatment services that have the longest wait times? (Chapter 3)
- Are CSBs providing statutorily required preadmission screenings and discharge planning services when they are needed, and, if not, why not? (Chapter 3)
- Do CSBs have sufficient staff to meet state expectations for the planned expansion of crisis services (Chapter 3)?
- What is the general quality of preadmission screenings across CSBs, and could specific types of technical assistance help ensure individuals who are recommended for in-patient psychiatric hospitalization truly need to be hospitalized? (Chapter 4)

- Is each CSB maximizing its collection of Medicaid fees so that state general funds may be used as a funding source of last resort, and could the state do more to support CSBs that are unable or unwilling to fully use Medicaid as a funding source? (Chapter 5)

Currently, state law allows, but does not require, DBHDS to monitor CSB performance in complying with performance contract requirements. Given the deficiencies identified in this report, the General Assembly should direct DBHDS to conduct performance monitoring on an ongoing basis. (A recommendation that the General Assembly direct, in statute, that DBHDS conduct performance monitoring and use available enforcement mechanisms is included in the next section.)

DBHDS must allocate sufficient resources to monitoring CSB performance and facilitating improvements. In conjunction with earlier recommendations to establish system goals and objectives and improve performance measures, DBHDS should develop and implement clear and comprehensive requirements and processes for monitoring CSB behavioral health services. DBHDS's monitoring requirements and processes should

- evaluate CSB performance on key consumer outcome measures that align with state goals for the CSB system and compliance with performance contract requirements on an ongoing basis;
- use existing data and information it collects, such as DLA-20 scores, to analyze the performance of CSBs and facilitate improvements;
- integrate the monitoring efforts and reporting requirements across the various offices of DBHDS involved in CSB funding and oversight, including the Office of Enterprise Management Services, the Office of Internal Audit, the Office of Community Quality Management, the Office of Fiscal Services and Grant Management, the Office of Child and Family Services, the Office of Adult Behavioral Health Services, and the Office of Crisis Supports and Services, to the maximum extent possible;
- establish processes for communicating the results of performance monitoring to CSBs, including the development of quality improvement plans; and
- clearly articulate the enforcement mechanisms, including technical assistance and guidance, corrective action plans, financial penalties, and contract termination, that will be used to address substantial underperformance or non-compliance.

“ It is a certainty that apparently simple mistakes, errors, and oversights in [PC] management (including Exhibits D) are, in part, a function of poor allocation/prioritization of agency resources in this regard. ”

– DBHDS staff

RECOMMENDATION 20

The General Assembly may wish to include language in the Appropriation Act directing the Department of Behavioral Health and Developmental Services (DBHDS) to develop and implement clear and comprehensive requirements and processes for monitoring community services boards' (CSBs) performance with respect to the provision of behavioral health services. At a minimum, DBHDS's monitoring requirements and processes should (i) evaluate CSB performance on key consumer outcome measures, including measures of functional impairments, and compliance with performance contract requirements on an ongoing basis; (ii) use existing data and information it collects to analyze performance of CSBs and facilitate needed improvements; (iii) integrate the monitoring efforts and reporting requirements across all offices involved in CSB funding and oversight; (iv) establish a process for communicating the results of performance monitoring to CSBs; (v) develop expectations for the content and outcomes of quality improvement plans; and (vi) clearly articulate the enforcement mechanisms that will be used to address substantial underperformance or non-compliance.

Accountability mechanisms should be used to ensure CSBs meet performance expectations

Accountability within a state-supervised, locally administered system is challenging and possible only when the entity (or entities) responsible for overseeing local providers is equipped with mechanisms to enforce compliance and is willing to use them to rectify non-compliance.

State law provides DBHDS with mechanisms to hold CSBs accountable for meeting performance expectations. These mechanisms include a remediation and dispute resolution process in which DBHDS may require CSBs to complete corrective action related to any identified instances of substantial noncompliance. If CSBs do not complete corrective action, DBHDS may delay payments of state or federal funds or reduce allocations or payments of state and federal funds. State law also allows DBHDS to terminate all or a portion of the performance contract if the remediation and dispute resolution processes fail. DBHDS may then use the funds associated with the terminated contract to negotiate a performance contract with a different CSB or private provider to provide the services that were terminated.

In practice, DBHDS rarely uses its existing enforcement mechanisms, and staff indicate this is partially because of their lack of good information on CSB performance. DBHDS staff responsible for monitoring compliance with the performance contracts report that they could likely take additional enforcement actions through corrective action plans but lack the information necessary to assess whether CSBs are complying with performance contracts. DBHDS staff were unaware of any instances when the department had reduced allocations to CSBs or terminated performance contracts, even in instances in which there was substantial noncompliance.

In conjunction with the recommended improvements to the performance contracts and to DBHDS's monitoring processes, DBHDS should more regularly use the established remediation and dispute resolution processes to address any instances of non-compliance or inadequate performance. DBHDS should also use the other existing enforcement mechanisms to hold CSBs accountable for substantial noncompliance or sustained poor performance, including the options to delay funding and terminate performance contracts, in part or in total. In instances of performance contract terminations, DBHDS should pursue contracts with private providers or other CSBs to deliver the terminated services (sidebar).

Other states contract the delivery of all community-based behavioral health services directly to private providers. For more information on other states' service delivery models, see Appendix D.

RECOMMENDATION 21

The General Assembly may wish to consider amending § 37.2-508 of the Code of Virginia to require the Department of Behavioral Health and Developmental Services to (i) regularly monitor community services boards' (CSB) compliance in meeting performance contract requirements; and (ii) use available enforcement mechanisms, as necessary, to ensure CSBs are in substantial compliance with the requirements established in their performance contracts.

Requiring DBHDS to share CSB performance information with the local CSB boards and other key state-level entities on a regular basis would also help improve accountability in the CSB system. Currently, DBHDS is not required to share any information to local CSB governing boards about their CSB's performance on a regular basis, including the extent to which they are meeting performance contract obligations. Although local boards have a statutory responsibility to review and evaluate the services provided by their CSB, doing so is challenging without useful information on the CSB's performance, including its performance relative to other CSBs, on key indicators.

CSB performance information should also be shared annually with key state level entities, including the Behavioral Health Commission and State Board of Behavioral Health and Developmental Services. Providing this performance information to these entities will help ensure that the legislative and executive branches are aware of CSB performance and further ensure CSBs are held accountable for meeting expectations and working toward state-level goals for the system.

RECOMMENDATION 22

The General Assembly may wish to include language in the Appropriation Act directing the Department of Behavioral Health and Developmental Services (DBHDS) to report community services board (CSB)-level performance information, including any substantial underperformance or non-compliance and associated enforcement actions, annually to (1) each CSB governing board, (2) the Behavioral Health Commission, and (3) the State Board of Behavioral Health and Developmental Services.

Appendix A: Study resolution

Effectiveness of Virginia's Community Services Boards

Authorized by the Commission on December 13, 2021

WHEREAS, Community Services Boards (CSBs) are Virginia's safety net providers for community-based behavioral health, substance use disorder, and developmental disability services for adults and children, funded through a combination of federal funds, state general funds, and local funds; and

WHEREAS, Virginia's 40 CSBs are administered locally and overseen by the Department of Behavioral Health and Developmental Services (DBHDS); and

WHEREAS, CSB services and funding have recently undergone numerous changes as part of the STEP-VA initiative, Medicaid behavioral health enhancement, and Medicaid expansion; and

WHEREAS, CSBs provide key services to help manage the state mental health hospital population, including discharge planning and behavioral health crisis services; and

WHEREAS, effective community-based behavioral healthcare systems can reduce the reliance on more acute and costly services, such as inpatient hospitalization; and

WHEREAS, previous JLARC reports have noted a need for DBHDS to align its funding model for CSBs with community needs and improve data gathered from CSBs; and

WHEREAS, JLARC has not comprehensively reviewed Virginia's public community-based behavioral health, substance use disorder, and developmental disability service system; now, therefore be it

RESOLVED by the Joint Legislative Audit and Review Commission that staff be directed to review the efficiency and effectiveness of the structure and service delivery of Virginia's community services boards.

In conducting its study, staff shall (i) determine what services CSBs are required to provide for adults and children and whether these requirements reflect Virginia's greatest mental and behavioral health priorities; (ii) evaluate whether the populations served by CSBs are appropriate; (iii) evaluate whether CSBs are staffed and funded to effectively respond to these requirements and priorities, including their ability to execute discharge plans for individuals in the state's mental health hospitals and provide behavioral health crisis services, (iv) determine the extent to which CSBs are able to either directly provide or facilitate access to behavioral health services in a timely, efficient, and effective manner and identify the reasons for any shortcomings, including challenges related to data and IT systems; (iv) assess the outcomes of pilot programs being operated by the CSBs; and (vii) determine whether the existing structure of the CSB system—including the number of CSBs, their service regions, their relationship to their local governments, the private sector, DBHDS, the state's mental health hospitals, and each other—could be improved to strengthen the effectiveness and efficiency of service delivery.

JLARC shall make recommendations as necessary and review other issues as warranted.

Appendix B: Research activities and methods

Key research activities JLARC performed for this study include:

- structured interviews with leadership and staff of the Virginia Department of Behavioral Health and Developmental Services (DBHDS) and other state agencies, leadership and staff of community services boards (CSBs), other behavioral health stakeholders, and subject-matter experts in the nation and in Virginia;
- surveys of CSB executive directors, emergency services directors, and preadmission screening clinicians;
- analysis of DBHDS data, other state agencies' data, and national data;
- site visits to CSBs;
- reviews of preadmission screenings;
- reviews of CSB performance contracts;
- reviews of previous reports on Virginia's CSB system;
- reviews of national research; and
- reviews of state documentation, such as those related to laws, regulations, and policies relevant to the provision of public community-based behavioral health services in Virginia.

Structured interviews

Structured interviews were a key research method for this report. JLARC conducted about 90 interviews. Key interviewees included:

- central office staff of DBHDS and other state agencies;
- leadership and staff of DBHDS's state psychiatric hospitals;
- leadership and staff of CSBs;
- leadership and staff of the Virginia Department of Medical Assistance Services (DMAS) and managed care organizations (MCOs); and
- stakeholders and subject-matter experts in Virginia and nationally.

Central office staff of DBHDS and other state agencies

JLARC conducted 20 structured interviews with DBHDS central office staff. Topics varied across interviews but were primarily designed to understand DBHDS's oversight functions, including ongoing monitoring, certification, training and technical assistance efforts, and other support activities. DBHDS staff were also asked for their perspectives on opportunities to improve Virginia's CSB system.

JLARC also interviewed staff of the Virginia Department of Health, the Virginia Department of Health Professions (DHP), the Auditor of Public Accounts, and the Virginia Retirement System (VRS).

Leadership and staff of DBHDS's state psychiatric hospitals

JLARC staff conducted individual and group interviews with executive directors, clinical and social work directors, supervisors, and staff from eight of the nine state psychiatric hospitals in Virginia, including:

- Catawba Hospital;
- Commonwealth Center for Children and Adolescents;
- Central State Hospital;
- Eastern State Hospital;
- Northern Virginia Mental Health Institute;
- Piedmont Geriatric Hospital;
- Southern Virginia Mental Health Institute; and
- Southwestern Virginia Mental Health Institute.

Interview topics focused on staff's perspectives on CSBs prescreening evaluations, bed search and discharge planning efforts, and opportunities to improve these services. Interviews also gathered staff's perspectives on factors outside of the CSBs' control that may also contribute to unnecessary admissions to state psychiatric hospitals, untimely discharges, or ineffective discharge plans.

Leadership and staff of community services boards

JLARC staff conducted 19 individual and group interviews with directors, supervisors, and front line staff of Virginia's CSBs in different areas of the state and of various sizes, including:

- Arlington Community Services Board;
- Fairfax-Falls Church Community Services Board;
- Henrico Area Mental Health and Developmental Services;
- Highlands Community Services;
- Loudoun County Community Services;
- New River Valley Community Services;
- Norfolk Community Services Board;
- Northwestern Community Services Board;
- Prince William County Community Services;
- Region Ten Community Services Board;
- Richmond Behavioral Health Authority;
- Rockbridge Area Community Services;
- Southside Behavioral Health; and
- Western Tidewater Community Services Board.

Interview topics focused on various aspects of CSB services, including the provision of crisis, pre-screening evaluation, bed search, and discharge planning services; workloads; recruitment and retentions of staff; the provision of services on a regional basis and through contracts with private providers; coordination with managed care organizations, law enforcement, state psychiatric hospitals, and

private providers; and satisfaction with DBHDS guidance, monitoring, and technical assistance. Interviews also gathered perspectives on opportunities to improve the CSB system.

JLARC staff also conducted virtual interviews with each of the eight managers of regional programs for community services boards. These interviews focused on the roles and responsibilities of the regional CSB offices; the provision of regional services; and opportunities to provide additional services regionally or improve regional programs.

