RIGHT HELP. RIGHT NOW.

Transforming Behavioral Health Care for Virginians

Governor Glenn Youngkin

Virginia.gov
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Executive summary

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

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

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

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

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

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

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

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

Within pre-crisis prevention services, the Plan focuses on youth mental health through promotion, prevention, school-based service delivery, and tele-behavioral health in K-12 and higher education settings. In addition, it ensures all Virginians know “who to call” by investing in 988 crisis call centers, “who will help” if in crisis by scaling crisis care response services, and “where to go” so there is “no-
wrong-door” to access crisis care. The Plan increases support for post-crisis recovery by helping Virginians who are transitioning out of crisis to reenter and rebuild within their communities, including through added capacity in mental health group homes. Furthermore, the Plan focuses on breaking down barriers such as stigma and workforce constraints through new roles (e.g., peer support) and engaging the broader care ecosystem, including faith-based organizations. These efforts will help deliver community-based, prevention-focused behavioral health care for all Virginians in a way that best matches their individual needs.
Introduction

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

Exhibit 1: Select recent initiatives in the Commonwealth

The Plan builds on the Commonwealth’s progress across several initiatives

- Permanent Supportive Housing Plan (PSH)
- Addiction Recovery Treatment Service (ARTS)
- System Transformation, Excellence and Performance (STEP-VA)
- Medicaid Expansion
- Project BRAVO
- 988 roll-out

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

2  DBHDS data: HHR Top Accomplishments, November 8, 2022.
However, Virginians still experience challenges accessing behavioral health care. They often wait hours, if not days, for inpatient psychiatric beds for voluntary and involuntary treatment. In addition, Mental Health America ranks Virginia 34th in overall mental health access, and most counties—106 of 133—are classified in full as mental health professional shortage areas. 4,5 Nearly one third of Virginia’s population lives in these counties. In addition, Virginia saw a decline in mental health among youth, dropping from 21st to 48th in Mental Health America’s ranking of states on Youth Mental Health.6

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

Mental Health America ranks Virginia 14th out of 50 states for Adult Mental Health

<table>
<thead>
<tr>
<th>Prevalence measures</th>
<th>Better</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virginia Adults with...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any mental illness (AMI)</td>
<td>19.9% 20.8%</td>
<td>18.6% 20.5%</td>
</tr>
<tr>
<td>Substance use disorder</td>
<td>7.7% 15.3%</td>
<td>7.3% 14.5%</td>
</tr>
<tr>
<td>Serious thoughts of suicide</td>
<td>4.6% 4.8%</td>
<td>4.2% 4.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Access barrier measures</th>
<th>Improving in US and VA</th>
<th>Worsening in US and VA</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI who are uninsured</td>
<td>10.8% 11.1%</td>
<td>6.5% 12.4%</td>
</tr>
<tr>
<td>AMI who did not receive treatment</td>
<td>54.7% 55.9%</td>
<td>47.4% 54.7%</td>
</tr>
</tbody>
</table>

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

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

Mental Health America ranks Virginia 48th out of 50 states for Youth Mental Health

21st

2022 Rank

Prevalence measures
Virginia Youth with...
Worsening in US and VA
At least one major depressive episode (MDE)
15.1% 16.4%
15.6% 19.6%
Substance use disorder
4.1% 6.4%
3.7% 7%
Severe MDE
10.6% 11.5%
13% 15.7%

Access barrier measures
Worsening in VA
MDE who did not receive mental health services
59.8% 60.3% 55.2% 60.2%
Private insurance that did not cover mental or emotional problems
8.1% 10.3%
6.4% 17%

2023 Rank

2022 2023 US Average Virginia Average
Improving
Worsening

0% 65%

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

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

Exhibit 4: Continuum of Behavioral Health Care in Virginia

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

Continuum of Behavioral Health Care
Pre-crisis prevention services
Crisis care
Post-crisis recovery and support

Services
Community services
Alternative custody/transportation
Residential care
Community services
988 call centers
Law enforcement
CSBs
Private providers
Public and private hospitals

Providers/Settings
Community Services Boards (CSBs)
Private providers
MCOs
Schools and colleges
988 call centers
Mobile crisis teams
Crisis receiving centers
Law enforcement
Emergency Custody Order
Temporary Detention Order

Outcomes
Recovery
Resilience
Community Integration

Source: VA HHR: DBHDS
In pre-crisis prevention services, Virginia’s 40 Community Services Boards (CSBs) play an important role in community-based care as they provide publicly funded behavioral health services in local communities. However, CSBs vary significantly in terms of per capita funding, governance structure, and services provided. Also, K-12 schools play a critical role in the prevention and management for youth; however, schools face a widespread shortage of school-based mental health professionals, inconsistent deployment of school-based telehealth supports, and limited training for educators on critical topics such as suicide prevention.

Exhibit 5: Per capita funding for Community Service Boards

Virginians who are in need of crisis care have limited options for where to go to receive timely care. In many parts of the state, law enforcement is often the de facto first response. This may also result in poor experience for the person in crisis, given that law enforcement is often not best equipped to respond to these types of emergencies. Limited alternatives mean that many Virginians in crisis end up going without care or are treated in high-cost emergency department settings. This system also results in diversion of law enforcement resources from public safety emergencies. When a person in crisis triggers a law enforcement response, they must be accompanied by officers to the emergency department; these officers wait 51 hours, on average, at the facility. Furthermore, Temporary Detention Orders (TDO) are issued for approximately 33% of individuals in crisis who are screened, triggering a long and resource-heavy process with minimal opportunities for care.

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

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

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

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

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

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

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

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⁹ DBHDS data: EBL and LOS data for BH commission, November 2022.
¹⁰ Ibid.
Approach

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

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

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

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

- Recognizing the diversity of experiences across populations, the agency developed five surveys to understand citizen experience. In November 2022, HHR launched surveys across respondent categories, including individuals who interact with adult behavioral health, child behavioral health, forensic, developmental disability, and substance use disorder services. The survey gathered quantitative and qualitative input across eight questions on Virginia’s behavioral health system. Two questions captured quantitative measures of stakeholder experience:

  - How satisfied are you with the overall availability of services in your community or geographic area?
  - How easy is it to “navigate” the system or learn how to access the services you need?
Six questions welcomed free form responses:

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

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

- How can services be improved in your community?

