

Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century

http://dls.virginia.gov/interim_studies_MHS.html

Thursday, September 24, 2015, 1:00 pm

Suffolk City Hall

442 W. Washington Street, Suffolk, Virginia

- I. Introductions and Opening Remarks**
- II. PRESENTATION: Mental Health Services in Jails Sheriffs** - Sheriff Ken Stolle, Virginia Beach and Sheriff Gabriel Morgan, Newport News
- III. PRESENTATION: Overview of Mental Health Services Funding** - Susan Massart, Legislative Fiscal Analyst, House Appropriations Committee & Mike Tweedy, Legislative Analyst, Senate Finance Committee
- IV. PRESENTATION: Department of Behavioral Health and Developmental Services Update and STEP VA: System Transformation, Excellence and Performance in Virginia** - Dr. Jack Barber, Interim Commissioner, Department of Behavioral Health and Developmental Services
- V. PRESENTATION: Strengths and Challenges of Virginia's Mental Health System: Perspectives from Individuals and Families** - Mira Signer, Executive Director, National Alliance on Mental Illness of Virginia
- VI. Work Group Reports**
- VII. Public Comment**
- VIII. Adjourn.**

NOTE: On Friday, September 25, 2015 members of the Joint Subcommittee will tour the Western Tidewater Community Services Board, Norfolk Community Services Board and Veterans Affairs Medical Center in Hampton. Due to patient privacy concerns, these informational tours will not be open to the public; however, information gathered on these tours will be shared with the public at the next meeting of the Joint Subcommittee.

Joint Subcommittee Members

Senator R. Creigh Deeds, Chairman
Delegate Robert B. Bell, III, Vice Chairman

Delegate Vivian E. Watts
Delegate T. Scott Garrett
Delegate Luke E. Torian
Delegate Peter F. Farrell
Delegate Joseph R. Yost
Delegate Margaret B. Ransone

Senator Janet D. Howell
Senator Emmett W. Hanger, Jr.
Senator George L. Barker
Senator John A. Cosgrove, Jr.

Staff

David Cotter, Senior Attorney
Sarah Stanton, Senior Attorney
Thomas Stevens, Staff Attorney
D. Hobie Lehman, Senate Committee Operations



Virginia Department of
Behavioral Health &
Developmental Services

DBHDS Updates and STEP VA: System Transformation, Excellence and Performance in Virginia

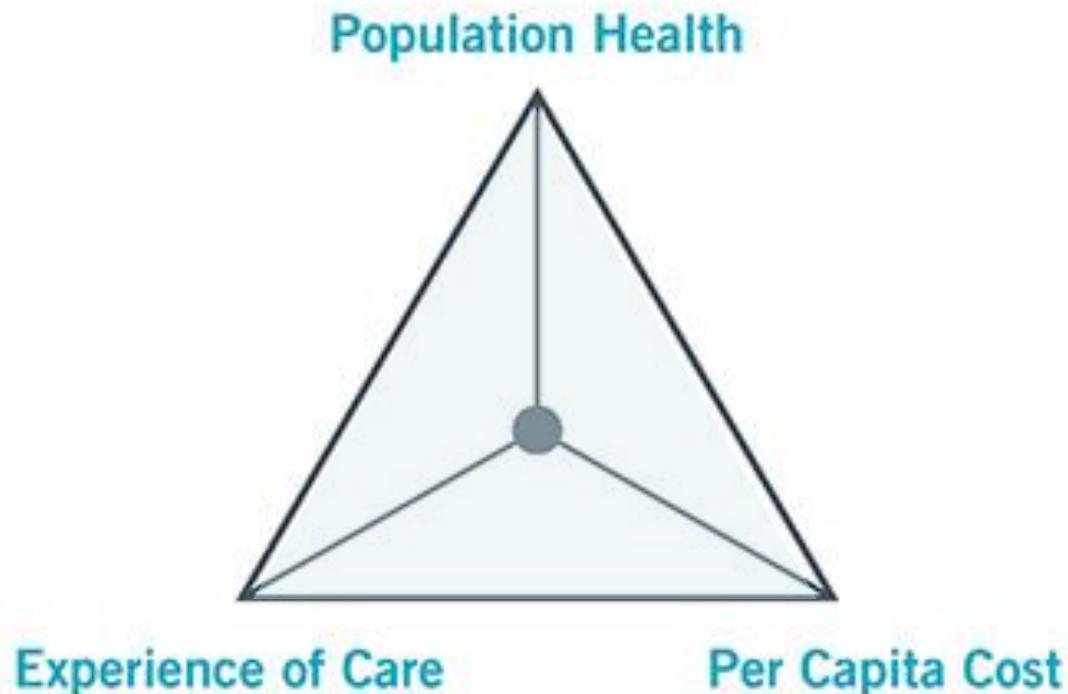
Virginia's pathway to excellence in behavioral healthcare



Jack Barber, MD
Interim Commissioner
Virginia Department of Behavioral Health
and Developmental Services