Leadership and staff of the Department of Medical Assistance Services and managed care organizations

JLARC conducted interviews with staff of the Department of Medical Assistance Services (DMAS), which were designed to understand DMAS's supervisory responsibilities and other roles related to supporting CSB services, perspectives on CSBs' role in public behavioral health, and opportunities to improve the CSB system.

JLARC also conducted interviews with staff of four MCOs, which are contracted by DMAS to manage behavioral health services for Virginia's Medicaid consumers. The interviews focused on gathering their perspectives on coordination between CSBs and MCOs, challenges and concerns working with CSBs, and ideas for addressing those concerns.

Stakeholders and subject-matter experts in Virginia and nationally

JLARC staff interviewed various Virginia stakeholder groups and subject-matter experts, including representatives of:

- The Behavioral Health Advisory Council;
- Mental Health America of Virginia;
- The Substance Abuse Services Council;
- The University of Virginia Institute of Law, Psychiatry and Public Policy;
- The Virginia Association of Community Services Boards;
- The Virginia Association of Regional Jails;
- The Virginia Health Care Foundation;
- The Virginia Hospital and Healthcare Association;
- The Virginia Network of Private Providers;
- The Virginia Sheriffs' Association; and
- Voices for Virginia's Children.

JLARC staff also interviewed national subject-matter experts, including representatives of:

- MTM services;
- JBS International;
- The National Association of State Mental Health Program Directors; and
- The National Association of State Mental Health Program Directors Research Institute (NRI).

These interviews were used to gather stakeholder perspectives on a variety of topics, including satisfaction with CSB services, challenges and concerns regarding the provision of those services, ideas for addressing those concerns, and actions taken in other states to address similar challenges.

Interviewees who have previously been contracted to provide assistance for Virginia's CSB system also provided insight into common challenges and concerns they had identified through their work with the system.

Surveys

For this study, JLARC staff conducted survey of: (1) CSB executive directors, and (2) CSB preadmission screening clinicians and emergency services directors.

Survey of community services board executive directors

The survey of community services board executive directors was administered electronically to executive directors of all 40 CSBs. The survey was designed to collect the executive directors' perspectives on staffing, recruitment, and retention; billing for services; the provision of core services, such as prescreening evaluations, crisis services, and discharge planning; and the rollout of the crisis continuum. The survey also collected information regarding CSBs' current staffing, use of private providers to deliver certain services, tracking efforts for same day access and wait times, and the number of physical locations in each CSB's catchment area. JLARC received responses from all 40 CSBs.

Survey of community services board preadmission screening clinicians and emergency services directors

The survey of community services board preadmission screening clinicians and emergency services directors was administered electronically to all preadmission screening clinicians who had been certified or recertified in 2021 or 2022 and to the directors of emergency services at all 40 CSBs. Some of the emergency services directors were also preadmission screening clinicians.

Preadmission screening clinicians received various questions pertaining to their responsibilities of conducting prescreening evaluations and bed searches, including their perspectives on the workload and administrative requirements; alternative supports and services to reduce psychiatric hospitalization; guidance and support; and job satisfaction. Emergency services directors received questions regarding recruitment and retention for emergency services; alternative supports and services to reduce psychiatric hospitalization; and guidance and support, including DBHDS support.

JLARC received at least one response from 39 of the 40 CSBs. Thirty of the 40 emergency services directors (75 percent) responded to the survey. In addition, JLARC received responses from certified preadmission screening clinicians across 39 CSBs. Of the estimated 510 certified preadmission screening clinicians across Virginia's 40 CSBs, 315 responded to this survey—a 62 percent response rate.

Data collection and analysis

JLARC collected several types of data from DBHDS, DMAS, VRS, and DHP to analyze for this study. JLARC staff also received and analyzed CSB-level data from DBHDS on spending, emergency services, and crisis services.

JLARC staff also accessed publicly available data from the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), the U.S. Census Bureau, the Centers for Disease Control and Prevention, and the Virginia Department of Health (VDH).

Analysis of CSB consumer and service utilization trends (Chapter 1 and 2)

JLARC used DBHDS's Community Consumer Submission 3 (CCS3) Consumer File and Service File data to calculate CSB consumer numbers, percentages, and trends across services, demographic groups, CSBs, regions, and fiscal years. Data was available for FY12 to FY22.

JLARC received consumer-level data from DBHDS on state psychiatric hospital admissions, extraordinary barriers to discharge from state psychiatric hospitals, CSB consumers, CSB services, and consumer outcomes.

Analysis of CSB funding (Chapter 1, 5, and 6)

JLARC staff analyzed CSB-level expenditure data collected by DBHDS through Little CARS. The data included all state, federal, and local funding; funding collected from Medicaid, private insurance, and other fees; retained earnings; and other funding sources that each CSB received to operate and provide mental health and substance abuse services. State and federal funding data included individual budget lines, which outlined the specific services and populations for which the funds were required to be used and whether the funds were distributed to individual CSBs or for regional programs. This data was available for FY12 to FY22.

JLARC staff analyzed Medicaid behavioral health spending data collected by DMAS. The data included all Medicaid spending for community-based behavioral health services provided by CSBs and other providers for FY12 through FY21.

Analysis of statewide and national behavioral health needs (Chapter 2)

JLARC staff used SAMHSA's National Survey on Drug Use and Health (NSDUH) publicly available data to estimate the prevalence of and number of adults and youth with mental illnesses and substance use disorders in the nation and in Virginia, as well as treatment rates for those populations. NSDUH data sources included NSDUH's Model-Based Prevalence Estimates reports, Interactive NSDUH Substate Estimates, and NSDUH's Restricted-use Data Analysis System. Data was available for 2008 to 2020, though not all years were available for all measures. Estimates may have been based on survey results from the year listed or the year listed as well as the prior year, depending on data availability.

JLARC used publicly available data from DBHDS's 2015, 2018, and 2020 Overview of Community Services in Virginia reports, the U.S. Census Bureau's Vintage 2020 Bridged-Race Postcensal Population Estimates, and Interactive NSDUH Substate Estimates to estimate the number of adults with a serious mental illness across regions of Virginia. That calculation was additionally used with DBHDS's CCS3 data to estimate CSB coverage of Virginians with a serious mental illness between 2012 and 2020.

JLARC also analyzed HRSA's National Survey on Children's Health publicly available data to calculate the percentage of children in Virginia who had an emotional or behavioral disorder in 2020.

JLARC staff used publicly available data from the Centers for Disease Control and Prevention WONDER Online Database to determine the fatality rates of intentional self-harm among adults and youth in Virginia between 2010 and 2020.

JLARC also used VDH's publicly available Fatal Overdose Tables to calculate rates of fatal drug overdoses in and across Virginia from 2012 to 2021.

Analysis of CSB consumer outcomes (Chapter 2)

JLARC staff analyzed CSB consumer-level data from DBHDS to assess consumer outcomes based on DLA-20 scores. The analysis included two parts: (1) an analysis of initial DLA-20 scores for every CSB consumer who received the assessment since 2019, and (2) an analysis of changes in DLA-20 scores for consumers who had repeated DLA-20 assessments that were at least six months apart.

Initial DLA-20 scores and changes in DLA-20 scores over time were analyzed statewide, by CSB, by functional levels, and by consumer demographics (race, ethnicity, age, and gender). A consumer's functional level was assigned based on their first DLA-20 score (e.g., a consumer with a score of 1.7 is in the "extremely severe impairment" group, and a consumer with a score of 4.3 is in the "moderate impairment" group).

The change in DLA-20 score was calculated using the consumer's first and most recent DLA-20 scores. The data was available from FY19 through FY22.

Analysis of CSB turnover and salary increases (Chapter 3)

JLARC used VRS data to understand turnover across VRS-participating CSBs (24 of 40) and the extent to which CSB staff have received salary increases appropriated by the General Assembly. JLARC requested and received "snapshot" files for June 30 of each fiscal year from FY12 to FY22. These files include a list of all employees of the 24 participating CSBs as well as additional information, including a unique identifier and each employee's salary as of June 30 of the applicable year. The data is not collected in a way that allowed for JLARC staff to determine the employee's service area (e.g., mental health services or developmental disability services) or whether the individual is administrative or direct care staff.

To analyze turnover, JLARC staff matched individual records to identify employees who were employed on June 30 of Year 1 (e.g., June 30, 2019) who were also employed on June 30 of Year 2 (e.g., June 30, 2020). JLARC staff calculated the total number of separations between June 30 of Year 1 and June 30 of Year 2 and divided this by the total number of staff employed on June 30 of Year 1.

To analyze CSB staff salary increases, JLARC staff matched individual records across years and subtracted their salary in Year 2 by their salary in Year 1. JLARC staff then calculated the percentage salary increase by dividing any increase between Year 1 and Year 2 by the employee's Year 1 salary.

JLARC staff determined the proportion of CSBs that appeared to not have given an across-the-board salary increase by identifying those CSBs that did not give a salary increase to at least two-thirds of their staff.

Analysis of data from Department of Health Professions surveys (Chapter 3)

Each year, the Department of Health Professions (DHP) Healthcare Workforce Data Center conducts a statewide survey of certain types of licensed behavioral health staff annually for various information, including the sector in which they work, their primary focus areas, and time allocation. DHP also collects the type of establishment, including a CSB, where the licensed staff works.

DHP surveys three types of behavioral health professionals: licensed clinical social workers (LCSWs), licensed professional counselors (LPCs), and licensed clinical psychologists (LCPs). All three types of licensed professionals work at community services boards.

DHP response rates are generally high for each type of licensed profession. For example, in the 2021 survey,

- 73% of all Virginia LCPs completed the survey;
- 80% of all Virginia LCSWs completed the survey; and
- 80% of all Virginia LPCs completed the survey.

JLARC staff requested and received aggregated 2021 survey data from DHP for each type of profession. DHP separated responses of individuals who reported they worked for a CSB from the responses of individuals who worked elsewhere. JLARC staff then compared responses to the survey between LCPs, LCSWs, and LPCs who worked at CSBs to those who worked at other types of establishments (or who were self-employed).

To analyze whether the behavioral health workforce is growing in Virginia, JLARC staff used publicly available data on the total number of licensees in each type of profession available through DHP. JLARC also analyzed data on the number of graduates from Virginia higher education institutions provided by staff of the Virginia Health Care Foundation.

To analyze trends in the sectors for which licensed professionals are working (e.g., private sector, non-profit organizations, or state and local government), JLARC staff used publicly available data on the DHP Healthcare Workforce Data Center's website and in published survey reports.

Analysis of state psychiatric hospital and emergency services trends (Chapter 4)

JLARC used consumer-level data collected by DBHDS to analyze state psychiatric hospital admissions trends statewide, by CSB, and by each facility. This included all admissions to these facilities, including individuals under a civil or forensic temporary detention order (TDO) and those admitted for other reasons, such as voluntary admissions or competency restoration. The data was available for FY12 to FY21.

JLARC also requested CSB-level data from DBHDS regarding the number of preadmission screenings conducted and TDOs executed. JLARC used this data to analyze TDO trends overtime and to calculate CSBs' civil TDO rates, based on the number of preadmission screenings conducted. This data was available from January 2015 through March 2022.

Analysis of state psychiatric hospital discharge trends (Chapter 4)

JLARC received consumer-level snapshot data on the extraordinary barriers to discharge list (EBL) from DBHDS to analyze (1) the number of individuals placed on this list overtime and (2) the primary barriers to discharge in April of each year. The April “snapshot” numbers of EBL placements were available between 2015 and 2022, while April “snapshots” of the primary barriers for discharge were only available between 2019 and 2022.

JLARC used publicly available 30- and 180-day readmission rates data from SAMHSA’s Uniform Reporting System to analyze Virginia’s state psychiatric hospital readmission rates and compare Virginia’s trends to those nationally. These rates only included individuals who had previously been placed in a state psychiatric hospital that were readmitted to such facilities within 30 or 180 days. This data was available from 2011 to 2020.

Analysis of residential crisis stabilization unit availability (Chapter 4)

JLARC staff analyzed DBHDS program licensing data to determine the number of CSBs and private providers licensed to run residential crisis stabilization units (RCSUs). Because of closures due to the COVID-19 pandemic, JLARC staff called each private provider to ensure they were still in operation and determine how many beds each of their facilities had. For CSBs, JLARC staff collected existing information from DBHDS reports to determine how many beds each CSB’s RCSU was licensed to operate and called CSBs when the bed capacity or operational status of their RCSU was unclear.

Site visits

JLARC staff visited nine community services boards:

- Fairfax-Falls Church Community Services Board;
- Henrico Area Mental Health and Developmental Services;
- Highlands Community Services;
- New River Valley Community Services;
- Norfolk Community Services Board;
- Northwestern Community Services Board;
- Prince William County Community Services;
- Richmond Behavioral Health Authority; and
- Rockbridge Area Community Services.