- What does your community have that is working well and could be replicated in other areas?

- Share a first-hand account of when the system worked well.

- Share a first-hand account of when the system did not work well.

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

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

13 Virginia HHR BH Services Survey, launched November 8, 2022, results as of November 30, 2022
14 Ibid
Exhibit 6: Satisfaction and Ease across survey respondents

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

<table>
<thead>
<tr>
<th>Satisfaction</th>
<th>Adult BH</th>
<th>Child BH</th>
<th>Developmental Disabilities</th>
<th>Forensic Services</th>
<th>Substance Use Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely Satisfied</td>
<td>15%</td>
<td>35%</td>
<td>38%</td>
<td>34%</td>
<td>39%</td>
</tr>
<tr>
<td>Somewhat Satisfied</td>
<td>19%</td>
<td>35%</td>
<td>21%</td>
<td>30%</td>
<td>22%</td>
</tr>
<tr>
<td>Neither dissatisfied nor satisfied</td>
<td>9%</td>
<td>8%</td>
<td>11%</td>
<td>19%</td>
<td>13%</td>
</tr>
<tr>
<td>Somewhat Dissatisfied</td>
<td>37%</td>
<td>34%</td>
<td>30%</td>
<td>30%</td>
<td>22%</td>
</tr>
<tr>
<td>Extremely Dissatisfied</td>
<td>38%</td>
<td>35%</td>
<td>31%</td>
<td>21%</td>
<td>33%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ease of Access</th>
<th>Adult BH</th>
<th>Child BH</th>
<th>Developmental Disabilities</th>
<th>Forensic Services</th>
<th>Substance Use Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely Easy</td>
<td>5%</td>
<td>4%</td>
<td>3%</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Somewhat Easy</td>
<td>15%</td>
<td>12%</td>
<td>12%</td>
<td>18%</td>
<td>18%</td>
</tr>
<tr>
<td>Neither difficult nor easy</td>
<td>15%</td>
<td>15%</td>
<td>14%</td>
<td>25%</td>
<td>21%</td>
</tr>
<tr>
<td>Somewhat Difficult</td>
<td>35%</td>
<td>36%</td>
<td>33%</td>
<td>28%</td>
<td>30%</td>
</tr>
<tr>
<td>Extremely Difficult</td>
<td>29%</td>
<td>35%</td>
<td>37%</td>
<td>24%</td>
<td>26%</td>
</tr>
</tbody>
</table>

1. Full question: How satisfied are you with the overall availability of services in your community or geographic area?
2. Full question: How easy is it to “navigate” the system or learn how to access the services you need?

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

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

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

1. Intensity analysis NLP methodology: preexisting trained model which was trained on Amazon reviews using keras library in python
2. Selected Top 20 responses to mitigate bias of response # (e.g., Adult BH had 1,129 respondents while Forensic Services had 115 respondents)
Exhibit 8: Adult BH services: Recurring themes in qualitative responses

Adult BH Survey Deep Dive: Word Clouds

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

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

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

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

Exhibit 9: Six Pillars of the Behavioral Health Plan

The Commonwealth’s Behavioral Health Plan is founded on six pillars

An aligned approach to BH that provides access to timely, effective, and community-based care to reduce the burden of mental health needs, developmental disabilities, and substance use disorders on Virginians and their families

| 1: We must strive to ensure same-day care for individuals experiencing behavioral health crises | 2: We must relieve the law enforcement communities’ burden while providing care and reduce the criminalization of behavioral health | 3: We must develop more capacity throughout the system, going beyond hospitals, especially to enhance community-based services | 4: We must provide targeted support for substance use disorder (SUD) and efforts to prevent overdose | 5: We must make the behavioral health workforce a priority, particularly in underserved communities | 6: We must identify service innovations and best practices in pre-crisis prevention services, crisis care, post-crisis recovery and support and develop tangible and achievable means to close capacity gaps |

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

- Engagement across stakeholders, including local communities, public and private providers, caretaker groups, law enforcement, and all payers (e.g., Medicaid, commercial insurers, other public and private sources)

- Alignment of incentive structures and funding sources, including expanding near-term funding while identifying sustainable sources across the public and private sectors (including strategies to maximize the impact of state dollars)

- Enhancement of technology and systems to support improved quality and outcomes, decision-making across stakeholders in the system, and effectiveness of the overall behavioral health system.

The following sections explore each of these six pillars in depth.
Pillar 1: We must strive to ensure same-day care for individuals experiencing behavioral health crises

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

Exhibit 10: Estimated current, planned, and target state capacity for crisis response and stabilization17

<table>
<thead>
<tr>
<th>Mobile crisis teams (MCT)</th>
<th>Current State (% of target)</th>
<th>Year 1 (% of target)</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Target state</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>36 (~50%)</td>
<td>70 (100%)</td>
<td>70 (100%)</td>
<td>70 (100%)</td>
<td>70</td>
</tr>
<tr>
<td>Crisis receiving center slots (&lt;23 hours)</td>
<td>186 (~40%)</td>
<td>290 (~60%)</td>
<td>360-380 (~80%)</td>
<td>450-500 (100%)</td>
<td>500</td>
</tr>
<tr>
<td>Short-term crisis beds (1-5 days)</td>
<td>252 (~60%)</td>
<td>324 (~80%)</td>
<td>350-360 (~90%)</td>
<td>380-400 (100%)</td>
<td>400</td>
</tr>
<tr>
<td>Comprehensive Psychiatric Emergency Programs (CPEP)</td>
<td>1</td>
<td>4+</td>
<td>TBD</td>
<td>TBD</td>
<td>Depend on buildout of CrisisNow VA</td>
</tr>
<tr>
<td>Acute psychiatric inpatient beds</td>
<td>~3,200</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td></td>
</tr>
</tbody>
</table>

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

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

16 Figures derived from the CrisisNow model calculator, which aligns with the National Guidelines for Behavioral Health Crisis Care, CrisisNow: Crisis Resource Need Calculator, 2022 (https://calculator.crisisnow.com/#/data-insights?chart=SC&geo=State&lob=All&location_key=VA&metric1=bh_high_needs&tab=Map).
17 Current and planned crisis care infrastructure estimates are based on November 2022, estimates, DBHDS. Estimates of potential future crisis care infrastructure in VA are based on estimates from the Crisis Resource Needs Calculator’s assumptions of:
   a. 230 crisis episodes requiring in-person response per 100,000 population on average
   b. National average rates of length of stay, occupancy rates, and utilization rates
   c. Initial triage rates of 32% to mobile crisis teams (MCTs), 54% to crisis receiving facilities (CRFs), 14% to EDs
   d. Referral rates of 30% from MCTs to CRFs, 35% from crisis receiving facilities to short-term crisis beds, 25% from short-term crisis beds to inpatient care, 100% from ED to inpatient care. Year 2 infrastructure estimates assume investment for 50% additional capacity to build on Year 1 capacity towards target state.
Virginia supported a successful launch of the 988 Suicide and Crisis Lifeline, where the in-state response rate of 91% exceeds the national target. Virginia was the first state to enact 988 legislation with a sustainable funding model.

