Office of the State Inspector General
Report to Governor McAuliffe
and the General Assembly

Virginia Department of Behavioral Health and Developmental Services
Discharge Assistance Program Performance Review

February 2014

Michael F.A. Morehart
State Inspector General

OSIG Report Number 2014-BHDS-005

COMMONWEALTH OF VIRGINIA

Office of the State Inspector General

Michael F.A. Morehart
State Inspector General

James Monroe Building
101 North 14th Street, 7th Floor
Richmond, Virginia 23219

Telephone (804) 625-3255
Fax (804) 786-2341

February 14, 2014

The Honorable Terence Richard "Terry" McAuliffe
Governor of Virginia
1111 East Broad Street
Richmond, Virginia 23219

Members of the Virginia General Assembly
General Assembly Building
Richmond, Virginia 23219

Re: *Performance Review of the Discharge Assistance Program administered by the Virginia Department of Behavioral Health and Developmental Services*

Dear Governor McAuliffe and Members of the General Assembly,

The attached *Report* contains the results of the Office of the State Inspector General's (OSIG) performance review of the Discharge Assistance Program (DAP) administered by the Department of Behavioral Health and Developmental Services (DBHDS). This review was conducted pursuant to the OSIG's authority contained in § 2.2-309.1(B)(1)&(2) Code *of Virginia*.

DAP funding provides supplemental funding to individuals who have been discharged from state-operated behavioral health facilities and supports them as they resume lives in their communities.

Reports by the Office of the Inspector General for Behavioral Health and Developmental Services (OIG-BHDS) in 2012 documented that approximately 13% the state-operated behavioral health beds were occupied by individuals determined to be discharge ready; while, at the same time, other individuals with mental illness were denied admission to state-operated hospitals because some facilities were at capacity.

In FY 2012, the DBHDS reported that the average annual cost to serve an individual in a state-operated behavioral health facility was $231,161, while the average cost to support a discharged individual living in the community with DAP funds was $27,027. In other words, on average, nine individuals could theoretically be served in the community for the cost of keeping one discharge-ready person involuntarily committed in the institutional setting of a state-operated facility.

While the OSIG was conducting this review, the DBHDS initiated new financial, data, and quality management improvements; identified additional services needed to reduce the Extraordinary Barriers List (EBL); and provided instructions for Community Service Boards (CSB) and Regions receiving DAP funding.[1] The OSIG believes these efforts, and the DBHDS's soon to be published *DAP Administrative Manual*, will provide for greater accountability and improve program efficiency and effectiveness.

The OSIG will provide updates to the Governor and the General Assembly on the DBHDS's progress implementing this *Report's* recommendations by means of its *Annual Report*.

If you have any questions concerning this *Report*, please contact me at (804) 625-3248, or I am always happy to meet with you at your convenience.

Respectfully,

Michael F. A. Morehart
State Inspector General

CC: Paul Reagan, Chief of Staff for Governor McAuliffe
John J. Pezzoli, Acting Commissioner, DBHDS

[1] *Analysis of Barriers to Discharge from State Hospitals, and Potential Solutions* dated May 28, 2013 (Appendix VII).

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Executive Summary

Across the Commonwealth today, the Discharge Assistance Program (DAP) is an integral part of the discharge planning process. The DAP provides supplemental funding to assist individuals who have been discharged from state behavioral health facilities with reintegrating into their communities. The DAP allows these individuals to exit state hospitals and resume their lives in the community.[1]

The Office of the State Inspector General's (OSIG) review of the DAP revealed the following:

i. The Department of Behavioral Health and Developmental Services (DBHDS) lacked documentation to support the DAP fund allocation methodology, as well as the current allocation of DAP funds to Community Services Boards (CSBs) and Regional Utilization Management Committees (regions).
ii. The DBHDS' DAP reporting requirements for CSBs and regions were inadequate.
iii. The DBHDS' audits of DAP funds were inadequate.
iv. The DBHDS lacked a documented strategy, including objectives, goals, and adequate performance measures, for the DAP.
v. The definition of discharge ready used by facility staff and community providers was misaligned.
vi. Most CSBs did not prepare an estimate of DAP plan costs until a willing community provider had been located.
vii. Insufficient community capacity existed to allow for the timely discharge of individuals from state-operated behavioral health facilities.
viii. The process of scrubbing, employed to identify unused DAP funds, is a best practice.

During this review, DBHDS took significant steps to address many of the issues identified in this report; however, additional steps remain that will, if undertaken, continue to enhance the efficiency, effectiveness, and economy of the DAP.

Statutory Authority

Pursuant to the *Code of Virginia (Code)* § 2.2-309(A)(9), the Office of the State Inspector General has the duty to "conduct performance reviews of state agencies to ascertain that sums appropriated have been or are being expended for the purposes for which the appropriation was made." The OSIG has the additional responsibility and authority under *Code* § 2.2-309.1(B)(2) to "Inspect, monitor, and review the quality of services provided in state facilities and by providers…."

Origin and Purpose of the Discharge Assistance Program

DAP funding was created in response to the 1999 U.S. Department of Justice (DOJ) finding that Virginians remained in psychiatric hospitals too long after they had been determined clinically ready for discharge from state-operated facilities.[2]

By FY 2000, DAP funding had grown into a statewide initiative at all adult behavioral health facilities. Across the Commonwealth today, DAP funding is an essential element in the active discharge planning process. The DAP provides supplemental funding to assist individuals who have been discharged from state-operated facilities with reintegration into the community. During FY 2012, 854 citizens received DAP funding.

For FY 2012, the DBHDS awarded $18.9 million in DAP funding to the state's CSBs and regions. The 2013 session of the General Assembly increased the DAP appropriation by $1.5 million for FY 2014.

Why review Discharge Assistance Program funding?

The DBHDS reported that the average annual cost to serve an individual in a state-operated behavioral health facility in FY 2012 was $231,161, while the average cost to support a discharged individual in the community with DAP funds was $27,027.[3] In other words, on average, nine individuals could theoretically be served in the community for the cost of keeping one discharge-ready person involuntarily committed in the institutional setting of a state-operated facility.

In 2012, the Office of the Inspector General-Behavioral Health and Developmental Services published the results of two statewide reviews. The reviews revealed that approximately 13% of state facility behavioral health beds were occupied by individuals determined clinically ready for discharge. At the same time, other citizens—determined to require hospitalization—were denied admission because some state facilities were full.[4]

Discharge Assistance Program Review Objectives

The four principal objectives of the OSIG review were to:

1. Evaluate the efficiency and effectiveness of the DAP in accomplishing its primary purpose of assisting individuals with their transition from state-operated behavioral health facilities to living in their communities and maintaining a successful community life.

2. Determine whether the funds appropriated for the DAP were administered in accordance with sound management and administrative practices and principles.
3. Determine whether DAP funds were spent for their intended purpose.
4. Identify DAP best practices and make recommendations to management that improve the efficiency, effectiveness, and economy of DAP administration.

Scope of the Discharge Assistance Program Review

The OSIG review focused primarily on FY 2012 DAP activity, it also included select FY 2011 and FY 2013 information pertaining to the utilization of DAP funding. In conducting this review, the OSIG relied on responses to questionnaires provided by the Commonwealth's 40 CSBs and the results of on-site reviews of the financial, administrative, and clinical records of 20 CSBs and five of the seven regions. The OSIG interviewed 174 individuals during this performance review: nine members of DBHDS executive leadership, 127 CSB staff members associated with DAP monitoring and management, and 38 DAP funding recipients. See Appendix III for the *Review Methodology* used for the DAP performance review.

[1] Throughout the state's public sector system of care, the acronym "DAP" is used as a surrogate for "discharge assistance planning," "discharge assistance project," or "discharge assistance program." When the acronym DAP is used in this Report, it means "discharge assistance program" and includes the actual appropriation and the state, regional, and local programming intended to assist individuals transitioning from state-operated facilities to return to their communities.

[2] U. S. Department of Justice, Civil Rights Division, *Findings from CRIPA Investigation of Western State Hospital, Staunton, Virginia:* October 6, 1999.

[3] During this review, both the number of persons served and the amount of annual DAP funding reported to us by the DBHDS changed.

[4] *Review of the Barriers to Discharge in State-Operated Adult Behavioral Health Facilities, OIG Report No. 207-12, issued by the Office of Inspector General for Behavioral Health and Developmental Services, April 25, 2012; and OIG Review of Emergency Services: Individuals meeting statutory criteria for temporary detention not admitted to a psychiatric facility for further evaluation and treatment, OIG Report No. 206-11, February 28, 2012.*

Background

History and Overview of the Discharge Assistance Program

DAP funding was created in response to a U.S. Department of Justice (DOJ) finding that some individuals in state-run psychiatric hospitals were kept after they had been determined clinically ready for discharge. By FY 2000, funding had grown into a statewide initiative encompassing all adult behavioral health facilities. Across the Commonwealth today, DAP funding is now a part of the active discharge planning process.

Historically, the DAP provided the funding to assist individuals discharged from state facilities that needed help outside of the basic array of community services. The assistance helped them address obstacles associated with their transition back into the community. When individuals were discharged, space became available in the state-operated psychiatric hospitals. This, in turn, allowed the admission of individuals requiring inpatient treatment.

According to the DBHDS, the first statewide DAP budget in FY 2001 was $11,890,526 and was initially projected to serve 441 individuals. In FY 2012, the DAP budget totaled $18,931,929 and served 854 individuals. During the 2013 session, the General Assembly increased DAP funding by $1.5 million for FY 2014.

According to information provided by the DBHDS, regional bodies are required to create practices consistent with DBHDS Regional Guidelines for managing, coordinating, and monitoring services provided, while also reviewing the effective utilization of these services.[5] In FY 2007, the DBHDS established a regional utilization management system for the oversight of DAP funding.

During the course of the OSIG DAP performance review, the DBHDS initiated its first formal internal review of the DAP and subsequently, on May 28, 2013, published the results in a document titled "Analysis of Barriers to Discharge from State Hospitals and Potential Solutions" (Appendix VII). This document announced that the DBHDS would undertake significant restructuring of its management oversight of the DAP and the Extraordinary Barriers List (EBL)—a list generated by DBHDS that identifies individuals in a state mental health facility who have been deemed clinically ready for discharge, but remain in the hospital for more than 30 days after that determination.

The restructuring included:

- Recognizing clinical readiness for discharge must be accompanied by the availability of suitable community-based services in order for a person to live outside of the hospital and acknowledging that "the lack of acceptable, available, and appropriate community services and supports results in delayed discharges."[6]
- Listing additional services needed to reduce the EBL, including:
    - a Program of Assertive Community Treatment (PACT), which would help individuals with a serious mental illness live in their communities.
    - stable and affordable housing.
    - additional intensive community residential treatment capacity.
    - other CSB residential services.
    - an expansion of discharge assistance capacity.
- Improving the overall practice and administration of the DAP and developing a *DAP Administration Manual* to standardize the determination of readiness for discharge across state hospitals.
- Standardizing Individual Discharge Assistance Program Plans (IDAPP) and DAP monitoring across regions.
- Improving the financial management of DAP.
- Refining and improving DAP data management.
- Developing a comprehensive quality improvement system for the DAP.

While the OSIG was conducting this review, the DBHDS outlined a new approach to managing DAP funding (Appendix VII) for the $1.5 million appropriated by the General Assembly for FY 2014. The new approach includes:

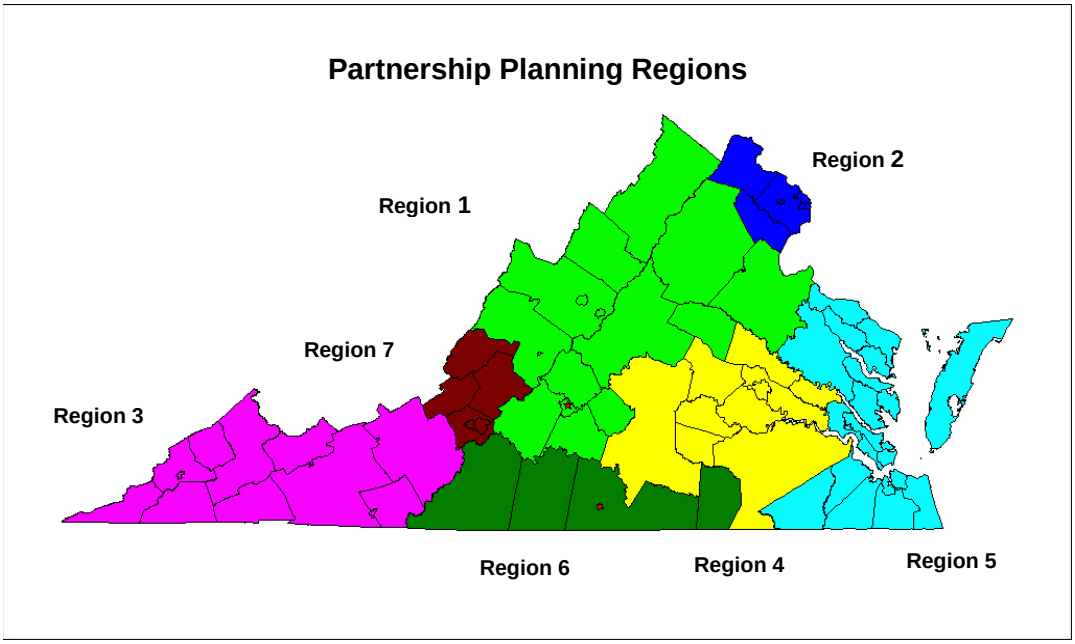
- Classifying the FY 2014 DAP funds as restricted.
- Declaring persons on the EBL as the priority population.
- Stating that the DBHDS will consider starting up new congregate housing programs in regions with significant numbers of persons on the EBL.
- Declaring that the DBHDS will not approve using FY 2014 DAP funds to address current regional or CSB fiscal deficits.
- Requiring that IDAPPs include reasonable and verifiable costs.
- Announcing that the DBHDS will establish a review team composed of headquarter staff, state hospital representatives, and the regions/CSBs to approve and fund IDAPPs.

The OSIG believes that this new approach to managing the DAP will improve the management of the DAP.

Planning Regions and the Discharge Assistance Program

There are five health planning regions (HPR) across the Commonwealth's service system, divided into seven partnership planning regions (PPR). The PPRs are similar to the HPRs with a few exceptions. PPRs are generally linked with an area served by a state facility, such as Western State Hospital, which predominantly serves PPR 1 and Northern Virginia Mental Health Institute, which serves PPR 2. These partnerships provide environments for addressing regional challenges and service needs and collaboratively plan and implement regional initiatives. Partnership participants include representatives from the CSBs, state facilities, community inpatient psychiatric hospitals, private providers, individuals receiving services, family members, advocates, and other stakeholders.

Figure 1: Partnership Planning Regions



Source: DBHDS Comprehensive State Plan, FY 2012–2018

Discharge Protocol

The DBHDS' behavioral health discharge protocol anticipates that discharge will occur within 30 days of the individual being determined clinically ready for discharge. Individuals whose discharge exceeds the protocol's defined 30-day limit are identified, and the barriers that prohibit their timely discharge are documented on the *Extraordinary Barriers to Discharge Form (DBH 1192)*. These individuals are then placed on the EBL until they are discharged, or they are no longer deemed clinically ready for discharge.

5 The framework for the regional management system is located on the DBHDS' website at: http://www.dbhds.virginia.gov/documents/occ-reg-utiliz-mgmt-guide.pdf.

