

Agency Strategic Plan

Department Of Mental Health, Mental Retardation and Substance Abuse Services

Agency Mission, Vision, and Values

Mission Statement:

The Department of Mental Health, Mental Retardation, and Substance Abuse Services (the Department) provides leadership and service to improve Virginia's system of quality treatment, habilitation, and prevention services for individuals and their families whose lives are affected by mental illness, mental retardation, or substance use disorders (alcohol or other drug dependence or abuse). The Department seeks to promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community life for these individuals.

Agency Vision:

We envision a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life, including work, school, family and other meaningful relationships.

Agency Values:

- **Focus First on Individuals Receiving Services**
 - Our decisions and actions consider first the best interests of individuals who receive services and their families.
 - We respect the potential and capacity of each individual receiving services.
 - We value and support the healing and recovery process.
- **Responsiveness to External and Internal Customers**
 - We seek input and involvement from our customers.
 - We share ideas and remain open to different opinions.
 - We listen to and respect what our customers say and respond promptly to their requests.
- **Partnership and Collaboration**
 - We create opportunities for partnerships, encourage teamwork, and support each other to succeed.
 - We accept shared ownership and seek win-win (mutually acceptable) solutions.
 - We communicate openly and clearly.
 - We are willing to take risks as we look for creative solutions and new ways of solving problems.
 - We make decisions and resolve problems at the level closest to the issue.
- **Professionalism, Integrity, and Trust**
 - We recognize and celebrate individual and team successes.
 - We use valid data that reflect best practices and positive results and outcomes.
 - We take responsibility for ourselves, for our actions, and for how these actions affect others.
 - We develop a supportive and learning environment and work continuously to improve the quality of the services we provide.
 - We keep our word and deliver what we promise.
 - We incorporate our values into everyday decisions.
- **Stewardship**
 - We protect the assets and interests of the entire services system.
 - We value and take care of staff.
 - We use the Commonwealth's resources in the most effective and efficient manner.

Agency Executive Progress Report

Current Service Performance

Virginia's publicly supported mental health (MH), mental retardation (MR), and substance abuse (SA) services system is comprised of the Department's central office and state hospitals and training centers; a network of 40

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community services boards, behavioral health authorities, or local government departments with policy-advisory boards (hereafter referred to as CSBs); local governments that establish, fund, and provide various administrative supports to CSBs; private and public providers of services licensed by the Department; and providers of other supports such as housing, job training, social services, and income assistance.

The Department operates nine state hospitals, five training centers, one medical center, and one residential treatment program for individuals who meet commitment criteria as sexually violent predators (SVPs). These 16 state facilities provide highly structured intensive inpatient treatment, rehabilitation, and habilitation services. State hospitals provide inpatient psychiatric acute stabilization, intermediate, and rehabilitation services to children, adults, and older adults. Training centers provide residential care and training in areas such as language, self-care, independent living, academic skills, and motor development. The Hiram Davis Medical Center (HDMC) provides medical and skilled nursing services to state facility consumers who have serious physical and medical needs. The Virginia Center for Behavioral Rehabilitation (VCBR) provides evaluation and rehabilitation services in a secure setting to individuals committed as SVPs. An unduplicated count of consumers served across all state facilities in FY 2006 totaled 7,476. Operating capacities (beds) and the numbers of consumers on state facility books as of October 12, 2006 follow:

- State hospitals: 1,693 beds with 1,547 patients on facility books (91 percent occupancy)
- Training centers: 1,591 beds with 1,432 residents on facility books (90 percent occupancy)
- HDMC: 87 beds with 60 patients on the center's books (69 percent occupancy)
- VCBR: 36 beds with 50 residents on the center's books (97 percent occupancy)

The Department supports the provision of accessible and effective public MH, MR, and SA treatment and prevention services through a network of CSBs that are established by local governments. CSBs are the single point of responsibility and authority for assessing individual needs, accessing a comprehensive array of services and supports, and managing state-controlled funds for community-based services. CSBs also perform preadmission screening for admission to state facilities and prepare discharge plans for state facility patients and residents who are returning to the community. In FY 2005, CSBs served 195,132 individuals, of whom 115,173 received MH services, 26,050 received MR services, and 53,909 received SA services. A totally unduplicated count of consumers across all service areas (MH, MR, and SA) was 174,183. The number of individuals receiving specific CSB services in FY 2005 follows:

- Emergency services: 51,433 consumers,
- Local inpatient services: 4,841 consumers,
- Outpatient and case management services: 194,231 consumers,
- Day support services: 16,393 consumers,
- Residential services: 24,447 consumers, and
- Early intervention services: 12,499 consumers.

Community MH, MR, and SA services, already strained to keep pace with demand and with hundreds of people on waiting lists for services, could potentially receive service requests from thousands of additional individuals, based on statistical prevalence methodology. The 2006-2012 Comprehensive State Plan, using statistical prevalence methodologies, estimates that 392,138 adults in Virginia have a serious mental illness, 73,877 children or adolescents have a serious emotional disturbance with significant impairment, 67,477 individuals have mental retardation, 18,116 young children (from 0 to 5 years of age) have developmental delays requiring early intervention services, and 335,545 adults or adolescents have an illicit drug or alcohol dependence disorder. While not all of these 887,153 individuals will seek services from the public sector, many of them will do so. Data collected for the 2006-2012 Comprehensive State Plan identifies over 6,000 adults and children on waiting lists for MH services, over 5,000 individuals on waiting lists for MR services, and over 3,400 adults and children or adolescents on waiting lists for SA services. Virginia's ongoing population growth will result in additional demand for services over time.

In April 2005, CSBs estimated the number of weeks that individuals waited for their services. On average,

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individuals waited three to four weeks for an initial assessment performed by CSBs. For CSB MH services, adults waited longest for highly intensive residential services (126 weeks) and intensive residential services (58 weeks). Children and adolescents waited longest for highly intensive residential services (12 weeks) and alternative day support arrangements (12 weeks). For CSB MR services, adults waited longest for intensive residential services (115 weeks), highly intensive residential (82 weeks), and supervised and supportive residential services (75 weeks). Children and adolescents waited longest for supervised residential services (237 weeks), highly intensive and intensive residential services (202 weeks), and rehabilitation services (83 weeks). For MR Waiver services adults waited longest for personal response services (87 weeks) and nursing services (74 weeks). Children and adolescents waited longest for personal assistance services (78 weeks) and nursing services (56 weeks). For CSB SA services, adults waited longest for methadone detox (11 weeks) and intensive outpatient services (8 weeks). Adolescents waited longest for medication services (6 weeks) and psychiatric services (5 weeks).

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Productivity

The Department has implemented the following improvements to increase productivity, improve services delivery, and achieve savings.

- **Regional Management of Inpatient Beds:** The Department has supported a regional approach to service planning, utilization, and delivery that has resulted in more effective and efficient utilization of local hospital and state inpatient psychiatric beds. Because lengths of stays are monitored closely and continuity of care has improved, more people are being served and outcomes are comparable or better.
- **Community Services Reporting Requirements:** As state and federal reporting requirements have become more extensive and complex, the Department and CSBs have worked together to respond to these requirements in a less burdensome manner. The community consumer submission (CCS), which extracts data from local CSB information systems, has allowed CSBs and the Department to comply with reporting requirements more efficiently and effectively, eliminate repetitive data entry in different automated or manual reports, respond more easily to ad hoc data requests, maintain fewer stand-alone software applications and reports, and reduce administrative workloads.
- **Management of MR and Day Support (DS) Waivers:** In 2006, an administrative decision was made to shift daily policy development and management of the MR and DS Waivers from the Department of Medical Assistance Services (DMAS) to the Department's Office of Mental Retardation Services. Both agencies are committed to making this shift in lead responsibilities in order to facilitate the development of a continuum of quality services that respond to the needs consumers. The new structure aligns well with the Department's System Transformation Initiative.
- **Electronic Health Records:** Implementation of the clinical components of an electronic health record (i.e., treatment planning and medication management systems) is a federal and state government priority. There is an emerging expectation that federal reimbursement for services will someday be contingent on an interoperable electronic medical record. To respond to this eventuality, the Department has developed a detailed plan for electronic medical record implementation over the next five years and is actively engaged in partnerships that will lead to interoperability and linkages with the emerging National Health Information Infrastructure. The Department has established relationships with three emerging regional health information organizations (RHIOs) in Tennessee, North Carolina and Northern Virginia and has begun to explore the option of a state RHIO for behavioral healthcare providers. All of these efforts are intended to streamline documentation in service delivery, eliminate redundant service delivery, improve continuity of care, and enhance quality of care.
- **Positive Behavior Support (PBS):** The Department is providing funds to train, mentor, and implement an endorsement process for 70 behavioral specialists over the next year. This training and endorsement process, which would qualify an individual to provide PBS (therapeutic consultation) as a Medicaid provider, will be available at no cost to staff from CSBs, state training centers, and private providers. The Partnership for People with Disabilities, VCU, and the Virginia Autism Resource Center (VARC) developed and piloted PBS training and endorsement process through a grant from the Virginia Board for People with Disabilities (VBPD).
- **The Advisory Consortium on Intellectual Disabilities (TACID):** This consortium serves as an advisory body to the Department on issues regarding policy, services, and supports to persons with mental retardation in Virginia. TACID is comprised of interested groups and individuals who wish to participate. Its membership includes all major stakeholder organizations, public and private providers, state agencies, and regional representatives from across the state. TACID develops written "Advisories" to the Department on legislative or policy issues and tracks activities of the various agencies serving this population.
- **Financial Management System (FMS) Migration:** The current HP3000 hardware and operating system for