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

1. **Launch statewide 988 promotion.** The Commonwealth has been ahead of the national curve in implementing 988 as a result of General Assembly action and crisis system transformation efforts. As call center capacity expands, Virginia can build on a successful 988 launch by messaging 988 as a resource across behavioral health needs, including substance use disorder. This initiative will continue to deploy messaging campaigns consistent with the Substance Abuse and Mental Health Services Administration (SAMHSA) 988 efforts and Virginia’s call capacity, including messaging that can occur before and after the July 2023 federal messaging campaign (e.g., social media, billboards).

2. **Enhance mobile crisis team capacity.** Mobile crisis teams are one of the key components of a crisis care system (See Appendix C). Only 36% of Virginia’s 70 planned mobile crisis teams (MCTs) are staffed. Building up resources and capacity building for the remaining MCTs will help Virginia provide adequate coverage across the Commonwealth. MCTs will provide rapid response and help reduce the burden on law enforcement.

3. **Enhance crisis receiving and stabilization capacity.** Virginia currently has 186 crisis receiving center slots and 252 short-term crisis beds. This initiative will help Virginia achieve the target crisis receiving and stabilization capacity of 500 slots and 400 beds. This community-based crisis care will support timely care for individuals and allow law enforcement to relinquish custody on a shorter timeline at a Crisis Receiving Center (CRC). Within this initiative, a “model” CRC will be built with a peer living room, 23-hour crisis receiving slots, short-term crisis stabilization beds, and a separate law enforcement entrance. This format aligns with best-in-class models, such as Arizona’s model. This initiative will also determine the balance of crisis receiving and stabilization centers and comprehensive psychiatric emergency program (CPEP) facilities at emergency departments. It will be based on existing resources, geographic coverage, and need; it will also provide other innovative psychiatric emergency alternatives.

4. **Develop outcomes-based payment approach.** An outcomes-based payment approach for crisis services could incentivize outcomes-oriented, cost-effective, and holistic crisis care. This initiative will link provider payment to patient outcomes and ensure that both Medicaid and commercial payers participate in the value-based prospective payment approach.

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18 DBHDS data: HHR Top Accomplishments, November 8th, 2022
20 DBHDS discussions, December 2022
5. Develop technology infrastructure to enable crisis systems. The continued buildout of technology infrastructure for crisis services will equip stakeholders—such as emergency services providers—with real-time data on availability of services and placement options. This technology infrastructure will also help track the key performance indicators necessary to support ongoing improvement across the crisis system and an outcomes-based prospective payment system. Key components of this initiative include a transformed, real-time bed registry, a mobile dispatch dashboard, and an interface with emergency department data. This system will help connect people to care faster and reduce the burden on stakeholders involved in the process (e.g., CSB pre-screeners). This technology infrastructure could be modeled off Arizona’s CrisisNow model\textsuperscript{24}\textsuperscript{24}

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

Exhibit 11: Pillar 1 initiatives

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

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Change management

Engage stakeholders on crisis resources | Continue to engage stakeholders on crisis resources |

Source: VA HHR, DBHDS data

\textsuperscript{24} Ibid
\textsuperscript{25} DBHDS discussions, December 2022.
Pillar 2: We must relieve the law enforcement communities’ burden while providing care and reducing the criminalization of behavioral health

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

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

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

26 DBHDS discussions, November 2022
27 DBHDS data: Comparison of state ECO-TDO laws and practices 2022, November 21, 2022
Exhibit 12: Law enforcement and crisis “day(s)-in-the-life-of” journey

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

29 DBHDS discussions, November 2022
Addressing these journey painpoints includes creating “off-ramps” throughout the journey to provide more timely and appropriate care for individuals in crisis (Exhibit 13).

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

Illustrative “Day(s)-in-life-of” journeys: Potential “off-ramps” could improve the experience of an individual in crisis

Source: DBHDS Report on Item 320.II of the 2021 Appropriations Act; DBHDS discussions
The workgroup identified four initiatives that could reduce the burden on law enforcement in the behavioral health system over three years (Exhibit 14):

### Exhibit 14: Pillar 2 initiatives

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Potential impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Promote co-responder models</td>
<td>Survey CSBs to establish fact base on co-response models across law enforcement (LE) departments in VA (e.g., current build-out and funding models)</td>
<td>Identify potential reimbursement options</td>
<td>Scale co-responder model to additional LE departments</td>
<td>Reduce TDOs (from 21,104 in SFY2022)</td>
</tr>
<tr>
<td>2. Provide training and support to CSBs (e.g., pre-screener role)</td>
<td>Understand variation in TDO issuance across CSBs including pre-screener role</td>
<td>Review pre-screening role, including professional requirements</td>
<td>Increase consistency across CSBs in issuance of TDOs (e.g., reduce variation across pre-screeners from ~10-70% across CSBs)</td>
<td></td>
</tr>
<tr>
<td>3. Reduce administrative burden for pre-screeners</td>
<td>Establish Public Health Information Exchange (in coordination with crisis pillar)</td>
<td>Add private provider information to Public Health Information Exchange</td>
<td>Reduce time that law enforcement is involved in BH response from average ~51 hours to time of transport</td>
<td></td>
</tr>
<tr>
<td>4. Scale alternative transport, custody, and treatment services</td>
<td>Develop change management plan for DBHDS and CRCs to enable “no wrong door”</td>
<td>Coordinate with crisis pillar to scale CRC model and conduct LE and other stakeholder site visits</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

1. **Promote co-responder models.** Co-responder models dispatch behavioral health specialists alongside law enforcement officers to behavioral health-related crisis calls. Together, they work to de-escalate the situation and get the individual in crisis the care required for their specific situation. This initiative will establish the current state on co-responder models in Virginia (e.g., Fauquier County), including mapping capacity, service area, and funding model(s). The initiative will support scaling this model and support law enforcement when responding to behavioral health crises.