6 Analysis of Barriers to Discharge from State Hospitals and Potential Solutions. Virginia Department of Behavioral Health and Developmental Services. May 28, 2013. Pursuant to § 2.2-309.1(B)(5), the OSIG will offer its comments and recommendations concerning this *d*ocument by separate management letter to the DBHDS.

Review Results

The Olmstead Decision

The U. S. Supreme Court found in its Olmstead decision that, once treatment professionals had determined that community placement was appropriate for an individual, continuing the involuntary commitment of a person with mental illness to a state institution was a violation of a person's civil rights under the Americans with Disabilities Act (ADA).[7] According to the Olmstead decision, discharge-ready individuals have a civil right to be discharged in a timely fashion from state institutions and treated in their community.

Virginia expanded the DAP initiative following a 1999 DOJ review that stated: "the Commonwealth does not have a sufficient number of community residential and other mental health support services to meet the needs of Western State patients. As a result, there are many patients at Western State whose treating professionals have determined that they are appropriate for discharge, but they remain hospitalized because needed community aftercare services are not available."[8]

Coinciding with DOJ's 1999 findings in Virginia, the court observed in the Olmstead decision that, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."[7]

Previous OIG-BHDS reports documented that discharge-ready people remained hospitalized for months due to a lack of available community resources—especially supported housing. The OSIG found that the DOJ's 1999 finding that Virginia lacked "a sufficient number of community supports" for the timely discharge of patients from state psychiatric hospitals remained applicable. See *"*Issue No. 8: Community Capacity***."***

The Utility of Discharge Assistance Program Funding

Thirty-three out of 40 DAP recipients the OSIG interviewed said they were satisfied with the services and supports they received as a result of DAP funding. Both support staff and recipients provided examples of the ways DAP resources were used to tailor supports to the unique needs of individuals.

DAP funds were described by 108 of 127 staff interviewed by the OSIG as the most flexible and person-centered funds in the behavioral health system.

Community-based DAP coordinators generally agreed that the flexibility of DAP is most apparent in allowing boards to support the Not Guilty by Reason of Insanity (NGRI) population during the conditional release process. Those interviewed reported that DAP funds were often used on a "one-time" basis to support community readiness assessment activities such as approved 8-hour to 48-hour passes that enable both the person and staff to gain a more comprehensive understanding of the person's readiness for release.

Discharge Assistance Program Funding Allocation

The process utilized to allocate DAP funds was described by the DBHDS as "multifaceted." The DBHDS stated: "the DBHDS manages the public behavioral health and developmental services system based on services and outcomes rather than by focusing on specific funding allocations." The DBHDS also stated: "As there have been no new DAP funds allocated since 2007, there has been no change in the allocation of funds from prior years."[9]

The review confirmed since at least 2007 CSBs have received substantially the same annual DAP funding, and certain criteria—fixed costs, service needs, historic service patterns, etc.—were not considered in the allocation of DAP funds. The review also found that the DBHDS did not have a documented strategy for the allocation of DAP funds, nor could it provide documentation to support the basis for the current allocation of DAP funds to CSBs and regions.

Issue No. 1: Funding Allocation

The DBHDS did not document its fund allocation methodology or process for the current allocation of DAP funds to CSBs and regions.

Recommendation

DBHDS should document its fund allocation methodology and maintain documentation to support its periodic reallocation decisions. The DBHDS' instructions to stakeholders on "MH 2014 DAP" funds sent on June 14, 2013, appears to provide a sound and reasonable framework for allocating DAP funds that could be used for the remaining $18.9 million in pre-FY 2014 DAP funds.

The DBHDS should evaluate the allocation of local and regional DAP funds annually, and then reallocate statewide DAP funding, as it considers appropriate, in order achieve maximum efficiency, effectiveness, and economy.

DBHDS Response to Issue No. 1

No formal documentation exists in a central location for all allocations of DAP state funds since the inception of the program. Prior to FY 2014, DAP allocations were based on Appropriations Act provisions, prevailing conditions, strategic priorities, and other factors such as the number of individuals on the state hospital extraordinary barriers to discharge lists for a region. For example, separate appropriations have been made over time for regional DAP funds, NGRI DAP funds, and local DAP funds. Whenever the DBHDS received appropriations of additional DAP funds, it communicated the conditions attached to the use of those funds to CSBs and documented the allocations in letters of notification.

Regarding the first recommendation, the DBHDS will develop a document by April 1 that describes the methodologies it used to allocate DAP appropriations prior to FY 2014. Regarding the second recommendation, based on its *Analysis Of Barriers To Discharge From State Hospitals and Potential Solutions*, the DBHDS added Exhibit C of the FY 2014 Community Services Performance Contract last August as Amendment No. 3, and provisions in Exhibit C authorize the DBHDS to reallocate state DAP funds among regions if specific criteria in the exhibit are not met.

OSIG COMMENT:

The DBHDS acknowledges above that, prior to the OSIG review, there was no "formal documentation" describing a formula for the allocation of FY 2012 DAP funding.

While the OSIG was conducting this review, the DBHDS created new financial, data, and quality management improvements, identified additional services needed to reduce the EBL, and provided instructions for CSBs and Regions receiving DAP funding. These improvements will introduce a measure of accountability in the DAP and are contained in the appended *Analysis of Barriers to Discharge from State Hospitals, and Potential Solutions* dated May 28, 2013 (Appendix VII).

The OSIG questions several items contained in the *Analysis of Barriers to Discharge, and Potential Solutions* document and will provide a separate management letter to the DBHDS noting areas of concern pursuant to *Code* § 2.2-309.1(B)(5) that requires the OSIG to "review, comment on, and make recommendations about, as appropriate, any reports prepared by the Department…."

Discharge Assistance Program Reporting Requirements

In 2010, the DBHDS changed DAP funding from restricted to earmarked. DBHDS management informed the OSIG this change was intended to enhance flexibility and improve efficiency through removing impediments to CSB use of DAP funds to meet patient needs. As a result of this change, CSBs were afforded greater latitude and fewer reporting requirements with respect to the expenditure of DAP funds.

The OSIG concurs with the DBHDS' premise that flexibility with respect to the use of DAP funding by CSBs is beneficial to ensuring that the needs of discharge-ready patients be addressed more promptly.

However, the OSIG review noted that on at least two occasions the DBHDS' emphasis on flexibility in combination with reduced reporting requirements resulted in DAP funds being used for non DAP-related purposes. During the course of this review the OSIG identified two CSBs that reported using "earmarked" unexpended year-end DAP funds totaling approximately $187,000 to support non DAP-related operating budget shortfalls, including supplementing the operating budget for a clubhouse and emergency services expenses.

In response to the aforementioned finding, the DBHDS stated that the expenditures: "may have been related to DAP directly or indirectly, but without the necessary detail, the DBHDS cannot determine if use of these funds was appropriate."[9]

The review also disclosed that regions experienced a cumulative FY 2012 year-end DAP fund balance, which totaled $1,650,000. After the completion of the OSIG field work, the DBHDS provided the OSIG the following FY 2009 and FY 2010 year-end DAP fund balances:[9]

- FY 2009 $1,475,799
- FY 2010 $1,692,887

With respect to the balances, the DBHDS stated: "the existence of unspent funds in the DAP at any point in time is to be expected due to the unique nature of the DAP and timing of the flow of resources within it."[9]

Additionally, the DBHDS stated the following regarding unspent DAP funds:

> "Consequently, at any point in time, there are five types of unspent state DAP funds:[9]
>
> - funds that are committed for ongoing approved IDAPPs but not yet spent,
> - funds that are committed for one-time approved IDAPPs but not yet spent,

- funds that are obligated for future ongoing IDAPPs not yet initiated,
- funds that are obligated for future one-time IDAPPs not yet initiated, and
- unobligated state DAP funds that subsequently may be obligated for new IDAPPs."

The OSIG does not dispute the DBHDS' statements regarding the classification of these funds. However, the review disclosed that the DBHDS did not require CSBs or regions to report the status of such funds, and consequently, had no mechanism to distinguish obligated or committed funds from available unspent funds that might have been utilized for higher priority purposes.

The OSIG noted that the DBHDS, in an email dated June 14, 2013, entitled "New FY 2014 DAP State Funds Allocation Process" (Appendix III), instructed CSBs and regions that the $1.5 million in recently appropriated DAP funding ("MH 2014 DAP") was restricted and would be used to reduce the EBL. All IDAPP using this $1.5 million would be reviewed and approved by the DBHDS, the state hospital, and the regional manager.[10]

This process will improve management control over the $1.5 million appropriation; however, the remaining $18.9 million earmarked DAP funds not subject to the DBHDS' June 2013 DAP protocols should also be addressed.

Issue No. 2: Inadequate Reporting Requirements for Regions and Community Service Boards

The DBHDS could not confirm actual FY 2012 DAP expenditure amounts, uses, or levels of service provided. The OSIG review determined this was in part attributable to relaxed reporting requirements resulting from DBHDS' FY 2010 change in the classification of DAP funds from "restricted" to "earmarked." As a direct result of this change, CSBs were no longer required to periodically report actual DAP fund expenditures to DBHDS (Appendix IV).

Recommendation

The DBHDS should require regions and/or CSBs to submit sufficiently detailed periodic financial reports and require timely review of same by management to ensure funds have been expended in accordance with their intended purpose.

In the absence of the aforementioned controls, the DBHDS should reconsider its policy and restrict all DAP funds. This would improve DBHDS' ability to adequately manage DAP funds statewide and significantly enhance recipient accountability, as well as the

DBHDS' ability to more closely monitor and ensure that the DAP is administered efficiently, effectively, and in accordance with intended purposes.

DBHDS Response to Issue No. 2

While the DBHDS has not verified actual DAP state fund expenditure amounts, DBHDS reporting does account for the uses of all DAP dollars and levels of services provided. Regarding the first recommendation, Exhibit C of the FY 2014 Community Services Performance Contract now requires CSBs and regions to report actual expenditures of DAP state funds and amounts of obligated but unspent state DAP funds, documenting that DAP funds have been expended for their intended purpose. Regarding the second recommendation, the DBHDS restricted new FY 2014 DAP funds and has indicated in its *Analysis Of Barriers To Discharge From State Hospitals and Potential Solutions* that it reserves the option of restricting other state DAP funds in the future if conditions listed in the *Analysis* are not met. Consequently, the DBHDS has determined that it is not necessary to restrict all state DAP funds at this time.

OSIG COMMENT:

The DBHDS's assertion that its reporting "…does account for all uses of all DAP dollars and levels of service provided" was not supported by the OSIG review results. Several instances were noted where DAP funds were spent for non-DAP purposes. While the DBHDS accounts for levels of service delivered through the Commonwealth's CSB system, it does not track, or account for, the actual expenditure of DAP funds.

The DBHDS acknowledges in its May 28, 2013 *Analysis of Barriers to Discharge* document that "This situation, where multiple DAP fund allocation and disbursement methods are at work simultaneously, complicates monitoring, financial reporting, and maximum utilization of all DAP funds." Also, "that CARS, CCS and regional DAP data do not reconcile with sufficient accuracy, which compromises oversight and monitoring." (Appendix VII)

The OSIG disagrees with the DBHDS's decision not to classify DAP funds as "restricted" – as had been the practice until 2010 – and requests that the DBHDS provide justification for reduced accountability following the OSIG's review that concluded DAP funds were used for non-DAP purposes.

Audits of the Discharge Assistance Program

The OSIG review revealed that historically the DBHDS had performed an annual audit of four out of 40 CSBs and had never audited regions. Additionally, DBHDS had not reviewed or audited DAP funds until the OSIG review of DAP commenced in October 2012.

The DBHDS advised that it performed annual risk assessments of all 40 CSBs and also examined the results of independent external audits, but these were "not specifically targeted on the DAP."[9] During FY 2012 and 2013 the DBHDS conducted five CSB reviews, as well as follow-ups related to previous years' reviews. The DBHDS added protocols specific to the DAP in FY 2013 related to the control and compliance environment in which the DAP operated.[10] However, the DBHDS pointed out that its Internal Audit Program did not have the staff necessary to expand DAP audits.

The OSIG review, while acknowledging the DBHDS' efforts and its personnel resource limitations, found that DAP-related audit efforts continue to be inadequate, particularly with regard to the management control inadequacies discussed throughout this report.

Issue No. 3: Audit of Discharge Assistance Program Funds

Historically, the DBHDS reviewed four out of 40 CSBs each year and did not audit regions' or CSBs' use of DAP funds.

Recommendation

The DBHDS should:

- Take steps to enhance the number and frequency of CSB reviews.
- Review regions and their use of DAP funds.
- Ensure that reviews include an audit of DAP funds.

DBHDS Response to Issue No. 3

Regarding the recommendation, the Community Services Performance Contract requires financial audits of CSBs, and the DBHDS conducts program and financial reviews of selected CSBs annually. The DBHDS conducted new reviews of four CSBs and follow up reviews of two other CSBs in FY 2014. However~~,~~ The DBHDS concurs with the recommendation to increase the number of CSBs for which it conducts program and financial reviews annually. While requests for the additional internal audit and program staff needed to conduct additional reviews compete with other high priorities such as expanding services to meet critical unmet needs, the DBHDS will continue to seek new resources to conduct reviews of additional CSBs.

The DBHDS currently reviews the regions' use of state DAP funds regularly through DBHDS staff participating in meetings of regional utilization bodies and reviewing regular reports on the use of DAP funds. Staff are non-voting members of regional utilization management committees. Staff attend at least monthly regional committee meetings where census management issues including IDAPP determinations are made and the status of all DAP funding in a region is reviewed. These meetings review, change, and approve individual IDAPPs or assignments of IDAPPs; review current and anticipated ongoing and one-time DAP funding; and review the status of IDAPP enrollees currently supported in the community. Information from these meetings is often also communicated to other regional management structures and meetings that DBHDS staff attends, including regional IDDAP scrubbings, state hospital and CSB discharge planner meetings, and regional leadership team meetings. The DBHDS added program reviews of DAP services to its CSB reviews and will add financial reviews of the use of DAP funds to these reviews in FY 2015. The DBHDS will describe these activities in the *DAP Administrative Manual*, which will be issued by April 1, 2014.

OSIG Comment:

The OSIG restates its finding that, prior to this review, the DBHDS historically audited four CSBs each year, along with the recommendation that the DBHDS take steps to enhance the number and frequency of CSB audits.

Discharge Assistance Program Performance Management

The review revealed that the DBHDS lacked a documented strategy that included prioritized objectives and goals, as well as adequate performance measures necessary to accurately assess DAP performance and to proactively guide the DBHDS', CSBs', and regions' coordinated administration and management of the DAP.

The OSIG found that DBHDS used a single performance measure—changes in the number served—to evaluate the DAP's success. That is, according to DBHDS, the success of DAP was demonstrated by the fact that in FY 2012 it served 854 individuals, compared to the originally projected 441 individuals (Appendix II).

Utilizing the number served as a performance measure does portray the general success of the program through the lens of increased population served; however, the use of a single performance measure does not provide a comprehensive or accurate measure of performance. To fully assess performance other measures must be evaluated, such as the number of

individuals awaiting discharge (including those on the EBL), length of stay on the EBL after having been determined ready for discharge, individual DAP cost, etc.

The DBHDS also measured the performance of the EBL by focusing only on the increase or decrease in the number of individuals included on this list. However, using this single performance measure, without also assessing average length of stay, did not provide a complete evaluation of performance.