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FMS will be discontinued at the end of calendar year 2005 because the vendor will no longer provide technical support. The Department will enhance productivity by installing a replacement Windows operating system and MS-SQL on three regional sites, reducing two sites from the current IT environment. The FMS migration was completed on June 30, 2006.

- **MR Supports Intensity Scale (SIS) Pilot:** The Department is piloting the SIS as a standardized assessment tool to measure the pattern and intensity of supports needed by an individual with developmental disabilities to be successful in the community. Virginia is one of 12 states and Canada that are early adopters of the SIS. A total of 83 providers from 9 CSBs, a private provider, and CVTC are trained as administrators of the Virginia version of the SIS, which will be used to assess approximately 1000 individuals. At the completion of this pilot, recommendations will be offered on how to improve this instrument and its future use in Virginia.
- **Recovery Readiness and Psychosocial Rehabilitation (PSR):** In 2005, the Department's state hospitals participated in a consumer and staff internal survey (the Virginia Recovery Assessment Inventory) to determine readiness for implementation of recovery principles and to measure consumer feedback on staff's understanding of recovery principles. The facilities also participated in a PSR Infrastructure Survey in response to findings by the Office of the Inspector General. As a result of the findings of these surveys, operational improvements to PSR programming have been implemented.
- **House Document (HD) 76 (The Cost and Feasibility of Alternatives to the State's Five Mental Retardation Training Centers):** The Department, with the assistance of TACID, proposed a plan for transforming the MR system to build community capacity that best supports Virginians with mental retardation. The feasibility study found that Virginia's MR system is underfunded, that many Virginians with mental retardation are underserved or unserved, and that the present "dual system" (state and community services) is difficult to coordinate and not the most efficient or effective approach to support. The strategies in the plan include improving and expanding the home and community based waivers, developing community alternatives for individuals currently living in state-operated ICFs/MR (state training centers), and refocusing the role of the state training centers.

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Major Initiatives and Related Progress

- **System Transformation:** The System Transformation Initiative is a historic opportunity to make a difference in the lives of individuals with mental illnesses, mental retardation, and co-occurring mental illnesses and substance use disorders who receive publicly-funded services and supports. This initiative will significantly expand community services and supports across Virginia and will replace two state hospitals, Eastern State Hospital (ESH) in Williamsburg and Western State Hospital (WSH) in Staunton, and two training centers, Southeastern Virginia Training Center (SEVTC) in Chesapeake and Central Virginia Training Center (CVTC) in Madison Heights.

The System Transformation Initiative is supporting the expansion of MH crisis stabilization services, recovery-oriented services, case management services, jail-based services, discharge assistance plans for the development of community services for civil and not guilty by reason of insanity (NGRI) patients in state facilities, and child and adolescent system of care and juvenile detention services. It also is supporting the addition of 145 MR Home and Community-Based Waiver slots to serve individuals on the statewide urgent needs list, 110 Waiver slots for children under the age of six, and 80 Waiver slots targeted to CVTC and SEVTC. The initiative also is providing Waiver start up funds and funds for guardianships.

- **Co-Occurring Services Integration Grant (COSIG):** In October 2004, the Department was awarded a \$3.5M grant to enhance the infrastructure of Virginia's public SA and MH services system to support the integration of services to individuals with co-occurring mental illness and substance use disorders. Virginia is one of 17 states are participating in this project. The COSIG grant focuses on policy, funding, IT, and workforce infrastructure development in support of more effective services. The Department is now entering the third year of this five-year grant. A major focus of the grant is on infrastructure development through implementation of the Continuous and Comprehensive Integrated System of Care Model, which promotes the identification of consumers with co-occurring disorders by enhancing CSB and state facility screening and assessment protocols. The Department is working with CSBs and state hospitals to develop service integration and dual-diagnosis capability. It is also examining the system's capability to provide treatment and other services to persons with co-occurring disorders and promote the adoption of evidence-based practices. Working with DMAS, grant staff helped revise the Medicaid Provider Manual and EPSDT protocols to clarify state Medicaid policy on reimbursement for treatment for this population group. Grant activities were initially organized around 13 pilot CSBs by have been expanded by establishing a regional structure where the pilot CSBs are taking on the role of change agents with other CSBs.

- **Real Choice Systems Change (RCSC):** The Department, in collaboration with DMAS and other stakeholders, has received a received a Systems Transformation Grant through the Centers for Medicare and Medicaid Services' RCSC grant competition. This grant will enable Virginia to take important next steps to transform Virginia's long-term service system to better support people with disabilities and their families. This grant will create individual budgeting and explore other consumer-directed options for individuals receiving or planning to receive waiver services; expand the Aging and Disability Resource Center by increasing the number of sites, expanding the target populations to persons with co-occurring mental retardation and mental illnesses, and creating a web-based mechanism for improved consumer access to and control of long-term supports statewide; ensure statewide implementation of person-centered planning (PCP) and self-direction practices through on-going training, technical assistance, and implementation incentives; review and revise regulations, policies, and procedures to reflect with PCP/self-direction; develop a system for regularly reporting and a process for improving the system; establish a web-based care management IT application in the MR and DD Waivers that streamlines admission and authorization processes; and produce a critical incident and management reporting system that interfaces with existing systems.

- **Project Remote:** The Department has established Project Remote, a targeted treatment program for prescription drug addiction in far Southwest Virginia. Federal funding for this project will provide \$500,000 each year for 3 years, totaling \$1.5 million. This matches state funds of \$500,000 per year to the region to

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address substance abuse. The project will implement an enhanced service model, developed with community input, which integrates pharmacologic therapies with behavioral interventions, linkages to treatment following detoxification, and recovery support to sustain positive treatment effects. Southwest Virginia was targeted because of a high increase of deaths from prescribed methadone in the area. Use of prescribed methadone for pain management increased following addiction problems with the drug Oxycontin. The training and services provided by the grant will cover three community services boards that encompass eight localities including Buchanan, Dickenson, Lee, Russell, Tazewell, Scott, Wise and Norton.

- **Medicare Part D:** The Department has successfully implemented Medicare Part D involving significant numbers of individuals who are either low income or indigent with disabilities that make them dually eligible for Medicare and Medicaid coverage. These individuals, who are fully or partially eligible for Medicare Part D pharmacy program coverage, comprise approximately 50 percent of those receiving services in state facilities. Medicare Part D maintains broadly-structured formularies, with substantially all of the following six major drug categories included in the program's formularies: antidepressants, antipsychotics, anticonvulsants, anticancer agents, immunosuppressants, and HIV/AIDS medications. The Department has assured that the pharmacy information systems used by state facilities are compatible with new Medicare processing requirements. State facility pharmacists have updated their databases to reflect the new formularies and individual consumer Medicare eligibility and specific plan data. The Department has signed contracts with 16 plans with 12 providers and collected \$5.2 million from January through June 2006. Implementation of Medicare Part D also has had a significant impact on community programs. Of the 17,000 individuals receiving services through the Community Resources Pharmacy (CRP), approximately 53 percent were determined to be eligible for Medicare Part D pharmacy services and about 6,000 individuals were determined to be dually eligible for Medicare and Medicaid services. All individuals who are eligible for Medicare Part D pharmacy services have been diverted to local pharmacies. For all new clients, the Department has been filling prescriptions for 30 days while the CRP determines Medicare Part D eligibility status.
- **Day Support (DS) Waiver -** In July 2005, a new DS Waiver for individuals with MR was implemented, resulting in an opportunity to remove 300 individuals from the MR Waiver waiting list.
- **Consumer and Family Networks:** In 2004, a MH consumer organization (VOCAL) received a state infrastructure grant to develop a statewide consumer network. The Department provided additional support to sustain this initiative and also contracted with a state advocacy organization, PACCT, to pull together family groups and parent resource centers into an integrated family coalition for the Commonwealth, using the Federation of Families model. In 2006, several state facilities began using the VOCAL network to insure consumer input in facility recovery and treatment project planning.
- **Leadership Training:** In May 2005, 38 senior managers from the Department's central office and state facilities participated in intensive leadership training at the Weldon Cooper Center for Public Service at the University of Virginia. The training focused on leadership style and team building. It provided an initial foundation in the Department's efforts to become a high performance organization. As of September 2006, 85 central office staff has received high performance organization (HPO) training underscoring the Department's commitment to pursue implementation of this model.