The National Healthcare Landscape

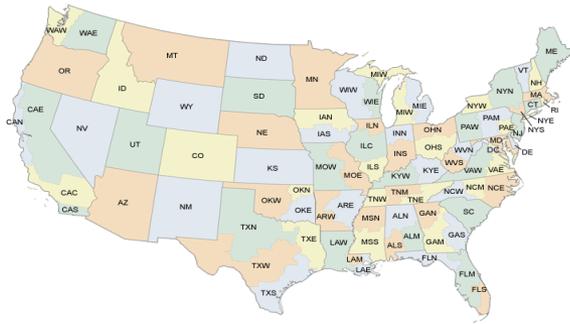
The IHI Triple Aim



From the Institute for Healthcare Improvement

Slide 2

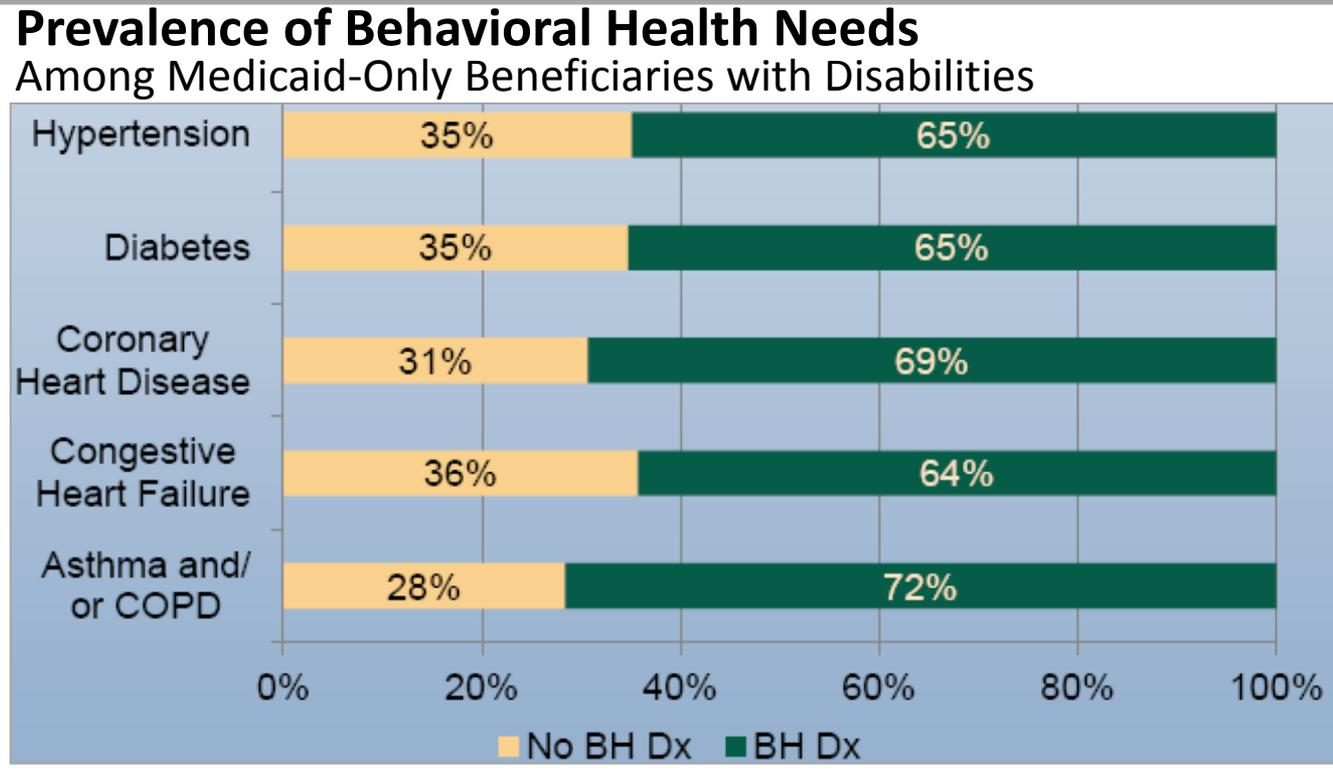
The Behavioral Healthcare Landscape



- **Comprehensive behavioral healthcare is essential to both population health and cost containment**
- Emphasis on prevention, early intervention and wellness
- Bidirectional Behavioral Health and Primary Health Care Integration
- Decreased reliance on institutional care
- Increased focus on community-based services and supports

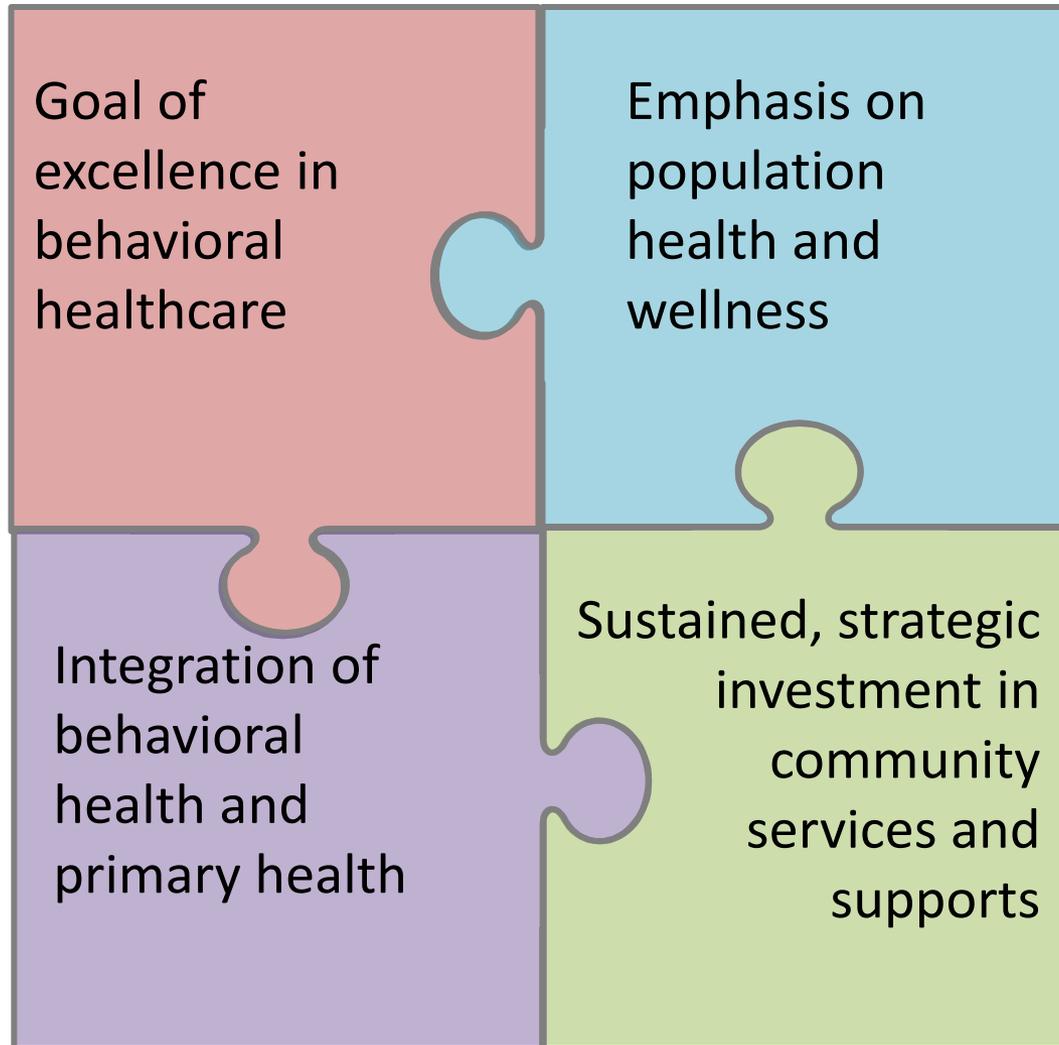
- How does VA measure up nationally?
 - 35th in BH funding in 2013
 - 40th in consumers served per capita
 - 15th in the nation in terms of expenditures per client.
- Not maximizing our investment
 - **50% of GF funding supports 3% of persons served**

Behavioral and Primary Healthcare Link



For those with common chronic conditions, health care costs are as much as **75% higher** for those with mental illness compared to those without a mental illness and the addition of a co-occurring substance use disorder results in **2- to 3-fold higher** health care costs. – CMS

Key Elements to Transformation



The Excellence in Mental Health Act

- Establishes Certified Community Behavioral Health Clinics (CCBHCs)
- There are two phases:
 - Phase 1: Provides up to \$2M for CCBHC Planning Grants
 - Phase 2: Up to 8 CCBHC Planning Grant states will be selected to participate in the demonstration program
- SAMHSA is making a total of \$24,635,000 available – Up to 25 states may receive grants of up to \$2 million.
- In addition, DBHDS is contributing \$2 million of its own resources to ensure STEP VA's success.