2. **Provide training and support to CSBs (e.g., pre-screener role).** There is high variation in TDO rates across CSBs, ranging from 11% to 71%31. This initiative will determine the drivers of variation in TDO rates and support statewide training for CSB pre-screeners. This initiative will also explore licensure and certification requirements for CSB pre-screeners.

3. **Reduce administrative burden for pre-screeners.** CSB pre-screeners currently must fill out a 9-page report and engage in time-consuming placement search processes that, on average, total 4 hours; the process includes using outdated technology such as faxes.32 This initiative will focus on reducing the administrative burden for pre-screeners to reduce the wait time for law enforcement officers.

4. **Scale alternative transport, custody, and treatment services.** In coordination with Pillar 1, this initiative will enable law enforcement to relinquish custody within crisis care settings and establish “no wrong door” crisis care. These changes will help reduce the 51-hour average wait time for law

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31 JLARC: Report to the Governor and the General Assembly of Virginia,” December 12, 2022
32 Report on Item 320.II of the 2021 Appropriations Act, December 29, 2021
They will also reduce on-duty law enforcement transportation times with individuals in crisis. Solutions will leverage existing capabilities in new ways, such as off-duty and alternative-transport programs and by scaling existing programs (e.g., Mt. Rogers CSB pilot) with greater funding to incentivize sufficient workforce mobilization.

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

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33 DBHDS discussions, November 2022
34 DBHDS discussions, November 2022
Pillar 3: We must develop more capacity throughout the system, going beyond hospitals, especially to enhance community-based services

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

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

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

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

**Initiatives**

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Potential impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Expand community-based models</strong></td>
<td>Plan for CCBHC Demonstration Program (e.g., data infrastructure, payment system)</td>
<td>Train 12 CSBs (e.g., CCBHC)</td>
<td>Train 28 CSBs (e.g., CCBHC)</td>
<td>Decrease in wait times for BH care</td>
</tr>
<tr>
<td><strong>2. Expand care integration</strong></td>
<td>Assess landscape of non-BH providers</td>
<td>Build on Virginia Mental Health Access Program</td>
<td>Ensure DB, emergency, other services continue across CSBs</td>
<td>Decrease in adults with any mental illness (AMI) who did not receive treatment</td>
</tr>
<tr>
<td><strong>3. Expand tele-behavioral health access</strong></td>
<td>Determine need for broadband to support telehealth objectives</td>
<td>Address broadband needs identified to support telehealth</td>
<td></td>
<td>Increase in individuals receiving BH care at parity, regardless of insurance status</td>
</tr>
<tr>
<td><strong>4. Increase youth BH support</strong></td>
<td>Scale school-based mental health trainings and services</td>
<td>Continue to reduce priority 3 waitlist</td>
<td>Increase in access to BH screening, early intervention, and referral at specialty provider setting</td>
<td></td>
</tr>
<tr>
<td><strong>5. Expand services for individuals with developmental disabilities</strong></td>
<td>Increase rates for waiver services</td>
<td>Assess performance and address opportunity improvement areas</td>
<td>Increase in integrated care (BH/physical health integration)</td>
<td></td>
</tr>
<tr>
<td><strong>6. Enhance re-entry and stabilization services</strong></td>
<td>Scale Permanent Supportive Housing and Mental Health Group Homes</td>
<td>Expand and support additional community reintegration needs (e.g., employment, care coordination, group homes)</td>
<td>Increase in children, youth that need treatment, getting access to care</td>
<td></td>
</tr>
</tbody>
</table>

1. Certified Community Behavioral Health Clinics (CCBHCs)

Source: VA HHR, DBHDS data

1. **Expand community-based models.** This initiative will focus on implementing the Certified Community Behavioral Health Clinic (CCBHC) model. CCBHCs are a federally supported model – by SAMHSA and the Centers for Medicare and Medicaid Services (CMS) – for delivering model-based behavioral health services. The ten US states that have implemented the CCBHC demonstration program have increased access to behavioral health services, reduced emergency department and hospital visits, improved integration of physical care, and enhanced SUD service capacity. If Virginia is selected for the CMS demonstration program, all 40 CSBs would have the opportunity to participate over the next 3 years and would represent an opportunity to create increased accountability for CSBs.

2. **Expand care integration.** Integration of behavioral health with primary care and specialty providers (e.g., OBGYN) can help positively impact behavioral health outcomes. For example, 66% of youth have better outcomes when receiving integrated care. This initiative will focus on improving the integration of behavioral health into other provider settings.

3. **Expand tele-behavioral health access.** Tele-behavioral health can provide behavioral health supports and service and decrease wait times to seek care. This initiative will assess the geographic need and broadband capabilities of communities to access tele-behavioral health. It will also assess where and how tele-behavioral health capabilities can be provided across the continuum and expand school-based tele-health services for K-12 and higher education students.

4. **Increase youth BH support.** National data show that ~45% of students who receive behavioral health treatment do so in schools. Through school-based behavioral health trainings and resources, school-based services and support to youth could be expanded. The illustrative user journey maps (Exhibits 16 and 17) chart the current state for youth and their families, highlighting pain points and

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

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

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

1. Day 1: Taylor sees her pediatrician for an annual physical exam. She complains of stomach aches and poor sleep, but she does not receive a mental health screening as part of the physical exam.

2. Week 2: Taylor sees her school nurse because of stomachaches and poor sleep. The school nurse takes care of her immediate symptoms but does not evaluate potential behavioral health considerations or refer for additional support/screening from another provider.

3. Taylor’s teacher also notices that Taylor is struggling academically and appears to have learning difficulties as she refers her to the school psychologist for an assessment.

4. Week 4: Taylor continues to struggle academically, physically, and emotionally, yet her parents are unsure how to help her. They feel uninformed and isolated, as they don’t have access to family navigators.

5. Week 5: One night, Taylor is unable to sleep and experiences acute stomach aches. Taylor’s mother rushes her to the emergency department (ED), where an exam and testing reveal no physiological cause for her discomfort, and she is diagnosed with generalized anxiety disorder and OCD. She is referred for outpatient treatment.