JLARC staff also conducted a site visit to the Highlands Community Services’ crisis center, which included a tour of the facility—including the crisis intervention team assessment center, 23-hour crisis stabilization unit, and the crisis stabilization unit—and observations of both a real and simulated pre-admission screening.

Review of preadmission screenings

JLARC staff reviewed a random sample of 100 prescreening evaluations from individuals who were placed under a TDO in a state psychiatric hospital. The composition of this sample included 59 prescreening evaluations for adult patients, 30 for children and adolescent patients, and 11 for geriatric patients.

JLARC staff used DBHDS state psychiatric hospital admissions data from FY20 to FY22 to identify individuals admitted to these facilities who had been placed there under a civil TDO. Patient prescreening evaluations were stratified based on size of the CSB catchment area and by age group (i.e., adults versus children and adolescents). Patient prescreening evaluations were then randomly selected from these subpopulations. The sample was then requested from DBHDS.

JLARC evaluated whether prescreening evaluations included critical components, including the risk assessment details section and the feasibility of less restrictive alternatives section. When available in the prescreening evaluations, JLARC also analyzed the length of time the prescreening evaluation took and the number of inpatient facilities contacted as part of the bed search process.

Review of CSB performance contracts

JLARC staff reviewed CSB performance contracts for FY22–FY23, including base contracts, all exhibits, and addendums for each CSB. Elements of the contracts reviewed included contract terms and conditions, service requirements, performance measures, and Exhibits D to catalog required services that were not listed in the base contracts.

Review of DBHDS internal audit reports

JLARC staff reviewed CSB operational reviews conducted by the DBHDS Office of Internal Audit in 2020 and 2021 as well as responses and follow up reports to these audits. The reports were reviewed in their entirety, including findings on CSB fiscal accountability, internal controls, processes, and compliance with performance contract requirements.

JLARC staff also reviewed CSB Annual Financial Report and Risk Assessment reports completed by the DBHDS Office of Budget Execution and Financial Report and the Office of the Comptroller. These reports are primarily based on a review of the CSB single audit reports, with a focus on compliance and internal control findings, as well as a detailed financial analysis of the financial statements of operating CSBs. These reports assessed the overall risk status of each operating CSB based on financial ratio analysis and audit findings.

Review of previous reports on Virginia's CSB system

JLARC staff reviewed a variety of previous reports, audits, presentations, and other materials published in recent years pertaining to CSBs. The review of these materials helped to inform the team's understanding of challenges previously identified related to the CSB system and assess the extent to which the current structure of the CSB system contributes to challenges impacting the delivery of publicly funded behavioral health services in Virginia.

Materials reviewed included:

- reports and presentations produced by, and shared with, the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century (Joint Subcommittee/Deed's Commission);
- previous JLARC reports on community services and CBSs, including the 2019 *CSB Funding* report, 2019 *Review of the STEP-VA Implementation*, the 1979 *Deinstitutionalization and Community Services* report, and 1986 follow up report;
- reports from the Commission on Mental Health Law Reform;
- the Governor's Taskforce on Improving Mental Health Services and Crisis Response report;
- materials from the DBHDS System Transformation Team;
- the Virginia Behavioral Health System Needs Assessment Final Report;
- the SB1488 TDO Taskforce report;
- the 2017 Plan for Financial Realignment of Virginia's Public Behavioral Health System;
- reports from the Independent Reviewer monitoring Virginia's implementation of the Department of Justice Settlement Agreement; and
- various other reports to the General Assembly, including DBHDS's CSB Funding and Medicaid Expansion, The Implementation of the Marcus David Peters Act, State Hospital Discharge Protocols, and the Dementia Services Workgroup Report.

Review of national research

JLARC staff reviewed numerous publications and resources on behavioral health services from national organizations, including resources from:

- The American Association for Emergency Psychiatry;
- The National Association of State Mental Health Program Directors;
- The National Association of State Mental Health Program Directors Research Institute (NRI);
- SAMHSA; and
- The Treatment Advocacy Center.

Document review

JLARC also reviewed numerous other documents and literature pertaining to community-based behavioral health services in Virginia and nationwide, such as:

- Virginia laws, regulations, and policies relating to DBHDS, DMAS, and CBSs;
- other states' public behavioral health laws, regulations, policies, and processes, such as their community-based mental health and substance abuse services laws and regulations, Medicaid managed care laws and policies, and involuntary commitment process; and
- journal articles and government reports on recent trends in the prevalence of behavioral health conditions.

Appendix C: Agency response

As part of an extensive validation process, the state agencies and other entities that are subject to a JLARC assessment are given the opportunity to comment on an exposure draft of the report. JLARC staff sent an exposure draft of this report to the secretary of health and human resources, Department of Behavioral Health and Developmental Services (DBHDS), Department of Medical Assistance Services, and the Department of Health Professions Healthcare Workforce Data Center.

Appropriate corrections resulting from technical and substantive comments are incorporated in this version of the report. This appendix includes a response letter from DBHDS.



COMMONWEALTH of VIRGINIA

NELSON SMITH
COMMISSIONER

DEPARTMENT OF
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December 5, 2022

Mr. Hal Greer, Director
Joint Legislative Audit and Review Commission
919 East Main Street
Richmond, VA 23219

Dear Mr. Greer:

Thank you for the opportunity to review the exposure draft of the JLARC report *CSB Behavioral Health Services*. We commend your staff for their dedication, rigor, and professionalism throughout the study process and believe this report reflects a comprehensive view of CSB behavioral health services and also provides recommendations and elements of a roadmap to move Virginia's complex system forward. We remain committed to working with you and the General Assembly to improve access, quality, consistency, and accountability related to behavioral health services in the Commonwealth.

DBHDS has recently articulated a system-wide "North Star Plan," around which we seek cross-sector, cross-agency, and cross-levels of governance buy-in from stakeholders to seek and partner towards this shared vision. The North Star includes three primary areas of focus:

- 1) Strengthen the workforce
- 2) Expand the comprehensive continuum of care
- 3) Modernize systems and processes

Many of the recommendations for DBHDS in the JLARC report were very consistent with these goals, and action plans which are currently in development and can be refined to include and integrate the findings of this report. These include further development of the crisis continuum, including increased residential crisis stabilization unit (RCSU) capacity across the lifespan and quality oversight of the prescreening process, as well as the implementation of the data exchange between CSBs and DBHDS, and increased oversight of workforce initiatives such as salary increases. As noted in the report, broader systems change requires a coordinated and comprehensive approach that takes into account the complexities between overlapping regulatory authorities and payers, and that can be integrated into developing action plans for the North Star Plan. It cannot be overstated the extent to which any actions taken by DBHDS through the

performance contract and related oversight procedures (i.e., the increased oversight, assessment, and data reporting recommendations included in the report) create additional administrative burden, which is experienced only by the CSBs and not other provider types. An example of this unique administrative burden can be seen in recommendations regarding the increased role of the DLA-20 and quality review of prescreening process. **To this end, we believe that to address the issues highlighted in this report, Virginia needs a single unifying model for the oversight and funding of CSBs. As such, the significant opportunities Virginia could harness through the federal Certified Community Behavioral Health Clinic (CCBHC) model deserves mention.**

CCBHCs are specially designated clinics that provide a comprehensive array of mental health and substance use services for children and adults. As is required currently of CSBs, CCBHCs must see anyone, regardless of diagnosis and insurance status. The hallmark features of the CCBHC model include access (regardless of ability to pay or insurance status) to an array of nine core services, accompanied by robust data and outcome reporting, quality benchmarks and associated incentive payments, and a prospective payment system. Designation as a CCBHC requires that clinics meet specific data and quality requirements and reports on standard metrics, and the CCBHC array of services is funded through a prospective payment system based on the cost of care. Virginia already has significant experience with the CCBHC model through a planning grant completed in 2016. At the time, the CCBHC model was a new demonstration and Virginia did not proceed with implementation of the full model. Yet, Virginia purposely designed the STEP-VA array of services based on the CCBHC array of services, and each step has received initial funding from the General Assembly.

Since the completion of the first Virginia planning grant, the two-year national demonstration was completed and the project has expanded in a number of ways, including the development of over 500 CCBHCs nationwide through clinic-based grant opportunities. In fact, four Virginia CSBs have taken steps to meet CCBHC federal criteria. In 2021, the Bipartisan Safer Communities Act authorized the significant expansion of the CCBHC demonstration to support additional states to implement the CCBHC model. Further, DBHDS and the Department of Medical Assistance Services (DMAS) are in the process of applying for a federal planning grant in December 2022 associated with CCBHC implementation. Building upon STEP-VA and Project BRAVO, completing this planning grant will be the next step in defining and supporting an accessible, high quality CSB system.

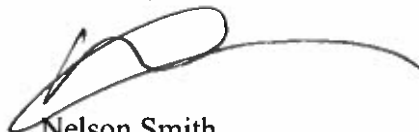
It is very important to note that without a comprehensive solution which accounts for the complexities between the US Centers for Medicare & Medicaid Services and the US Substance Abuse and Mental Health Services Administration at a federal level and DBHDS, DMAS, and the managed care organizations at a state level, it will be difficult to orchestrate the implementation of actions that would substantially improve the system conditions and thus the provision of behavioral health services for Virginians. Of course, the implementation of a single specialty provider type will not address all of Virginia's system issues in behavioral health. However, it would allow a sustainable path forward for consistent and predictable funding and quality oversight of a core array of services offered through the CSB system. Additionally, as Virginia defined the certification requirements for CCBHCs, it would require that explicit decisions be made regarding not only the CCBHC scope but also the historic CSB scope of services and the reimbursement of services. This includes crucial clarifications included in the

JLARC report such as discharge planning and emergency services, as well as targeted case management for individuals with serious mental illness (SMI) and substance-use disorders.

We believe the CCBHC model provides a coordinated and comprehensive roadmap for addressing JLARC recommendations surrounding the relationship between CSBs and managed care companies, and DBHDS quality oversight of CSBs. The CCBHC also includes a data-driven approach with clear expectations and outcomes. This model and the strategic goals set forth in the North Star plan, will allow Virginia to make meaningful improvements while ensuring we are aligned with the Governor's vision of making Virginia the best place to live, work, and raise a family.

Again, thank you for the opportunity to comment on this report. We appreciate your comprehensive analysis and hard work of your staff to develop the recommendations. We look forward to continuing our partnership in the advancement of the behavioral health service system of the Commonwealth.

Sincerely,

A handwritten signature in black ink, appearing to read 'Nelson Smith', with a long horizontal flourish extending to the right.

Nelson Smith
Commissioner

Appendix D: Community-based behavioral health service delivery system structures and approaches to service delivery

JLARC staff examined the structure of the community services board (CSB) system and its relationship to the broader publicly funded behavioral health system, which also includes the state inpatient psychiatric hospitals and Medicaid-funded services delivered by private providers. JLARC staff also compared Virginia's CSB system structure to the structure of community-based behavioral health service delivery systems in other states.

Virginia's overall CSB system structure is generally similar to other states with large populations

States' approaches to structuring their community-based behavioral health service delivery system can generally be grouped into two major categories: centralized and decentralized. In centralized systems, all publicly funded behavioral health services, including community-based services, are directly funded and provided by the state. Only two states deliver community based services through a centralized system. In decentralized systems, the state provides funding for and oversees community-based behavioral health services, but services are delivered by non-state entities. Decentralized systems are further distinguished by whether or not services are delivered with or without the involvement of local government entities.

Virginia is one of 12 states that involve local government in delivery of community-based services

Like 48 states, Virginia delivers community-based behavioral health services using a decentralized model. However, only 12 states, including Virginia, allocate state funding to local government entities, which in turn deliver the services either directly or through contracts with private providers. This model involving local government entities is primarily used by states with larger populations, including California, New York, North Carolina, Ohio, Pennsylvania, and Washington State. Thirty-six states use a decentralized model of delivery but deliver services primarily through direct contracts with private providers without local government involvement. Only two states and the District of Columbia use fully centralized models in which the state directly funds and provides all services.

Service delivery model is not clearly linked to the performance of community-based behavioral health systems. State-level data on the effectiveness and efficiency of community-based behavioral health systems is very limited; however, available data does not indicate there is a direct relationship between system structure and key behavioral health metrics. For instance, key measures of the prevalence of behavioral health issues and access to care do not directly correspond to states' community-based behavioral health system structures. In interviews with JLARC staff, subject-matter experts noted that no one system structure is inherently more effective than another.

Although no one system structure is inherently more efficient or effective, subject-matter experts do report that there are some tradeoffs between different models of service delivery. For example, cen-

tralized, state-operated systems tend to more easily implement statewide initiatives, have greater consistency in the types of services that are available, and make it easier to hold providers accountable. However, these systems are less flexible and responsive to local needs, and tend to rank lower on access to care measures.