The EMHA Opportunity

System Transformation, Excellence and Performance (STEP Virginia)

The Path to a Healthy Virginia

What EMHA Offers:

- Same Day Access
- Standardized core community services
- 24/7 Mobile crisis
- Veterans services
- Robust child services
- Connections to primary care



What EMHA Solves:

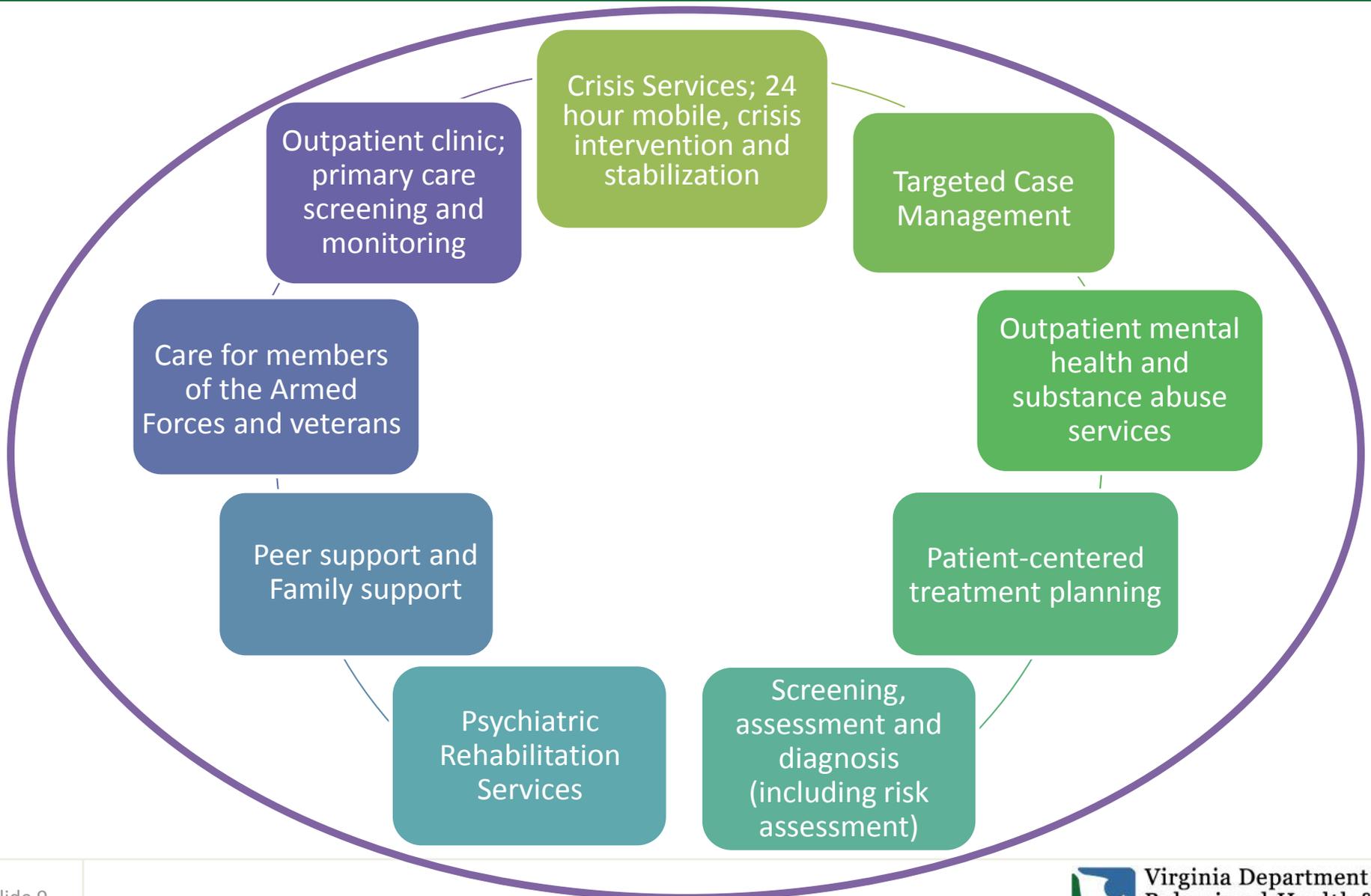
- Access
- Geographic disparities in service offerings
- Inconsistent quality
- Funding
- Capacity

Summary: STEP VA Application and Objectives

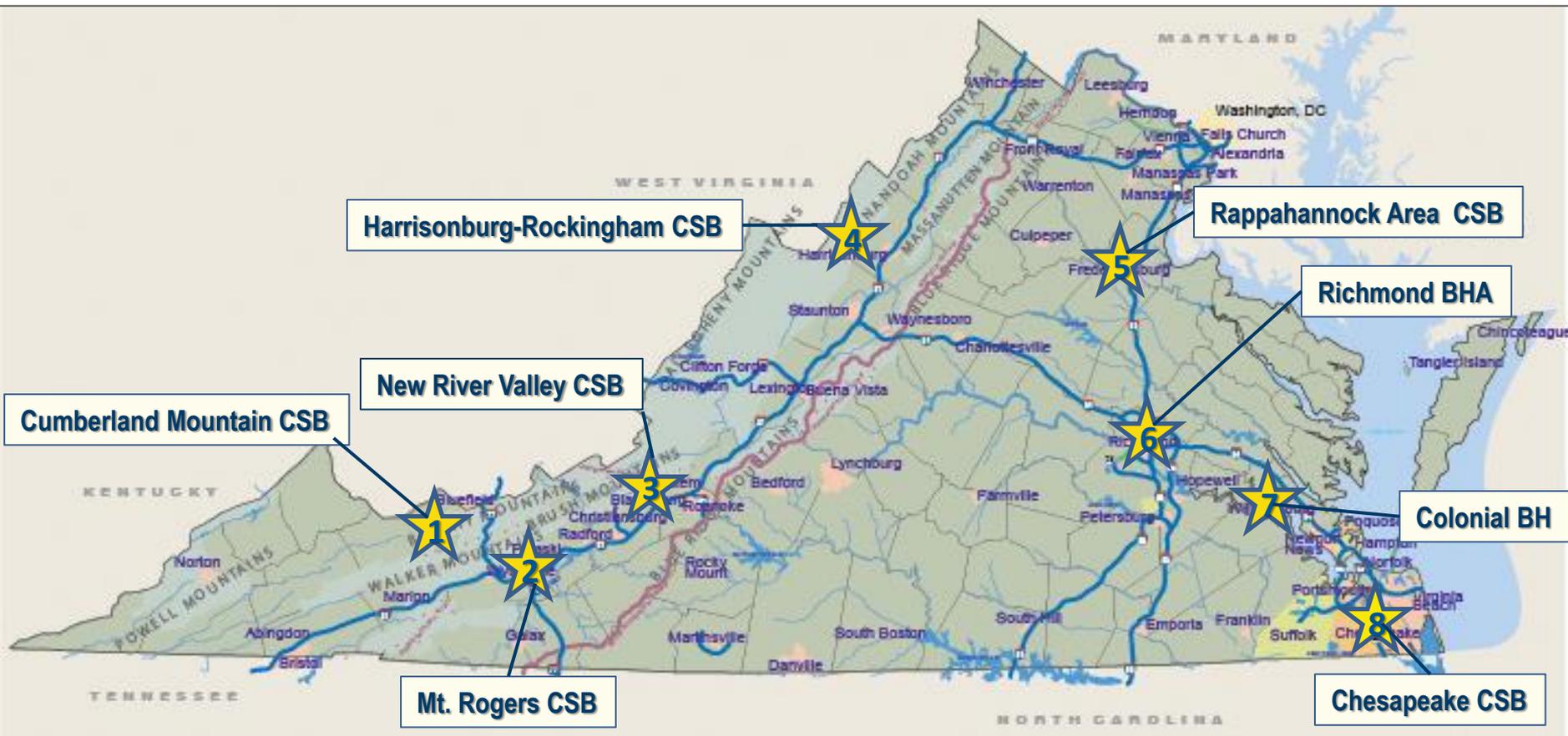
- Virginia's application was submitted before the Aug. 5, 2015 deadline.
- The objectives of STEP VA include:
 1. Establishment of the CCBHC certification process,
 2. Implementation of evidence-based practices in all CCBHCs,
 3. Promotion of bidirectional primary health and behavioral health integration,
 4. Provision of same day access,
 5. Reduction in health disparities, and
 6. Establishment of a Prospective Payment System (PPS) providing bonus payments for achieving quality outcomes.