6. However, she won’t be able to receive outpatient treatment until 4 months from now.

Source: DBHDS and expert interviews, November 2022.

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

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

1. Day 1: Taylor sees her pediatrician for an annual physical exam.

2. Week 2: Taylor visits the school nurse.

3. Week 3: School psychologist refers Taylor to an outpatient child psychologist and acquaints her family with the local CSB. However, Taylor is unable to secure an appointment with the psychologist until 4 months from now.

4. Week 4: Taylor continues to struggle academically.

5. Week 5: Taylor’s mother rushes her to the ER.

6. Week 6: Taylor returns to the ER but doesn’t get care.

Source: DBHDS and expert interviews, November 2022.
5. **Expand services for the DD population.** Individuals with developmental disabilities (DDs) and their families have had to navigate a complex system and long waiting lists to access the care they need to live independently (e.g., ~3,000 Virginians are on the priority one waitlist for DD Waiver services). This initiative will fund additional waiver slots and enhance rates for waiver providers to improve access to care and quality of life for individuals with developmental disabilities and the families who support them.

6. **Enhance re-entry and stabilization services.** This initiative aims to support individuals’ re-entry into their communities post-hospitalization or long-term inpatient care. It will help with permanent or temporary housing support, care coordination and wraparound community supports, transition planning pre-discharge, and employment support.

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

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44 For example, the number of individuals receiving behavioral health care regardless of insurance status, access to behavioral health screening, early intervention, and referral at specialty provider setting can be measured and benchmarked across the system.
Pillar 4: We must provide targeted support for substance use disorder and efforts to prevent overdose

A substance use crisis is unfolding nationally, and communities across the country are struggling with addiction and overdose. In Virginia, the prevalence of substance use disorder (SUD) diagnoses doubled for both adults and youth in one year – for adults increasing from 7.3% to 14.5% and for youth from 3.7% to 7.0%.

Overall, the state saw a 35% increase in overdose deaths between June 2021 and June 2022.

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

Exhibit 18: Pillar 4 initiatives

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Develop mobile treatment and crisis response specific for SUD</td>
<td>Develop substance use journeys to pressure test against crisis system design</td>
<td>Expand to additional pilot geographies</td>
<td>Launch model statewide</td>
</tr>
<tr>
<td>2. Empower communities in addressing the SUD crisis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Target programs with the greatest potential to prevent adverse outcomes</td>
<td>Assess potential for harm reduction</td>
<td>Build capacity to link state social and health services for harm reduction</td>
<td></td>
</tr>
<tr>
<td>4. Expand innovative programs for proven and effective treatments across the continuum</td>
<td>Convene cross-agency planning for evidence-based treatment pilots</td>
<td>Expand delivery of evidence-based treatments</td>
<td>Scale programs statewide</td>
</tr>
<tr>
<td>5. Reduce barriers to recovery</td>
<td>Assess current policies and leverages to reduce barriers to recovery (e.g., peer roles, transition programs) and expand or pilot approaches</td>
<td>Expand pilots for specific subpopulations</td>
<td>Scale programs statewide</td>
</tr>
</tbody>
</table>

Potential impact
- Increase access to timely care for individuals seeking treatment for substance use in prevention and management settings
- Increase access for individuals experiencing substance use-related crises
- Reduce rates of relapse through improved peer support resources and housing supports for individuals in recovery

Source: VA HHR

1. **Develop mobile treatment and crisis response specific for SUD.** Given both the severity of the substance use crisis and the high rates of co-occurrence between mental health and SUD, a well-designed crisis response system cannot be diagnosis dependent. In 2020, emergency department (ED) visits increased 28% for SUD-related events, even while overall ED visits declined by 2.3%.

To ensure that individuals experiencing crises involving substance use get the appropriate in-person assistance...
response, the Commonwealth’s mobile crisis team roll-out will include SUD specific capabilities and trained staff.\textsuperscript{49} This process will begin with articulating the mobile crisis strategy with specific considerations for substance-use-related crises in Year 1 and scale statewide in Years 2 and 3, including integration with the broader crisis and behavioral health ecosystem.

2. **Empower communities to address the substance use crisis.** Addressing the substance use crisis requires education and awareness initiatives focused on primary prevention and stigma reduction, including efforts led by the broader community. These efforts include schools, faith-based organizations, and community-based organizations. For example, Community Coalitions of Virginia and Peer/Parent Mentor programs support people who are struggling with substance use by enabling family togetherness, creating safe spaces, and offering prevention and recovery tools. Over three years, opportunities will be identified to enable organizations to provide these services sustainably and at-scale.

3. **Target programs with the greatest potential to prevent adverse outcomes.** This initiative aims to scale evidence-based practices that have been demonstrated to be effective in the fight against the substance use crisis, which include Naloxone distribution (e.g., by mail, in specific community settings, to law enforcement officers) and scaling the presence of harm-reduction programs across the state. This initiative will identify additional evidence-based practices to scale and then expand those practices statewide over the coming three years. Included in this initiative are efforts to address the high fatality rate of overdoses involving fentanyl, which represented 71.8% of all fatal overdoses in Virginia in 2020 (through either prescription, illicit, and/or analogs).\textsuperscript{50}

4. **Expand innovative programs for proven and effective treatments across the continuum.** This initiative aims to continue to support and expand ongoing SUD programs (e.g., ARTS). Additionally, the initiative will scale innovative and effective SUD treatments (e.g., peer mentorship, therapies that drive reduction in substance use) to enable holistic support across the care continuum.

5. **Reduce barriers to recovery.** This initiative will support individuals in recovery as they transition from residential or detox facilities, long-term inpatient care, and jails/prisons. Individuals will be supported in their prevention and ongoing recovery efforts through programs like Bridge Clinics and employment and housing supports. The initiative will assess current programs and policies for opportunities to expand or pilot approaches in Year 1 and scale programs in Years 2 and 3.