Decentralized systems are generally more flexible, but have less consistency in services and often face challenges implementing statewide initiatives. Decentralized systems *with local government* involvement (like Virginia) are particularly responsive to local needs, promote community engagement, and encourage local funding support for services, but are more difficult to hold accountable for effective and efficient operations. Decentralized systems *without local government* involvement may offer some cost-savings and efficiency gains by working directly with private providers, but require robust state oversight to ensure quality services and typically do not have substantial or consistent local funding.

Virginia's total number of CSBs is comparable to the number of local entities in other states with similar systems and populations

In any decentralized community-based behavioral health system, the total number of local entities that administer the system should be sufficient to assess and respond to the unique needs of the local populations and to ensure that administrative funds are spent efficiently. The Code of Virginia did not create a specific number of CSBs but instead directs each county or city to establish or join with other localities to create a CSB. Importantly, the total number of CSBs does not directly relate to the number of locations at which consumers are able to access services, because each CSB operates multiple service locations. For more information on CSB service locations, see Appendix F.

The total number of CSBs appears generally in line with other states with similar decentralized systems. Currently, Virginia has 40 CSBs serving 133 localities, with most CSBs serving multiple localities. There is one CSB for about every 216,000 Virginians, which is a slightly lower ratio than some other states JLARC staff reviewed. For example,

- Ohio has 51 local boards, with each board serving about 231,000 people;
- Pennsylvania has 48 county Mental Health and Developmental Services offices, with each office serving about 270,000 people; and
- New York has 58 local government units, with each unit serving about 342,000 people.

Some other states with similar community-based behavioral service delivery models require that each local entity's catchment area include a minimum number of people. For example, Ohio requires that each local board district have a population of at least 50,000. In Virginia, 36 CSBs served populations of at least 50,000 people based on 2020 population data. Among the other four CSBs' catchment areas, the population ranged from about 14,500 people to about 44,000 people. The median CSB catchment area population in 2020 was about 172,000 people.

States frequently reorganize their public behavioral health systems and have moved toward integrating state-level administrative entities

National survey data, conversations with national experts, and JLARC staff's review of other state systems indicate that states are regularly reorganizing and restructuring their public behavioral health

systems. In 2021, the National Association of State Mental Health Program Directors Research Institute reported that 14 states were restructuring their delivery of community-based behavioral health services, and that 23 states had reorganized their state behavioral health agency in the last two years. For example, North Carolina is in the process of completing its third major reorganization of its community-behavioral health system since 2001, and Washington State recently completed a significant reorganization of its state level agencies, merging the state behavioral health and Medicaid agencies.

Although the nature of these reorganizations has differed from state to state, a common trend has been the integration of public behavioral health administrative entities and functions at the state level. Generally, these reorganizations were intended to reduce fragmentation and complexity of both oversight and service delivery of behavioral health services. States have primarily reorganized in the following ways:

- integration of mental health services and substance use disorders services under a single agency and/or delivery of mental health and substance use disorder services at the local level. As of 2021, 42 states, including Virginia, combine the state level administration of mental health and substance use disorders into a single agency;
- integration of the state behavioral health agency with the state Medicaid agency. As of 2021, at least six states had combined their state mental health and state Medicaid agencies; and
- integration of behavioral health services with physical health services administratively through combined state-level agencies. For example, 35 states' lead mental health agency is administratively located within larger umbrella state agencies, like a Department of Human Services or Department of Health.

In Virginia, the administration of mental health and substance use disorder services is integrated under the Department of Behavioral Health and Developmental Services (DBHDS). Medicaid is administered by a separate state agency—the Department of Medical Assistance Services (DMAS). Physical health services are also administered by a separate state agency—the Department of Health. All three of these agencies fall under the purview of the secretary of health and human resources.

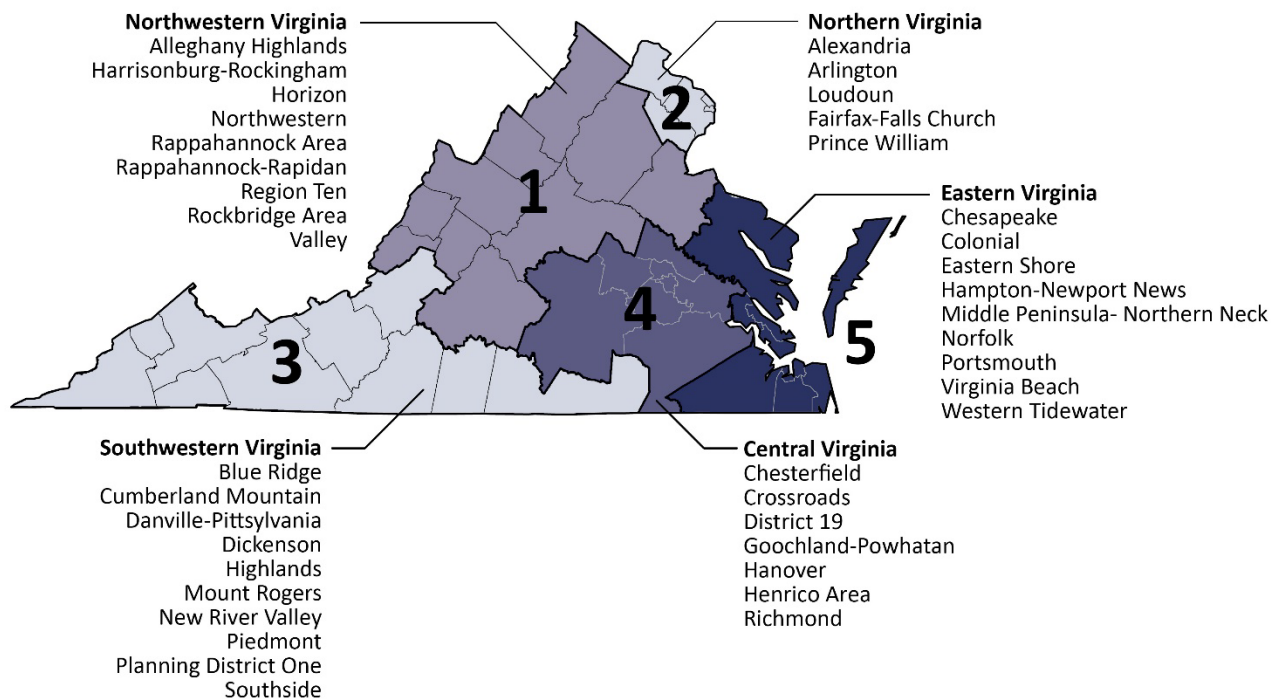
CSBs work together regionally and contract with private providers to deliver some behavioral health services

To deliver some types of behavioral health services to consumers, such as residential crisis stabilization, CSBs coordinate through semi-structured regional arrangements. There is no official statutory basis for CSB regional arrangements, but DBHDS has assigned each CSB to one of five regions for the administration of regional funds and programs. Each of these regions generally track closely with state psychiatric hospital catchment areas. Region 3 is further separated into three sub-regions because of geographic proximity to multiple state hospitals (Figure D-1).

Note: For the purposes of the report, regionalization/regional services refers to multiple CSBs collaborating to deliver services across multiple CSB catchment areas using shared funds. Twenty-nine CSBs serve multiple localities within their catchment area as multi-jurisdictional, operating boards that were formed by multiple local governments. JLARC staff are not referring to these regional arrangements in this section.

Figure D-1

CSBs are grouped into five primary regions for administering regional funds and programs



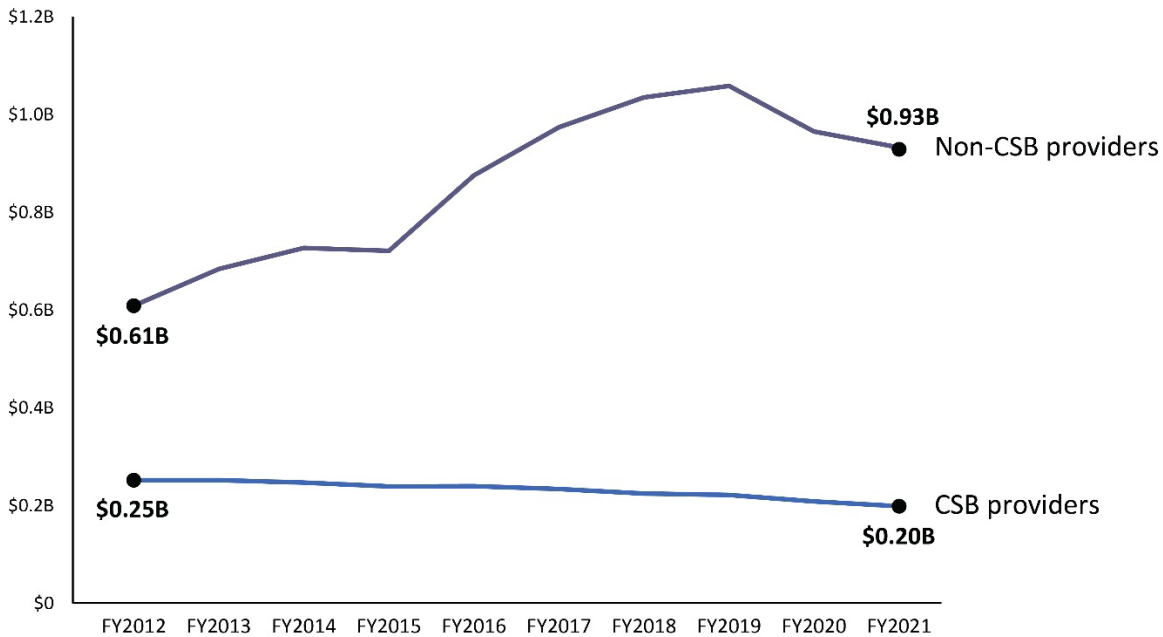
SOURCE: DBHDS documentation.

NOTE: Region 3 is further divided into region 3a (Blue Ridge Behavioral Healthcare) and 3b (Danville-Pittsylvania Community Services, Piedmont Community Services, and Southside CSB). The remaining CSBs in Region 3 are considered Region 3c.

CSBs are only one piece of the broader publicly funded behavioral health system, which also includes state psychiatric hospitals and services delivered by private providers who accept Medicaid. Although CSBs are often thought of as the primary providers of publicly funded, community-based behavioral

health services in the state, spending data indicates that private providers are the most common providers of these services. In FY21, private providers accounted for nearly 82 percent of all Medicaid behavioral health spending in Virginia, while CSBs accounted for only about 18 percent (Figure D-2). CSBs report often working with various private providers to deliver services in their catchment areas.

FIGURE D-2
Non-CSB private providers deliver the majority of Medicaid funded behavioral health services



SOURCE: DMAS spending data, FYs 2012-2021.

NOTE: Includes all behavioral health services paid for through Medicaid, including inpatient and mental health case management services. Figure is adjusted for inflation using medical CPI.

Regional arrangements manage hospital utilization programs and deliver a variety of services, and funding for CSB regional programs has increased substantially

All CSBs coordinate with their respective regional partners to help manage utilization of state psychiatric beds in the region, primarily through the use of Local Inpatient Purchase of Service (LIPOS) and Discharge Assistance Planning (DAP) funds. Each region has a Regional Utilization Management team made up of representatives from the CSBs in the region. This team collaboratively makes decision on the use of funds to either assist with payment for private hospital beds for uninsured individuals (LIPOS), or to facilitate discharges from state hospitals back to the community (DAP).

Over the past decade, the total amount and proportion of state general funds allocated for regional programs has increased substantially. Funds allocated on a regional basis are primarily directed to high cost, high intensity services, such as crisis stabilization units and permanent supportive housing, and other hospital utilization programs, like DAP funds. Regional programs may include self-contained, single-purpose programs (like residential crisis stabilization units) directly operated by a CSB or programs CSBs contract to private providers, who serve individuals from all CSBs in the region. Between

FY12 and FY22, funding for regional programs increased from about \$86 million (27 percent of state general funds for behavioral health) to about \$218 million (about 49 percent of state general funds for behavioral health), when adjusted for inflation. This increase was primarily driven by growth in regional funding for STEP-VA outpatient (\$43 million in FY20, \$15 million in FY21, and \$22 million in FY22), STEP-VA mobile crisis funding (\$8.8 million in FY21 and \$18.9 million in FY22), and DAP funding. DAP funds have grown from less than \$10 million in FY12 to about \$46 million in FY22.