In October 2012, the DBHDS' *DAP Summary* stated that the "Current EBL is 148; down from the average of 165 reported in [the] April 2012 OIG-BHDS Study [Appendix II]." The OSIG agrees that the number of people discharged is a key performance measure. However, taking a snapshot of any single month, especially without considering the average length of stay for each individual on the EBL, is an incomplete method of measuring performance that could result in ambiguous results.

As depicted in *Figure 2*, there were fewer people on the EBL in July 2012 than in January 2012; however, the average length of stay (LOS) had increased by 20 days per person. The cumulative cost to the Commonwealth (based upon averages supplied by the DBHDS) for serving this discharge ready group continued to grow, even though the number of individuals on the EBL had decreased.

Figure 2—Cost Difference Between 1/1/12 and 7/1/12 to Maintain Individuals on the EBL

Date	Number of Individuals	Average Time on List (LOS)	Facility Bed Days on List*	Daily Cost to Virginia ($633/Day)**
1/1/12	165	246	40,590	$25,693,470
7/1/12	161	266	43,092	$27,108,858

***** Facility bed days is the product of multiplying the number of people on the EBL by the average LOS for the same period.
****** $633/day is the DBHDS' published annual cost of $231,161 divided by 365, yielding an average cost for a bed day at all state-operated facilities.

Issue No. 4: Performance Management

The DBHDS lacked a documented strategy that included objectives, goals, and adequate performance measures necessary to more efficiently and effectively administer and manage the DAP.

Recommendation

The DBHDS should develop, document, and periodically review (at least semi-annually) DAP-specific goals, objectives, and performance measures to enhance DAP

management. The OSIG concurs with the recent recommendations of the DBHDS' private sector consultant that the "Department should consider organizing around strategic and programmatic functions" and "linking performance to outcomes." For example, the program should develop objectives, goals, and measures centered on issues such as addressing barriers to discharge.

DBHDS Response to Issue No. 4

Regarding the recommendation, the DBHDS concurs with this recommendation and will develop meaningful performance goals and measures for the DAP. The goals and measures will be included in the forthcoming *DAP Administrative Manual* and will be effective for FY 2015.

OSIG COMMENT:

The OSIG requests that the DBHDS provide a copy of the *DAP Administrative Manual* describing DAP objectives, goals, and performance measures to the OSIG for review and comment.

The Extraordinary Barriers List

The Extraordinary Barriers List and Discharge Assistance Program Funding

The DBHDS stated that the DAP is intended to address the *Olmstead* decision and the EBL of each state hospital. Therefore, it is appropriate to evaluate the use of DAP funding in relation to the EBL.

In July 2012, there were 161 adults on the EBL. The table below (*Figure 3*) illustrates the fiscal impact of the EBL on the Commonwealth. This table displays the LOS for each person (from the date they were originally placed on the EBL to July 1, 2012) multiplied by the average cost per bed day for each individual's facility. The average cost per person is less for those facilities with the lowest LOS than for the facilities with longer LOS.

Figure 3. Summary of Costs for Persons on the EBL as of July 2012

FACILITY	Total # on EBL	Average LOS on EBL in Days	Average Cost Per Person	Total Costs for Persons on EBL
Catawba	12	234	$151,033	$ 1,812,393
Central State	16	123	$78,241	$ 1,251,852
Eastern State	57	283	$195,691	$ 11,154,365
No VA MHI	27	373	$246,473	$ 6,654,763

FACILITY	Total # on EBL	Average LOS on EBL in Days	Average Cost Per Person	Total Costs for Persons on EBL
Piedmont	19	226	$147,536	$ 2,803,175
Southern VA MHI	18	286	$171,752	$ 3,091,527
Southwestern VA MHI	5	147	$86,508	$ 432,540
Western State	7	272	$161,362	$ 1,129,534
Totals	**161**	**266**	**$ 175,964**	**$ 28,330,149**

Source: Data furnished to OSIG by DBHDS in response to OSIG review inquiries. April 2013.

The above summary of costs for persons on the EBL as of July 2012, combined with the illustration of calculated costs for hospital vs. community care below, suggest that the Commonwealth likely spent millions of dollars more to serve individuals at a level of care that they had been clinically determined to no longer require.

Illustration of Hospital Care Costs vs. Community Care Costs

The OSIG's review of DBHDS records revealed that 104 individuals (of the 161 depicted in *Figure 3*) were removed from the EBL between July 2012 and March 2013. Of this group, 73 were discharged, twenty-one were removed from the list because they decompensated, two individuals died, and eight individuals were removed from the list for reasons that were unclear. Of the 73 individuals discharged, 42 received DAP assistance.

According to the sponsoring CSBs, the average DAP plan amount for each of the 42 individuals discharged during the first nine months of FY 2013 was $28,455. Using the 42 discharged individuals from above as an example, based on the mean average provided by the CSBs, if the 42 discharged individuals had been served in a community-based program for the average (daily) DAP cost for 266 days of community-based care instead, the cost would have been approximately $871,416 ($78 per day x 42 individuals x 266 days) compared to approximately $7,395,864 ($662 per day x 42 individuals x 266 days) in state-operated facilities. In other words, based on the average expense supplied by the DBHDS, it would have cost an estimated $6.5 million ($7,395,864 – $871,416) more to serve the 42 recently discharged individuals in state-operated facilities than to serve them in their communities with DAP funds.

Barriers to Discharge

Suitable, affordable housing with appropriate supervision and supports remains the primary barrier to discharge for individuals on the EBL.[11] Data provided by the CSBs revealed that securing suitable residence was the main barrier for about two-thirds of the individuals on the

EBL in July 2011. Access to nursing homes, assisted living facilities, and other residential options that provide either increased structure or supervision were determined to be the housing options of greatest need.

The OSIG review confirmed that, not only were limited beds available, but even when residential options existed, providers were not always willing to provide services to individuals on the EBL because of complex medical issues and/or challenging behaviors. Specialized services to address the complex needs of individuals on the EBL are often necessary for assuring success in the community (Issue No. 8: Community Capacity).

Differences in Definitions of Discharge Ready

DBHDS' *Discharge Protocols*[12] state that clinical readiness for discharge occurs when a person no longer meets criteria for involuntary treatment (imminent danger to self or others) or has received maximum benefit from hospitalization. The majority of discharge liaisons interviewed during this review reported that CSBs were often unwilling to accept individuals from state facilities who had either behavioral challenges or behavioral challenges coupled with medical complications. Inpatient hospital settings, which are highly supervised and structured, offer more therapeutic options for behavioral and medical interventions than the vast majority of community settings.

Successful integration of individuals with either behavioral challenges or behavioral challenges coupled with medical complications often requires that the community program setting mirror the level of supervision and structure of the state facility. As a result, if the community program lacks the supervision and structure corresponding to the hospital setting, the CSBs do not always consider the patient to be discharge ready. Residential programs that emulate inpatient supports are rare, and when they do exist, there is no guarantee that the community programs will be "willing providers." This results in disconnect between the definitions of ready for discharge.

During this review, providers and liaisons confirmed that this facility/community disconnect contributed to the extended delay of persons being discharged from the facilities. According to results from an OSIG DAP survey, 60% of community providers shared concerns regarding assuming preventable risks to the person, or their community, associated with inadequate community supports prior to discharge.

Issue No. 5: Differing Definitions of Discharge Ready

The definition of clinically ready for discharge used by state hospital facility staff was different than the definition used by CSBs and community providers.

The transition of individuals between state facilities and community services was hampered because the community definition of discharge ready was not aligned with the facility definition and programs in the community sometimes did not mirror the levels of support available in state-operated facilities.

RECOMMENDATION

The DBHDS should assure that community providers and facility clinicians develop a common understanding and use the same criteria for determining when an individual is discharge ready.

DBHDS Response to Issue No. 5

The definition of clinical readiness for discharge used by state hospital staff and CSB staff is the same. It is based on the Department's definition that has been used consistently across the services system for more than six months. The transition of individuals from state hospitals to community services has not been hampered by a non-alignment of the definition of clinical readiness for discharge; it may have been hampered by disagreements about the availability of needed community services for a particular individual.

Regarding the recommendation, two factors determine an individual's discharge from a state hospital. The first factor is that an individual has received the maximum benefit of hospitalization, no longer needs inpatient psychiatric treatment, and is clinically ready for discharge. In July, 2013, all state hospitals and treatment teams began using a four-level scale to standardize the determination of clinical readiness for discharge for the first factor. The four levels are that the individual is:

1. clinically ready for discharge,
2. approaching clinical readiness for discharge,
3. not clinically ready for discharge, or
4. experiencing significant clinical instability limiting privileges and engagement in treatment.

Each level has associated behavioral anchors that define the specific conditions associated with each level of clinical readiness for discharge. All CSBs and facilities use this methodology in the discharge planning process and to communicate about an

individual's clinical readiness for discharge. Thus, there is no confusion about this rating scale or its implementation. The second factor is the availability of the array of community services identified in the individual's discharge plan. The DBHDS acknowledges there may be some confusion about the application of these two factors and will provide additional guidance and clarification about their implementation in the forthcoming *DAP Administrative Manual*.

OSIG COMMENT:

As acknowledged by the DBHDS above and supported by the OSIG, consistency in determining discharge readiness has been recently established among the facilities. The OSIG recommends that the DBHDS survey CSBs to understand why they expressed concerns during the OSIG's review process that facilities viewed discharge readiness differently than community providers.

The OSIG notes with approval the DBHDS's recent commitment to standardize the terminology and nomenclature surrounding discharge readiness. Additionally, we endorse the DBHDS's stated intention to use the data gathered by more closely monitoring the DAP to identify unmet service needs in the community that have historically interfered with the timely discharge of individuals from state facilities.

Misalignment of Discharge Policy and Practice

The OSIG review of DBHDS policies and practices that document the extraordinary barriers to discharge and needs upon discharge revealed that the policies and practices did not reflect more recent DBHDS facility and CSB changes in clinical practice, which are more recovery-oriented and person-centered than was the case in the early 2000s. This misalignment is illustrated by comparing and contrasting the *Needs Upon Discharge Form*, *Wellness Recovery Action Plan (WRAP)*, and the *Discharge Summary* forms.

The *Needs Upon Discharge Form*, designed to identify the services and supports necessary for an individual to successfully reside in the community, functions more as a tracking tool than a treatment planning tool that actively engages the individual who must ultimately have a sense of ownership of the community transition plan. The form and the *Discharge Summary* do not consistently incorporate the needs that individuals identify in *WRAPs*, a tool that DBHDS and consumer groups stress as essential to promoting greater self-direction and personal accountability.

This lack of a fully aligned discharge planning process ultimately reduces the likelihood of an individual being exposed to a consistent message of recovery and person-centeredness during treatment. Additionally, given that the *Needs Upon Discharge Form* drives the development of

the individualized service plan and the DAP plan, an alignment is essential for the development of a realistic, coherent, and fiscally sound plan of action.

Case Study illustrating the misalignment of discharge policy and practice

The individual entered a Virginia state mental health (MH) facility in 2012 on transfer from another state MH facility and was discharged to the community after four months of inpatient treatment. At a recertification hearing, the hospital staff recommended to the Special Justice that the person be transferred to another setting. The recommendation was based on the individual having an intellectual disability (ID) diagnosis in addition to the admitting MH diagnosis and the apparent unresponsiveness to treatment interventions at the mental health facility. The Special Justice gave the facility and the CSB 60 days to find another placement.

As part of their discharge planning process, the CSB staff visited the individual three days before a follow-up hearing scheduled to monitor progress. At the hearing, it was reported by facility staff that the individual no longer had an Axis 1 diagnosis, although the individual was being treated with a number of psychotropic medications and had a history of MH diagnosis, including PTSD, major depression, dissociative disorder, and bipolar disorder. The removal of the Axis 1 diagnosis was not discussed with the CSB in advance of the hearing.

The Special Justice noted that since there was no Axis 1 diagnosis, the individual could not remain at the state MH facility, and discharge within seven days was required. The CSB is now supporting the individual with a DAP plan developed over time that annually costs approximately $105K. The individual had at least one psychiatric readmission since discharge.

Issue No. 6: Misaligned Discharge Policies and Practices

Policies and practices for discharge and extraordinary barriers should reflect the goals and objectives of their related programs. In the case of clinical policy regarding documentation of the extraordinary barriers to discharge, the actual clinical practice uses more recovery-oriented and person-centered methods. As an example, the *Needs Upon Discharge Form* serves as a tracking tool and not a treatment planning tool. This form and the related *Discharge Summary* do not consistently incorporate the needs from *WRAPs*. This disconnect exists because the forms only identify the services and supports necessary for the person to successfully reside in the community and can hinder the development of a meaningful community transition plan.

Recommendation

The DBHDS should assure DAP discharge policies and practices are aligned with the goals and objectives of recovery-oriented and person-centered methods. Specifically, the *Needs Upon Discharge Form* and the *Discharge Summary* should incorporate the needs from *WRAPs*.

DBHDS Response to Issue No. 6

Regarding the recommendation, the DBHDS believes current discharge policies and procedures are recovery-oriented and person-centered. The state hospital treatment team develops the needs upon discharge form, which lists the needs an individual will have upon leaving the state hospital, with the active participation of the individual. A WRAP is an individual's personal guide to maintaining his or her own recovery, but it is not a clinical record developed by hospital staff. Although all state hospitals support WRAP planning, not all individuals may want to develop a WRAP. A WRAP informs treatment and discharge planning along with other sources of information about personal preferences and needs. The discharge summary is prepared by the treatment team following discharge.

OSIG COMMENT:

The OSIG appreciates the difference between WRAPs and the *Needs Upon Discharge Summary* and suggests that, consistent with the values of person-centered recovery, the WRAP serve as one resource to inform the development of the *Needs Upon Discharge Summary*.

Discharge Assistance Plan Cost Projections

All but one of the 20 CSBs visited reported that the projected costs for implementing plans were not established until a community provider had been identified, despite the existence of historical data that could have been used to create a budget for planning purposes. The lack of an estimate pending discharge assistance minimizes opportunities for rapid action on one-time plans that could be supported with year-end balances within a region, or from statewide balances that are not expected to be ongoing. Moreover, the lack of any standardized process for estimating the cost of pending DAP plans reduced opportunities for DBHDS to identify the statewide need for funding during the budget planning process.

Issue No. 7: Individual Discharge Assistance Program Plan Estimates

Most CSBs did not prepare an estimate of DAP plan costs until a willing community provider had been located.

Despite the availability of historical data, only one of the 20 CSBs visited during the review reported creating estimated DAP plan costs for individuals before a community provider agreed to serve the person. The lack of an estimate minimized the opportunity for rapid action on one-time plans that could have been funded with year-end DAP balances.

Recommendation

DBHDS should work with CSBs and regions to assure that DAP plan estimates are prepared when a person is placed on the EBL. The funding needed to serve individuals on a CSB or region EBL could be quantified.

DBHDS Response to Issue No. 7

CSBs move the discharge planning process forward by identifying and confirming placements, any supports required, service providers and, if needed, DAP supports. CSBs do not prepare an estimate of an IDAPP's cost early in the discharge process because of the many changing variables that can affect the final cost. For example, the individual's service needs or preferences may change, providers may no longer have available slots in their services, or the individual's circumstances may change. Because the final cost can vary significantly from an initial estimate, this practice would encumber resources needlessly that then would not be available to serve someone else and would result in less efficient use of the resources.