9 (plus 1) Components of Excellence



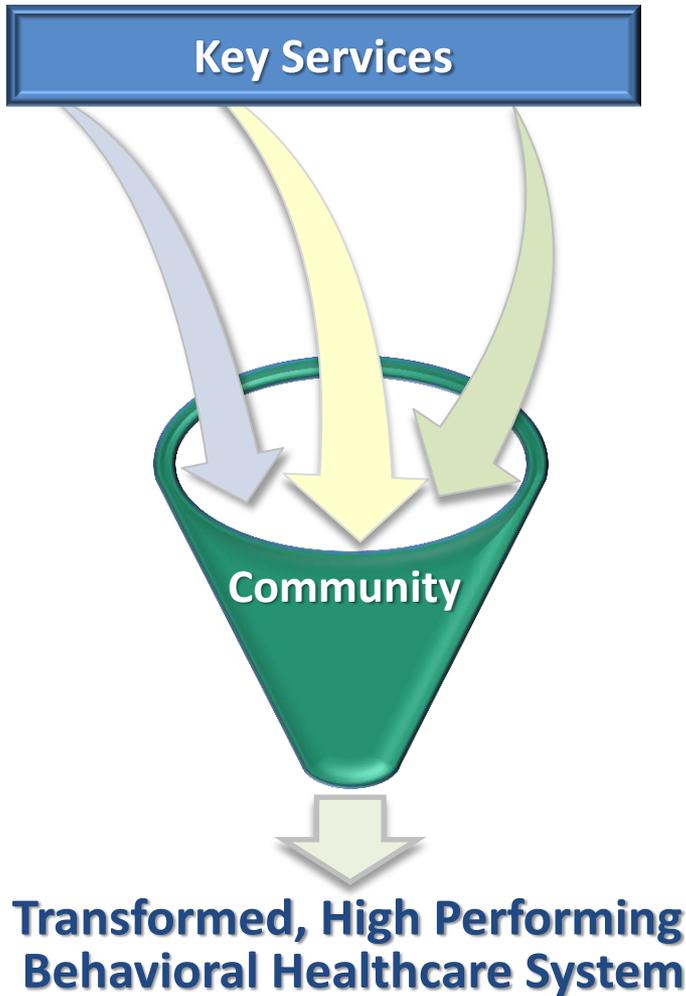
Virginia's Eight CCBHCs



1. Cumberland Mountain CSB
2. Mt. Rogers CSB
3. New River Valley CSB
4. Harrisonburg-Rockingham CSB

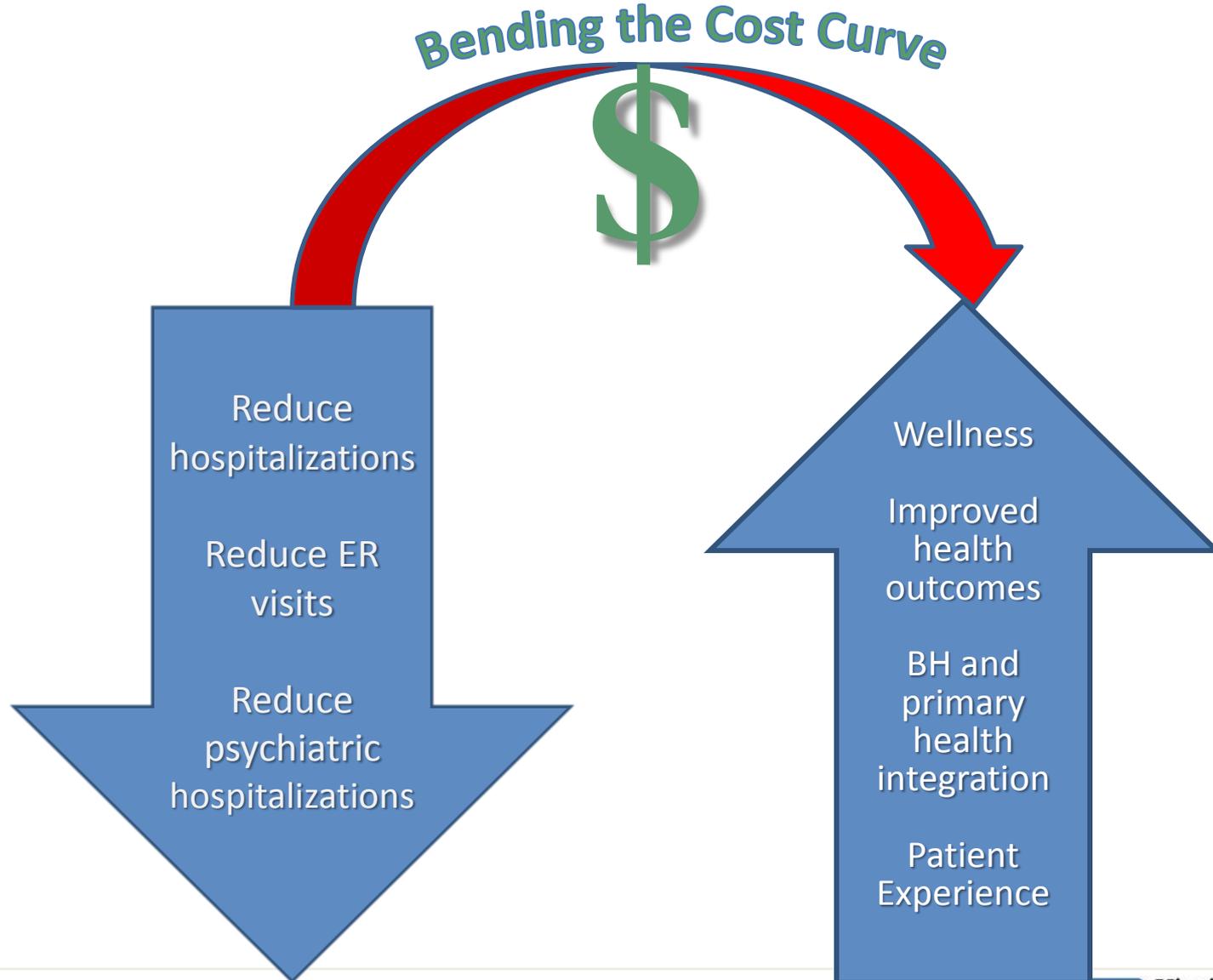
5. Rappahannock Area CSB
6. Richmond Behavioral Health Authority
7. Colonial Behavioral Health
8. Chesapeake CSB