Formality of regional relationships and level of collaboration between CSBs varies

Despite the growth in regional funds and emphasis on regional collaboration for programs like crisis services, the formality of the structure of the regional offices and the extent of collaboration between CSBs in each region vary significantly. Region 2 (Northern Virginia) appears to be the most structured regional arrangement, with a formal Regional Projects Office with several dedicated staff members, two regional oversight groups, and regular collaboration around multiple regional initiatives. Region 3 appears to have the least formal regional relationship, with collaboration efforts primarily focused on the hospital utilization management programs and some recently initiated information-sharing efforts. The other regional project offices have varying levels of structure and formality of relationships between, but regions appear to be trending toward more formal relationships resembling the Northern Virginia Regional Projects Office model, according to interviews with regional project office staff.

The regions with more formal regional project offices (like Region 2 and Region 4) report substantial benefits to regular collaboration, including strategic decision making regarding use of regional funds to meet the unique needs of consumers in the region.

Some other states have a greater regional administrative presence

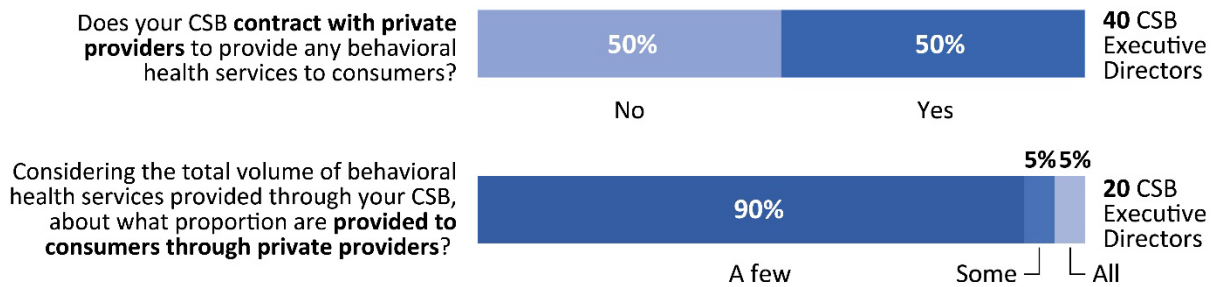
While most states with decentralized community-based behavioral health service delivery systems like Virginia administer and oversee the system through a central state-level entity, several states decentralize some responsibility to regional offices located throughout the state. For example, in Pennsylvania, the 48 county Mental Health and Developmental Services (MH/DS) program offices are overseen by four regional field offices of the state Bureau of Community and Hospital Operations. These field offices are responsible for reviewing county mental health plans and budgets, licensing mental health services, conducting contract oversight of MCOs in the region, monitoring and investigating major incidents and complaints, and partnering with county and state entities on planning for their service areas.

Similarly, in Wisconsin, the state's 72 counties are divided into five regions. Each region has a Department of Health Services Regional Office that helps to support county and tribal efforts. The Area Administrators at the regional offices serve as liaisons with state office staff, and offer in-person technical assistance, guidance, and issue resolution assistance to county representatives in their region. The regional area administrators provide assistance with human services functions beyond behavioral health, but are reportedly a key resource for assisting county human service departments with questions, issues, and technical assistance.

CSBs directly contract with private providers to varying degrees

The Code of Virginia permits CSBs to either provide services directly or enter into contracts with private providers to deliver services required by state law. Some CSBs deliver all behavioral health services directly, while others contract some service delivery out to private providers. In response to JLARC’s survey of CSB executive directors, half reported that they directly contract with private providers to deliver at least some services. Of those 20 CSBs, most (18) reported contracting out for “a few” (1 percent to 25 percent) of their services. One CSB executive director reported contracting out “some” (25 percent to 44 percent) services, while another CSB (Planning District 1) contracts out all of its services to private providers (Figure D-3). Among the half of CSB executive directors that contract at least some services to private providers, non-hospital inpatient services (such as detox and rehabilitation services) and early intervention services were the most commonly reported contracted services.

Figure D-3
Half of CSBs reporting contracting with private providers, but most only contract a small proportion



SOURCE: 2022 JLARC survey of CSB executive directors.

NOTE: In survey, “All” was 100 percent, “Most” was 76 percent to 99 percent, “A majority” was 56 percent to 75 percent, “About half” was 45 percent to 55 percent, “Some” was 26 percent to 44 percent, and “A few” was 1 percent to 25 percent.

Of the 20 CSBs that contract with private providers to deliver some services, half reported that they did so because their CSB did not have the types of staff necessary to provide the particular service. Other commonly reported reasons included not having *enough* staff to provide the particular service (seven executive directors), and not having the physical space or facilities necessary to provide the particular service (five executive directors). Additionally, several CSBs reported that they collaborate with community partners whenever possible and that contracting for services (when available) can cost less over the long term.

In addition to directly contracting with private providers, CSBs also serve as a pass-through entity for state funds to private providers. This is most often the case with DAP and LIPOS funds that are allocated to CSBs on a regional basis. For DAP funds, CSBs will work with their regional CSB partners to develop plans for purchasing services from providers in the community to deliver services necessary to move individuals from more restrictive inpatient placements, including state hospitals. Similarly, LIPOS funds are administered by CSBs and used to purchase hospital beds from private providers in the community rather than placing individuals in state hospitals. As discussed earlier in this appendix,

funding for these programs, and DAP in particular, has increased substantially over the past decade. Between direct contracts with CSBs and the increased use of private providers to spend state regional funds, private providers continue to play an important and increasing role in the CSB system.

Some other states place greater emphasis on the use of private providers

Some states rely more heavily on private providers to deliver community-based behavioral health services to individuals. For example, in Ohio, the local Alcohol, Drug, and Mental Health boards contract with private providers for prevention, treatment, and recovery services. The boards themselves do not directly deliver services and instead are responsible for planning, evaluating, and funding the local system of behavioral health services. Similarly, in Pennsylvania, county mental health and developmental services program offices primarily refer individuals to contracted local provider agencies.

Additionally, while Virginia *permits* CSBs to contract with private providers to deliver community-based behavioral health services, some other states *require* that local entities attempt to contract with private providers before developing and delivering services themselves. For example, both California and Nebraska have statutory provisions that require local boards to first utilize private resources and facilities, or attempt to contract with private providers, to deliver publicly funded behavioral health services before the locality may provide services themselves.

Appendix E: CSB behavioral health crisis facilities and services

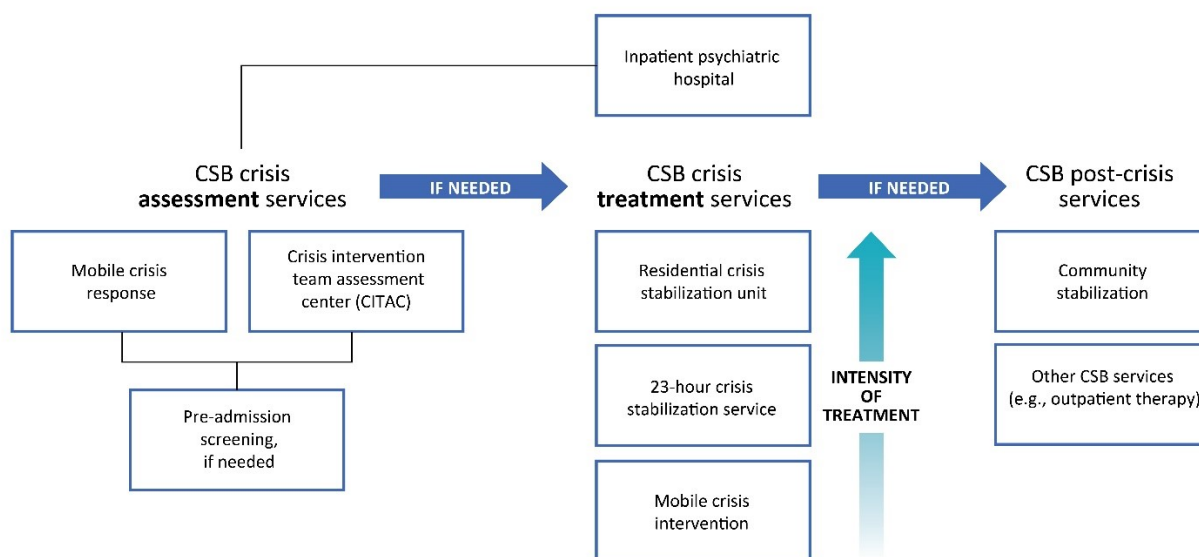
This appendix is intended to serve as a resource for legislators interested in better understanding behavioral health crisis services offered by CSBs and crisis services currently in development across the CSB system.

Behavioral health crisis services currently offered by CSBs

CSBs offer several types of crisis services, although not all CSBs offer each service and some services may be offered only regionally. Generally, these crisis services can be separated into three categories: (1) crisis assessment services; (2) crisis treatment services; and (3) post-crisis services (Figure E-1).

FIGURE E-1

CSB crisis services include both assessment and treatment services



SOURCE: JLARC staff analyses of national publications, reviews of DBHDS documentation and presentations, and site visits to CSBs.

NOTE: Not all CSBs provide each of these services and some (e.g., residential crisis stabilization units) are provided regionally. Figure is for illustrative purposes.

Crisis Intervention Team Assessment Centers (CITACs) (assessments)

Crisis Intervention Team Assessment Centers (CITACs) are locations, sometimes at a CSB and sometimes at another facility, where law enforcement can bring people in crisis who have made contact with law enforcement because of their behavior but have not been arrested or charged with a crime. The goal of CITACs is to divert people in crisis from jails and emergency departments. Treatment is not provided at CITACs, aside from basic crisis intervention. At a CITAC, a person in crisis who is under an emergency custody order (ECO) can be assessed and prescreened for admission to an inpatient psychiatric facility. There are currently 42 CITACs across the state, 13 of which are located at CSBs and 29 of which are located at private hospitals.

The term “CITAC” is often used synonymously with “drop-off center,” but law enforcement are not always able to drop off a person under an emergency custody order (ECO) at a CITAC. CITACs typically operate with limited hours because of fluctuating demand and staffing constraints. In addition, a law enforcement officer must be present to take custody of the individual. CITACs generally have at least one law enforcement officer on duty during operating hours, but depending on the number of individuals being served at the CITAC, that officer may be too busy to take custody of the individual.

Mobile crisis response (assessments/basic crisis treatment)

Mobile crisis response provides rapid response from a team of behavioral health professionals to people experiencing behavioral health crises. Mobile crisis teams can meet people in crisis in the community in a setting that is comfortable for them. The goal of mobile crisis response is to assess the person in crisis to determine their needs, help de-escalate their crisis with crisis intervention services when possible, and connect the person to needed services up to and including inpatient hospitalization.

Mobile crisis teams can complete preadmission screenings for inpatient psychiatric hospitalization when necessary. A person in crisis must consent to mobile crisis services, and if necessary, a professional on a mobile crisis team can request an ECO if the person does not consent but needs to be further evaluated.

23-hour crisis stabilization services (facility-based non-residential treatment)

Twenty-three hour crisis stabilization services are non-residential crisis stabilization services that are delivered to individuals in a home-like setting for less than 24 hours. These services generally involve more intensive services than individuals would receive from a mobile crisis team, but less intensive services than they would receive at a residential crisis stabilization unit.

People receiving 23-hour crisis stabilization services receive services such as assessments, evaluations by a psychiatrist or psychiatric nurse practitioner, brief therapy, and service planning. This service is delivered in a home-like facility that is designed to be comfortable for the person in crisis, and is available to accept people in crisis any time of day, seven days a week at facilities that offer these services. People in crisis receive 23-hour crisis stabilization services in a slot known as a “chair,” rather than a “bed,” since the service is non-residential.

DBHDS has referred to these home-like facilities with varying terms, including “23-hour crisis receiving centers,” “psychiatric emergency center (23 hours),” “23-hour observation,” “CRC,” “CRC lite,” and “23-hour observation bed.”

Residential crisis stabilization units (residential crisis treatment)

Residential crisis stabilization units (RCSUs) are facilities that provide crisis stabilization services in a home-like environment where a person typically stays for several days. These facilities serve people experiencing a severe behavioral health crisis that does not require inpatient psychiatric hospitalization, but requires intensive services to stabilize the person. Services at RCSUs include therapy, medication and psychiatry services, peer support, and service planning.

Some RCSUs accept individuals who are under a temporary detention order (TDO), but they are not required to do so.

RCSUs can also serve as a step-down location for people transitioning from inpatient psychiatric hospitalization back into the community.

Crisis Receiving Centers (CRCs) (assessments, non-residential, and residential treatment)

DBHDS and CSBs have reported plans to integrate some RCSUs, 23-hour crisis stabilization programs, and CITACs into one facility. DBHDS now refers to these facilities as “crisis receiving centers.” Locating these programs in the same place allows these programs to share staff, potentially alleviating ongoing staffing issues, and is in alignment with the Crisis Now model.