Regarding the recommendation, while the DBHDS has concerns that this recommendation may serve as a barrier to rapid deployment of resources, it will review the applicability, feasibility, and desirability of this recommendation with representatives from CSBs, the regions, and state hospitals by April 1, 2014.

OSIG COMMENT:

The OSIG's recommendation was not that DAP resources be encumbered. The OSIG recommended that CSBs prepare DAP plan estimates to facilitate the rapid deployment of unspent DAP funds—especially at fiscal year-end. The fact that the service needs of some individuals may evolve should not preclude reasonable planning to estimate the cost for serving all discharge ready individuals.

The process envisioned by the OSIG is not unlike the DBHDS requirement for "MH 2014 DAP" that requires the development of pre-discharge DAP plan estimates in order to access MH 2014 DAP funds, except that the development of DAP plan estimates is unrelated to DBHDS approval as with the MH 2014 DAP funds. (Appendix VI)

Regional Management Utilization Management Committees

As discussed in the Background section of the report, the state is divided into five Health Planning Regions (HPR) and seven Planning Partnership Regions (PPR). Each state facility is associated with a particular PPR as demonstrated in *Figure 6*.

Figure 6: PPRs and Associated CSBs

Partnership Planning Region	Community Services Boards
PPR 1 Northwestern Region Western State Hospital	Horizon Behavioral Health Authority (BHA), Harrisonburg-Rockingham CSB, Northwestern Community Services, Rappahannock-Rapidan CSB, Rappahannock Area CSB, Region Ten CSB, Rockbridge Area Community Services, and Valley CSB
PPR 2 Northern Region Northern Virginia Mental Health Institute	Alexandria CSB, Arlington County CSB, Fairfax-Falls Church CSB, Loudoun County CSB, and Prince William CSB
PPR 3 Southwestern Region Southwestern Virginia Mental Health Institute	Cumberland Mountain CSB, Dickenson County Behavioral Health Services, Highlands Community Services, Mount Rogers CSB, New River Valley Community Services, and Planning District One Behavioral Health Service
PPR 4 Central Region Central State Hospital	Chesterfield CSB, Crossroads CSB, District 19 CSB, Goochland-Powhatan Community Services, Hanover County CSB, Henrico Area Mental Health and Developmental Services Board, and Richmond BHA
PPR 5 Tidewater Region Eastern State Hospital	Chesapeake CSB, Colonial Behavioral Health, Eastern Shore CSB, Hampton-Newport News CSB, Middle Peninsula-Northern Neck CSB, Norfolk CSB , Portsmouth Department of Behavioral Healthcare Services, Virginia Beach CSB, and Western Tidewater CSB
PPR 6 Southern Region Southern VA Mental Health Institute	Danville-Pittsylvania Community Services, Piedmont Community Services, and Southside CSB
PPR 7 Catawba Region Catawba Hospital	Alleghany Highlands CSB and Blue Ridge Behavioral Healthcare

Source: DBHDS Office of Community Contracting

Individuals' access to and discharge from state hospitals and publically funded care provided by private psychiatric hospitals is managed by regions. Active regional management is challenged

by the continuing loss of both public and private psychiatric beds and by regional differences in needs, resources, and service availability.

Interviews with DBHDS leadership and CSB executive directors revealed that a review of regional adherence to the established guidelines has never occurred, although the DBHDS guidance document recommends the establishment of "meaningful and workable measures to assess the success of regional utilization management processes in each region." Perhaps because there has never been a statewide examination of the regional system, the OSIG discovered a wide variation in data collection, management funding philosophy, and utilization of resources across the Commonwealth. See "Issue No. 3: Audit of DAP Funds."

According to the DBHDS' *Regional Utilization Management Guidance* (2007), there are two pertinent measures of success for the regions:

1. Inpatient psychiatric hospital beds are available within a reasonable time for individuals in crisis who cannot be diverted to less intensively structured alternatives, such as crisis intervention or stabilization services, and who need these beds; or
2. Consumers no longer in need of acute care services do not remain in those settings.[13]

Based on the above DBHDS definitions, the regional utilization management organizations cannot be considered a success.

The previously cited 2012 OIG-BHDS reports document that hundreds of people statewide were denied admission to state facilities for temporary detention, while state facility beds were occupied by people that had been determined clinically ready for discharge, but who nevertheless remained institutionalized for an average of eight months.[14]

Recently, the DBHDS proposed that "All local and regional DAP funds allocated within the region shall be managed by the regional utilization review and consultation team in the region on which the CSB participates [Appendix III]." Based on the demonstrated inability of the regional utilization teams to achieve success to date, the OSIG cannot endorse the DBHDS' stated intention to transfer DAP management to these regional entities.

The two previously described measures of success highlight the interdependence between the state-operated facilities and CSBs to provide timely access to services at the most appropriate and least restrictive level of care. The decrease in public and private psychiatric beds during the

last decade, while the state's population has increased by more than 10%, has not been accompanied by a commensurate expansion of community-based programs and resources.

The practical result of this imbalance is that some state facilities are unable to discharge stabilized residents, who have been determined clinically ready for discharge, and return them to their communities. At the same time, other individuals needing admission under temporary detention orders are denied admission to a state hospital because the beds are occupied by persons that have been determined to be clinically ready for discharge.

CSBs have no control over a number of admissions to the state facilities including: transfers of forensic patients to civil status in state hospitals, jail transfers, and inter-facility transfers. These admissions complicate regional utilization management activities and place additional pressure on state-operated facilities to meet the inpatient needs of persons with serious mental illness (SMI).

Issue No. 8: Community Capacity

Insufficient community-based programs exist to allow for the timely discharge of individuals from state-operated behavioral health facilities.

The review revealed that as of July 1, 2012, 161 individuals were included on the DBHDS' EBL. These people had been determined clinically ready for discharge, but because of a lack of available community resources to resolve identified barriers (e.g., a lack of community housing, services, etc.), remained in state-operated facilities.

Maintaining individuals in state-operated facilities, once they have been determined clinically ready for discharge, not only restricts the access of others in need of such services because of limited facility capacity, but also because of the higher cost of inpatient care, is an inefficient and ineffective use of limited resources. Additionally, this practice puts the Commonwealth at risk for violation of the *Americans with Disabilities Act* as interpreted by the 1999 *Olmstead* decision, which requires that individuals determined clinically ready for discharge be allowed to return to a more integrated community setting.[7]

Recommendation

The DBHDS, in coordination with appropriate stakeholders (e.g., regional and CSB representatives, private providers, et al.), should develop and implement a strategy covering DAP-specific objectives, goals, action items, and attendant performance

measures (addressing each region or CSB) designed to resolve identified barriers to discharge in order to improve the efficiency and effectiveness of the DAP.

The OSIG restates the 2012 recommendation of the OIG-BHDS that: The DBHDS publish on its website a HIPPA-compliant quarterly update summarizing the number of individuals on the EBL at each state hospital that includes: the specific barrier(s) to a person's discharge, the estimated cost (supplied by the sponsoring CSB or region) to discharge each person, and the length of time each individual has been on the list.[15]
The OSIG would add that individuals removed from the EBL, but not discharged, should be reflected in the quarterly update, along with the reason(s) for their removal from the Extraordinary Barriers List.

DBHDS Response to Issue No. 8

The DBHDS concurs that there is insufficient community capacity to meet the service needs of all individuals. The DBHDS has documented these needs thoroughly in the *Creating Opportunities* strategic plan and numerous targeted planning documents that have been the basis for several capacity-building budget requests and appropriations.

The first recommendation to develop performance goals and measures is addressed in the DBHDS response to Issue No. 4. The DBHDS has not implemented the second recommendation to publish specific information on its web site about individuals on the EBL because of HIPAA and human rights privacy protection concerns. However, the DBHDS will review this recommendation and develop a plan for publishing the total number of individuals on the EBL on its web site and update the number monthly. Regarding the third recommendation, the DBHDS will add information about individuals removed from the EBL and the reasons for their removal to the information it already provides to the OSIG monthly as quickly as this can be implemented.

OSIG COMMENT:

The OSIG reaffirms the OIG-BHDS 2012 Recommendation as stated above that, commencing April 15, 2014, the DBHDS publish a quarterly HIPAA-compliant update summarizing the number of individuals on the EBL, the barriers to discharge, the length of time on the EBL, and the estimated cost associated with serving each person in the community.

The creation of this list will provide an important metric to create a performance-based management system for the EBL, and the DAP, and a thoughtfully constructed list

should not present any privacy concerns. The *Comprehensive State Plan* (2014-2020), and other DBHDS publications, contain abundant examples that present summaries of patient/client information in HIPAA-compliant formats.

Regional Discharge Assistance Program Scrubbing

Persons discharged from the state facilities with the use of DAP funds have a DAP plan developed. This plan outlines the clinical services needed by the individual to achieve maximum therapeutic benefit in the community. Most regions and CSBs employ a process referred to as "scrubbing." Scrubbing is an ongoing assessment of clinical needs to identify resources that are no longer needed to serve a person in order to redirect the resources to serve another DAP recipient. The process involves a review of each person's level of clinical services to determine if any unused resources are available for redistribution to other individuals. Scrubbing of DAP plans varies in intensity and frequency among individual boards and regions.

For example, a DAP plan may identify that a person could benefit from daily psychosocial rehabilitation or day support services, but the person only opts to go three days a week instead of the proposed five. The projected funding, which included full participation, in actuality is for three days. For example, if the service costs $80 a day that equates to $400 per week or roughly $1600 each month, but in the case described the actual cost is $240 per week or $960 per month, leaving a difference of $160 per week or $640 monthly. In addition, many DAP recipients require temporary support until their federal entitlements, including Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) are re-established—usually a few months. Once a recipient's SSI or SSDI begins arriving, that person's DAP plan should be commensurately reduced and the funds available for redeployment to others.

Issue No 9: Scrubbing—A Best Practice

Scrubbing, which is practiced by most CSBs and regions, results in the efficient utilization of DAP funds. Timely scrubbing allows unencumbered funds to be used to assist other discharge-ready individuals return their communities.

The periodic review of DAP plans is an important management tool to update service costs and to identify unused funds that can be redeployed.

Recommendation

All DAP plans (local and regional) should be reviewed, at least quarterly, and unused sums returned to the local or regional DAP pool to help fund additional discharges.

DBHDS Response to Issue No. 9

The DBHDS agrees that the scrubbing of DAP plans currently practiced by CSBs and regions is a best practice and appreciates the OSIG recognition of this practice. The DBHDS concurs with this recommendation and notes that it reflects current practice. The DBHDS will provide additional guidance about this practice in the forthcoming *DAP Administrative Manual*.

OSIG COMMENT:

The OSIG requests that the DBHDS provide a copy of the *DAP Administrative Manual* describing DAP objectives, goals, and performance measures to the OSIG for review and comment.

Regional Management Summaries

A few general observations of the system of regional management are as follows:

- There are two distinct regional funding approaches in the Commonwealth. These different approaches were established as regional preferences. The allocation of DAP funds for PPRs 1, 3, 6, and 7 are disbursed directly to the CSBs and there are no additional regional funds. The remaining PPRs (2, 4, and 5) have dual funding with DBHDS allocations to both the region and individual boards (local and Regional Discharge Assistance Project [RDAP] funding).
- While all regions have established routine forums for monitoring regional utilization management processes, the most successful regions are those that have developed a strong, open, and ongoing dialogue between the state facility and the CSBs, including careful monitoring of both admissions and discharges. This process was most evident in PPR 1.
- There are different definitions of "clinically ready for discharge" among the regions. Variations in discharge-ready criteria impact numbers of persons placed on the EBL and the timeliness of discharge.
- Boards within regions do not always have an agreed upon or consistent approach regarding the use of funds for DAP purposes. For example, some of the boards in PPR 5 only use DAP funds as "bridge funds," meaning that unless a guaranteed third-party funding stream, such as Medicaid is secured, then the person in the hospital will not be discharged to the community.

  When used as bridge funding, a person is not approved for DAP funding unless a third party payer, like Medicaid, can be identified before the person is released from the hospital. Under the bridge model, DAP is intended to be temporary, usually a period of a few months, until permanent third-party funding is in place.

DBHDS Response to DAP Review Findings and Recommendations

The OSIG requests DBHDS provide a written response by April 15, 2014 regarding its efforts and intended actions per the findings and recommendations set forth in this report.

[7] *Olmstead* v. L.C., 527 U.S. 581 (1999).
[8] U. S. Department of Justice, Civil Rights Division, *Findings from CRIPA Investigation of Western State Hospital, Staunton, Virginia:* October 6, 1999. http://www.justice.gov/crt/about/spl/documents/westernfl.php.
[9] Letter from James W. Stewart III, Commissioner to Michael F.A. Morehart, State Inspector General. *The DBHDS Response to OSIG Report Number 2013-02*. September 20, 2013.
[10] DBHDS email to system leadership dated June 14, 2013 captioned: *New FY 2014 DAP State Funds Allocation Process.*
[11] OIG Report Number 207-12, *Review of the Barriers to Discharge in the Adult Behavioral Healthcare Facilities.* Issued April 2012.
[12] DBHDS Website: http://www.dbhds.virginia.gov/documents/omh-dischargeprotocols.pdf
[13] *Regional Utilization Management Guidance* (2007). http://www.dbhds.virginia.gov/documents/occ-Reg-Utiliz-Mgmt-Guide.pdf.
[14] *Review of the Barriers to Discharge in State-Operated Adult Behavioral Health Facilities, OIG Report No. 207-12, issued by the Office of Inspector General for Behavioral Health and Developmental Services, April 25, 2012; and OIG Review of Emergency Services: Individuals meeting statutory criteria for temporary detention not admitted to a psychiatric facility for further evaluation and treatment, OIG Report No. 206-11, February 28, 2012.*
[15] *Review of the Barriers to Discharge in State-Operated Adult Behavioral Health Facilities, OIG Report No. 207-12, issued by the Office of Inspector General for Behavioral Health and Developmental Services, April 25, 2012*