Key Community Services Investments



- Comprehensive Outpatient Services
- Robust Crisis Services; 24 hour mobile, crisis intervention and stabilization
- Permanent Supportive Housing
- Supported Employment
- Children's Mental Health/Trauma Services
- Transition Age/First Break
- Geropsychiatric Care
- Jail Diversion & Community Re-entry
- Behavioral Health Services to Veterans
- Acute Detoxification
- Prevention and Early Intervention

What EMHA and CCBHCs Can Achieve in Virginia



THE VISION: A Life in the Community



Four Transformation Teams

Four initial focus areas of the Transformation Initiative

- Adult Behavioral Health
- Adult Developmental Services
- Children & Adolescent Behavioral Health Services
- Services to Individuals Who are Justice-involved

Three Phase Approach

- 1. Team Meetings** – Four teams meet for about six months to develop recommendations around specific questions.
- 2. Stakeholder Review** – A Stakeholder Group comprised of providers, advocates, family members, and persons with lived experience receive and review the teams' recommendations.
- 3. Public Comment** – Intensive, six week public comment period:
 - Recommendations posted on the DBHDS website along with a link to submit public comment.
 - Commissioner and Transformation Team Co-Chairs hold public meetings across the Commonwealth: Williamsburg, Charlottesville, Woodbridge and Wytheville.

Spring 2015 Recommendations: Ten “Core” Themes

Ten themes emerged across all of the recommendations:

- 1** Formalize and fund core services and supports across a continuum of care – focus on the Right Services and the Right Place at the Right Time
- 2** Require reimbursement for case management services
- 3** Strengthen the community-based system of services and supports statewide
- 4** Standardize quality of care expectations statewide
- 5** Align and maximize effectiveness of available funding streams
- 6** Harness the power of data across agencies in the Secretariat to utilize and improve health outcomes
- 7** Integrate behavioral health with physical health and social services
- 8** Strengthen the workforce to ensure access to services
- 9** Promote through policy and reimbursement a person-centered approach to care, merging the activities and processes of mental health, substance abuse, and DD/ID with those of child welfare, juvenile justice, educational, and health services
- 10** Develop and conduct customized trainings to organizations who interact with populations – Employers, Schools, Jails, etc.

Overall Recommendations

1. Increase access to services, including screening and assessment.
2. Expand person-centered/patient-centered practices.
3. Improve the spectrum of crisis services.
4. Implement and fund more targeted case management.
5. Strengthen peer and family services.
6. Ensure better integration of behavioral healthcare with primary care along with employment, housing, education, and other social services.

Fall 2015 Transformation Cycle

- In May, Transformation Teams received a new charge and members to provide needed expertise to effectively address the new questions for the Fall 2015 transformation cycle.
- Teams have all started the next cycle. The cycle will include meetings with the Stakeholder Group, presentation of recommendations to the Commissioner, and public town hall meetings.
- More information on the Transformation Teams is available on the DBHDS website.
<http://www.dbhds.virginia.gov/about-dbhds/commissioner-transformation-teams>

Involuntary Commitment Work Group

CHAPTER 742

An Act to direct the Commissioner of Behavioral Health and Developmental Services to develop a comprehensive plan to authorize psychiatrists and emergency physicians to evaluate individuals for involuntary civil admission.

[H 2368]

Approved April 15, 2015

Be it enacted by the General Assembly of Virginia:

1. § 1. *The Commissioner of Behavioral Health and Developmental Services (the Commissioner) shall, in conjunction with relevant stakeholders including the Virginia Association of Community Services Boards, the National Alliance on Mental Illness - Virginia, the Psychiatric Society of Virginia, the Virginia College of Emergency Physicians, the Virginia Hospital and Healthcare Association, the Virginia Academy of Clinical Psychologists, the Medical Society of Virginia, and the University of Virginia Institute for Law, Psychiatry, and Public Policy, review the current practice of conducting emergency evaluations for individuals subject to involuntary civil admission. Such review shall identify community services boards and catchment areas where significant delays in responding to emergency evaluations are occurring or have occurred in recent years. Further, the Commissioner shall develop a comprehensive plan to authorize psychiatrists and emergency physicians to evaluate individuals for involuntary civil admission where appropriate to expedite emergency evaluations. The review and comprehensive plan including recommendations shall be completed by November 15, 2015, and reported to the Governor and the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century, the House Committee on Health, Welfare and Institutions, and the Senate Committee on Education and Health.*

Workgroup Structure and Goal

- 15 member study group including policy experts, including UVA ILPPP staff, psychiatrists, emergency room physician, psychologists, emergency services clinician, advocacy groups.
- Held eight two-hour meetings, met monthly since February.
- **Goal:** Determine whether allowing additional mental health professionals to initiate TDOs would improve emergency mental health services quality, efficiency and access.
- **Guiding principles:**
 1. Improve the experience of persons served
 2. Maintain system monitoring
 3. Promote outcome measurement

TDO Assessment Process

COLOR CODES – ELEMENTS & PHASES OF THE TDO ASSESSMENT PROCESS

CSB/ Emergency Services (ES) Clinician

Emergency Medical Physician/Emergency Department (ED)

Shared: CSB, ED, Law Enforcement (LE), Emergency Medical Physician

Shared: CSB, ED, Emergency Medical Physician

Courts/Magistrate/ Special Justice

Shared: LE & CSB

State Operated Psychiatric Hospital

*** Note: Medical Assessment/TDOs can be sought at any point during this process if the individual is exhibited symptoms requiring medical treatment.**