Crisis hotlines and regional 988 call centers

Every CSB currently operates a crisis hotline that people in Virginia can call when they or someone they know are experiencing a behavioral health crisis. These hotlines operate 24/7, and many situations are resolved through these calls. The crisis hotlines can also connect people in crisis with mobile crisis teams or more intensive crisis services when needed.

In addition, Virginia operates regional call centers that accept calls from the national 988 mental health crisis line and can connect people to CSB crisis services when needed. DBHDS and CSBs are currently working to integrate the national 988 crisis hotline with CSB crisis hotlines on a regional basis. Currently, calling 988 connects a person to a call center based on their area code, at which point they can be transferred or given the number for a crisis line in their area if their area code is from another part of the state or country.

Community stabilization

After an initial crisis response from a CSB, a person who experienced a crisis may be referred to community stabilization. These services are considered a crisis service, but are longer term (up to 30 days) and intended to use support systems and provider relationships in the community to prevent a person from experiencing another crisis. As part of community stabilization, behavioral health professionals help the person build skills to maintain their stability, help them connect with their existing social supports and help those supports learn how to de-escalate a crisis, and coordinate follow-up services with other providers.

Crisis services most likely to reduce unnecessary state psychiatric hospital placements

A full continuum of different levels of crisis services can help reduce unnecessary psychiatric hospitalizations in the long term, and the kind of treatment that is right for a person in crisis depends on the person’s condition and circumstances. However, some crisis services are more likely to reduce unnecessary psychiatric hospitalizations in the short term because they serve people with the most severe symptoms who would likely end up hospitalized if another option did not exist. These services—residential crisis stabilization and 23-hour crisis stabilization—focus on treatment for the person in crisis, rather than just an assessment of the person’s needs like mobile crisis services or CITACs.

Residential crisis stabilization at an RCSU can reduce unnecessary psychiatric hospitalizations for both adults and children. To most effectively reduce unnecessary psychiatric hospitalizations, RCSUs need to be able and willing to accept people who are under a temporary detention order (TDO).

Research on the effectiveness of treatment in an RCSU is limited but indicates this treatment reduces admissions to state psychiatric facilities, repeated admissions to psychiatric hospitals, and subsequent bookings into jail, and may also help people in crisis improve their functioning. CSB directors and emergency services workers also reported in a JLARC survey that additional RCSUs beds would help reduce unnecessary psychiatric hospitalizations, especially for children.

Research on the effectiveness of **23-hour crisis stabilization** on reducing hospitalizations is also limited but is considered a best practice by the Substance Abuse and Mental Health Services Administration (SAMHSA).

This service may be especially important for people experiencing a crisis related to drug or alcohol intoxication, because it gives individuals a safe place to regain their sobriety. State psychiatric hospitals report that between 20 and 50 percent of the civil TDO admissions to their facilities are unnecessary, and a portion of these unnecessary admissions are because a person is intoxicated and displaying behavioral health symptoms. If the person had a safe place to regain sobriety, they would be less likely to be admitted to a state psychiatric hospital.

Mobile crisis response and CITACs are likely to help people in crisis receive assessments sooner and avoid emergency department visits or jail bookings. Clinicians responsible for responding as part of a mobile crisis team or conducting assessments at CITACs may be able to de-escalate a crisis, depending on the person's circumstances. While effective in determining a person's treatment needs, however, these services have a less direct impact on reducing unnecessary hospitalizations because they do not provide the intensive services needed for people needing a higher level of care.

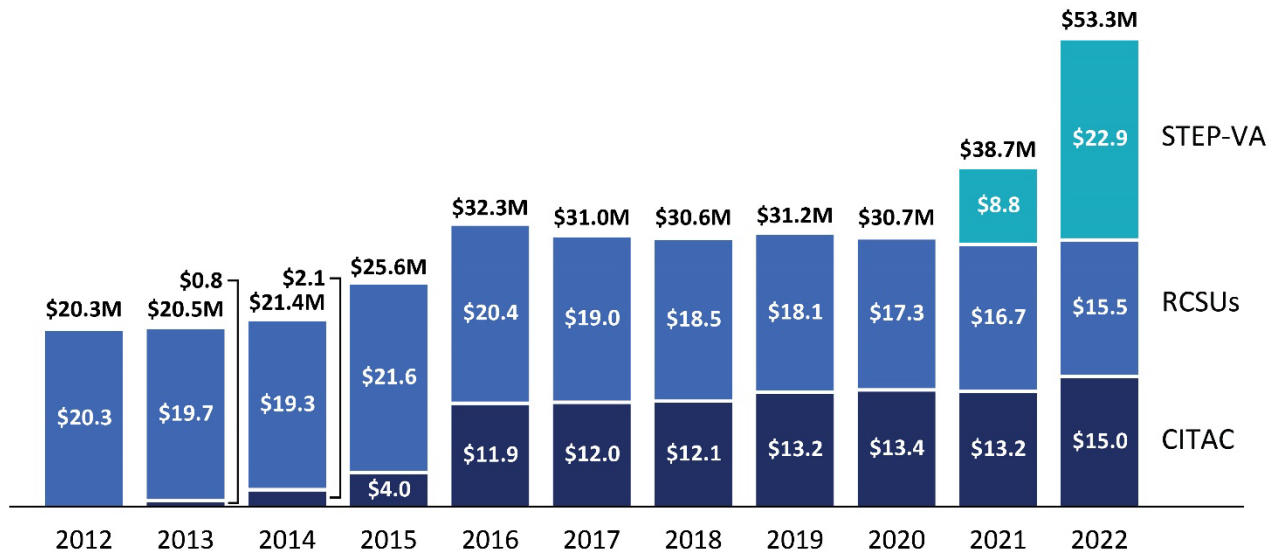
State general funds provided for crisis services

State general fund spending on crisis services more than doubled between FY12 and FY22, adjusted for inflation (Figure E-2). Spending on RCSUs specifically decreased 23 percent over that period, so most of the spending growth is accounted for by increasing investment in CITACs and mobile crisis services. Most types of CSB crisis services are now also covered by Medicaid.

More recently, General Fund appropriations for crisis services in the FY23–FY24 budget total \$182.2 million over two years (or about \$91 million per year—more than double the appropriation in FY17). Most of the increase is accounted for by STEP-VA dollars, which DBHDS has primarily allocated to mobile crisis response and the new regional crisis call centers.

The state appropriated \$7.5 million in new one-time funding in FY23 for three new crisis receiving centers (in northwestern, southwestern, and Northern Virginia), and provided \$11 million total in new funding over FYs 23-24 for CSBs who want to expand existing CITACs into crisis receiving centers.

FIGURE E-2
State general fund spending on crisis services has increased significantly since FY 2012



SOURCE: JLARC analysis of DBHDS Little CARS financial data, FYs 2012–2022 (inflation adjusted using medical CPI).
 NOTE: This graphic does not include certain spending on crisis services because some funding is provided to CSBs in categories that include crisis services alongside other services, so it is not possible to break out this spending. RCSUs=Residential Crisis Stabilization Units, CITACs=Crisis Intervention Team Assessment Centers, and STEP-VA crisis=funding for mobile crisis teams. DBHDS distributes funding for these crisis services to the CSBs.

Staffing for crisis services

Crisis services staff are a mix of professionals who are qualified to provide various services such as crisis intervention, therapy, assessment and diagnosis, prescribing psychiatric medication, and pre-screening for inpatient psychiatric hospitalization. These professionals include:

- psychiatrists and psychiatric nurse practitioners;
- licensed mental health professionals (LMHPs), such as licensed clinical social workers and licensed professional counselors;
- qualified mental health professionals (QMHPs);
- certified substance abuse counselors (CSACs);
- peer recovery specialists; and
- nurses, including RNs and LPNs.

Not every crisis service requires all of these professionals for full staffing. For instance, mobile crisis response requires a combination of LMHPs, QMHPs, CSACs, and peer recovery specialists, and mobile crisis teams vary in size. Conversely, both RCSUs and 23-hour crisis stabilization services must have a psychiatrist or psychiatric nurse practitioner available at all times, although the person need not

physically be at the facility full time and could be shared with other programs or work for the program part time. Nurses typically staff RCSUs and 23-hour crisis stabilization programs when needed.

Outcomes of state investments in crisis services

The state has little information on outcomes for people who receive crisis services from CSBs. State oversight of CSB service outcomes in general has been limited, and existing outcome measures are insufficient. (See Chapter 6 for a discussion of oversight and outcome measures.)

DBHDS has focused on measures related to service utilization (e.g., percentage of RCSU beds used, how quickly crisis hotline calls are answered) and service results (e.g., percentage of mobile crisis responses that resulted in law enforcement involvement), rather than what happens to people who receive crisis services after the services are complete. For example, a key outcome that states should measure for RCSUs is whether a person is admitted to a psychiatric hospital within 30 days of being released from an RCSU, but DBHDS does not track this information.

With the rollout of new and expanded crisis services, DBHDS plans to collect data to measure the effectiveness of crisis services using a new crisis data platform. Outcome measures are still in development. The crisis data platform was supposed to be fully operational as of July 2021 but has experienced significant technical difficulties and was not fully operational at all CSBs as of October 2022.

Some information about utilization of certain crisis services, as opposed to outcome measures, is available.

- There were about 10,600 assessments completed at CITACs in FY22, 63 percent of which resulted in a person in crisis being put under a TDO. This number is a significant decline from pre-pandemic levels. In FY19, about 15,000 assessments were completed at CITACs, 62 percent of which resulted in a TDO.
- RCSUs served approximately 2,800 people statewide in FY22, with an average length of stay around five days. This number is a significant decline from pre-pandemic levels. In FY19, RCSUs served about 4,800 people statewide. The decline is likely due in part to COVID-19 restrictions that required RCSUs to reduce their capacity.
- Information about the number of people served by 23-hour crisis stabilization programs and mobile crisis teams is not available because the existing DBHDS service data does not specify what type of crisis stabilization service (aside from at an RCSU) a person received.

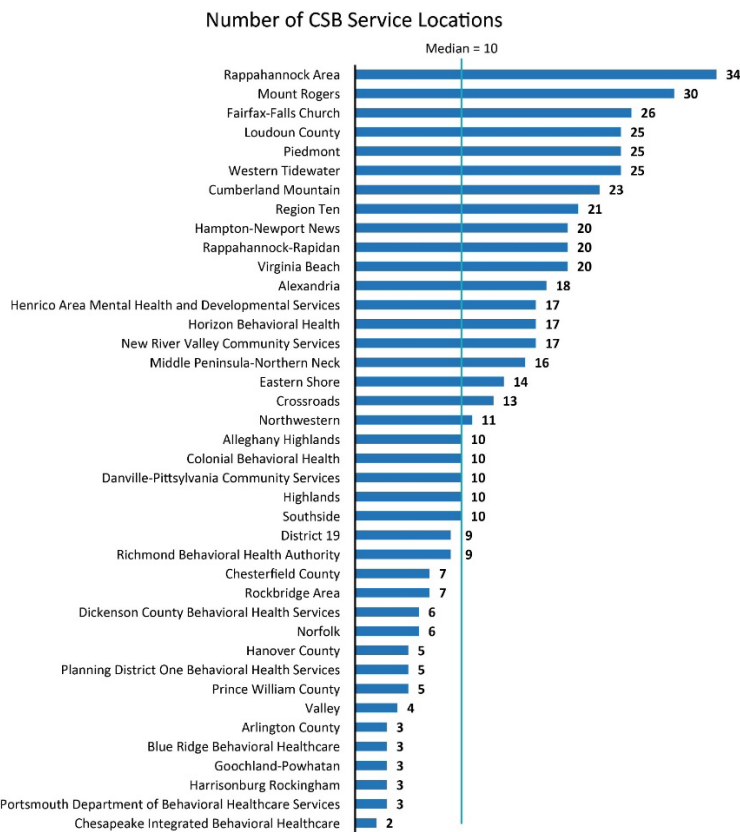
Appendix F: CSB behavioral health service locations

While Appendix D highlights that Virginia’s number of CSBs per capita is comparable to other states with decentralized behavioral health service delivery systems, each CSB offers multiple service locations. The Department of Behavioral Health and Developmental Services does not keep comprehensive information on the exact number of CSB behavioral health service locations in the state or the services provided at each of these locations. This appendix uses the limited available data to provide some additional information on where CSBs deliver services throughout the state.

Each CSB operates multiple service locations

In response to JLARC’s survey, all CSBs executive directors reported that their CSB operated multiple behavioral health service locations within their respective catchment areas. The total number of behavioral health service locations operated by each CSB varies significantly, with one CSB reportedly operating just two service locations (Chesapeake Integrated Behavioral Health) and another CSB reportedly operating 34 service locations (Rappahannock Area Community Services). The median number of service locations operated by CSBs across the state was 10 (Figure F-1).

Figure F-1
Number of behavioral health service locations operated by each CSB varies significantly



SOURCE: JLARC survey of CSB executive directors.