Appendix I—Glossary of Terms

ADA	Americans with Disabilities Act of 1990. The ADA is a wide-ranging civil rights law that prohibits, under certain circumstances, discrimination based on disability.
BH	Behavioral Health. Refers to the collective field of mental health and substance abuse.
BHA	Behavioral Health Authority. A public body and a body corporate and politically organized in accordance with the provisions of Chapter 6 of Title 37.2 of the Code of Virginia, that is appointed by and accountable to the governing body of the city or county that established it for the provision of mental health, developmental, and substance abuse services.
Clinically Ready for Discharge	Broadly defined as when the person no longer meets criteria for involuntary treatment (imminent danger to self or others) or has reached maximum benefit from hospitalization.
Community-based	Services provided in community settings and most often the services are managed by a community services board or behavioral health authority.
Community Transition	The process of an individual leaving an inpatient treatment setting and returning to a community living setting.
CSB	Community Service Board. A public body and a body corporate and politic organized in accordance with the provisions of Chapter 6 of Title 37.2 of the Code of Virginia that is appointed by and accountable to the governing body of the city or county that established it for the provision of mental health, developmental, and substance abuse services.
DAP	Discharge Assistance Project. The acronym "DAP" is used throughout this Report as a surrogate for the "Discharge Assistance Project"; however, within the Commonwealth's behavioral health system the terms Discharge Assistance Program and Discharge Assistance Planning sometimes use the acronym "DAP." As used herein, however, the term "Discharge Assistance Project" is used to describe the appropriations that fund the Discharge Assistance Program.
DBHDS	Department of Behavioral Health and Developmental Services. Formally known as the Department of Mental Health, Mental Retardation, and Substance Abuse Services.
Discharge Ready	See Clinically Ready for Discharge.
Discharge Summary	A clinical report prepared by the hospital treatment team at the conclusion of a hospital stay. It outlines the individual's chief complaint,

	diagnostic findings, treatments, the individual's response, and recommendations on discharge.
DOJ	Department of Justice. A 1998 settlement agreement between the DOJ and the Commonwealth led to the creation of the Discharge Assistance Project.
Extraordinary Barriers to Discharge Form	Form that documents barriers prohibiting timely discharge.
EBL	Extraordinary Barriers List. A list generated by DBHDS that identifies individuals in a state mental health facility who have been deemed clinically ready for discharge, but remain in the hospital for more than 30 days after that determination. Individuals remain on the EBL until they are discharged, or their condition deteriorates and they no longer are considered clinically ready for discharge.
HPR	Health Planning Region. Health planning regions are the geographical areas in Virginia that are covered by regional health planning agencies.
IDAPP	Individual Discharge Assistance Program Plan. IDAPP is a plan that entails the estimated cost of services for an individual DAP plan recipient. These plans will vary over time as support services change or federal or state entitlements and benefits (SSI, SSDI, Medicaid, or auxiliary Grant Funds) are approved.
Local DAP	See DAP. Projects managed by an individual CSB/BHA with dollars allocated directly to them in order to support discharge of individuals on the EBL. DAP plans implemented at the local level are monitored by the CSB/BHA and may also be reviewed periodically by a Regional Utilization Management Committee (RUMC).
LOS	Length of Stay.
Needs Upon Discharge Form	A form used by CSB/BHA staff and state facility staff to identify the services and supports that an individual will need to support a successful transition to a community setting. The form is accessed through a secured on-line process.
NGRI	Not Guilty by Reason of Insanity.
Olmstead	Refers to the 1999 United States Supreme Court decision that under the Americans with Disabilities Act, individuals with mental disabilities have the right to live in the community rather than in institutions if, in the words of the opinion of the Court, "*the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the*

	affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities."
OSIG	Office of the State Inspector General. OSIG investigates complaints alleging fraud, waste, abuse, or corruption by a state agency or non-state agency.
PACT	Program of Assertive Community Treatment. Consists of a comprehensive behavioral health care team that works with an individual to help that person live successfully in the community.
Performance Contract	A contract between DBHDS and the CSBs that defines the responsibilities of each party for the delivery of services, service quality and fiscal accountability.
Person-centered	An approach to treatment that places emphasis on the individual being at the center of all service planning in order to develop plans that reflect the unique needs and interest of the individual.
PPR	Partnership Planning Region. Established by DBHDS and intended to provide environments for addressing regional challenges and service needs and to collaborate in planning and implementing regional initiatives. Partnership participants, by design, are to include representatives from the CSBs, BHAs, state facilities, community inpatient psychiatric hospitals and other private providers, individuals receiving services, family members, advocates, and other stakeholders.
RDAP	Regional Discharge Assistance Project. The shared management and oversight by CSBs and BHAs in a defined Partnership Planning Region, of funds linked directly to enabling community placement of individuals in state mental health facilities who had been hospitalized for much longer than clinically necessary and who required a higher level of supports and structure than those provided by the standard array of services being offered in the community.
Ready for Discharge	See Clinically Ready for Discharge
Recovery	A philosophy of treatment that emphasizes the belief that mental illness, even in the most serious of forms, does not preclude the individual from living a meaningful life.
RUMC	Regional Utilization Management Committee. A group comprised of individual CSB/BHA and state facility staffs that provide direct oversight of DAP funding decisions and monitor use of other regional funds or programs, such as LIPOS, or crisis stabilization. DBHDS Central Office staffs frequently participate in these meetings.

Scrubbing	The process used by an individual CSB/BHA or a Regional Utilization Management Committee to review approved discharge assistance plans. The scrubbing process accounts for savings in the initial projected plan through changes in the level of service or through other payment sources being identified, i.e., Medicaid. These efforts create opportunities for initial plans to be reduced and the savings to be used to support an additional discharge plan.
SSDI	Social Security Disability Insurance. Designed to provide income supplements to people who are physically restricted in their ability to be employed because of a notable disability. SSD can be supplied on either a temporary or permanent basis, usually directly correlated to whether the person's disability is temporary or permanent.
SSI	Supplemental Security Income. A Federal income supplement program designed to help aged, blind, and disabled people, who have little or no income; and it provides cash to meet basic needs for food, clothing, and shelter.
WRAP	Wellness Recovery Action Plan. A person-centered plan designed to aid an individual with managing his/her illness through wellness goals and crisis management activities.

Appendix II—Discharge Assistance Program (DAP) Summary

(Source: Department of Behavioral Health and Developmental Services, 2012)

History

- First DAP initiatives began in FY 98, at NVMHI and CSH.
- Goal was to discharge identified long-stay patients who no longer required hospitalization but who could not be supported in the community without specialized services and supports.
- Methodology was to develop Individualized Service Plan (ISP) for each targeted DAP recipient, identify the costs of care to be provided, and fund the ISP through the CSB delivering services and supports. Funds follow the person.
- Amount of DAP for the individual ISPs is based on the unreimbursed cost of each DAP enrollee's ISP.
- Additional DAP investments followed in successive years, and were linked to the Commonwealth's response to the Supreme Court *Olmstead vs. LC* decision.
- Separate DAP initiatives were consolidated into a single program FY 01 named the Discharge Assistance Program (DAP)
- Regional DAP was initiated in FY 2005, i.e., regions (vs DBHDS) assumed responsibility for managing ISPs and fund allocations to CSBs.
- Last specific DAP appropriation was FY 07.

Current Funding and Utilization

- Statewide, FY 2013 funding for DAP is $20,945,748.
- 775 individuals are currently enrolled and receiving services through DAP. These individuals average 6.7 hospitalizations and have experienced approximately 5 years in state hospitals prior to DAP.
- Average annual cost per DAP plan is $27,027 (approximately 12% of the $231,161 average annual cost per bed in a DBHDS psychiatric facility).
- All DBHDS adult and geriatric hospitals have participated and all 40 CSBs support DAP enrollees.

DAP Program Management

- Management and coordination of DAP is handled by regions (i.e., quarterly review and adjustment of ISPs, monitoring of Extraordinary Barriers List (EBL) at state facilities, analysis of new requests for DAP funds, management of fund allocations, data collection and reporting, etc.).
- Regional management teams meet monthly.
- Individual CSB management of DAP services and funds is in accordance with provisions in CSB Performance Contract.
- Initial projections of persons to be served from all DAP initiatives totals 441. The difference between the projected 441 and the actual 775 persons served reflects changes in ISPs and close monitoring and management of DAP resources.

Current Interest in DAP

- DBHDS's *Creating Opportunities* Strategic Plan identified additional DAP resources as a high priority to improve state hospital effectiveness and efficiency.
- OIG Report 206-11 (Feb 2012) regarding unexecuted temporary detention orders and related problems with access to inpatient care, recommended create additional community capacity to serve discharge-ready individuals currently residing at ESH and SWVMHI.
- OIG Report 207-12 (April 2012) regarding barriers to discharge from state facilities recommended that DBHDS seek to expand funding for Discharge Assistance Projects that help individuals transition to the community, facilitating access to entitled federal benefits that can support community-based services.
- Current EBL is 148; down from the average 165 reported in the April 2012 OIG Study.

Appendix III—Review Methodology

This review proceeded on parallel and overlapping tracks with administrative and site surveys of CSBs, the DBHDS, and the regional utilization committees.[16] Our review also included:

1. Face-to-face interviews that were conducted with 174 individuals consisting of:
    a. Nine members of DBHDS executive leadership;
    b. 127 CSB staff members associated with DAP monitoring and management; and
    c. 38 DAP funding recipients.
2. Questionnaires and surveys that were developed and provided to all 40 CSBs;
3. On-site reviews of DAP fiscal and clinical policies and practices that were conducted at 20 CSBs including:
    a. Evaluating consistency of the individual services and support plan (ISP) at discharge with the subsequent DAP ISPs;
    b. Assessing whether justification existed for continuing the level of service;
    c. Reviewing the allocation and use of DAP funding; and
    d. Examining any unused DAP funding at fiscal year end.
4. Observations that were made at five of the seven regional utilization committees' proceedings; and,
5. Review of clinical and financial records of 78 service recipients during site visits to 20 CSBs.[17]

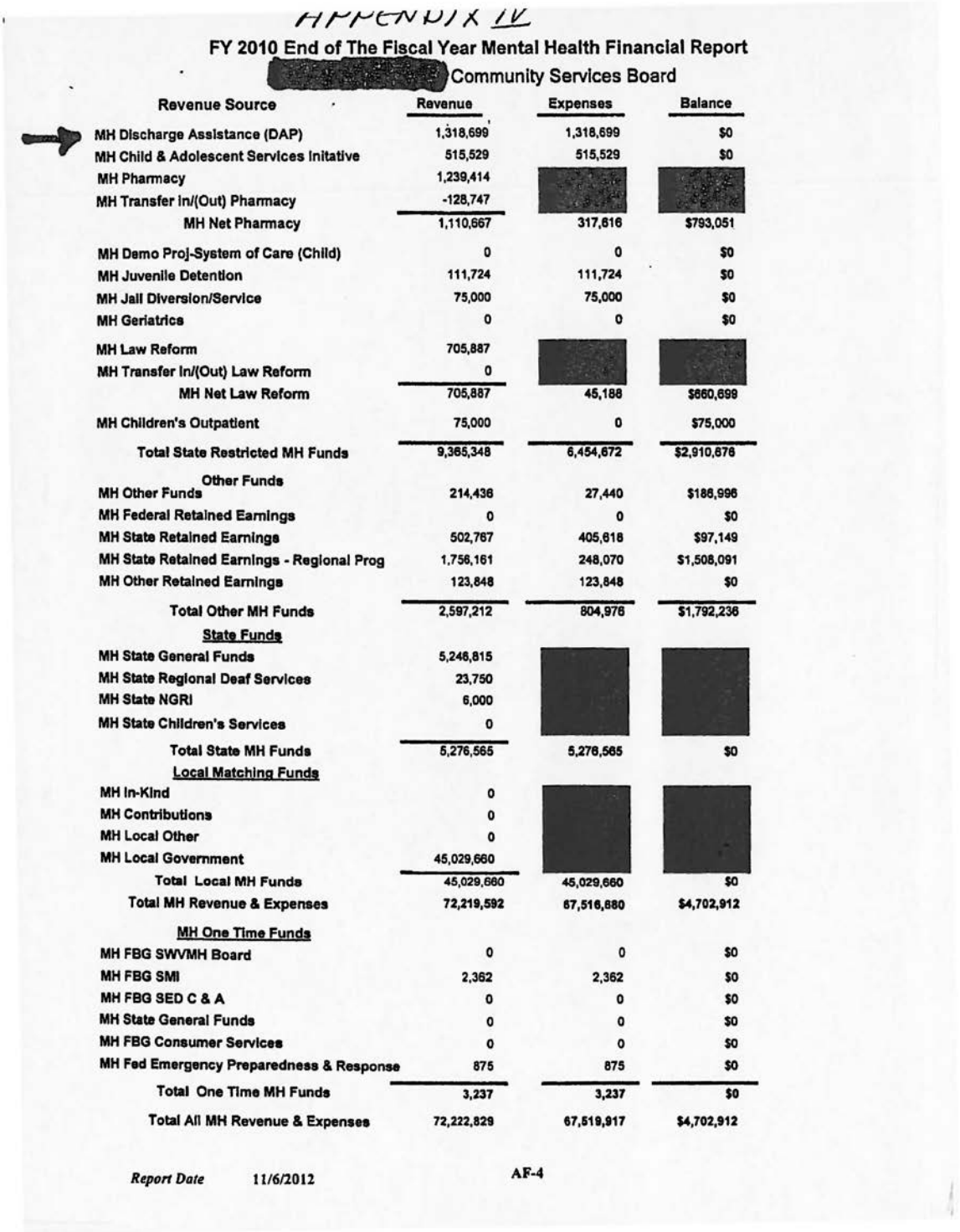
In October 2012, the DBHDS reported that the EBL had decreased from 161 to 142 individuals (Appendix II). The OSIG performed a limited post-review examination of the EBL and FY 2013 facility discharges to assess and understand the factors underlying this reported reduction and the impact, if any, on the findings of the this report. The results of this limited post-review, which are discussed later in the Review Results section of this report, did not materially alter our review findings.

[16] [1] The DBHDS and the CSBs enter into an extensive agreement describing the relationship, roles and responsibilities between this executive branch of state government and CSBs that are created by the *Code of Virginia* to assess needs and provide certain community behavioral health and developmental services. A copy of the *Performance Contract* between the DBHDS and the CSBs can be found at web link: http://www.dbhds.virginia.gov/documents/occ-2012-PerformanceContract.pdf.

[17] Due to privacy regulations from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the documentation of our review of clinical records and results of provider and patient interviews were destroyed.