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Virginia Ranking and Trends

State Profile Information collected by the National Association of State Mental Health Program Directors (NASMHPD) Research Institute found that in FY 2004, Virginia ranked 30th among the states in per capita expenditures for MH services. Virginia ranked 9th among the states in per capita expenditures for state inpatient services and 39th in per capita expenditures for community services. Virginia's per capita expenditure for community services (\$27.99) was well below the national per capita expenditure (\$93.04). Virginia's per capita expenditure for state inpatient services (\$40.18) was considerably more than the national per capita expenditure (\$26.22). Nationally, state MH agency-controlled expenses in FY 2004 were 1.92 percent of total state government expenditures, compared to 1.68 percent in Virginia.

According to the University of Colorado, in its analysis of state developmental disabilities (DD) programs, Virginia increased its spending for community DD services by 30 percent between FY 2000 and FY 2002 and again by 9 percent between FY 2002 and 2004. However, Virginia's state fiscal effort in FY 2004 – its spending for MR/DD services per \$1,000 of aggregate statewide personal income – ranked 45th for all MR/DD services, 47th for community services, and 38th for institutional services. In FY 2004, Virginia ranked 41st in its federal and state MR Home and Community-based Waiver spending per citizen of the general population, or \$33 compared to a national average of \$54.

Based on the 2003 and 2004 National Surveys on Drug Use and Health, Virginia ranks 38th in the prevalence of any illicit drug use in the past month by individuals ages 12 or older. Virginia's rate of 7.25 percent (434,000 individuals) is below the national rate of 8.06 percent. Virginia ranks 30th in the prevalence of binge use of alcohol in the past month by individual ages 12 or older; Virginia's rate of 20.17 percent (1,327,000 individuals) is below the national rate of 22.69 percent. Virginia's rank is 38th regarding dependence on or abuse of any illicit drug or alcohol in the past year – 8.66 percent (519,000 individuals ages 12 or over) compared to a national average of 9.22 percent.

Customer Trends and Coverage

The local public MH, MR, and SA services system has continued to increase in complexity during the past decade. CSBs are now serving more consumers with more severe disabilities, with the numbers of consumers with serious mental illnesses or serious emotional disturbances increased by 25.82 percent between FY 1997 and FY 2003. Services provided to consumers have increased in intensity or specialization. The average units of service per consumer for mental health case management increased from 16.87 hours per consumer in FY 1997 to 19.03 hours in FY 2003, a 12.80 percent increase in intensity. In community MR for FY 2004, the largest percentages of Medicaid Waiver payments were for the more intensive services of residential support and day support - together making up 84 percent of MR Waiver payments. The remaining 16 percent was split between in-home residential support services and all other MR Waiver services, including personal assistance services (PAS) and supported employment services. The more flexible, inexpensive services in the Waiver are not being used as often as the more costly and intensive residential and day support options. The demand for various community services fluctuates over time by locality in response to a wide variety of influences. These influences include the availability or non-availability of services from CSBs or other agencies, shifting demographic patterns (e.g., variable population growth and migration among regions) across Virginia, and decisions made by consumers or family members about when, where, and from whom to seek services.

Between FY 1996 and FY 2006, the average daily census at the state hospital, excluding Hiram Davis Medical Center and the Virginia Center for Behavioral Rehabilitation, declined by 33 percent (from 2,222 to 1,490); admissions declined by 29 percent (from 7,468 to 5,334); and separations declined by 30 percent (from 7,529 to 5,293). Between FY 1996 and FY 2006, the average daily census at state training centers declined by 32 percent (from 2,132 to 1,451); admissions increased by 29 percent (from 87 to 112); and separations decreased by 16 percent (from 223 to 188).

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Future Direction, Expectations, and Priorities

- Changes in the population needing MH, MR, and SA services over the next six years are likely to mirror those in the overall United States population. Community MH, MR, and SA programs will increasingly serve an older population, many of whom may experience complications from a variety of physical illnesses. Increasing numbers of individuals will require CSB services and supports and other specialized services to enable them to continue to reside in community settings. Changes in the state's Medicaid benefit package, more flexible Medicaid reimbursement mechanisms for community-based services, and new models of community-based services will be required to avoid over-reliance on expensive institutional care and enable older adults to remain as independent as possible in their own homes.
- The Department has developed a Mental Retardation Service and Supports by Level of Care Model to expand the range of services and supports options to individuals who meet the level of care criteria established by Medicaid for ICF/MR eligibility. This model promotes flexibility, choice, and independence. It included five levels of services and supports that range from basic community-based non-residential services and family supports to intensive 24-hour center-based services. Continued investment in community services and supports capacity is a necessary prerequisite for implementation of the MR model. This includes expansion of community MR Waiver slots, increases in MR Waiver rates to assure community capacity, and expansion of community services and supports, including non-MR Waiver services and family supports.
- According to a national study of state services, the majority of individuals with mental retardation reside with family members. The current generation of parents of individuals with mental retardation is aging and many, due to infirmity or death, will soon be unable to care for their adult children. In 2002, an estimated 16,903 individuals with mental retardation were living with caregivers aged 60 years and older. Demand for alternative housing and structured support options will increase dramatically as the large cohort of baby boomer parents reach retirement age.
- The service system's increasing ability to assess mental retardation and co-occurring mental or physical disabilities, including mental illness, autism, and severe physical disabilities, will challenge a system that is already deficient in addressing support and treatment needs of these groups. Greater numbers of children in Virginia's school systems are being identified as having autism, both with and without a co-occurring condition of mental retardation. This increase reflects a national trend that some label as an epidemic. A significant portion of individuals seeking treatment for substance use disorders also suffers from some form of mental illness. Left undiagnosed and untreated, mental illness will hinder the individual's effort to attain stability and remain drug or alcohol free. Yet, too few professionals are trained to address both disorders and there is a dearth of psychiatric resources available to treatment programs for substance use disorders.
- The National Household Survey on Drug Use and Health (NSDUH) shows declines from 2002 to 2005 among youth ages 12-17 for past month use of alcohol, cigarettes, marijuana, hallucinogens (such as Ecstasy and LSD), and the non-medical use of prescription-type psychotherapeutic drugs. The past month use of cocaine and inhalants, however, showed no change among youth during that time period. Among youth ages 18 to 25 years, rates of current use of alcohol were similar in 2002 and 2005. Cigarette use and Ecstasy use declined among adults, but cocaine use and non-medical use prescription drugs increased.
- Southwestern Virginia continues to experience a significant increase in overdose deaths from methadone (a synthetic opiate) prescribed by rural physicians as an analgesic and lacks any significant capacity to effectively treat opiate addiction. Methamphetamine is also becoming more prevalent.
- Significant advances continue to occur in treatment technologies. Evidence-based, promising, and emerging treatment models requiring training and ongoing supervision to assure fidelity are rapidly becoming available for dissemination to community practitioners. Appropriate integration of these models and advancement into the public service system requires access to treatment professionals who are trained (or willing to be trained) to

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provide these services, as well as administrators who understand their application.