Elements & Phases of the TDO Assessment Process

PHASE 1

Referral Options

Individual at CSB for evaluation for TDO

Individual in ED for evaluation for TDO

Medical assessment sought*

Individual in their home for evaluation for TDO

Individual in the community* for evaluation for TDO

LE has Individual in custody for evaluation for TDO

PHASE 2

Initial Notification

Regional state hospital notified of potential TDO admission

Mental Health professional identified to complete TDO evaluation

PHASE 3

Assessment Conducted

Prescreening Report/ Involuntary detention assessment conducted (including risk assessment)

Custody maintained

MSE/interview completed

Appropriate clinical history and records reviewed

Appropriate and relevant collateral contacts made

Past & present treatment providers contacted

Advance directives reviewed

Preadmission screening report completed

Least restrictive alternatives reviewed

PHASE 4

Assessment Results

Regional state hospital notified of assessment results

Custody maintained

TDO criteria met

Medical assessment sought*

TDO criteria not met

Voluntary hospitalization

Community-based treatment referral

Released with discharge instructions and linkages

Medical TDO obtained if warranted*

PHASE 5

Disposition Reviewed

Psychiatric Bed Registry accessed

Custody maintained

Appropriate community hospitals/CSU contacted

Information faxed to potential admitting hospital

Physician-to-physician communication re: admission

Community-based hospital/CSU denies admission

Linkage with admitting community-based hospital/CSU

SOPH hospitalization as last resort hospital

PHASE 6

Disposition Completed

Magistrate contacted to request TDO to identified hospital/CSU

Custody maintained

TDO completed and executed

Individual transported to TDO facility

Commitment hearing scheduled

Prescreening evaluation presented at hearing

Determination of:
Involuntary commitment
Voluntary commitment
MOT
Release

*Schools, jails, police station, shelters

8 hour maximum



Strengths and Challenges of Virginia's Mental Health System: Perspectives from Individuals and Families

Presentation to The Joint Subcommittee to Study Mental Health Services in the Twenty-First Century

SEPTEMBER 24, 2015

Who we are

- Statewide nonprofit organization
- Support, education, and advocacy
- 20 affiliates
- Membership of “lived experience”
- 17,874 Virginians reached through our volunteer-driven education and support programs (2014)
- 3,064 HelpLine responses (2014)

When any family or individual has to navigate the system, these are the words that are often used...



But when mental health is involved these words are used, too...

Shame

Lost

Misunderstood

Blame

Helpless

Depression

Anger

Loss **Hopeless**

Unworthy

Stigma

10 Pillars of a High-Quality State Mental Health System

1. Comprehensive
2. Integrated
3. Adequately funded
4. Focused on recovery, health promotion & morbidity reduction
5. Safe and respectful treatment environments
6. Accessible
7. Culturally competent
8. Consumer-centered and consumer- and family-driven
9. Well-staffed and trained
10. Transparent and accountable

Source: NAMI, Grading the States, 2009

Strengths of Virginia's mental health system

- Movement to infuse principles of recovery, health promotion, and resiliency
- DBHDS/CSB system gives the state a vehicle to enact policy and accountability standards
- Private providers give options and capacity
- Localized system fosters buy-in and support
- Many examples of excellence, success, effectiveness, and collaboration with families and people needing help

Challenges of Virginia's mental health system

- Fragmented, confusing to navigate, lack of consumer choice
- Multiple agencies impact and govern CSBs
- System is largely crisis-driven
- Inconsistent array of services/inequity funding
- All CSBs have capacity and access challenges
- Lack of clarity and guidelines governing the relationship between public and private providers

Challenges- Continued

- Medicaid dollars spent in the private sector not reinvested
- Private insurance – lack of parity
- Difficulty accessing inpatient care
- Barriers to Discharge List at state hospitals
- Uninsured patient population
- High number of jail inmates with mental illness
- Housing

Governance Structures

Three major models of behavioral health system governance in the US:

1. Centralized, state control where the state directly operates community-based programs (4 states)
2. Mostly state control where the state contracts directly with community-based programs (31 states)
3. Mostly local control where the state funds county or city authorities to operate community-based programs (15 states including Virginia)

Needs Assessment: Adult Mental Health System

Top Priorities

1. Expand permanent supportive housing
2. Integrate mental health care with primary health care
3. Strengthen round-the-clock emergency services and stabilization for crises
4. Expand intensive outpatient services
5. Cover the uninsured/Medicaid expansion
6. Improve/ensure acute care access (hospital beds)

Needs Assessment: Child Mental Health System

Top Priorities

1. Implement parent and youth peer support services in the child serving systems
2. Expand the array of services so that there is a true continuum of care for children and youth with mental health needs and their families
3. Expand transition age youth services to every community
4. Bring Systems of Care values and principles to scale in Virginia

Recommendations

1. Fund Peer Support Specialists and Parent Support Partners
2. Determine base level of community services and how to deliver them
3. Articulate the roles and expectations of public and private providers
4. Expand early intervention and “First Episode” models
5. Expand array of services for under 18
6. Expand permanent supportive housing
7. Address the problem of uninsured clients
8. Address challenges with private hospitals
9. Strengthen jail diversion (i.e. specialty dockets and CIT)
10. Improve usage of mandatory outpatient treatment

Thank you

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Recent Budget Actions Affecting Behavioral Health Services



Joint Subcommittee to Study
Mental Health Services in the 21st Century

Susan E. Massart, House Appropriations Committee Staff

Michael S. Tweedy, Senate Finance Committee Staff

September 24, 2015

Recent Budget Actions Reflect Efforts to Provide Critical Behavioral Health Services

- Actions built on recent mental health legislation, recommendations of Governor's Task Forces on Improving Mental Health Services and Crisis Response, School and Campus Safety, and efforts to target critical needs
- Individual Services – new Medicaid waiver program
- Community Services
 - Medicaid Community Services
 - Discharge Assistance Program
 - Programs for Assertive Community Treatment (PACT)
 - Crisis intervention/therapeutic drop-off centers
 - Children's psychiatry and crisis response services
 - Peer Recovery Services
 - Supportive housing
- Inpatient Services
 - Expanded community inpatient capacity
 - Expanded capacity at state mental health hospitals