Appendix IV—FY 2010 and 2011 End of the Fiscal Year Mental Health Financial Reports

FY 2010 End of the Fiscal Year Mental Health Financial Report



APPENDIX IV

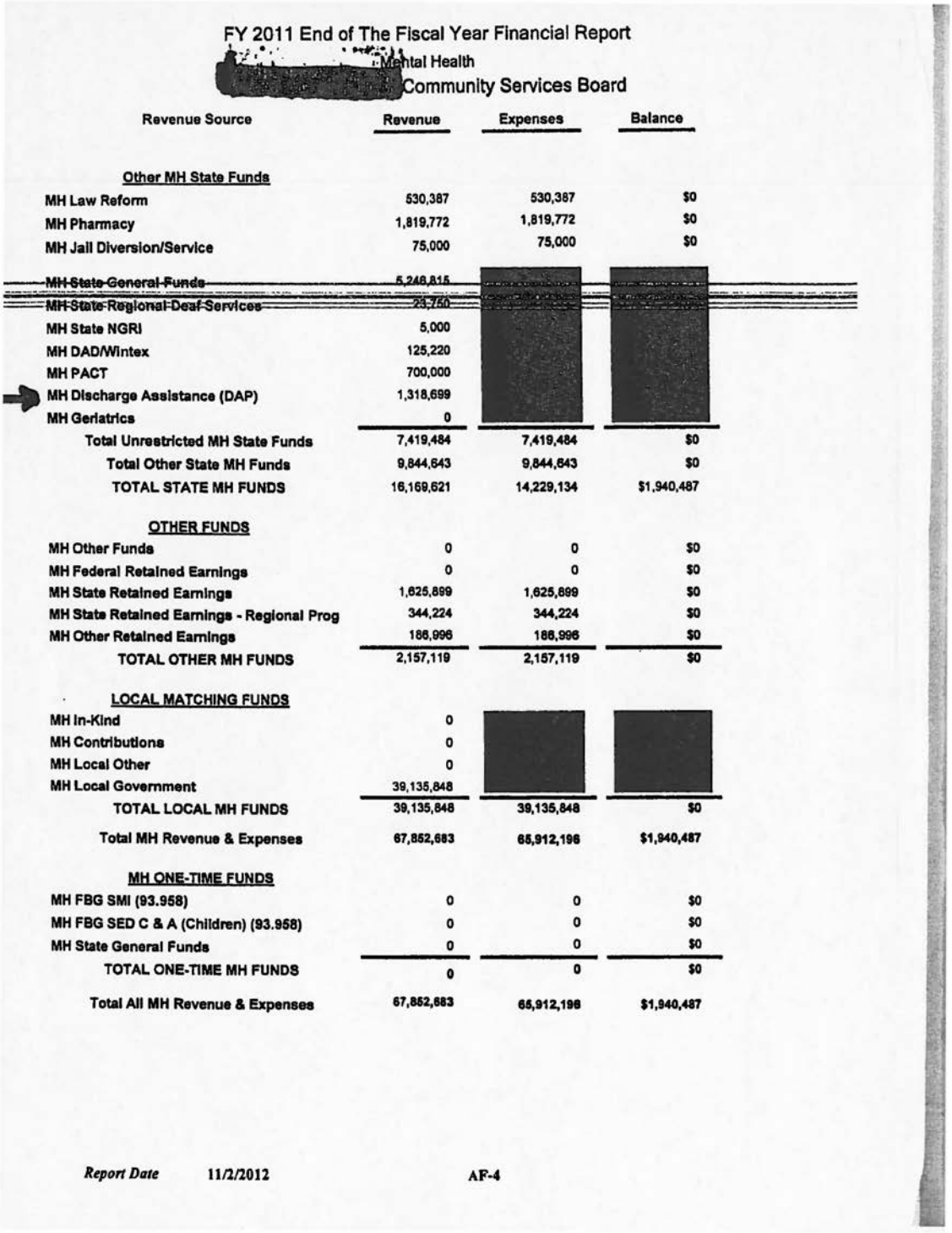
FY 2010 End of The Fiscal Year Mental Health Financial Report

[redacted] Community Services Board

Revenue Source	Revenue	Expenses	Balance
MH Discharge Assistance (DAP)	1,318,699	1,318,699	$0
MH Child & Adolescent Services Initative	515,529	515,529	$0
MH Pharmacy	1,239,414	[redacted]	[redacted]
MH Transfer In/(Out) Pharmacy	-128,747		
MH Net Pharmacy	1,110,667	317,616	$793,051
MH Demo Proj-System of Care (Child)	0	0	$0
MH Juvenile Detention	111,724	111,724	$0
MH Jail Diversion/Service	75,000	75,000	$0
MH Geriatrics	0	0	$0
MH Law Reform	705,887	[redacted]	[redacted]
MH Transfer In/(Out) Law Reform	0		
MH Net Law Reform	705,887	45,188	$660,699
MH Children's Outpatient	75,000	0	$75,000
Total State Restricted MH Funds	9,365,348	6,454,672	$2,910,676
Other Funds			
MH Other Funds	214,436	27,440	$186,996
MH Federal Retained Earnings	0	0	$0
MH State Retained Earnings	502,767	405,618	$97,149
MH State Retained Earnings - Regional Prog	1,756,161	248,070	$1,508,091
MH Other Retained Earnings	123,848	123,848	$0
Total Other MH Funds	2,597,212	804,976	$1,792,236
State Funds			
MH State General Funds	5,246,815	[redacted]	[redacted]
MH State Regional Deaf Services	23,750		
MH State NGRI	6,000		
MH State Children's Services	0		
Total State MH Funds	5,276,565	5,276,565	$0
Local Matching Funds			
MH In-Kind	0	[redacted]	[redacted]
MH Contributions	0		
MH Local Other	0		
MH Local Government	45,029,660		
Total Local MH Funds	45,029,660	45,029,660	$0
Total MH Revenue & Expenses	72,219,592	67,516,880	$4,702,912
MH One Time Funds			
MH FBG SWVMH Board	0	0	$0
MH FBG SMI	2,362	2,362	$0
MH FBG SED C & A	0	0	$0
MH State General Funds	0	0	$0
MH FBG Consumer Services	0	0	$0
MH Fed Emergency Preparedness & Response	875	875	$0
Total One Time MH Funds	3,237	3,237	$0
Total All MH Revenue & Expenses	72,222,829	67,519,917	$4,702,912

Report Date 11/6/2012

AF-4



FY 2011 End of The Fiscal Year Financial Report

[redacted] Mental Health

[redacted] Community Services Board

Revenue Source	Revenue	Expenses	Balance
Other MH State Funds			
MH Law Reform	530,387	530,387	$0
MH Pharmacy	1,819,772	1,819,772	$0
MH Jail Diversion/Service	75,000	75,000	$0
~~MH State General Funds~~	~~5,248,815~~	[redacted]	[redacted]
~~MH State Regional Deaf Services~~	~~23,750~~		
MH State NGRI	5,000		
MH DAD/Wintex	125,220		
MH PACT	700,000		
MH Discharge Assistance (DAP)	1,318,699		
MH Geriatrics	0		
Total Unrestricted MH State Funds	7,419,484	7,419,484	$0
Total Other State MH Funds	9,844,643	9,844,643	$0
TOTAL STATE MH FUNDS	16,169,621	14,229,134	$1,940,487
OTHER FUNDS			
MH Other Funds	0	0	$0
MH Federal Retained Earnings	0	0	$0
MH State Retained Earnings	1,625,899	1,625,899	$0
MH State Retained Earnings - Regional Prog	344,224	344,224	$0
MH Other Retained Earnings	186,996	186,996	$0
TOTAL OTHER MH FUNDS	2,157,119	2,157,119	$0
LOCAL MATCHING FUNDS			
MH In-Kind	0	[redacted]	[redacted]
MH Contributions	0		
MH Local Other	0		
MH Local Government	39,135,848		
TOTAL LOCAL MH FUNDS	39,135,848	39,135,848	$0
Total MH Revenue & Expenses	67,852,683	65,912,196	$1,940,487
MH ONE-TIME FUNDS			
MH FBG SMI (93.958)	0	0	$0
MH FBG SED C & A (Children) (93.958)	0	0	$0
MH State General Funds	0	0	$0
TOTAL ONE-TIME MH FUNDS	0	0	$0
Total All MH Revenue & Expenses	67,852,683	65,912,196	$1,940,487

Report Date 11/2/2012 AF-4

Appendix V—Fiscal Year 2012 Regional and Local Discharge Assistance Program Funding

FY12 - Community Services Board	Regional DAP	Local DAP	Total
Alexandria	-	183,085	183,085
Alleghany-Highland	156,589	-	156,589
Arlington County	-	976,027	976,027
Blue Ridge Behavioral Healthcare	550,346	283,964	834,310
Central Virginia	720	506,638	507,358
Chesapeake	-	234,941	234,941
Chesterfield	-	161,366	161,366
Colonial	-	83,504	83,504
Crossroads	-	234,520	234,520
Cumberland Mountain	147,108	83,160	230,268
Danville-Pittsylvania	1,351,294	155,361	1,506,655
Dickenson County Behavioral Health Services	135,996	-	135,996
District 19 Community Services Board	-	458,434	458,434
Eastern Shore	-	19,760	19,760
Fairfax-Falls Church	1,749,374	1,318,699	3,068,073
Goochland-Powhatan	-	58,666	58,666
Hampton-Newport News	-	222,752	222,752
Hanover County Community Services Board	-	-	-
Harrisonburg-Rockingham Community Services Board	48,287	601,175	649,462
Henrico Area	-	-	-
Highlands	18,958	149,515	168,473
Loudoun County Community Services Board	-	253,039	253,039
Middle Peninsula-Northern Neck	-	133,639	133,639
Mount Rogers	317,329	397,119	714,448
New River Valley	315,609	320,290	635,899
Norfolk Community Services Board	-	177,292	177,292
Northwestern	61,635	570,136	631,771
Piedmont	-	112,220	112,220
Planning District I	202,120	92,654	294,774
Portsmouth	-	52,642	52,642
Prince William County Community Services Board	-	259,496	259,496
Rappahannock Area Community Services Board	-	549,929	549,929
Rappahannock-Rapidan Community Services Board	29,719	114,879	144,598
Region Ten Community Services Board	40,140	1,050,162	1,090,302
Richmond	1,476,209	-	1,476,209
Rockbridge Area Community Services	-	115,323	115,323
Southside Community Services Board	-	885	885
Valley Community Services Board	23,355	967,962	991,317
Virginia Beach Community Services Board	-	392,268	392,268
Western Tidewater Community Services Board	961,794	53,845	1,015,639
TOTAL	7,586,582	11,345,347	18,931,929

Appendix VI—Department of Behavioral Health and Developmental Services Instructions to Stakeholders for Utilizing Mental Health 2014 Discharge Assistance Program Funding

From: Pezzoli, John (DBHDS)
Sent: Friday, June 14, 2013 4:09 PM
To: Gilmore, Mike (VDSS); Alleghany Highlands - Ingrid Barber; Arlington - Cindy Kemp; Blue Ridge - Tim Steller; Chesapeake - Joe Scislowciz ; Chesterfield - Debbie Burcham; Colonial - David Coe; Crossroads - Will Rogers; Cumberland Mt. - Ron Allison; Danville Pittsylvania - Jim Bebeau; Dickenson County - Joe Fuller; District 19 - Joe Hubbard; Eastern Shore - Mark Freeze; Fairfax - George Braunstein; Bergquist, Susan (DBHDS); Hampton - Chuck Hall; Hanover County - Ivy Sager; Harrisonburg - Lacy Whitmore; Henrico Area - Mike O'Connor; Highlands - Jeff Fox; Horizon Behavioral Health - Nancy Cottingham; Loudoun - Joseph Wilson; Walsh, Charles (DBHDS); Mount Rogers - Lisa Moore; New River Valley - Susan Baker; Norfolk - Sarah Fuller ; Northwestern - Buddy Hall; PD-1 - Sandy O'Dell; Piedmont - Jim Tobin; Portsmouth - Bill Park; Prince William - Tom Geib; Rappahannock Area - Ron Branscome; Rappahannock-Rapidan - Brian Duncan; Region Ten - Robert Johnson; Richmond - Jack Lanier; Rockbridge - Dennis Cropper; Southside - Donald Burge; VACSB - Mary Ann Bergeron; Valley - David E. Deering; Virginia Beach - Aileen L. Smith; Western Tidewater - Demetrios Peratsakis
Cc: Stewart, Jim (DBHDS); Garland, Olivia (DBHDS); Darr, Don (DBHDS); Gilding, Paul (DBHDS); Martinez, Jim (DBHDS); Morgan, Beverly (DBHDS); O'Bier, William (DBHDS); Payne, Russell (DBHDS); Rothenberg, Joel (DBHDS); Schaefer, Michael (DBHDS); Shank, Michael (DBHDS); Van Bodegom Smith, Rosanna (DBHDS); McGuire, Meghan (DBHDS); Walker, Ruth Anne (DBHDS); Aaron, Jeff (DBHDS); Barber, Jack (DBHDS); Herr, Daniel (DBHDS); Herrick, Steve (DBHDS); Lyon, David (DBHDS); McClaskey, Cynthia (DBHDS); Mitchell, Walton (DBHDS); Montgomery, Vicki (DBHDS); Newton, Jim (DBHDS)
Subject: New FY 2014 DAP State Funds Allocation Process

DBHDS is pleased to begin implementation of the 2013 action of the Governor and the General Assembly to allocate an additional $1,500,000 for the Discharge Assistance Program (DAP). DAP is a partnership between DBHDS and the CSBs/BHAs to develop and support integrated community living arrangements for persons in state hospitals who are clinically ready for discharge but face barriers due to unavailability of funding for needed services. The support of the Governor and General Assembly recognizes the success of this program in securing permanent opportunities in the community for persons with great needs and challenges previously served by our state hospitals. The purpose of my e-mail is to describe the Department's process for allocating and disbursing these new funds so that we can begin identifying individuals who will be supported with these funds and discharging them as soon as possible.

DBHDS has developed a process for distributing these new funds that is modified from current DAP funding in order to assure their rapid and targeted use and to document their success in achieving the goals set for them. The Department anticipates funding a total of approximately

30 or more individualized discharge assistance program plans (IDAPPs) statewide with the new DAP funds. The Department will rely as always on the experience and expertise of CSBs, state hospitals, and planning partnership regions in the selection, plan implementation, and monitoring of individuals whose IDAPPs will be implemented using. To achieve these goals, the Department has established the following parameters for the use of the new funds.

1. The new funds are identified as MH 2014 DAP* funds. The asterisk identifies these funds as restricted funds, unlike current and ongoing DAP funds, which are and will remain earmarked. The CSBs must track and report expenditures of restricted funds separately.

2. The priority for use of MH DAP 2014* funds will be community placement of individuals on the Extraordinary Barriers to Discharge List (EBL) as of 7/12/13, with an emphasis on those individuals having the longest tenure on the EBL for whom a funded IDAPP offers promise of success in the community. IDAPPs may be submitted for any individual in adult or geriatric state hospital beds regardless of their legal status or diagnosis when the lack of DAP funding is the primary barrier to discharge.

3. When a region (or cooperating regions) has a significant number of individuals on the EBL with similar needs, the Department will consider early start-up and operation (or contracting) of congregate housing programs that provide supportive services to meet the clinical needs of those individuals as allowable costs in a package of IDAPPs for them.

4. A very limited group of individuals who are approaching clinical readiness for discharge (#2-rating on the Uniform Discharge Readiness Rating Scale) may have barriers of such clinical and supportive extremes that additional funding will be required. While not the primary focus for MH 2014 DAP* funds, the Department may consider a limited number of IDAPP submissions for these individuals.

5. The Department will not approve IDAPPs that have been previously developed and approved on a CSB or regional pre-existing or pending basis. The Department will not approve using new MH 2014 DAP* funding to address any current CSB or regional DAP fiscal deficits. Any region with significant amounts of unobligated local or regional FY 2013 DAP funds must submit IDAPPs using those funds before submitting IDAPPs for MH 2014 DAP* funding.

6. Each region seeking MH 2104DAP* funds must develop and approve completed IDAPPs including any necessary supporting documentation and substantiation of individual need and submit them to Russell Payne in the Department no later than July 31, 2013.

To be eligible for MH 2014 DAP* funds, each IDAPP must:

a. be complete and include reasonable and verifiable costs,

b. contain a reasonable and viable projected discharge date,

c. include supporting documentation that MH 2014 DAP*funds are necessary to support the discharge,

d. include other projected revenues in the IDAPP to minimize the use of MH 2014 DAP* funds,

e. identify the case management CSB that will implement the IDAPP,

f. contain an identified provider for each service that is able and ready to provide it, and

g. include the approval of the individual's state hospital treatment team and hospital director.

In addition, the region must ensure that the discharge plan, CSB discharge planning notes, and the Extraordinary Barriers Report in the Secure Site are current for the individual and substantiate the need for MH 2014 DAP* funding.

6. Once it has received the IDAPPs, the Department will establish a review team composed of Central Office, state hospital, and regional manager representatives to review, negotiate any necessary revisions, and recommend IDAPPs to the Department for approval and funding. In this review process, the review committee will prioritize IDAPPs that:

a. are complete and reasonable,

b. contain reasonable and feasible discharge dates, and

c. include other realistically projected revenues to defray the total cost of the IDAPP.

7. Then, the Department will notify CSBs of their awards by Friday, August 30, 2014, and the notification will include any additional monitoring and reporting requirements.