Importantly, the number of service locations reported by executive directors is limited to the physical locations operated *directly by the CSB* to provide behavioral health services to customers, and does not include other locations where CSB staff may be co-located with other entities to deliver services, like local hospitals or schools.

DBHDS licensing data provides additional insight into CSB service delivery locations

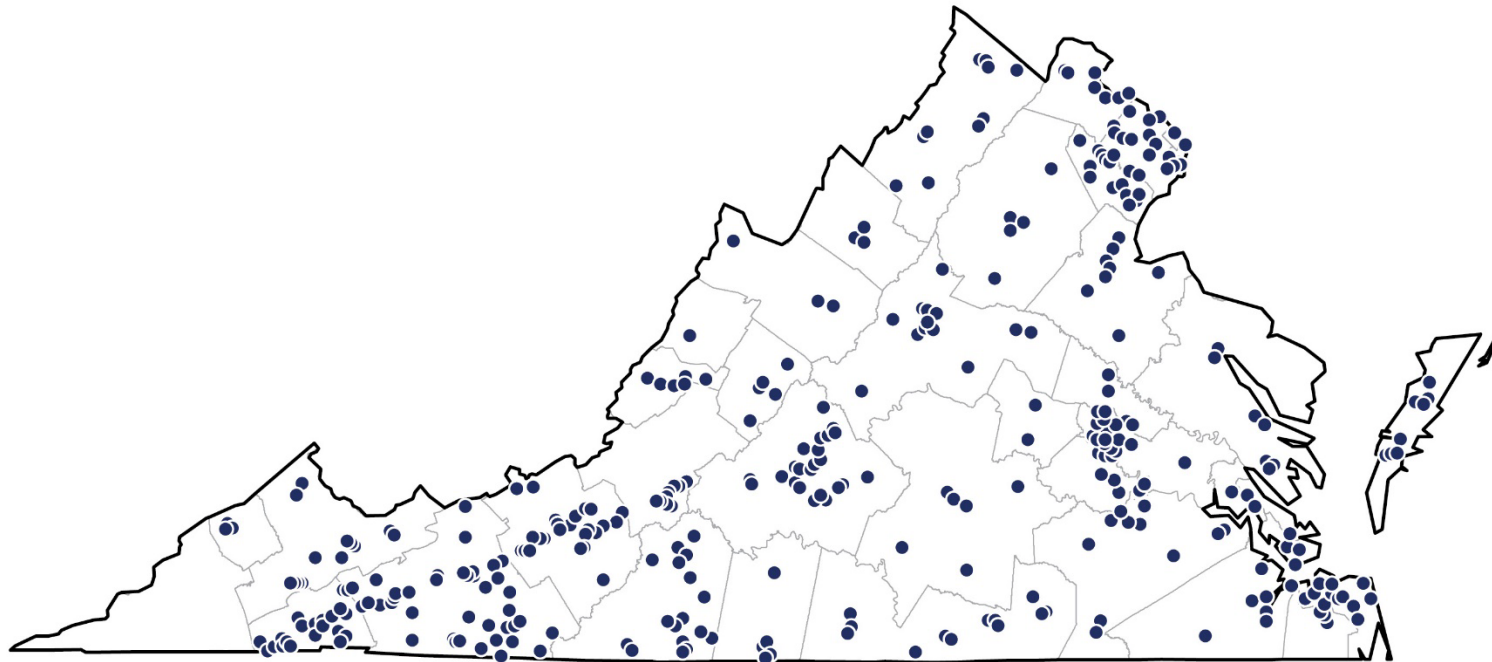
Currently, data on CSB service locations and the services provided at each location is relatively limited. DBHDS does not systematically record or maintain information on CSB service locations but does maintain data on locations where *licensed* services may be provided. JLARC staff used this licensing data to map CSB-operated behavioral health service locations throughout the state. This data indicates that CSBs offer licensed services in many different locations, but locations are often concentrated in areas with more dense populations. Importantly, this data, and the corresponding map, do not include service locations operated by private providers that CSBs contract with to deliver services. CSBs contract with private providers to deliver some behavioral health services to varying degrees, with half of CSBs reporting that they contract at least some services out to private providers (see Appendix D). Figure F-2 depicts the licensed behavioral health service locations operated by CSBs.

Additionally, DBHDS licensing data provides some insight into the *different types of services* available at CSB-operated service delivery locations. Figures F-3, F-4, F-5, and F-6 depict the licensed service locations of some of the core CSB services, including behavioral health case management, behavioral health outpatient services, residential crisis stabilization services, and non-residential crisis stabilization services.

Importantly, each of CSBs' service locations may offer multiple licensed services. Also, this data provides the location of each licensed provider, but does not indicate the program capacity or availability. Some locations may not currently offer the service providers are licensed for at that location.

For reference, a figure that identifies each CSB catchment area (Figure F-7) is also provided at the end of this appendix.

Figure F-2
CSBs offer licensed behavioral health services in many locations throughout the state

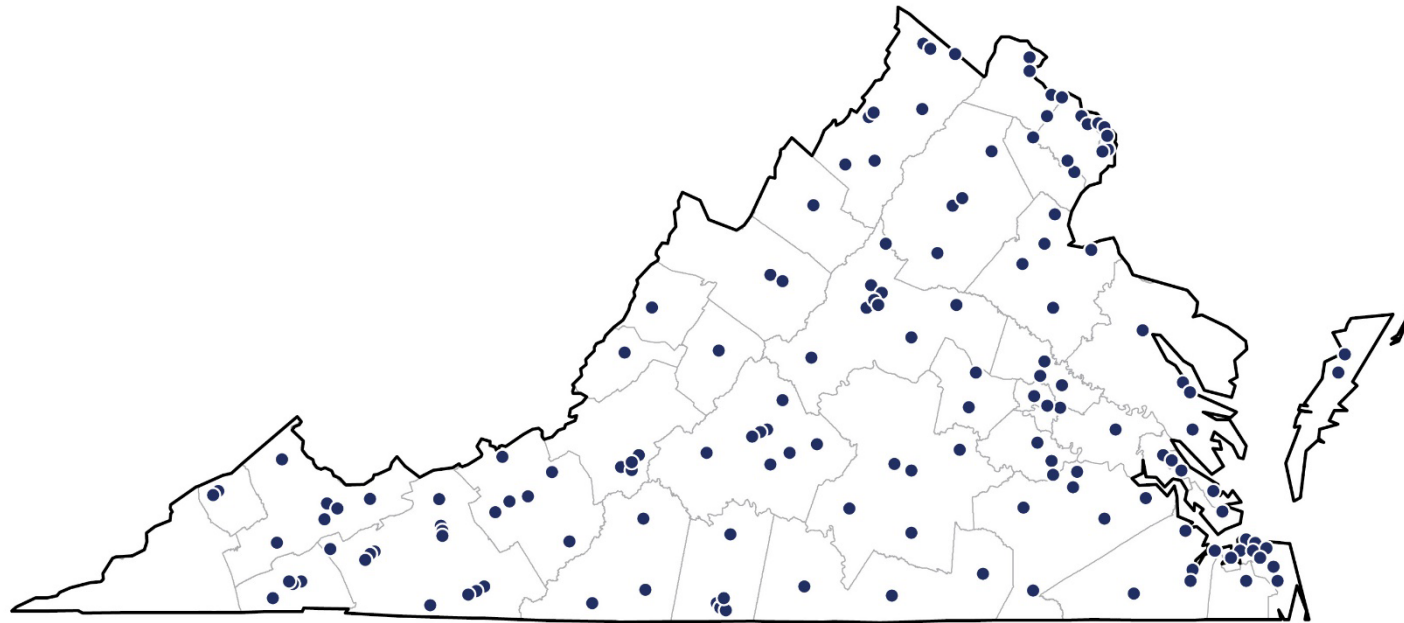


Licensed CSB behavioral health services locations

SOURCE: JLARC analysis of DBHDS licensing data, September 2022.

NOTE: Map includes only locations at which CSBs are licensed to provide mental health or substance use disorder services. Some locations may be licensed to provide services that are not currently offered. ID/DD service locations are not included. Non-licensed service locations are not included. Service locations of private providers contracting with CSBs are not included. CSB service locations may offer more than one licensed service.

Figure F-3
Licensed CSB behavioral health case management locations

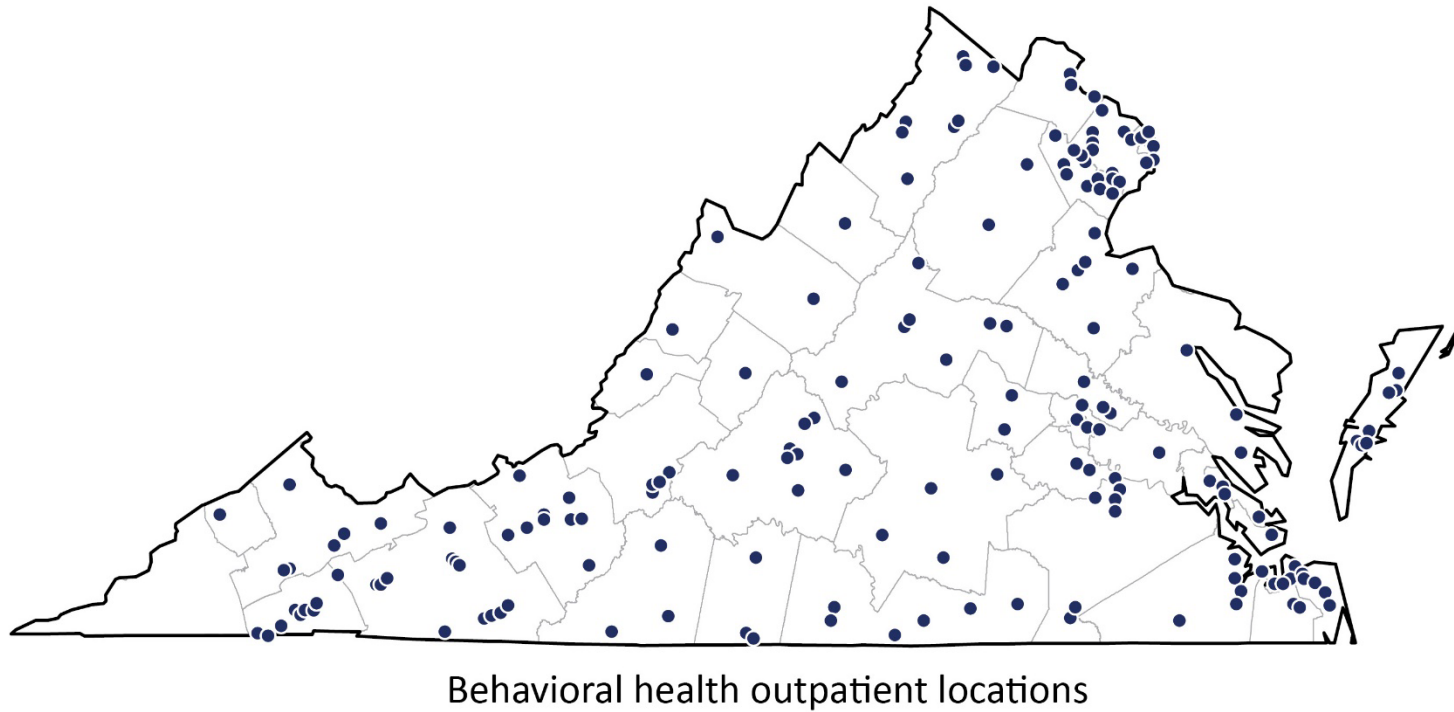


Case management locations

SOURCE: JLARC analysis of DBHDS licensing data, September 2022.

NOTE: Map includes only C locations at which CSBs are licensed to provide mental health or substance abuse disorder case management services. Some locations licensed to offer case management may not currently offer it. ID/DD service locations are not included. Non-licensed service locations are not included. Service locations of private providers contracted with CSBs are not included. CSB service locations may offer more than one licensed service.