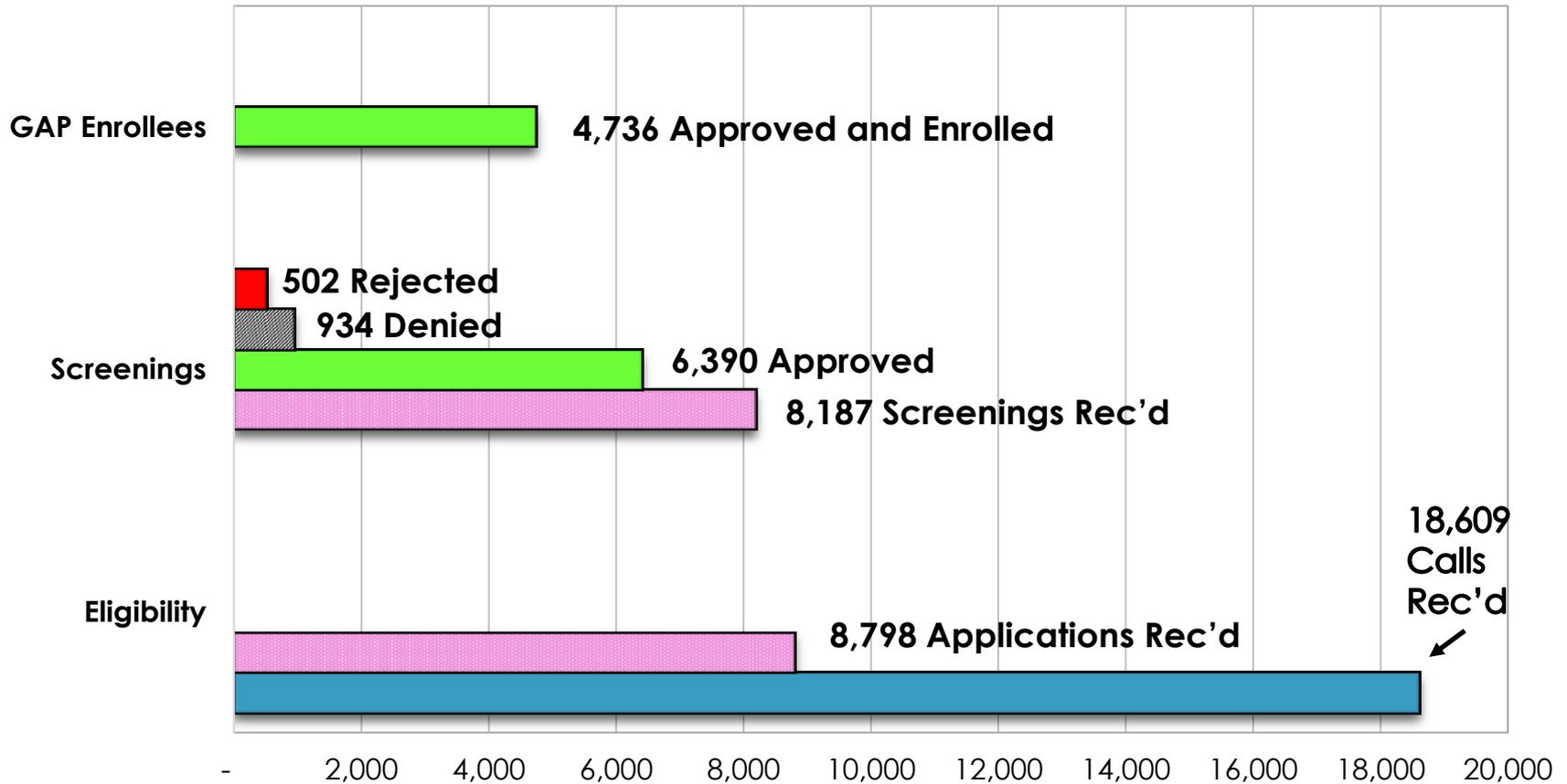
Overview of Funding for BH Services

- General Assembly added \$161.0 million GF over the 2014-16 biennium to expand services for individuals with serious mental illness
 - \$96.5 million GF for a new Medicaid waiver program to support low-income individuals with serious mental illness
 - \$37.2 million for targeted community-based programs
 - \$14.4 million to add adult bed capacity at Eastern State Hospital and backfill loss of revenues from declining need for geriatric beds
 - \$11.5 million for mental health legislation passed by the 2014 General Assembly
 - \$8.5 million to expand capacity at state facilities to be the provider of last resort
 - \$2.8 million to expand time periods for ECOs/TDOs
 - \$233,586 for the acute bed registry
- In addition, \$642.1 million GF was included in the Medicaid forecast over the biennium to support the growing cost of Medicaid funded mental health services

Medicaid Waiver (GAP) for Individuals with Serious Mental Illness (SMI)

- 2015 General Assembly provided \$96.5 million GF and \$99.6 million NGF over the biennium for GAP Medicaid waiver program
 - Serves low-income adults with serious mental illness at or below 60% of the federal poverty level
 - Provides targeted Medicaid physical and behavioral health services
 - Physician and outpatient clinic services
 - Prescription medicine
 - Outpatient diagnostic and lab services
 - Case management and care coordination
 - Psychiatric evaluation, management and treatment
 - Crisis line
 - Crisis intervention and stabilization
 - Psychosocial rehabilitation
 - Outpatient psychiatric and substance abuse treatment services
 - Substance abuse intensive outpatient treatment
 - Methadone and opioid treatment
 - Peer support services

GAP Program Stats as of August 2015



Medicaid Community BH Funding

- A significant portion of funding for community mental health services is provided through the Medicaid program which is funded on a 50/50 basis with the federal government
- Expenditures for Medicaid funded community mental health services have grown by 22.5% from FY 2012 to FY 2015
 - FY 2015 expenditures include GAP waiver costs

Medicaid Expenditures for Mental Health (MH) Services (All funds \$ in millions)

| Service Category | FY 2012 | FY 2013 | FY 2014 | FY 2015 | FY 2016 ³ |
|---------------------------------------|---------|---------|---------|---------|----------------------|
| Community Rehabilitation ¹ | \$458.9 | \$491.4 | \$523.2 | \$503.8 | \$538.8 |
| Case Management | \$75.4 | \$79.4 | \$78.6 | \$80.3 | \$112.3 |
| Residential Services ² | \$31.6 | \$33.8 | \$33.9 | \$28.7 | \$32.5 |

¹Community rehabilitation services include intensive in-home, mental health skill building, psycho-social rehab., crisis intervention and stabilization, intensive community treatment, substance abuse service, psychiatric services.

²Residential services are provided in 3 different licensed levels: psychiatric facility care, therapeutic group homes or a residential structured program.

³2016 numbers represent the appropriation amount which was projected in the 2014 Medicaid forecast. The November 2015 Medicaid forecast will provide an update for FY 2016.