Please contact Russell Payne at russell.payne@dbhds.virginia.gov or (804)786-1395 or (804)921-2318(cell) if you have questions about these procedures. I will also welcome your calls for comments or questions at either of the two numbers provided below.

This is a great opportunity to not only help many people return to their communities, but also to deliver on our promise and goal of "Creating Opportunities" for people with behavioral health needs in the community. I look forward to working with you to achieve these goals.

John J. Pezzoli
Assistant Commissioner for Behavioral Health Services
Virginia Department of Behavioral Health and Developmental Services

P.O. Box 1797
Richmond, Virginia 22318-1797
804-786-3921
Cell: 804-432-4285

Appendix VII—Analysis of Barriers to Discharge from State Hospitals and Potential Solutions

ANALYSIS OF BARRIERS TO DISCHARGE FROM STATE HOSPITALS AND POTENTIAL SOLUTIONS

VIRGINIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

MAY 28, 2013

This paper presents a brief overview and analysis of state hospital utilization, the state hospital discharge planning process, barriers to discharge, the "Extraordinary Barriers to Discharge List" (EBL), the DBHDS Discharge Assistance Program (DAP), and possible improvements to these.

1. State Hospital Utilization, FY 2012

The number of state hospital beds for adults and older adults (65+) has declined over time as more acute inpatient treatment is provided in community hospitals and more individuals are served in non-hospital settings. As this trend has occurred, a greater percentage of state hospital beds are occupied by individuals with longer lengths of stay and more complex needs.

The June 30, 2012 operational bed capacity of state hospitals for 18+ YO adults (DBHDS hospitals) was 1,439 beds. In FY 2012, these facilities admitted 3,555 persons, with most of these being court-ordered admissions. These facilities discharged 3,593 individuals during FY 2012, and these discharged individuals had an average length of stay (ALOS) of 164 days. Admissions, discharges and ALOS varied widely among facilities, as shown in Table 1 below, reflecting the different missions of each hospital as well as differences in inpatient mix, inpatient treatment programs offered and regional services and supports.

Length of stay (LOS) in state hospitals is extended when individuals are clinically ready for discharge but insufficient community services and supports are available to discharge the individual. Of FY 2012 total discharges, 357 were individuals who spent at least 30 additional days in the hospital after they were determined to be clinically ready for discharge, resulting in placement on the hospital's Extraordinary Barriers to Discharge List (EBL). These individuals spent an average of 229 additional days in the hospital after they were deemed to be ready for discharge. Utilization data for each hospital is presented in the following Table 1.

Table 1: DBHDS State Hospital Utilization FY 2012

HOSPITAL	Operational Beds 6/30/2012	Avg. Daily Census FY 2012	FY 2012 Admissions	FY 2012 Discharges	ALOS FY 2012 Discharges	Discharges from EBL List	EBL Discharges % of Total	ALOS on EBL List
CATAWBA HOSP	120	93	309	304	94	35	12%	152
CENTRAL STATE HOSP	279	216	545	570	205	40	7%	144
EASTERN STATE HOSP	302	267	248	245	792	105	43%	337
NORTHERN VA MH INST	123	112	763	756	52	33	4%	234
PIEDMONT HOSP	135	102	62	71	571	39	55%	176
SOUTHERN VA MH INST	72	71	287	286	114	43	15%	218
SW VIRGINIA MH INST	162	149	756	763	65	18	2%	276
WESTERN STATE HOSP	246	221	585	598	147	44	7%	149
Total	1439	1231	3555	3593	164	357	10%	229

2. The Discharge Planning Process

Since 2001, state hospitals and CSBs have followed prescribed procedures, embodied in the DBHDS mental health *Discharge Protocols,* to determine an individual's readiness for discharge and to plan for needed community services and supports following hospitalization. The discharge planning process begins immediately upon hospitalization. Readiness for discharge is determined by the hospital treatment team with community services board (CSB) consultation. An individual is deemed clinically ready for discharge when he or she achieves the treatment goals identified in his treatment plan and state hospital level of care is no longer required.

When an individual is determined clinically ready for discharge, the CSB is expected to take immediate steps to finalize the discharge plan and complete the discharge within 10 working days. However, if the CSB cannot complete the discharge within 30 days of the date the person was clinically ready for discharge, then the CSB submits documentation through the DBHDS Secure Site Database identifying the specific barrier(s) on the *Extraordinary Barriers to Discharge Form* and the individual is added to the Extraordinary Barriers to Discharge List (EBL).

The process described above illustrates an important fact, namely, that "clinical readiness for discharge" does not by itself determine when a person will be discharged. Rather, a person's actual discharge is a result not only of the person's clinical readiness for discharge (i.e., has met treatment goals and no longer needs hospital care) but also of the availability and suitability of the community services and supports that the person needs to live outside of the hospital. The individual's preferences (or those of family or guardians) may also be a factor in the discharge. The lack of acceptable, available and appropriate community services and supports results in delayed discharges.

3. Extraordinary Barriers to Discharge List

The completed *Extraordinary Barriers to Discharge Form* describes the issues that are preventing discharge and the steps that are being taken by the CSB to address them. Within prescribed timeframes,

discharge planning notes are submitted and updated until the extraordinary barriers have been addressed and the individual is discharged.

In each of the planning partnership regions associated with DBHDS's seven adult state hospitals, CSBs and state hospitals have established Regional Utilization Review and Consultation Teams. These teams review the circumstances of all individuals who have been on the hospital's EBL for more than 30 days and identify the community services and any special funding needed to meet their community support needs. The teams meet monthly or more frequently, depending on the state hospital census or the number of cases to be reviewed.

The review team reports the results of these reviews and related actions to a regional authorization body set up by the region's CSBs to operate regional programs, provide or purchase services on behalf of the region, conduct utilization management, and engage in regional quality improvement efforts. DBHDS staff also monitor the progress of hospitalized individuals with extraordinary barriers to discharge through the DBHDS Secure Site Database and the AVATAR (state hospital) database.

4. Extraordinary Barriers to Discharge List as of October 12, 2012

On October 12, 2012, there were 148 individuals on the EBL in state hospitals as shown in Table 2, below. This was approximately 10% of the total operational adult and geriatric beds at state hospitals and is down from the average of 165 reported in the April 2012 Study by the Office of the Inspector General.

Table 2: Individuals on the EBL, October 12, 2012

HOSPITAL	Operational Beds 6/30/2012	Avg. Daily Census FY 2012	Number on EBL 10/12/2012	Percent of ADC on EBL
CATAWBA HOSPITAL	120	93	9	8%
CENTRAL STATE HOSPITAL	279	216	12	4%
EASTERN STATE HOSPITAL	302	267	53	18%
NORTHERN VA MH INST	123	112	27	22%
PIEDMONT HOSPITAL	135	102	15	11%
HOSPITAL	**Operational Beds 6/30/2012**	**Avg. Daily Census FY 2012**	**Number on EBL 10/12/2012**	**Percent of ADC on EBL**
SOUTHERN VA MH INST	72	71	13	18%
SW VIRGINIA MH INST	162	149	5	3%
WESTERN STATE HOSPITAL	246	221	14	6%
Total	**1439**	**1231**	**148**	**10%**

5. Types of Barriers to Discharge

The EBL accounts for 12 major types of barriers to discharge. Each barrier to discharge, and the total number of individuals on the EBL from all hospitals that had each type of barrier to discharge on October 12, 2012, is shown below in Table 3.

Table 3: Barriers to Discharge, Total Number of EBL Inpatients by Type of Barrier, October 12, 2012

TYPES OF BARRIERS TO DISCHARGE, OCTOBER 12, 2012 (TOTAL INDIVIDUALS ON EBL = 148)	Number on EBL	Percent of Total
FORENSIC LEGAL STATUS (OTHER THAN NGRI)	26	18%
HAS EXTENSIVE BEHAVIORAL NEEDS	25	17%
MAJOR MEDICAL CONDITION/CHRONIC HEALTH PROBLEM	12	8%
NGRI LEGAL STATUS	25	17%
LACKS GUARDIAN OR AUTHORIZED REPRESENTATIVE (AR)	16	11%
REFUSES DISCHARGE PLAN	11	7%
NEEDS NURSING HOME	28	19%
NEEDS HOUSING	28	19%
NEEDS HIGHLY INTENSIVE RESIDENTIAL SERVICE*	25	17%
NEEDS INTENSIVE RESIDENTIAL SERVICE*	16	11%
NEEDS SUPERVISED RESIDENTIAL SERVICE*	14	9%
NEEDS SPECIALIZED PLACEMENT OR FUNDING	12	8%

***Note:** Highly Intensive, Intensive, and Supervised residential services are defined in DBHDS *Core Services Taxonomy 7.2*

As shown in Table 3, above, while every person on the EBL has at least one barrier to timely discharge, many persons on the EBL have multiple barriers to discharge. Of particular note are the barriers described below, which may occur either singly or in combination:

a. Forensic and NGRI Legal Status—Forensic individuals are tied to the criminal justice system and each individual's movement through treatment is processed through the courts. A significant number of forensic individuals are discharged back to jails and prisons, while others are acquitted and found "not guilty by reason of insanity" (NGRI). Risk management, administrative, and legal factors contribute to extended lengths of stay for NGRI acquittees, for whom the judge of the court in which the individual was adjudicated makes the final determination of readiness for discharge.

Virginia's graduated release process mandates that NGRI individuals move gradually through increased liberties that prove the individual's (and the community's) ability to manage risks

outside of the hospital. Courts are reluctant to authorize discharge unless the individual has successfully demonstrated readiness for discharge by working through the entire graduated release process.

NGRI acquittal also results in suspension or termination of entitlements, such as SSI and SSDI income and Medicaid coverage, and the individual remains ineligible until after discharge. The lack of financial resources can prevent individuals from working through the NGRI release process due to their inability to pay for services.

Lastly, the "NGRI" label itself is often a significant barrier to discharge. An NGRI adjudication does not equate to innocence. Rather, it indicates that the individual did commit the criminal act but lacked criminal intent. Many NGRI acquittees have significant prior criminal records as well. Not surprisingly, bias against these individuals also makes it difficult for them to access services and supports.

b. Admissions to Nursing Facilities—A number of barriers affect the timely discharge of individuals to nursing facilities. Depending on the payer source and the individual's medical condition, reimbursement may be a challenge. Young adults may find it difficult to access care. Complex and challenging medical conditions such as dementia or multiple chronic disorders can increase the amount of nursing staff time or the amount of treatment required to care for an individual. Consent for treatment can also be an issue for such individuals. Finally, managing challenging behaviors that present a serious risk of harm to the individual or other residents may increase the nursing facility's liability. The following factors are common impediments to admission to a nursing facility:

- Medicaid is the only payer source.
- Having a dementia diagnosis, but no guardian, agent or durable Power of Attorney in place.
- The person is uncooperative with care.
- Recent challenging behavior, including combative behavior and frequent verbal abuse.
- Hospice care is likely needed in the near future (which lowers the Nursing Facility's reimbursement rate).
- Use of multiple psychotropic medications and or PRN prescriptions for behavioral issues.
- Antipsychotic medications used by individuals with dementia but without a diagnosis of psychosis.
- A history of wandering (or elopement risk).
- Recent substance abuse history, or likelihood of actively seeking alcohol or drugs.
- Frequent transportation needed for outside medical care (e.g., chemotherapy or radiation treatment).
- Requires restraints for behavioral or safety issues.
- Criminal history.

c. Housing and Residential Service Needs—One of the most common barriers to discharge is housing with the appropriate supports. Compared to individuals not on the EBL at time of discharge, a much smaller percentage of individuals on the EBL go to housing in their own (or family's) home. A much greater percentage of EBL individuals go to Assisted Living Facilities (ALFs), where room and board with daily supervision and limited support services are provided in-house.

Many individuals who remain in the community following discharge, whether originally discharged from the EBL or not, transition to less restrictive residential settings over time. This suggests that more readily available regular, affordable housing with sufficient and reliable services and supports is needed to promote independent living opportunities and reduce Virginia's unnecessary reliance on more restrictive settings

d. Behavioral Challenges—Many individuals on the EBL present challenging behaviors or conditions that that are difficult to manage and that make it harder to find willing providers. These can include complex psychiatric symptoms, aggressive or sexually inappropriate behavior, and other conditions. Sometimes, a prior history of these challenges, even if not recent, can interfere with community placement.

As described earlier, assembling the right package of available and appropriate community services and supports for these individuals can be difficult. DBHDS and CSBs have supported many initiatives to reduce barriers to discharge and the EBL itself, as described in the next section below.

6. Previous DBHDS Initiatives to Reduce Number of Individuals on EBL

In 1997, pursuant to a Settlement Agreement between the Commonwealth of Virginia and the U.S. Department of Justice (DOJ), DBHDS began systematic monitoring of barriers to discharge from state hospitals in order to identify and develop targeted community services. The need for this activity was underscored by the U.S. Supreme Court's *Olmstead* ruling in 1999. By FY 2000, over $10 million in state funds had been dedicated to reducing the census at state hospitals by providing targeted community-based services and supports to adults who had experienced very long inpatient stays. Since then, several additional initiatives have expanded community services, reduced state hospital admissions and enhanced timely discharge from state facilities. These initiatives, with current funding levels and the first years these appropriations were made and the last years of any additional appropriations, are shown below:

- $18.9 million for Discharge Assistance Program (DAP), 1998/2007;
- $10.6 million for Programs of Assertive Community Treatment (ACT), 1998/2005;
- $10.9 million for Housing and Residential Services, 1999/2002;

- $15.5 million for Residential Crisis Stabilization Programs, 2006/2011;
- $1.0 million for two Specialized Geriatric Mental Health Services programs (funded with federal CMHS Block Grant funds), 2008;
- $12.0 million for Emergency Mental Health Response Services, 2009;
- $29.8 million for additional community services to increase community outpatient, emergency, psychiatry, jail diversion, and case management capacity, 2007/2011.