Impediments

- Communities lack basic MH, MR, and SA services capacity to address existing demand and anticipated population growth. As state general funds have remained static and costs have increased, treatment capacity is declining, particularly for individuals who are not eligible for Medicaid. This has further limited the service system's ability to meet demands for services. In many communities, start-up funding to build community infrastructure is not available.
- Increasing demands have been placed on the public services system and local hospital emergency rooms as private insurance benefits for behavioral healthcare continue to deteriorate, Medicaid and insurance reimbursement rates fail to cover even direct costs for covered services, and the number of uninsured Virginians continues to increase. Some private providers are either closing beds or no longer serving publicly funded consumers because third party reimbursement rates do not cover the cost of providing their services. In addition, the overall number of inpatient beds has declined.
- The lack of health insurance parity for the treatment of mental illnesses and substance use disorders forces many persons who would seek private sector care to rely on the public system for treatment. Although fees are charged based on ability to pay, more expensive modalities, such as residential treatment, are underwritten by tax dollars.
- Currently, there is no rate structure for MR Waiver providers and appropriations for provider rate increases are often sporadic and unpredictable. Until July 2006 when a 10 percent rate increase went into effect, there had been virtually no adjustments to the MR Waiver reimbursement rates in over 13 years. Further, in some areas of Virginia, Medicaid fees do not cover the cost of providing services, resulting in significant recruitment and retention challenges, as discussed below. Additional rate increases will be needed to enable service providers to stabilize their workforce through competitive pay rates.
- Across the services system, providers are experiencing difficulties recruiting and retaining qualified employees, particularly in highly marketable fields such as direct care workers. These difficulties will increase as the services system's current workforce grows older. The Department's existing workforce is aging, with an average age of 46 years for all positions and 49 years for nursing positions. Over 10 percent of Department employees will be eligible to retire in the next five years. Routine operations may be difficult to sustain as employees with historic knowledge and specialized skills are lost. Their replacements will come from a shrinking pool of healthcare workers.
- State hospitals and training centers are located in 12 geographic areas, with 412 buildings encompassing about 6.5 million square feet. The average age of all facility buildings is 49 years, with a median age of 55 years. The majority of occupied state facility buildings are in poor to very poor condition. Many state facility buildings are uninhabitable, require extensive renovation, or are not suited for current patient or resident needs. Funding for four facility replacement projects have been approved. ESH has received construction funding and planning funding has been appropriated for WSH, CVTC, and SEVTC.
- Fragmentation continues to exist across the agencies serving individuals with mental illnesses, serious emotional disturbances, mental retardation, and substance use disorders. Funding streams continue to be categorical, making it difficult to provide the flexibility needed to create choices among the services and supports that promote self-determination and person-centered planning, empowerment, recovery, and resilience for individuals receiving services.

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Agency Background Information

Statutory Authority

State Statutes

- Chapter 26 of Title 2.2 of the Code of Virginia establishes the Substance Abuse Services Council to coordinate the Commonwealth's public and private efforts to control substance abuse, requires the Office of Substance Abuse Services in the Department to provide staff assistance to the Council, and requires a Comprehensive Interagency State Plan.
- Chapter 53 of Title 2.2 of the Code of Virginia establishes the Early Intervention Services System to implement Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.) and describes the lead agency's responsibilities. The Department is the lead agency.
- Chapter 11 of Title 16.1 of the Code of Virginia sets out the provisions of juvenile and domestic relations court law, including authorizing the Department to conduct evaluations of the competency of juvenile defendants to stand trial.
- Chapters 11 and 11.1 of Title 19.2 of the Code of Virginia authorize the Department to provide forensic services to individuals in the criminal justice system, including evaluations of competency, determinations of sanity, restoration to competency services, and treatment services for individuals adjudicated not guilty by reason of insanity.
- Chapter 2 of Title 37.2 of the Code of Virginia establishes the State Mental Health, Mental Retardation and Substance Abuse Services Board and outlines its duties and powers.
- Chapter 3 of Title 37.2 of the Code of Virginia establishes the Department of Mental Health, Mental Retardation and Substance Abuse Services under the supervision and management of the Commissioner. This chapter outlines duties and powers of the Commissioner, including supervising and managing the Department and its state facilities, which provide care and treatment for persons with mental illness and treatment, training, or habilitation of persons with mental retardation. State facilities also provide inpatient pharmacy services, geriatric services for elderly individuals, inpatient medical services, inpatient forensic services, education and training programs for school-age consumers, and facility administrative and support services. It also lists responsibilities of the Department, including the development of a six-year comprehensive plan.
- Chapter 4 of Title 37.2 of the Code of Virginia describes the protections available to consumers of mental health, mental retardation, and substance abuse services, including their human rights and the Department's licensing of providers, and establishes the Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services.
- Chapter 5 of Title 37.2 of the Code of Virginia authorizes the establishment and operation of community services boards (CSBs) by local governments to provide community mental health, mental retardation, and substance abuse services and authorizes the Department to fund CSBs.
- Chapter 6 of Title 37.2 of the Code of Virginia authorizes the establishment and operation of a behavioral health authority (BHA) by a specified city or county to provide community mental health, mental retardation, and substance abuse services and authorizes the Department to fund a BHA.
- Chapter 7 of Title 37.2 of the Code of Virginia authorizes the Department to perform certain functions related to the operation of state hospitals and training centers (state facilities) that serve individuals with mental illness

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or mental retardation respectively.

- Chapter 8 of Title 37.2 of the Code of Virginia addresses admissions and dispositions of individuals relative to facilities. It authorizes the Department or CSBs to provide drugs or medicines from funds appropriated to the Department for that purpose for consumers discharged from state facilities when they or the persons liable for their care and treatment are financially unable to pay for or otherwise access them (aftercare pharmacy services).
- Chapter 9 of Title 37.2 of the Code of Virginia authorizes the civil commitment of sexually violent predators, requires the Department to operate or contract for a secure confinement facility to provide behavioral rehabilitation services to them, and requires the Department to implement conditional release orders.
- Section 54.1-3437.1 of the Code of Virginia authorizes the Board of Pharmacy to issue a limited manufacturing permit to the pharmacy directly operated by the Department that serves consumers of the CSBs for the purpose of repackaging drugs.

Federal Statutes and Regulations

- Public Law 102-321 authorizes the federal Substance Abuse and Mental Health Services Administration to provide federal funds to the Department for community mental health services.
- The Nursing Home Reform provisions of the Omnibus Budget Reconciliation Act of 1987 allow for preadmission screening evaluations and determinations for OBRA eligibility.
- Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.) and 34 CFR 303.303.11-325 under the Individuals with Disabilities Education Act authorize the state to implement a statewide, comprehensive, coordinated, multidisciplinary, interagency system of early intervention services for infants and toddlers with disabilities and their families. The Individuals with Disabilities Education Act also defines who receives special education services in state facilities.
- Sections 1921-1954 of the Public Health Services Act authorize the federal Substance Abuse Treatment and Prevention (SAPT) Block Grant, providing federal funds to the Department for community substance abuse treatment and prevention services.
- The federal Centers for Medicaid and Medicare (CMS) certifies all ICF/MR beds in training centers operated by the Department and acute care beds and skilled nursing beds at the CVTC.

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Department Of Mental Health, Mental Retardation and Substance Abuse Services

Customer Base:

Customer Description	Served	Potential
Adults served in state hospitals	4,491	5,748
Children and adolescents served in state hospitals	664	764
Children with mental retardation who need family support services	2,000	5,000
Community services boards and behavioral health authority (CSBs)	40	40
Consumers and family members receiving services from consumer-run programs, consumer and family education programs, or family-run support and education programs	2,249	5,000
Department of Corrections inmates meeting criteria as sexually violent predators (SVP) and eligible at release for SVP civil commitment	64	600
Governor (Office of the Inspector General Reports)	1	1
Individuals discharged from state hospitals and those diverted from state hospitalization to local acute care served by the Aftercare Pharmacy	5,892	5,812
Individuals meeting SVP criteria and civilly committed to the Virginia Center for Behavioral Rehabilitation (VCBR)	32	300
Individuals meeting SVP criteria and conditionally released for SVP treatment	32	50
Individuals served by nursing homes with mental retardation who are recipients of OBRA services	188	762
Individuals served by the CRP who are on community intake status	2,302	2,302
Individuals served by the CRP who have Medicaid drug coverage	785	1,000
Individuals served in state training centers	1,586	1,661
Individuals with active criminal justice system involvement who require secure forensic services	1,472	1,766
Individuals with mental retardation served by or seeking services from CSBs	26,050	31,224
Individuals with or at risk of serious mental illnesses or serious emotional disturbances served by or seeking services from CSBs	115,173	121,540
Individuals with substance use disorders served by or seeking services from CSBs	53,909	57,298
Infants and toddlers and their families served in Part C early intervention services	10,212	11,029
Juveniles requiring restoration to competency treatment services	126	158
Licensed providers of MH, MR, and SA services and developmental disability waiver services (including CSBs, other public, and private providers)	2,764	3,180
Local and regional jails	84	84
Members of committees and councils established or required by state or federal statutes or regulations staffed and supported by Department central office staff	525	525
Members of the General Assembly (Office of the Inspector General Reports)	140	140
Members, State Mental Health, Mental Retardation and Substance Abuse Services Board	9	9
Nursing homes	178	273
Participants in community prevention programs and coalitions	351,462	351,462
Patients at Hiram Davis Medical Center	196	208
Patients on state hospital medical/surgical units	446	468
Patients on the Central Virginia Training Center medical/surgical unit	478	502
Persons who make complaints about licensed providers that result in investigations	483	500
Senior adults (65 and older) receiving services in state hospitals	695	785