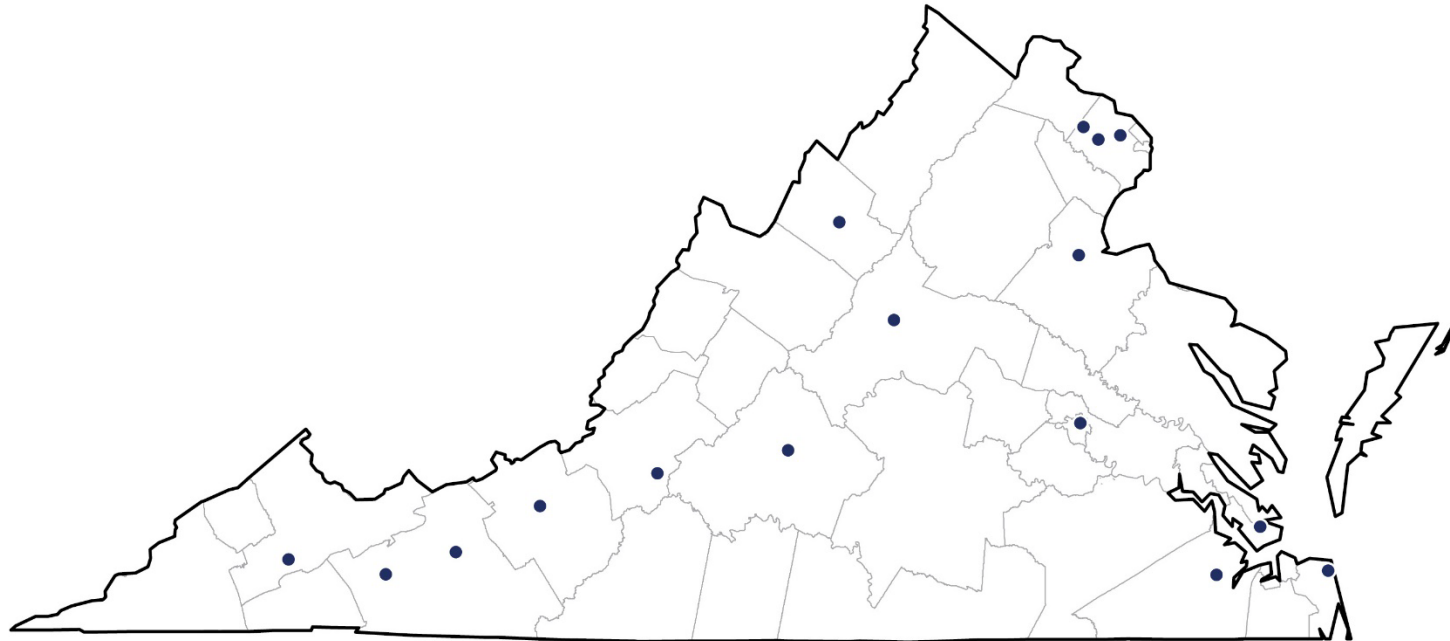
Figure F-4
Licensed CSB behavioral health outpatient service locations



SOURCE: JLARC analysis of DBHDS licensing data, September 2022.

NOTE: Map includes only locations at which CSBs are licensed to provide mental health or substance use disorder outpatient services. It is possible that these services may not currently be offered at some locations that are licensed to operate them. ID/DD service locations are not included. Non-licensed service locations are not included. Service locations of private provider contracted with CSBs are not included. CSB service locations may offer more than one licensed service.

Figure F-5
Licensed CSB residential crisis stabilization service locations

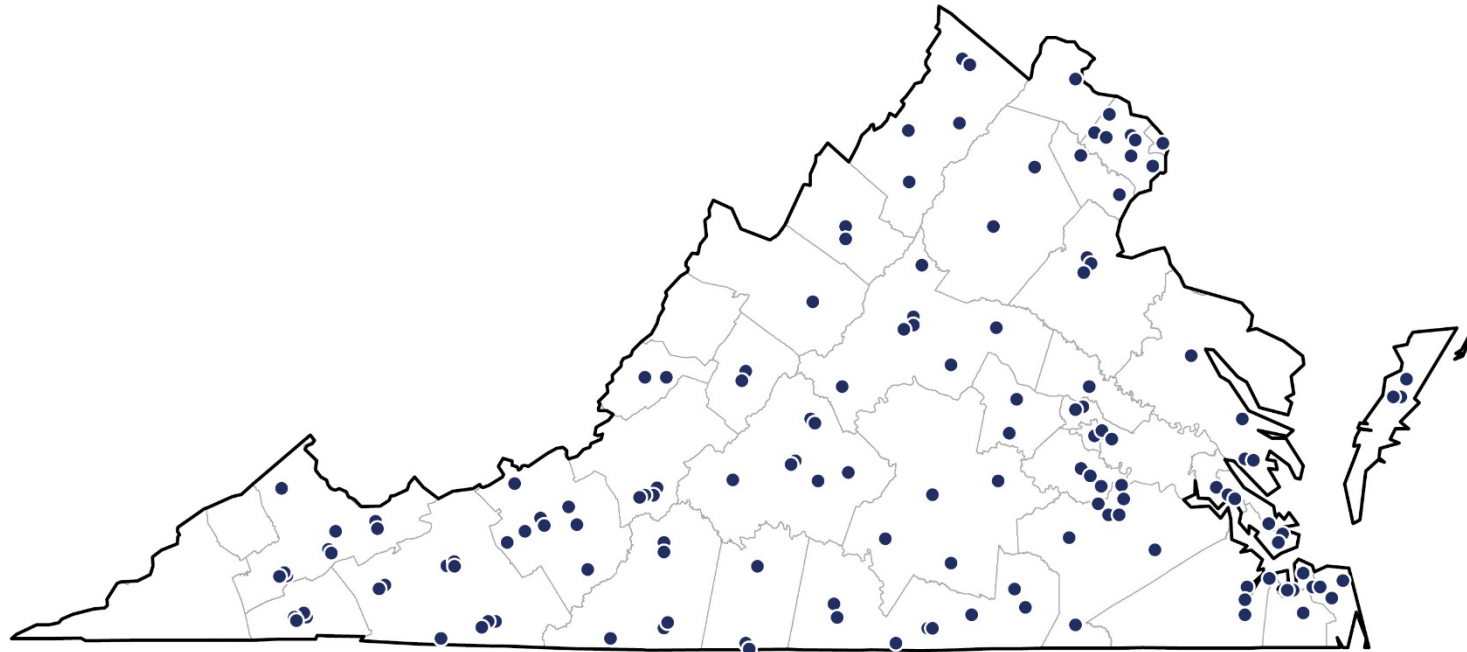


Residential crisis stabilization locations

SOURCE: JLARC analysis of DBHDS licensing data, September 2022.

NOTE: Map includes only locations at which CSBs are licensed to provide residential crisis stabilization services. It is possible that these services may not currently be offered at some locations that are licensed to operate them. ID/DD service locations are not included. Non-licensed service locations are not included. Service locations of private provider contracted with CSBs are not included. CSB service locations may offer more than one licensed service.

Figure F-6
Licensed CSB non-residential crisis stabilization service locations

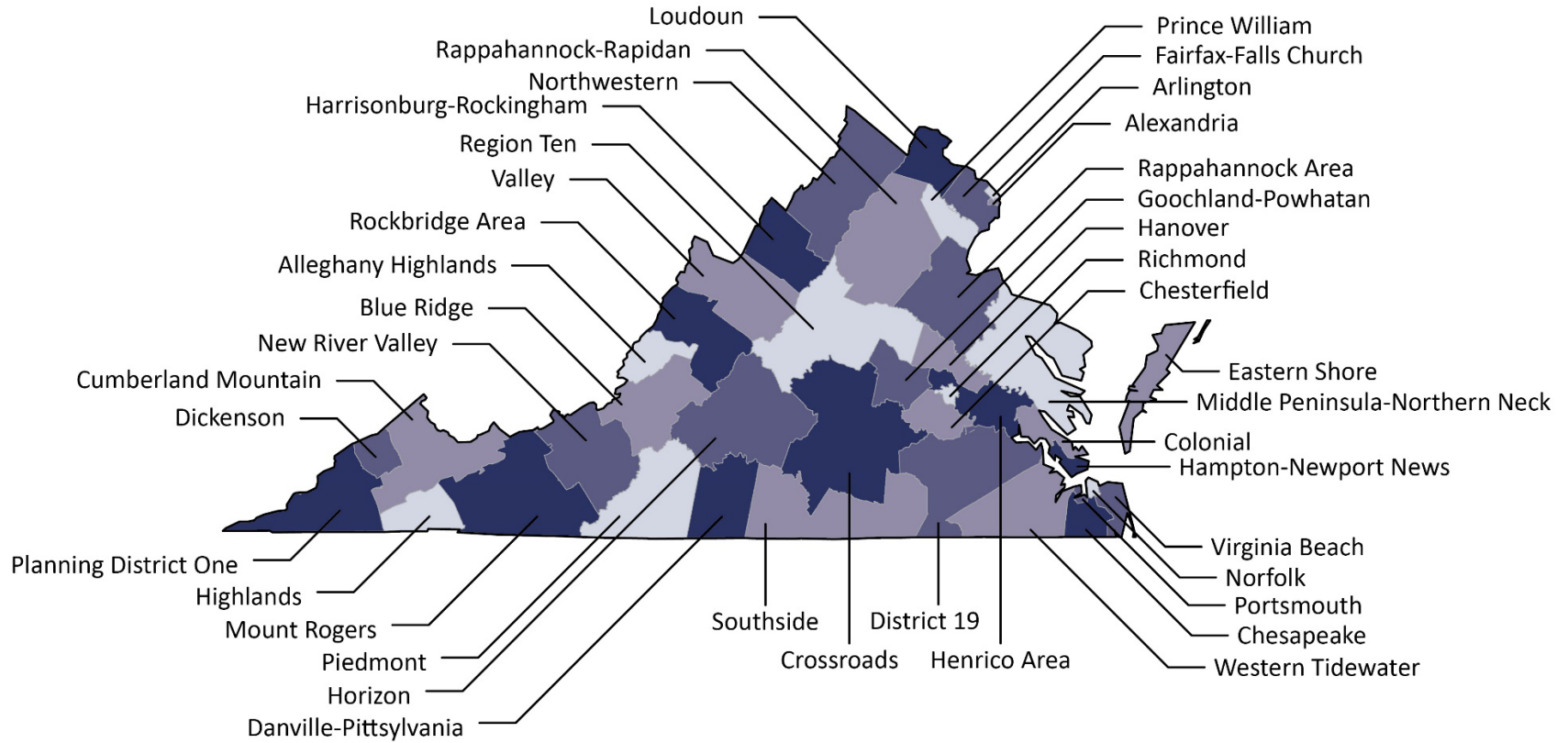


Non-residential crisis stabilization service locations

SOURCE: JLARC analysis of DBHDS licensing data, September 2022.

NOTE: Map includes only locations at which CSBs are licensed to provide non-residential crisis stabilization services. It is possible that these services may not currently be offered at some locations that are licensed to operate them. ID/DD service locations are not included. Non-licensed service locations are not included. Service locations of private provider contracted with CSBs are not included. CSB service locations may offer more than one licensed service.

Figure F-7
CSB catchment areas



SOURCE: DBHDS documentation.

Appendix G: CSB service definitions

To support the diverse needs of Virginians with behavioral health conditions that significantly impair their functioning, CSBs provide a range of emergency and non-emergency services. The main types of services provided in FY22 are outlined below. Not all CSBs provide all of these services, and some CSBs provide other types of services. Individual CSB service provision depends on core service requirements, funding, staffing, and local need.

TABLE A-1
Emergency services

CSB services	Service definition
Crisis intervention	Response to an individual in crisis, including counseling, triage, and/or evaluation.
Discharge planning	Identification and coordination of needed community-based services for individuals before their release from state psychiatric hospitals.
Preadmission screenings	Assessments to determine whether an individual is in need of care at a state psychiatric hospital or other psychiatric treatment. A pre-admission screening is required before placement at a state psychiatric hospital.
Residential crisis stabilization	Short-term intensive community-based residential treatment for individuals in crisis.

SOURCE: JLARC analysis of DBHDS Core Services Taxonomy and CCS3 data.

TABLE A-2
Non-emergency services

CSB services	Service definition
Assessments and evaluations	Assessments, including court-ordered or psychological evaluations, of behavioral health conditions and referrals for any needed services and supports.
Case management	Service facilitation that includes assessing needs, planning and coordinating services, assisting individuals in obtaining needed services, and monitoring service delivery.
Day support	Structured treatment, activity, or training programs, generally lasting for multiple hours per day, for groups or individuals in non-residential settings.
Detoxification and medication assisted treatment	Medical inpatient and outpatient withdrawal support services to eliminate or reduce the effects of alcohol or other drugs in the individual's body.
Employment services	Work and support services to groups or individuals in non-residential settings.
Medical services	Psychiatric evaluations and psychiatric, medical, nursing, and medication services.
Outpatient services	A broad category of services that may include diagnosis and evaluation, counseling, psychotherapy, behavior management, and other services. The intensity of services may depend on the individual's needs.
Permanent supportive housing	Programs that combine housing supports, such as rental subsidies, and services for individuals with a mental illness or substance use disorder. Programs are intended to help individuals address their behavioral health condition and maintain stable housing.
Residential treatment services	Overnight care, with varying levels of intensity and duration, in the community.

SOURCE: JLARC analysis of DBHDS Core Services Taxonomy, CCS3 Extract Specifications, CCS3 data, and other DBHDS documentation.



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