7. Additional Services Needed to Reduce EBL

In particular, the following strategies would further reduce the current number of individuals who are clinically ready for discharge, but who remain in state hospitals on Extraordinary Barriers Lists due to a lack of sufficient community-based services:

a. Increase Number of Programs of Assertive Community Treatment (PACT)—Programs of Assertive Community Treatment (PACT) provide an intensive level of support services to individuals in independent housing. A PACT program is a self-contained, multi-disciplinary team of clinical staff, including a psychiatrist, that provides treatment, rehabilitation, and support in the community to enrolled individuals who require a high level of intensive treatment but do not need to live in a supervised setting. In FY 2012, Virginia's 15 PACT teams served 1,363 individuals who had experienced an average of 5 hospitalizations and approximately 1.6 years in state hospitals prior to their enrollment in PACT services. Outcomes of PACT services include fewer hospitalizations and reduced hospital days, longer periods of community tenure, increased housing stability and reduced criminal justice contact (e.g., arrest).

b. Expand Stable and Affordable Housing—Housing is considered affordable when 30% of monthly income is enough to cover rent and utilities. An individual living on Supplemental Security Income (SSI) in 2013 receives $710 per month, so an SSI recipient's affordable housing rate is only $213 per month. In contrast, the fair market rent (FMR, established each year by the U.S. Department of Housing and Urban Development) for a one-bedroom unit in 2013 ranges from a low of $463 (65% of SSI) in Dickenson and Floyd counties to a high of $1,191 (168% of SSI) in northern Virginia. To make housing affordable for SSI recipients, therefore, monthly housing assistance payments of between $250 in low-cost areas to $978 in high cost areas would be needed to support their ability to live in least restrictive environments. Similar resources (for mortgage, taxes, and utility costs) would also be needed by providers serving such individuals in other types of housing**.**

c. Develop Additional Intensive Community Residential Treatment (ICRT) Capacity—Intensive Community Residential Treatment (ICRT) offers stable community housing for individuals with more severe limitations who need more daily supervision. Region II currently operates 3 ICRTs to house and support 23 individuals with histories of long state

hospitalizations and unsuccessful tenure in less intensive residential settings. Each program has a unique configuration, but all are designed to meet the needs of persons typical of those found on the EBL. Such full service residential programs can cost more than $80,000 annually per individual and Medicaid does not cover this category of mental health residential services.

d. Increase Capacity in Other CSB Residential Services—The ability of CSBs to provide supervised and supportive residential services is very limited. In FY 2012, CSBs provided a total of 932 highly intensive (48), intensive (191), and supervised (693) residential beds to mental health service recipients. Significant additional resources would be needed to serve persons on the EBL in need of these services.

e. Expand Non-Residential CSB Services—While housing and residential services are essential for many individuals on the EBL, they are not the only supports required. Like most other individuals returning to the community from hospitalization, a full array of services and supports will be needed by individuals on the EBL. However, CSBs lack sufficient capacity across a broad range of services, and cannot fully serve individuals transitioning from state hospitals and those already in the community, such as persons not covered by insurance or Medicaid. DBHDS tallies available CSB waiting list information biennially for the DBHDS *Comprehensive State Plan*. The waiting list figures from the *Comprehensive State Plan 2012 – 2018*, published December, 2011, are shown in Table 4, below.

Table 4: Adults on CSB Waiting Lists by Mental Health Service Category, December 2011

SERVICE CATEGORY	Number of Persons Total N = 4,071	% of Total
Outpatient Services		
Counseling and Psychotherapy	1,639	40%
Medication Management	1,308	32%
Psychiatric Services	1,181	29%
Assertive Community Treatment	196	5%
Intensive In-Home	3	0%
Case Management		
Case Management	879	22%
Day Support Services		
Rehabilitation	339	8%
Day Treatment/Partial Hospitalization	270	7%
Employment Services		
Individual Supported Employment	491	12%
Sheltered Employment	183	4%
Group Supported Employment	87	2%

SERVICE CATEGORY	Number of Persons Total N = 4,071	% of Total
Residential Services		
Supportive	752	18%
Supervised	328	8%
Intensive	180	4%
Highly Intensive	130	3%

f. Expand Discharge Assistance Program (DAP) Capacity—Historically, the DBHDS Discharge Assistance Program has been extremely successful in enabling hospitalized individuals with long lengths of stay and complex service needs to be supported in community settings. In FY 2012, 854 persons received DAP-funded services statewide (including those receiving one-time DAP supports) with 760 active DAP enrollees receiving ongoing services as of June 30, 2012. Many DAP enrollees were once on the extraordinary barriers to discharge list at state hospitals. Expansion of DAP resources has historically enabled DBHDS state hospitals to reduce their EBL numbers by enabling CSBs to put in place the services and supports these individuals need in order to be successfully discharged.

8. Basis for DBHDS Review

Spurred by the proposed 2012 House Joint Resolution 18 (Del. O'Bannon) and in response to the 2012 OIG *Review of the Barriers to Discharge in State-Operated Adult Behavioral Health Facilities* (#207-12, April 2012), DBHDS completed a review of the Extraordinary Barriers to Discharge List and the DAP program to examine areas for possible improvement. A more detailed analysis of this effort is presented in the following sections.

9. Overview of the DBHDS Discharge Assistance Program (DAP)

The Discharge Assistance Program (DAP) is a pool of flexible state general funds allocated to each region and to CSBs to support individualized services and supports to enable identified individuals in state hospitals to live in the community. Regional allocations DAP funds are targeted to specific state hospital patients whose community service and support needs can't be addressed through the typical array of CSB services and community supports. Usually, these are individuals with long lengths of stay, complex conditions, or specialized needs that create barriers to discharge. For this reason, individuals on the EBL at state hospitals are often targeted for DAP resources.

To access DAP funds, CSBs and state hospitals develop an Individualized Discharge Assistance Program Plan (IDAPP) for each DAP recipient, including the annual cost of the services to be provided. CSBs determine the placement and community supports in accordance with the DBHDS Discharge Protocols. DAP funds "follow the person" from the point of discharge from

the state hospital, and the planned services are funded through the CSB delivering or managing the services and supports. Revenues generated by the CSB from Medicaid or other payer sources are deducted from the cost of each IDAPP with the remainder funded by DAP funds.

Management and coordination of IDAPPs and funds are handled by regional management teams, which meet monthly. IDAPPs are submitted by CSBs to Regional Utilization Review and Consultation teams for approval. The Regional Utilization Review and Consultation teams also conduct quarterly IDAPP reviews, adjust funded IDAPPs as needed, analyze the Extraordinary Barriers List (EBL) at state hospitals, evaluate new requests for DAP funds, and manage fund allocations, data collection and reporting. Individual CSB management of DAP services and funds is in accordance with provisions in the Community Services Performance Contract.

Current state general fund DAP allocations (FY 2013) to CSBs total $18,931,929.

10. DBHDS Review of DAP Program

The Department's study of the DAP program revealed some areas where changes in practice would improve the overall administration of the DAP program. These areas of improvement, many of which are already underway, are described in more detail in sections a-f, below. In addition, DBHDS is developing a *DAP Administrative Manual* to consolidate all DAP administrative requirements, procedures, forms, etc in a single easy-to-access document. Areas of improvement identified in DBHDS's review include the following:

a. Standardized Determination of Readiness for Discharge Across State Hospitals—As described earlier (see footnote 3, page 3), DBHDS hospitals do not currently use a standardized approach for determining clinical readiness for discharge. DBHDS has determined, however, that Western State Hospital (WSH) has a sufficiently rigorous and effective methodology that can be adopted for use by other facilities. The WSH approach includes a 4-point rating scale with clear behavioral anchors describing distinct stages of an individual's clinical readiness for discharge. The WSH clinical readiness for discharge scale is embedded in a broader hospital instruction setting forth procedures for discharge planning and related activities, including management of the Extraordinary Barriers to Discharge List. The WSH protocol will be implemented at all DBHDS state hospitals, and will be part of the Electronic Health Record systems of all state hospitals as these systems come on line.

b. Standardized IDAPP and DAP Monitoring Across Regions—DAP began in 1998 with two small, targeted initiatives at the Northern Virginia Mental Health Institute and Central State Hospital. Since that time, other DAP initiatives were funded, and these separate initiatives were consolidated several years later. This incremental development process resulted in CSBs and regions using different Individualized Discharge Assistance Program Plans (IDAPP)

and regional report formats. This variability complicates monitoring and prevents effective cross-region comparisons. In July, 2012, DBHDS initiated implementation of a standardized approach for managing DAP resources at the regional level. Specifically, the following was implemented, or underway, on December 31, 2012:

- Use of a single, uniform Individualized Discharge Assistance Program Plan document for development, renewal and revision of individual DAP plans. All existing DAP plans (775) will be converted to this format;
- Requirements for uniform supporting documentation to justify all funded DAP plans;
- Consistent maintenance of all IDAPPs by CSBs, regions and DBHDS;
- Requirements for uniform regional DAP reporting;
- Implementation of a statewide encryption system allowing secure transmission of protected health information contained in IDAPPs and related documentation.

c. DAP Financial Management Improvements—At the outset of the DAP initiative, DAP funds were allocated directly from DBHDS to individual CSBs based on their approved IDAPPs. Successive DAP initiatives followed and were funded in the same way. These funds are referred to as "Local DAP" funds and continue to be allocated directly from DBHDS to CSBs. In more recent years, new DAP funds were allocated to regions, to be managed through the regional management infrastructure. In some regions, these so-called "Regional DAP" funds were divided up among the region's CSBs and were allocated directly by DBHDS to the CSBs. In other regions, "Regional DAP" funds are allocated to the regional CSB fiscal agent, and in turn reimbursed to the region's CSBs by the regional CSB fiscal agent based on expensed incurred.

This situation, where multiple DAP fund allocation and disbursement methods are at work simultaneously, complicates monitoring, financial reporting, and maximum utilization of all DAP funds. The Department is negotiating a revision of the FY 2014 Community Services Performance Contract Renewal, and will revise the Core Services Taxonomy Appendices E and F on regional programs if necessary, to enhance its monitoring of and financial accountability for state DAP funding and to achieve acceptable movement in decreasing the number of individuals on the EBL. The revision may include the following requirements for the management and utilization of all state DAP funds.

i. The FY 2013 DAP funding structure of local (CSB-specific) and regional state DAP fund allocations shall remain in place for FY 2014, and these funds shall continue to be earmarked rather than restricted funds.

ii. All local and regional state DAP funds allocated within the region shall be managed by the regional utilization review and consultation team in the region on which the CSB participates.

iii. State hospital staff with decision-making authority shall participate on the regional management group and the regional utilization review and consultation group in the region.

iv. The regional management group shall have the authority to move local DAP funds, subject to the approval of the Department, or to reallocate regional DAP funds among CSBs from CSBs that cannot use them in a reasonable time to those that need additional DAP funds to implement more IDAPPs to reduce the EBL at the state hospital serving the region.

v. If CSBs in the region cannot expend at least a specified percent and obligate at least a specified percent of the total annual local and regional state DAP fund allocations on a regional basis by the end of the fiscal year, the Department may work with the CSBs in the region to transfer state DAP funds to other regions to reduce the EBL at each state hospital to the greatest extent possible.

vi. The CSB, through the regional management group and the regional utilization review and consultation team on which it participates, shall ensure that other funds such as Medicaid payments are used to offset the costs of approved IDAPPs to the greatest extent possible so that state DAP funds can be used to implement additional IDAPPs to reduce state hospital EBLs.

vii. The Department shall monitor IDAPPs and the expenditure of local and regional state DAP funds in each region through mid-year and end-of-the-fiscal year reports submitted by the regional managers to assure that at least a specified percent of the annual allocations of all state DAP funds are expended and a specified percent of all state DAP funds are obligated, unless there are clear and acceptable explanations for unexpended or unobligated amounts of state DAP funds at the end of the fiscal year. The reports shall be in a format developed by the Department in consultation with regional managers and CSBs that separately displays the actual expenditures of local and regional state DAP funds for ongoing and one-time IDAPPs.

viii. The Department may conduct utilization reviews of the CSB or region at any time to confirm the effective utilization of local and regional DAP funds and the implementation of all approved ongoing and one-time IDAPPs. The Department shall work with CSBs and regional managers to develop clear and consistent criteria for the identification of individuals who would be eligible for IDAPPs and for the acceptable use of local and regional state DAP funds.

ix. The regional manager shall submit a quarterly summary of IDAPPs to the Department in a format developed by the Department in consultation with the regional managers and CSBs that displays the following year-to-date information separately for ongoing and one-time IDAPPs: numbers of IDAPPs that have been implemented, the total projected costs of IDAPPS, and the net local state DAP funds and net regional state DAP funds.

However, if there is not acceptable movement in decreasing the number of individuals on the EBL or if significant amounts (e.g., more than a specified amount such as 10 or 20%) of

local or regional state DAP funds remain unspent, then for FY 2015, the Department may implement the one or more of the following actions:

- Merge all existing DAP funding streams (local and regional) into one regional funding stream managed by the regions;
- Restrict the use of these funds, rather than leaving them earmarked;
- Attach the restriction to any balances of unexpended DAP funds after the end of a fiscal year; and
- When necessary, move funds among regions, if the funds are not needed or being fully utilized in acceptable ways.

d. DAP Data Improvements—DBHDS tracks DAP consumers and funding using different data sources. First, DAP consumers are identified with a discreet identifying code in the Community Consumer Submission (CCS, the automated client level data extracted from CSB data systems monthly). The CCS data, with the consumer designation code, identifies the types and amounts of services received by each DAP enrollee. Second, CCS data is merged with data from the Community Automated Reporting System (CARS, the system through which CSBs report service revenues and expenditures, including DAP expenditures) to identify the costs of DAP services delivered by CSBs. Lastly, DAP consumers and expenditures are tracked by each region through the regional utilization management process. DBHDS has found, however, that CARS, CCS and regional DAP data do not reconcile with sufficient accuracy, which compromises oversight and monitoring.

To remedy this situation, DBHDS issued guidance to CSBs and regions on December 20, 2012, requiring each CSB to conduct a systematic review of CCS data to ensure that each DAP enrollee was properly coded with the existing DAP identifier code) and accounted for in CCS (including recipients served with "one-time" DAP supports). All CSBs and regions were directed to ensure that the unduplicated number of DAP consumers in CCS reconciled with regional accounting of DAP enrollees. Also, all CSBs and regions were instructed to conform their CCS client service data to the actual IDAPP for each enrollee, to ensure that CCS and the IDAPP are consistent.

e. DAP Quality Improvement—Beginning January 1, 2013, in consultation with CSBs and regions, DBHDS began to utilize CCS as the primary data source for DAP consumer and service tracking, and will begin to generate quality reports to the regions to improve accuracy, reliability and consistency of DAP data and reporting at the CSB, regional and state level. This will be the basis for development and implementation of a comprehensive monitoring and quality improvement process encompassing the above management improvements.

f. DAP Capacity–Building—DAP has been widely acclaimed as a successful approach to help integrate individuals receiving services in state hospitals who have complex service and support needs into community settings. As identified in the 2011 *Creating Opportunities Strategic Plan*, DBHDS and CSBs have continued to make increased DAP funding a top priority. In Governor McDonnell's Budget, an additional $750,000 in DAP funds is proposed for FY 2014, and the General Assembly added an additional $750,000, for a total of $1.5M.

11. Conclusion

Several current and proposed initiatives described above play or could play a significant role in reducing the number of individuals who are unnecessarily reside in state hospitals, both by providing alternatives to state hospital admission and timely access to appropriate community services at the point of discharge. The needs of individuals on the EBL at any one point in time will vary, as will the cost to serve them in the community. The capacity to provide a wide array of flexible, community-based services and supports is essential. Some approaches, such as Assertive Community Treatment (ACT) and Intensive Community Residential Treatment (ICRT), require an investment large enough to sustain the program (i.e., the full ACT team or the ICRT facility). Others, like individualized assistance provided to individuals who were receiving forensic services and older adults can be more easily scaled in relation to number of individuals receiving services. Funding mechanisms such as DAP can provide the right level of flexibility required. Virginia has demonstrated its commitment to individuals transitioning from state hospitals to community services but significant, sustained, and adequately funded efforts will be required to ultimately eliminate Extraordinary Barrier Lists in the Commonwealth's state hospitals.

12. Acknowledgement

This report builds on the Office of the State Inspector General 's April 2012 *Review of the Barriers to Discharge in State-Operated Adult Behavioral Health Facilities* (#207-12) and its continuing efforts to study the needs of hospitalized individuals and individuals supported by DAP funds in community settings. In addition, DBHDS commends the CSB, facility and regional staff who serve and support DAP recipients faithfully and effectively each day.

For additional information, contact John Pezzoli, Assistant Commissioner for Behavioral Health, DBHDS, at john.pezzoli@dbhds.virginia.gov