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Customer Base:

Customer Description	Served	Potential
State facility employees	9,248	9,248
State facility patients and residents receiving inpatient medical services in local hospitals through special hospitalization	543	597
State hospitals and training centers	16	16
Training center residents receiving vocational/educational services	1,366	1,503
Virginia Circuit and District Courts	325	325

Anticipated Changes In Agency Customer Base:

The Department anticipates the customer base for MH, MR, and SA services provided in community and state facility settings will continue to increase for a variety of reasons.

- Virginia's population is increasing, becoming more culturally diverse, and growing older. The customer base for MH, MR, and SA services will change to reflect these demographic trends.
- State facilities and community providers are already serving proportionately greater numbers of individuals with significant or complex service needs. State training center residents, particularly, will have serious medical conditions and physical risk factors. The number of state hospital patients with chronic medical conditions such as diabetes and hypertension will continue to increase. These individuals will require specialized health services, more medications, and ongoing preventive care.
- The frequency of individuals with co-occurring combinations of mental illnesses, substance use disorders, or mental retardation or other cognitive deficits, will increase, requiring more complex, specialized interventions and care.
- A growing number of Virginians have either limited or no MH insurance benefits that, too often, result in less than optimal treatment and care. These individuals will place increasing pressure the public services system.
- Limited affordable housing, insufficient numbers of residential treatment options, and the decreasing availability of local, acute inpatient beds will contribute to the Department's expanding customer base.
- Increased numbers of juveniles receiving restoration of competency services also are anticipated.
- As CSBs purchase more local inpatient beds and develop community crisis stabilization services, increasing numbers of individuals will be eligible for Community Resource Pharmacy services.
- Anticipated significant increases in the number of private providers and service locations, including newly established brain injury programs, will affect the Department's ability to license programs and protect the safety and human rights of individuals receiving services.
- Availability of Medicaid Early, Periodic, Screening, Detection, and Treatment (EPSDT) services for eligible youth will increase service referrals of adolescents in need of treatment for substance use disorders.

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Agency Partners:

Commitment Review Committee (CRC):

The Department's Conditional Release program staff serves on the CRC committee, which is operated by the Department of Corrections. The Department of Corrections screens SVP-eligible inmates for CRC review. The CRC reviews these cases and sends forward to the Office of the Attorney General those appropriate for SVP civil commitment.

Community Services Boards and Behavioral Health Authority (CSBs):

The Department allocates state and federal funds to the 40 CSBs to support the provision of community MH, MR, and SA services and supports. It regulates CSBs and works with CSBs to streamline licensing and other regulatory and reporting processes. CSBs participate in Department in policy, planning, and regulatory development for the services system. The Commissioner enters into contracts with CSBs to provide juvenile competency evaluation and restoration services

Consumers, Family Members, and Advocacy Organizations:

Consumers, advocacy organizations, and consumer and family groups provide important feedback to the Department, the CSBs, and the state facilities on service needs, services, and policy, planning, and regulatory development activity for the public services system. Department staff meet with MH, MR, and SA advocacy organizations, and consumer and family groups to address issues of mutual concern. These organizations have a voice in policy, planning, and regulatory development for the services system. Some consumers and family members serve on CSBs. Consumer-run organizations provide very valuable services and supports for MH consumers and some advocacy organizations provide training and education for consumers and family members. State facility staff and CSBs work closely with consumers and family members in providing care, treatment, habilitation, and case management services. Consumers and family members are actively and meaningfully involved in all aspects treatment and discharge planning and community participation.

Federal Agencies:

The Department meets federal requirements associated with the receipt of block grants and other resources that support the provision of MH, MR, and SA services and for the development of services system capacity and technology. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides grants to the Department that support community MH and SA services. SAMHSA provides technical assistance to the Department and the CSBs about requirements associated the receipt of the grant funds. Similarly, the Office of Special Education Services (OSES) in the Department of Education provides grants of federal funds to the Department that support Part C early intervention services for infants and toddlers and their families. OSES also provides technical assistance to the Department on requirements associated with receipt of these grant funds.

Local Governments:

Because they establish CSBs, local governments have an important relationship with the Central Office through the CSBs. Local governments approve their CSBs' performance contracts that provide the basis for funding the CSBs. They also provide financial resources to the CSBs to match state funds, and, in some instances, may provide administrative services that are essential to CSBs' efficient operation. Through its licensing function, the Department works with local zoning, fire, health, taxation, social services and Comprehensive Services Act officials to implement regulations and share information.

Private Providers (for profit and non-profit organizations):

Private providers are critical components of the publicly funded MH, MR, and SA system. They deliver a significant portion of community services across the state through contracts with CSBs. Many private providers also deliver substantial amounts of Medicaid MR Waiver services to consumers pursuant to individualized plans of care developed and approved by CSBs, and all of these consumers receive Medicaid targeted case management services from CSBs. Local acute care hospitals are important providers of inpatient treatment purchased by CSBs through local bed purchases and by state facilities for patients or residents who require inpatient medical care. CSBs and the state hospitals work closely with

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local hospitals in coordinating admissions and discharges. CSBs, in cooperation with state hospital staff, plan, coordinate and monitor community residential placements in nursing homes, group homes and assisted living facilities to insure successful community transition and adjustment. The Department works with private providers to ensure that they meet licensing and human rights requirements. The Commissioner enters into contracts with private providers to provide juvenile restoration services and conduct post restoration evaluations of juvenile competency. Also through contracts with the Department, private community providers deliver sexually violent predator treatment, supervision, and monitoring services. Private providers also participate in policy, planning, and regulatory development for the services system.

Provider Associations:

Department staff meet with provider associations to address issues of mutual concern. These associations participate in policy, planning, and regulatory development for the services system. Department Forensic staff work closely with the Virginia Sheriff's Association, the Virginia Association of Regional Jails and the Virginia Hospital and Healthcare Association in developing an agenda for positive change in the forensic program.

State and Local Agencies:

The Department works closely with many state and local agencies that provide or fund services and supports that respond to the needs of individuals with mental illnesses, mental retardation, or substance use disorders. These include partnerships with the Departments of Medical Assistance Services (DMAS), Social Services (DSS), Health (DOH), Rehabilitative Services (DRS), Housing and Community Development (DHCD), Corrections (DOC), Juvenile Justice (DJJ), Criminal Justice Services (DCJS), Aging (DA), and Education (DOE). Central Office and state facility staff work with the Virginia Office for Protection and Advocacy (VOPA) to ensure protections and advocacy for the human and legal rights of individuals with mental, cognitive or developmental disabilities. Partnerships with local agencies such as school systems, local social services, local health departments, and area agencies on aging are critical to the success of community MH, MR, and SA services. These include Medicaid MH services, MR Waiver services, auxiliary grants for adult living facilities, Medicaid eligibility determinations, various social services, guardianship programs, health care, vocational training, housing assistance, and services for TANF recipients. Some of these local agencies also provide Part C early intervention services to infants and toddlers and may serve as Part C local lead agencies (LLAs). State and local agency representatives participate as members of various state and regional planning committees, including the Special Populations Workgroups and Regional Strategic Planning Partnerships focused on transforming the services system. The Department works closely with the Office of the Attorney General, which provides legal consultation, training, and technical assistance in a number of important areas, including civil commitment training; serving as counsel to the Department on the State Board and Human Rights Committee; assisting the Department in the development or revision of legislation; reviewing Department regulations, State Board policies, and key departmental instructions; and providing specialized training, expert testimony, and consultation various forensic and sexually violent predator issues. Department staff also work closely with the Department of Planning and Budget (DPB) around budget planning and finance expertise, with the Department of Accounts (DOA) in the receipt of accounting and processing services, financial reporting guidance and payroll expertise, and with the Department of General Services (DGS) around guidance regarding facility physical plant services.