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

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

\textsuperscript{50} Virginia Department of Health: Office of the Chief Medical Examiner, Q3 Report, 2021
Pillar 5: We must make the behavioral health workforce a priority, particularly in underserved communities

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

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

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

Virginia Health Professional Shortage Areas by County, Mental Health, HRSA

80%

106 of 133 counties are classified in full as a mental health professional shortage area

33% of the Virginia population lives in these counties (2.8M out of 8.6M)

Mental Health America rankings

34th Access to Care

39th Mental Health Workforce Availability

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

51 Claude Moore Charitable Foundation: Virginia’s Human Services Workforce, Strategic Investment Initiatives Report, August 19, 2022
52 Data.HRSA.gov: Health Resources and Services Administration Mental Health Care Professional Shortage Areas, by State, as of September 30, 2022
The shortage of behavioral health providers is predominantly in rural areas as current supply of psychologists, psychiatrists, and facilities is concentrated around urban areas (Exhibit 20).

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

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

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

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53 Ibid
54 Virginia Health Care Foundation: Assessment of the Capacity of Virginia’s Licensed Behavioral Health Workforce, January 2022
55 Mental Health America: Access to Care Ranking 2023, based on 2019-2020 data
56 DBHDS Discussions, Design Sprint, December 2022
Exhibit 21: Pillar 5 initiatives

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

1. **Increase recruiting by reducing constraints where appropriate.** Constraints on job placement may include potentially onerous licensing requirements and other prerequisites that restrict an individual’s eligibility for a job based on prior personal background. While these requirements exist to safeguard patients, there is an opportunity to assess parameters for licensure requirements to determine whether there are opportunities to update the approach to expand the pipeline of incoming behavioral health providers.57

2. **Work toward rate and compensation parity across private and public sectors.** Compensation for behavioral health providers lags that of other healthcare providers, especially in public facilities.58 Addressing this reality will require first developing a detailed understanding of the disparities by role and geography. In order to address these disparities, this initiative will identify near-term opportunities for investment in specific roles and facilities (e.g., opportunities created by the rollout of the CCBHC model) as well as administrative changes that are required to enable sustainable funding to support compensation. This initiative will also build on current commitments to invest in non-direct care providers in state psychiatric facilities.59

3. **Increase capabilities for non-BH providers to provide BH care.** Extending the capabilities of non-behavioral health providers—including primary care physicians, pediatrics, and other providers—can also expand the pipeline (e.g., through training programs to upskill behavioral health competencies). This initiative will build on and expand local and role-specific examples, including current training programs focused on nurse practitioners and registered nurses, to upskill the non-behavioral health workforce.

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57 DBHDS/DHP Discussions, Design Sprint, December 2022
58 Ibid
59 Ibid
4. **Increase pipeline of incoming BH providers through educational opportunities and “grow your own” roles.** Increasing the educational pipeline of behavioral health providers requires supplementing current opportunities offered by the higher education system. This initiative includes near-term investments to fund loan forgiveness programs and increase the number of residency positions for behavioral-health-focused medical professionals in the Commonwealth. It also includes an intention to explore the opportunity to develop “grow your own” roles where new roles are developed in-state to address a community need. The mental health crisis has massively impacted youth; yet, in Virginia, there are only 211 Child and Adolescent Psychiatrists. This initiative could leverage innovations to address these constraints (e.g., “Behavioral Health Coaches” roles) to address the BH needs of children and youth.60

5. **Reduce the administrative burden for providers.** The administrative burden associated with clinical paperwork, billing, and other administrative tasks contributes to job dissatisfaction for providers in both the public and private sectors.61 The initiative aims to reassess current requirements for clinical and billing paperwork for behavioral health providers and identify tech-enabled solutions to streamline current processes.

6. **Support public campaigns to increase the attractiveness of BH roles.** In addition to the above initiatives that address structural challenges of the behavioral health workforce, state support of public campaigns can also increase the attractiveness of behavioral health provider roles. This initiative will focus on identifying, supporting, and scaling relevant public education campaigns aimed at promoting and valuing behavioral health provider roles.

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

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60 Children and Youth Behavioral Health Initiative (CYBHI). 2022
61 DBHDS/DHP Discussions, Design Sprint, December 2022
Pillar 6: We must identify service innovations and best practices in pre-crisis prevention services, crisis care, post-crisis recovery and support and develop tangible and achievable means to close capacity gaps

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

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

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

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

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62 Analysis of third-party claims data from: IBM’s Truven Commercial Database (2018-2020); IBM’s Truven Medicaid Database (2018-2020); 5% Sample CMS Medicare Limited Data Set, 2018-2020; Definitive Enrollment Data at the MSA-level 2017-19; DRG Medicaid FFS/MCO data, 2018-2020; Medicaid State Index
63 Virginia Department of Planning and Budget data. Note totals shown for 2020 reflect Medicaid Expansion and federal funding received during the Public Health Emergency is included for 2020 and 2022.
Pillar 6 initiatives (Exhibit 22) offer an approach to tackle the remaining challenges in an integrated and holistic way:

### Exhibit 22: Pillar 6 initiatives

#### Attributes of Pillar 6
- **Identification:** Identify service innovations and best practices in prevention and management, crisis services, re-entry services and develop tangible and achievable means to close capacity gaps.
- **Outcomes:** Increase coverage for BH services in commercial and Medicaid managed care.
- **Focus:** Increase provider satisfaction by reducing administrative burden and overhead for providers.
- **Characteristics:** Make progress towards aspirations of BH parity.