Community Behavioral Health Services

- Discharge Assistance Program (DAP)
 - Funding provided on a regional basis to CSBs to assist individuals with the transition from state mental health facilities to the community
 - Program targets individuals who have been determined clinically ready for discharge but face barriers to treatment in the community
- Programs of Assertive Community Treatment (PACT)
 - Funding for multidisciplinary teams to provide highly individualized services 24/7 to persons with the most severe and persistent mental illness
 - DBHDS reported that 2014 data indicate a 76 percent reduction in consumers' state hospital use following PACT enrollment (over 243,000 fewer bed days), an ongoing savings of approximately 101 state hospital beds
 - Over 85 percent of PACT consumers maintained stable housing and experienced few or no readmissions to psychiatric hospitals, and over 90 percent have no arrests.

| Added Funding for DAP and PACT (GF \$ in millions) | | | | |
|--|---------|---------|---------------|-----------------------------|
| Program | FY 2014 | FY 2015 | FY 2016 | Notes |
| DAP | \$1.5 | \$0.25 | \$0.5 | Serves ± 75 individuals |
| Total Approp. | | | \$21.5 | |
| PACT | | \$0.95 | \$6.8 | Adds up to 7 teams |
| Total Approp. | | | \$16.7 | Funds up to 23 teams |

Crisis Intervention / Therapeutic Drop-off Centers

- General Assembly provided funding to expand drop-off centers as an alternative to incarceration for individuals with serious mental illness at an estimated level of \$300,000 per center
 - DBHDS reported that drop-off centers reduce the average time law enforcement spend with an individual under an ECO from 4-6 hours to 1-2 hours

| Added Funding for CIT/Drop-off Centers (GF \$ in millions) | | |
|--|---------------|--|
| Fiscal Year | GF \$ Added | Notes |
| FY 2013 | \$0.6 | Grants for up to 3 drop-off centers |
| FY 2014 | \$1.5 | Added funding supports up to 6 more centers |
| FY 2015 | \$1.8 | Grants for up to 6 drop-off centers |
| FY 2016* | \$9.0 | Grants for up to 18 drop-off centers |
| Total Approp. | \$10.5 | Grants provided for 32 drop-off centers |

- During CY 2013, the Office of Attorney General disbursed \$2.6 million to 14 Police Departments and 6 Sheriff's Offices for CIT training, and \$800,282 to DCJS to implement a statewide, multi-phased CIT Train-the-Trainer program

Children's & Youth Services

- Children's Psychiatry and Crisis Services - regional funding
- Preliminary data shows increased access from FY 2013 to FY 2015
 - Almost 5,200 more children served with child psychiatry
 - Almost 3,000 more children provided with emergency services (39% increase)
 - Almost 800 more children provided with mobile crisis stabilization (117% increase)
 - 52 more children (53%) served by crisis residential services (not used by all regions)
- Youth Outpatient Mental Health Services
 - Targeted at youth ages 17 to 24 with focus on outpatient services such as psychotherapy, medications and counseling

Added Funding for Children and Youth Services (GF \$ in millions)

| Services | FY 2013 | FY 2014 | FY 2015 | FY 2016 |
|--|---------|---------|---------|---------|
| Children's Psychiatry & Crisis Services* | \$1.5 | \$3.65 | \$0.5 | \$3.0 |
| Youth Outpatient Svs. | | | \$3.5 | \$4.0 |

*FY 2016 total appropriation for Children's Psychiatry & Crisis Services is \$6.65 million GF.

Other Behavioral Health Services

- Supportive Housing
 - Provided \$2.1 million GF in FY 2016 for supportive housing for 150 SMI individuals to avoid costly hospitalizations, homelessness and incarceration
- Peer Support Recovery Program
 - Services designed and delivered by peers in recovery, in coordination with professional staff to engage individuals in treatment, preventing relapses and promoting long-term recovery
 - \$550,000 GF in FY 2015
 - \$1.0 million GF in FY 2016
 - \$300,000 GF each year of 2014-16 biennium to replace grant funds for a community recovery program in the Piedmont region
- Tele-psychiatry Equipment
 - Provided funding for the purchase of new or updated tele-communications equipment for CSBs to conduct or obtain clinical evaluations off-site
 - \$1.1 million GF in FY 2015
 - \$620,000 GF in FY 2016

Other Behavioral Health Services

- Acute Bed Registry
 - \$111,715 GF in FY 2015
 - \$121,871 GF in FY 2016
- Mental Health First Aid Training
 - 2013 General Assembly provided \$600,000 in FY 2014 for mental health first aid training and certification
 - Recommendation of the Governor's Taskforce on School and Campus Safety
 - Targets training to school personnel, organizations, first responders and other community “gatekeepers” who have extensive public contact
 - 12-hour interactive course focuses on risk factors; warning signs and symptoms; and teaches basic skills for providing help to someone who may be experiencing symptoms
- Suicide Prevention
 - 2013 General Assembly provided \$500,000 GF in FY 2014 to implement a comprehensive suicide prevention plan across agencies
 - Plan was to include public education, evidence-based training, health and behavioral health provider capacity-building, and related suicide prevention activity

Inpatient Services

- Local Inpatient Purchase of Services (LIPOS)
 - 2014-16 biennium provided funds to CSBs to purchase inpatient services in the community, diverting individuals from state facilities
- Expanded inpatient capacity at state facilities
 - Re-opened 13 beds at Northern Virginia Mental Health Institute (NVMHI) and added capacity at Eastern State Hospital (ESH)
 - 2014-16 biennium provided funds to implement ECO/TDO legislation to ensure sufficient capacity at state facilities in the event a placement cannot be found for an individual in the community

| Added Funding for Inpatient Services (GF \$ in millions) | | | | |
|---|---------|---------|---------|---------|
| | FY 2013 | FY 2014 | FY 2015 | FY 2016 |
| LIPOS* | | | \$0.25 | \$2.65 |
| NVMHI 13 Beds | \$0.6 | \$0.7 | In Base | In Base |
| State Facility-Provider of Last Resort | | | \$4.4 | \$4.1 |
| ESH-Expand Capacity | | | \$2.2 | \$2.2 |
| ESH-Backfill Geriatric Revenue Loss | | | \$5.0 | \$5.0 |
| *FY 2016 appropriation for LIPOS totaled almost \$10.9 million. Of the \$2.65 added in FY 2016, \$1.2 million was targeted for children's community inpatient services. | | | | |

Involuntary Mental Commitments

- Expenditures for treatment costs related to involuntary mental commitments are funded through appropriations to the Department of Medical Assistance Services
- Expenditures for Medicaid involuntary mental commitments have grown by 33% from FY 2012 to FY 2015

| Expenditures for Involuntary Mental Commitments (GF \$ in millions) | | | | |
|---|----------------|----------------|----------------|-----------------|
| FY 2012 | FY 2013 | FY 2014 | FY 2015 | FY 2016* |
| \$11.8 | \$10.4 | \$12.6 | \$15.0 | \$15.7 |

*2016 represents the appropriation amount which will be updated by DMAS later this year through its forecast process.

Budget Language

- Language related to behavioral health and developmental services
 - Adopted language during the 2014 Session directing DBHDS to review the current services provided at the state's mental health hospitals and consider options for consolidating and reorganizing the delivery of state services to include:
 - Programmatic assessment and fiscal impact of long-term needs for inpatient services for geriatric, adult, and forensic populations
 - Fiscal impact of the reduction in 3rd party payments from reducing the geriatric patient population served in state hospitals
 - Report due October 1, 2015
 - 2015 General Assembly added language directing DBHDS to review Piedmont Geriatric and Catawba hospitals and examine alternate options for care, especially geriatric psychiatric care
 - Report due November 1, 2015
 - Provided \$3.8 million GF in FY 2015 and \$9.1 million GF in FY 2016 to offset the loss of Medicare and Medicaid revenue due to a change in the classification of these facilities from hospitals to nursing homes to comply with federal requirements