Virginia Institutions of Higher Education (Colleges, Universities, and Community Colleges):

The academic medical centers, academic programs of other colleges and universities, and community colleges work with the Department to collaboratively address workforce issues, to promote the implementation of evidence-based and other promising practices, and to train the services system's existing and emerging workforce. The Institute of Law, Psychiatry, and Public Policy at the University of Virginia provides training for juvenile and adult forensic evaluators and civil admission prescreeners and provides SVP civil commitment training. The Institute has partnered with the Department's Office of Forensic Services for more than 25 years to develop improved evaluation and treatment services for

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forensic clients and to promote outpatient approaches to service delivery.

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Agency Products and Services:

Current Products and Services

Community MH, MR, and SA Services Provided by or Through CSBs:

A. Community Mental Health Services

- Emergency services, including crisis intervention and preadmission screening
- Local acute psychiatric inpatient services
- Outpatient services, including therapy and counseling, medication services, and intensive in-home services
- Assertive community treatment (PACT teams and ICT programs)
- Case management services
- Day treatment and partial hospitalization, including therapeutic day treatment for children and adolescents
- Rehabilitation services, including psychosocial rehabilitation programs
- Sheltered employment
- Group supported employment
- Individual supported employment
- Highly intensive residential services, such as crisis stabilization programs and residential treatment centers
- Intensive residential services, such as group homes
- Supervised residential services, such as supervised apartments, domiciliary care, and sponsored placements
- Supportive residential services, such as supported living arrangements
- Prevention services
- Early intervention services
- Consumer monitoring
- Assessment and evaluation services
- Consumer-run peer and support services
- Consumer and family member education and training activities

B. Community Mental Retardation Services

- Outpatient services, including behavioral management and consultation and medication services
- Case management services
- Habilitation services
- Sheltered employment
- Group supported employment
- Individual supported employment
- Highly intensive residential services, such as community ICF/MR programs
- Intensive residential services, such as group homes
- Supervised residential services, such as supervised apartments, domiciliary care, and sponsored placements
- Supportive residential services, such as in-home respite care and supported living arrangements
- Prevention services
- Early intervention services
- Consumer monitoring
- Assessment and evaluation services
- Medicaid targeted case management and MR Waiver services reimbursed by the DMAS
- Early intervention services for infants and toddlers under Part C

C. Community Substance Abuse Services

- Emergency services, including crisis intervention
- Local acute psychiatric inpatient services

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- Community-based substance abuse medical detoxification inpatient services
- Outpatient services, including therapy, counseling, intensive outpatient, opioid detoxification, and opioid treatment
- Day treatment and partial hospitalization
- Rehabilitation services, including psychosocial rehabilitation programs
- Sheltered employment
- Group supported employment
- Individual supported employment
- Intensive residential services, such as primary care, intermediate and long-term habilitation, and group homes
- Jail-based habilitation services
- Supervised residential services, such as supervised apartments, domiciliary care, and sponsored placements
- Supportive residential services, such as supported living arrangements
- Prevention services, including community prevention coalitions
- Early intervention services
- Substance abuse social detoxification services
- Substance abuse motivational treatment
- Consumer monitoring
- Assessment and evaluation services
- Special projects (e.g., Co-Occurring Services Integration Grant (COSIG) and Strengthening Families)

Services Provided by State Mental Hospitals and Training Centers:

A. Inpatient Medical Services Products and Services

- Physician services
- Nursing services
- Skilled nursing care
- Special hospitalization (purchase of medical care from local hospitals)
- Pathology lab
- Radiology
- EEG/EKG
- Dental services and dental anesthesiology
- Speech and audiology
- Physical, occupational, and recreational therapy
- Ophthalmology services
- Respiratory therapy
- Psychology services
- Medical supplies
- Detoxification

B. State Mental Health Facility Services

- Psychiatric assessment, stabilization and medication management
- Psychosocial rehabilitation programming, including psycho-education and recovery-oriented programming
- Psychology services
- Nursing services
- Social work services
- Co-occurring MH/SA services
- Peer support services
- Recreational, physical and occupational therapies

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C. State Mental Retardation Training Center Services

- Medical and psychiatric assessment
- Occupational, speech, physical, recreational therapies
- Short-term respite and emergency care
- Habilitation and skill acquisition for community integration
- Person-centered planning
- Regional Community Support Center services and supports to individuals living in the community

D. Inpatient Geriatric Care Services

- Psychiatric and medical assessment
- Psychology services
- Nursing services
- Social work services
- Recreational, physical and occupational therapies
- Individualized treatment plans
- Medication management and rehabilitation
- Discharge planning and coordination

E. Facility-based Education and Skills Training

- Pre-vocational skills
- Habilitation services
- Sheltered workshop
- Work readiness training
- Community based employment
- Functional academics based on the consumer's Individual Education Plan.

F. Forensic and Behavioral Rehabilitation Security

Forensic Services

- Expert inpatient and outpatient MH evaluations and reports for the courts
- Emergency treatment services
- Treatment to restore competency to stand trial
- Commitment for treatment for individuals acquitted of a criminal offense as Not Guilty by Reason of Insanity
- Expert court testimony in forensic matters
- Statewide training in forensic MH evaluations for the criminal courts
- Coordination with CSBs of public community MH services for forensic consumers
- Training, consultation, and assistance on forensic issues

SVP Behavior Rehabilitation Services

- Sex offender rehabilitation services within a maximum-security perimeter
- Review of CRC and SVP evaluations
- Annual and as needed sex offender evaluation and treatment training
- Quality management feedback to CRC evaluators
- Annual SVP commitment reviews for the courts

Pharmacy Services

A. Aftercare Pharmacy Service Area Products and Services

- Medication management -- dispensing, preparation, packaging, compounding, labeling and mailing
- Provision of drug and medication information to CSBs, consumers, and family members
- Utilization of cost containment methods, including the "Medsavers" program
- Participation in the Department's Pharmacy, Therapeutics and Formulary Committee
- Participation in the development of a Behavioral Quality Indicator program

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B. Inpatient Pharmacy Service Area Products and Services

- Medication selection and procurement
- Medication management and education
- Service oversight and cost containment
- Medication preparation and dispensing
- Medicare Part D participation

Facility Administrative and Support Services

- Administrative leadership and regulatory compliance
- Information technology support
- Food services for state facility patients and residents
- Housekeeping services to ensure a clean and safe environment
- Linen and laundry services
- Physical plant services, including building maintenance and security services
- Power plan operations
- Employee training and education services

Central Office Administrative and Support Service Area Products and Services

A. Policy, Legislation, Strategic and Comprehensive Plans, and Studies:

- State Board and operational and programmatic policies, regulations, and guidance documents
- Legislative analysis, proposal development, and studies
- Strategic, comprehensive, and continuity of operations plans
- Consumer surveys
- Staff support to boards, councils, and committees established in state or federal requirements

B. Consumer Protections:

- Human Rights investigations and reports
- Criminal background checks for prospective state facility and certain community employees

C. Services System and Program Development and Oversight:

- Training and technical assistance and general guidance to CSBs, state facilities, and providers
- Performance Contracts with CSBs that fund services
- Medicaid MR Waiver pre-authorization of services
- Nursing home pre-admission screening and resident reviews (PASRR)
- Terrorism and disaster preparedness, response, and recovery operations
- Compilation and analysis of service data and quality indicators
- Grant application development and implementation of grant-funded projects
- Quality assurance reports

D. Agency Operations:

- Financial management, reporting, and allocation and disbursement of state and federal funds
- Development of central office contracts and business agreements
- Revenue collection
- Internal audits, audits of data and reports, and compliance reviews
- Information technology systems development and support
- Workforce management, recruitment, training, and development
- Risk management and HIPAA compliance
- General support services for central office operations (mail, parking, procurement)

E. Management of the SVP Conditional Release Program:

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- Development of conditional release safety and treatment plans
- Training to expand community treatment capacity
- Recruitment, training, and management for community conditional release treatment teams

F. Supervision of the Juvenile Competency Restoration Program:

- Juvenile Forensic Evaluation and Juvenile Competency Restoration procedures
- Arrangements for Competency to Stand Trial restoration treatment services
- Administration of fee for services contracts with CSBs and private providers
- Technical assistance, training, supervision, oversight, and general guidance to services providers
- Quality assurance and compilation of service data and quality indicators