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Potential impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Enhance administrative processes and provider trainings to reduce provider burden</td>
<td>Convene agencies with directive to establish uniform standards for BRAVO providers, e.g., Provider (e.g., QMHP) training curriculum + Medicaid MCO administration practice</td>
<td>Work with Medicaid MCOs to coordinate delivery of common qualified mental health professionals (QMH) training</td>
<td>Evaluate effectiveness of QMH training</td>
<td>Improve service delivery quality and increase access to services</td>
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<tr>
<td></td>
<td>Develop public education campaign to build BH system awareness for individuals and providers</td>
<td>Work with Medicaid MCOs to improve administrative processes</td>
<td>Determine additional workforce focus for training standardization</td>
<td>Increase provider satisfaction by reducing administrative burden and overhead for providers</td>
</tr>
<tr>
<td>2. Assess and align BH provider network to address service gaps</td>
<td>Convene agencies to develop an analytical approach to determine BH network and workforce gaps</td>
<td>Implement MCO BH network accessibility and adequacy standards through re-procurement</td>
<td>Determine workforce network capacity priorities</td>
<td>Make progress towards aspirations of BH parity</td>
</tr>
<tr>
<td></td>
<td>Establish model to measure BH network adequacy and determine priorities</td>
<td></td>
<td>Monitor MCO performance on new network adequacy contract requirements, refine over time</td>
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<tr>
<td>3. Develop outcomes-based payment strategies</td>
<td>Design and plan for launch of CCBHC model (e.g., develop reimbursement model)</td>
<td>Build out CCBHC reimbursement model</td>
<td>Refine and scale CCBHC reimbursement model</td>
<td></td>
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<tr>
<td></td>
<td>Create an outcomes-based payment model that holds MCOs accountable for BH quality and outcomes</td>
<td>Award Medicaid MCO contracts that include BH outcomes-based payment standards (e.g., that increase PDI)</td>
<td>Continually refine and strengthen BH outcomes-based payment model in Medicaid MCO contracts</td>
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<tr>
<td>4. Increase youth BH support through specialized programs in Medicaid managed care</td>
<td>Explore design options for specialized program/services for children and youth BH through Medicaid managed care</td>
<td>Determine path forward for children/youth BH (e.g., Model of Care, specialized program/services)</td>
<td>Implement new programs and strategies</td>
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<td></td>
<td>Facilitate DSS/DMAS collaboration; focus on Model of Care for youth and notification processes</td>
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<tr>
<td>5. Work with commercial health plans to enhance BH service coverage</td>
<td>Determine opportunities and strategies to increase coverage for BH services in commercial insurance (e.g., enhancing Essential Health Benefits)</td>
<td>Implement changes to increase coverage of BH services and establish processes for managing and monitoring</td>
<td>Implement management and monitoring processes</td>
<td></td>
</tr>
</tbody>
</table>

Source: VA HHR, DBHDS data

1. **Enhance administrative processes and provider trainings to reduce provider burden.** Given the recent rollout of BRAVO services and the disruptions caused by the evolving pandemic, additional effort is required to train providers (e.g., Qualified Mental Health Professionals) on service offerings and requirements. Reviewing and aligning administrative requirements across Medicaid MCOs can also enable increased uptake of services among providers and allow providers to spend more time delivering care. Finally, additional efforts to create awareness about services among Virginians would increase understanding, access, and uptake.

2. **Assess and align BH provider network to address service gaps.** While the Medicaid MCO program includes standards for provider network accessibility and adequacy that each MCO must meet, these standards do not fully or holistically address the capacity needed in the system. Virginia would benefit from developing a deeper analytical understanding of Medicaid provider network capacity and gaps. It could benefit from exploring contract standards—including local response times and availability of behavioral health providers—while accounting for geographic variations. DMAS and licensing agencies can start by establishing a methodology to determine priority needs for specific behavioral health provider types and developing standards, measurement, and monitoring approaches to address them.

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

3. **Increase youth BH support through specialized programs in Medicaid managed care.** In several other states, the unique challenges involved in caring for youth with behavioral health needs enrolled in Medicaid have been addressed through specialized managed care standards or programs (e.g., Ohio’s OhioRise program). In Virginia, there are multiple entities involved in the provision of care for Virginia’s youth and children. The Medicaid model of care currently used in Virginia can be reviewed to encourage further collaboration between the local departments of social services (LDSS) and the Medicaid MCOs. This effort would yield stronger partnerships that benefit Virginia’s youth, children, and families. Additional consideration will be given to Medicaid managed care program design and model options for youth and children in need of behavioral health supports.

4. **Work with commercial health plans to enhance BH service coverage.** The actions described in this plan to strengthen the behavioral health system through Medicaid can be furthered through enhanced offerings from commercial insurers and the support of large employers in the state. Increased coverage for behavioral health services through commercial insurance (e.g., refinements to Essential Health Benefits) will be considered as an important step toward realizing the aspirations of behavioral health parity.

These initiatives will deliver results in three ways: (1) improving service quality and access to services for all Virginians; (2) increasing satisfaction for behavioral health providers by reducing administrative burdens; (3) making progress towards behavioral health parity.
Governor Youngkin will propose a series of immediate steps to bolster his three-year transformation plan, including over $230 million in new funding for behavioral health in his proposed amendments to the 2022-2024 Biennial Budget released on December 15, 2022. The centerpiece of these proposals will include a $20 million proposal to fully-fund 30+ new mobile crisis teams to respond to calls into Virginia’s 988 hotline. With this new funding, the Governor’s commitment to behavioral health will top $660 million in additional funding in the next fiscal year.

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

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

<table>
<thead>
<tr>
<th>Pre-crisis prevention services</th>
<th>Crisis care</th>
<th>Post-crisis recovery and support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pillar 1:</strong> We must strive to ensure same-day care for individuals experiencing behavioral health crises</td>
<td>• Expansion of mobile crisis units: $120M1</td>
<td></td>
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<tr>
<td></td>
<td>• Build out infrastructure for crisis receiving: $58.1M2</td>
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<tr>
<td></td>
<td>• Innovative hospital-based psychiatric emergency alternatives: $29M1</td>
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<tr>
<td><strong>Pillar 2:</strong> We must relieve law enforcement communities’ burden and reduce criminalization of mental health</td>
<td>• Mental health transportation plan: $4.1M</td>
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<td></td>
<td>• Support off-duty officer program: $1M</td>
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<tr>
<td></td>
<td>• Flexible use of mental health pilot program funds</td>
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<td></td>
<td>• Dedicated sworn officers for ECO/TDO: $4M</td>
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<tr>
<td><strong>Pillar 3:</strong> We must develop more capacity throughout the system, going beyond hospitals, especially community-based services</td>
<td>• Telehealth services for K-12 and higher ed: $1M</td>
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<td></td>
<td>• Expansion of school-based mental health services: $15M</td>
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<tr>
<td></td>
<td>• Plan for CIBHC Demo program: SAMSA grant in progress</td>
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<td></td>
<td>• CSB training: $1M CDC Grant</td>
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<td></td>
<td>• Improvements to waiver administration system: $0.5M</td>
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<td></td>
<td>• Increase rates for personal care, respite, and companion services: $41.1M3</td>
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<tr>
<td></td>
<td>• Fund 500 additional DD waiver slots: $11.3M</td>
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<tr>
<td><strong>Pillar 4:</strong> We must provide targeted support for substance use disorder and efforts to prevent overdose</td>
<td>• Campaign to reduce fentanyl deaths: $5M</td>
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<tr>
<td></td>
<td>• Increase access to Naloxone: $1M3</td>
<td></td>
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<tr>
<td></td>
<td>• Designate portion of opioid settlement fund for fentanyl: $7M</td>
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<tr>
<td><strong>Pillar 5:</strong> We must make the BH workforce a priority, particularly in underserved communities</td>
<td>• Additional funding for state facility staff: $18M1</td>
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<tr>
<td></td>
<td>• Additional psychiatric residency slots: $15M</td>
<td></td>
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<tr>
<td></td>
<td>• Additional loan repayments for psychiatric nurse and nurse practitioners: $1M</td>
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<tr>
<td></td>
<td>• Loan repayment for child and adolescent psychiatric providers: $3M3</td>
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<tr>
<td><strong>Pillar 6:</strong> We must identify service innovations and best practices in prevention and management, crisis services, re-entry services and develop tangible and achievable means to close capacity gaps</td>
<td>• Administrative costs for managed care organization re-procurement: $4.3M1</td>
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<tr>
<td></td>
<td>• MCO contract changes to be proposed in 2024 General Assembly session for approval</td>
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</table>