G. Architectural and engineering services (State facilities and Woodrow Wilson Rehab. Center):

- State facility capital master plans
- Oversight of facility capital projects' design and implementation
- Energy audits

Regulation of Public Facilities and Services Products and Services

- Issue new licenses and renew licenses of MH, MR, SA, developmental disability, and brain injury services providers
- Unannounced monitoring of licensed services
- Complaint investigations of licensed services
- Receive and review data on serious injuries and deaths in services
- Revocation and sanction actions against licensed service
- Information to the public about licensed providers
- Verification to payment sources (DMAS and DSS) that a provider is licensed
- Training of applicants to become licensed

Facility and Community Program Inspection and Monitoring (Office of the Inspector General)

- Reports of findings and recommendations regarding the quality of services that result from inspections of facilities operated by and programs licensed by the Department.
- Investigations of complaints regarding abuse, neglect and quality of services
- Consultation to state facilities and licensed programs regarding compliance with OIG recommendations
- Review of Department instructions and regulations
- Support to the Office of the Governor and the General Assembly, as requested

Factors Impacting Agency Products and Services

Factors Affecting Community Mental Health, Mental Retardation and Substance Abuse Services

- Demand for community MH, MR, and SA services is expected to increase as Virginia's population grows.
- The President's New Freedom initiative, along with ongoing Olmstead concerns, will continue to emphasize the development of community services. However, possible federal efforts to reform Medicaid could have potentially catastrophic effects on the provision of community MH and MR services, in terms of services covered, eligibility of individuals, and the financial impact of any Medicaid reform on other parts of the state's budget. Any additional constraints on eligibility or covered services would increase the demand for and reliance on CSB services.
- The increased costs of providing services without corresponding increases in state and federal funds will result in the provision of fewer MH, MR, and SA services to fewer individuals and an increased unmet demand for services. Absent or inadequate increases in base amounts of state or federal funds to support the normal ongoing costs of providing services, such as cost-of-living increases, or to address unavoidable increases in operating expenses, such as the escalating costs of existing and new

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psychotropic medications, have adversely affected the capacity of CSBs and private providers to maintain current levels of services. It appears that the federal government intends to reduce the level of ongoing block grant funding that it provides to the states for community MH and SA services.

- The absence of adequate reimbursement rates for Medicaid State Plan Option and Medicaid MR services will continue to make it increasingly difficult to sustain essential core services offered by CSBs and private providers. This will increase the demand for and reliance on CSB services that are supported only with state, local matching, or federal funds. Inadequate reimbursement rates and the resulting lack of available cost-effective community services mean consumers in some instances end up using higher cost services instead.
- The decreasing availability of adequate health insurance coverage for the treatment of mental illnesses and the increasing numbers of individuals without health insurance who do not qualify for Medicaid will increase the demand for services provided by CSBs that are supported with only state, local matching, or federal funds. The lack of parity in Medicaid and other insurance coverage for SA services also increases the demand for and reliance on CSB services that are supported only with state, local matching, or federal funds.
- The decreasing availability of qualified professionals, particularly direct care staff, makes it more difficult for CSBs and private providers to maintain or expand existing services or develop new services to address unmet demands for services, to deliver quality services, to maintain the most challenging persons in the community, or to adopt or develop new service modalities or approaches, such as evidenced-based practices. For example, there is a growing need for community-based practitioners of positive behavioral supports. A better trained and a more stable direct care work force is a critical need throughout the state at all service levels.
- Improved assessment and screening of adults and children with co-occurring mental illness and substance use disorders or co-occurring mental retardation and mental illness or mental retardation and substance use disorders will increase demands for integrated services to treat these co-occurring conditions.
- Increasingly complex federal requirements to report treatment and prevention outcome data will require additional staff resources to provide direct clinical services. For example, the federal National Outcome Measures will require CSB to collect and report outcome measures in at least six domains for both MH and SA.
- The inability to communicate HIPPA-sensitive information electronically between the Department and all providers slows processes of service authorization and incident reporting.
- A new federal emphasis on the development and support of services provided by faith-based organizations may affect current service providers and introduce significant complexity into the administration, management, and provision of community SA services.
- A persistent lack of residential treatment services capacity adversely affects the services system's ability to address unmet service needs.
- All community SA prevention services are supported by federal block and competitive grants. Lack of state funds inhibits the ability of the services system to provide all of the prevention programs that are needed and would have a significant impact on the reduction of substance use disorders and their associated services costs.
- Increased state and federal emphases on identifying and serving substance-exposed newborns, substance-affected children, and their families involved with the child welfare system and juvenile and domestic relations courts will increase service referrals and introduce increased needs for collaboration, care coordination, and training across systems.

Factors Affecting Services Provided by State Hospitals and Training Centers

- As the Department invests in community services and rigorously screens and continuously reviews the acuity and level of functioning of state hospital patients to ensure that inpatient services continue to be needed, demand for inpatient beds is expected to decrease. This decrease could be offset by increased demands resulting from population growth, continued reductions in the number of local hospital

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psychiatric beds statewide, inadequate financial support to develop community crisis stabilization and intensive community treatment, lack of available and affordable housing and residential treatment options, and further deterioration in mental health insurance benefits. The lack of integrated community treatment for persons with co-occurring mental illness and substance use disorders or co-occurring mental retardation and mental illness or mental retardation and substance use disorders also could increase demand for state hospital services.

- Future demand for state training center services will be decreased by the increased availability of community MR services and supports, including MR Waiver group homes, community ICF/MR facilities, and behavioral consultation and medical, dental, and other services provided through the Regional Support Centers.
- Demand for secure forensic evaluation and treatment services is anticipated to increase as the population grows, resulting in more people on waiting lists for admission to secure units and longer wait times. Demand for secure forensic services may be offset by community MH agency, law enforcement, and court response to the behaviors of individuals with mental illness in community settings. The lack of community MH crisis intervention and crisis stabilization services and the complexity of arranging inpatient treatment for individuals in crisis often result in individuals being arrested and incarcerated, in lieu of community-based or state hospital treatment. Once arrested, these individuals often require a year or more of inpatient treatment to render them able to stand trial for criminal charges that could have been avoided if a jail diversion approach were available.
- Changes to the Code defining SVP qualifying crimes and SVP screening criteria have increased the number of inmates who meet the SVP civil commitment standards by approximately 300 percent, necessitating the expansion of state hospital civil commitment resources and beds and community treatment and supervision resources for individuals who are conditionally released.
- Gradual declines in the census of state facilities and increased emphasis on medical screening to ensure that complex medical problems of individuals are addressed in local hospitals prior to their admission to a state facility have the potential to decrease utilization of facility medical/surgical units and reduce the costs associated with outpatient medical services and hospitalizations in local hospitals purchased by state facilities.
- The reluctance of older adults to seek MH treatment and the poor service coordination among agencies providing services to this population often results in a more complicated clinical picture when a person finally does present for services. Older adults comprise slightly less than four percent of the consumers served by CSBs, compared to 16 percent of the population generally. This reluctance to seek treatment early, coupled with the insufficient availability of specialized services and expertise in CSBs and the lack of a focal point in the Department to facilitate the development of services for this population, may increase demand for inpatient services.
- The cost for facility-based education and skills training education services and associated materials is expected to increase, as will the cost to transport individuals to off-campus instruction services. Public school program costs, paid by the state facility to local public schools if the consumer's needs are best met there, will continue to increase.
- The current poor condition of state facility buildings will require significant infrastructure investment and replacement.
- Clinical, environmental, and administrative standards set by the Centers for Medicaid and Medicare (CMS) and by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) are likely to continue to become more complex, burdensome, and more expensive to implement.

Factors Affecting Pharmacy Services

- Medicare Part D implementation has increased demands on state facility pharmacies. Facility pharmacies are accepting all Medicare Part D third party payers and billing on behalf of all eligible consumers.
- The decrease in demand for Community Resource Pharmacy (CRP) services resulting from Medicare Part D will be offset as local inpatient purchase of service options and community crisis stabilization

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capacity is increased. Individuals receiving CRP services are requiring numerous changes in medication regimens and have much faster response and turnaround times.