Source: VA HHR, Governor’s proposed 2024 budget

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1. $4.3M includes total funding for Medicaid procurement (not strictly BH components)
2. Includes DD and CCC Plus populations
3. Amounts are incremental to existing budget

33
Included in the Governor’s revised budget is:

- $20 million to fund 30+ new mobile crisis teams to meet the Year 1 statewide goal of responding to 988 hotline calls
- $58 million to increase the number of Crisis Receiving Centers and Crisis Stabilization Units, fully funding the number of necessary centers in Southwest Virginia and Hampton Roads
- $15 million to expand the elementary, middle, and high school-based mental health program to dozens of new communities
- $9 million to expand tele-behavioral health services in public schools and on college campuses
- $20 million for partnerships with hospitals to create alternatives to emergency departments for those in crisis
- $9 million for transportation and in-hospital monitoring by law enforcement and other personnel
- $8 million for Serious Mental Illness housing, creating 100 new placements for SMI patients with extraordinary barriers to discharge
- $57 million for 500 additional Medicaid Waiver Priority 1 Waitlist Slots and increased provider rates, including respite and companion services
- $15 million in opioid abatement initiatives including a campaign to reduce fentanyl poisoning among youth

1. This funding will be the “down payment” on successfully transforming the behavioral health system in Virginia. These installments are the first steps in establishing the necessary program infrastructure. As the workforce increases, community-based services are anticipated to increase and diversify. Once the system and infrastructure are in place, the cost is anticipated to be reduced, especially with the increased role of Medicaid and other insurers. Also, the increase in pre-crisis prevention services should result in fewer people in crisis care and post-crisis recovery, reducing the total cost of these services. In addition, if the post-crisis recovery and support system is more robust, then not as many people will return to crisis—relieving demand and cost on the system.
Conclusion

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

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

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

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

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

Appendix
Appendix A: Stakeholders engaged November-December 2022

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

- Behavioral Health Commission
- BHDS Board
- Board of Supervisors (Central)
- Board of Supervisors (Eastern)
- Board of Supervisors (Northern)
- Board of Supervisors (Western)
- Board of Supervisors Meeting (Southwestern)
- Central Virginia Health Services
- Chesterfield County Sheriffs
- Chesterfield Safe / Virginia Foundation for Healthy Youth
- Crossroads of Abingdon
- DBHDS Central Office Staff
- DBHDS State Facility Directors
- Endependence Center Inc.
- Hanover County Public Schools Counseling Services
- Highland Community Services
- Mental Health America Virginia
- Montgomery County Sheriffs
- National Alliance for Mental Illness – Virginia
- Opioid Abatement Authority
- The Arc of Virginia (Central)
- The Arc of Virginia (Northern)
- The Arc of Virginia (Tidewater)
- The Arc of Virginia (West)
• Virginia Association of Community Service Boards Conference
• Virginia Assn Community Based Providers
• Virginia Assn Health Plans
• Virginia Department for the Deaf and Hard of Hearing
• Virginia Foundation for Healthy Youth
• Virginia Hospital and Healthcare Association (Staff)
• Virginia Hospital and Healthcare Association (Steering Committee and other Members)
• Virginia Municipal League
• Virginia Network of Private Providers
• Virginia Municipal League - Mayors, City Managers (Central)
• Virginia Municipal League - Mayors, City Managers (Eastern)
• Virginia Municipal League - Mayors, City Managers (Western)
• VOCAL Virginia
• Warren County Community Health Coalition
• Warren High School
Appendix B: Summary of key crisis care system components (based on SAMHSA National Guidelines for Behavioral Health Crisis Care)

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

**Crisis care system components**

- Regional crisis call centers -- 988
  "Someone to talk to"
  Real-time access to a live person every moment of every day for individuals in crisis

- Mobile crisis teams
  "Someone to respond"
  Community-based intervention to individuals in need wherever they are; including at home, work, or anywhere else in the community

- Crisis receiving and stabilization facilities (e.g., crisis receiving chairs, short-term crisis beds)
  "A place to go"
  No-wrong-door access to mental health and substance use care (e.g., accepts all walk-ins, police drop-offs)

**Virginia’s current crisis care system**

- 2 regional crisis call centers
  - PRS-operated in Oakton, VA covers 4 regions
  - Frontier Health-operated in Johnson City, TN covers 1 region (southwest VA)

- 90 mobile crisis teams
  - 36 mobile crisis team units funded and staffed
  - 54 additional units in-flight

- 170+ crisis receiving chairs
  236 short-term crisis beds
  Provided by 17 CSBs with crisis stabilization services (2 for children only) and 25+ regional hub MOUs provide crisis stabilization services

Sources: SAMHSA, DBHDS data

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

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

**Average length of stay (ALOS) by state psychiatric hospital (days)**

- Piedmont
- Geriatric Hospital
- Eastern State Hospital
- Central State Hospital
- Southwestern Virginia Mental Health Institute
- Western State Hospital
- South Virginia Mental Health Institute
- Catawba Hospital
- Northern Virginia Mental Health Institute
- Commonwealth Center for Children & Adolescents

**Current utilization**

- 94%
- 97%
- 100%
- 99%
- 99%
- 88%
- 94%
- 97%
- 85%
- 95%

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