- The growing number of individuals who are medically uninsured or underinsured results in unrecoverable medication costs to the Commonwealth.
- Prescription drugs are the fastest growing segment in health care expenses in the United States. Psychotropic medications account for more than \$60 billion nationally in annual sales from pharmaceutical companies. As new, more effective but expensive medications are introduced and prescribed, direct pharmaceutical costs will continue to increase.
- There is a pharmacist shortage in Virginia and nationally. The Department's pharmacist salaries are among the lowest in the state, making recruitment and retention of pharmacists extremely difficult.
- The Department must comply with the recent federal mandate to implement bar codes, effective April 26, 2006.
- The current state facility pharmacy computer system was purchased in the 1980s and is outdated and inadequate. It is unable to communicate with other data systems, most significantly the Department's current billing system and patient demographics database.

Factors Affecting Administrative and Support Services (Central Office)

- The average age of the central office workforce is just under 52 years old and their average length of state service is almost 18 years. Almost 15 percent of employees will be eligible to retire in the next five years. This level of turnover, especially in key positions, could significantly affect central office operations.
- New requirements in Governor's Executive Orders and changes in regulations from external agencies such as DOA, DHRM, DPB, DGS, and VITA. Additional workload requirements, often unfunded, from federal or state agencies could affect central office administrative and support services.
- Changes in economic conditions affecting Virginia may limit the ability of the central office to hire the number of staff needed to accomplish the objectives of the service.
- Central office administrative and support services may be affected by new federal performance measurement requirements and the implementation of VITA's standards for production application information technology systems.
- Consumers and advocacy group issues continue to affect central office operational priorities, strategic and comprehensive planning, and policy and regulatory development activities.

Factors Affecting Facility Administrative and Support Services

- The state facility workforce is aging just as the state workforce in general. This is particularly true for facilities in rural areas where staff turnover is lower than in more urban areas. Recruitment and retention of the facility workforce of the future will be a challenge.
- New requirements in Governor's Executive Orders and changes in regulations from external agencies such as DOA, DHRM, DPB, DGS, and additional workload requirements, often unfunded, from federal or state agencies could affect state facility administrative and support services. Changes in the Department's regulations related to human rights also could affect state facility administrative and support services.
- Individuals with more complex and severe medical disabilities will place additional demands on facility support services, increasing demand for special diets, additional laundry services, more frequent housekeeping, and specialized safety and security.
- Changes in economic conditions affecting Virginia may limit the ability of facilities to hire the number of staff needed to accomplish the objectives of the service.
- Facility administrative and support services also may be affected by the rapidly changing healthcare environment, annual increases in health care costs, facility relationships with VITA and implementation of technological changes such as the electronic health record, and future potential outsourcing of state facility administrative and support functions.
- Facility building renovation needs driven by building or life safety code changes and aging capital

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equipment also could affect facility administrative and support functions.

Factors Affecting Regulation of Health Care Service Providers

- New or revised federal and state statutes and regulatory or funding requirements affecting licensing of MH, MR, and SA services and DD Waiver services
- Increased demands resulting from development of new MH, MR, and SA services and DD Waiver services licensed by the Department
- Licensing staffing levels and competitive pressures affecting recruitment and retention of new staff
- Consumers and advocacy group issues
- Information technology changes
- Media or community attention to licensed services as a result of serious incidents or community concerns.

Factors Affecting Facility and Community Inspection and Monitoring (Office of the Inspector General)

- Federal Department of Justice (DOJ) expectations regarding ongoing compliance by the state facilities with DOJ-VA settlement agreements
- The gradual downsizing of state facilities and increase in the severity and complexity of consumers' needs
- The shift of care for many consumers with severe disabilities to the community
- An increase in the number of community-based public and private providers
- Limited staffing with which to carry out the responsibilities established in the Code of Virginia.

Anticipated Changes in Agency Products and Services

Anticipated Changes in Community MH, MR, and SA Services

- The Department's ongoing collaborative efforts with CSBs and other stakeholders to transform the public MH, MR, and SA services system will increase the need and demand for existing and new types of community services as state facility capacity continues to be reduced gradually and community service capacity is increased.
- Improved early screening, assessment, and clinical practice patterns will allow for more efficient, effective interventions to greater numbers of consumers and improved treatment outcomes.
- As part of this transformation, CSBs and regional consortia of CSBs need to acquire the requisite capacity to manage their utilization of state facility and community inpatient psychiatric beds. This will require increased staff and infrastructure to conduct extensive and complex utilization management and review activities, but this activity will result in much more effective and efficient use of expensive and scarce state and local hospital beds.
- Federal block grant requirements and the National Outcome Measures will require that CSBs offer evidence-based treatment and prevention programs and practices. The identification and adoption of evidence-based or consensus-determined best practices, such as assertive community treatment, supported employment, illness management, recovery services, multi-systemic therapy, functional family therapy, and systems of care for children and adolescents with serious emotional disturbances, will require additional resources to implement, monitor, and evaluate these practices and services.
- Changes in the infrastructure from a more facility-based system of care to a system of more community services and supports will continue to cause dramatic increases in the number of licensed providers. This increase in new providers and emerging evidence-based practices will require increased demand for training personnel in order to maintain minimum standards of quality.

Anticipated Changes in Services Provided by State Hospitals and Training Centers

- Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Centers for Medicare and Medicaid Services (CMS) standards will continue to emphasize the provision of person-centered active treatment. This requires a well-trained workforce that is kept current with best clinical practices.
- Nationally, JCAHO is expecting healthcare organizations to increase use of information technology

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such as electronic health care records to improve staff clinical communication and quality assurance and reduce medication errors. Cost containment efforts regarding medication and monitoring of service quality also will require increased computerization.

- Utilization of telecommunication for clinical consultation to isolated or distant community providers is likely to increase.
- Both JCAHO and CMS will continue to increase inpatient standards for environmental safety. State facility buildings must be appropriate to consumer needs and must meet 2000 Fire/Life Safety Standards.
- Facility buildings at all training centers must be replaced over the next three biennia due to their extreme age, poor plant condition, and inappropriateness to consumer needs. The Department is proposing implementation of the MR Services and Supports Options by Level of Care (the MR Model) that would replace the training centers with smaller, appropriately designed and efficient Intensive Support Centers (ISCs) and an extensive array of flexible community-based service options, including enhanced and improved community MR Waiver and family supports, community ICF/MRs, and MR Waiver group homes. The ISCs or state medical schools would operate Regional Community Support Centers that would provide dental, behavioral, medical, and other clinical services to individuals in the community.
- The Department and its partner agencies will work to improve the current process of managing the care provided to individuals with mental illness who become involved with the criminal justice system in Virginia.

Anticipated Changes in Pharmacy Services

- The Food and Drug Administration published a final rule on Bar Code Label Requirements on certain products dispensed from pharmacies. Implementation of this technology will help identify patients receiving medications and improve patient safety.
- The atypical antipsychotic class of medications has recently been shown to effectively control manic symptoms of bipolar disorder, as well as offer a superior side effect profile compared to older agents. The FDA's approval of these drugs in alternative disease states (bipolar disorder, etc.) may further increase the utilization within this class of drugs.

Anticipated Changes in Administrative and Support Services (Central Office)

- The central office will implement training for state facility staff and community providers focused on implementing recovery, resilience, and person-centered principles and practices.
- Central office human rights activities, including investigations, will increase as the number of MH, MR, and SA service providers will continue to grow.
- SVP Conditional Release service needs will increase each year as more individuals meeting the criteria as sexually violent predators are conditionally released, have their probation or parole obligation end, or are released from the Virginia Center for Behavioral Rehabilitation.
- The number of court orders for juvenile competency restoration issued per annum has doubled since FY 2000 and is expected to continue to increase.
- The central office will conduct more program and utilization reviews and financial and compliance audits to ensure accountability and compliance with federal and state statutes and regulations.
- The central office will adopt and promote through training, consultation, and technical assistance, evidence-based, best and promising practices that incorporate recovery, resilience, and person-centered principles and practices.
- The central office will develop state-of-the-art information technology systems to meet current management, monitoring, and compliance needs. It will establish a data collection and analysis capacity for quality assurance and improvement and performance measurement activities.

Anticipated Changes in Facility Administrative and Support Services

- Other than the potential privatization of specific services, no major changes in state facility administrative and support services are anticipated.

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Anticipated Changes in Regulation of Public Facilities and Services

- The Department became responsible for licensing brain injury services in FY 2006. This has significantly increased the number of private providers and service locations licensed by the Department. This increase will affect the agency's ability to protect the human rights of consumers receiving services and to assure these programs meet licensing requirements.
- Although funding for three new licensing positions was allocated in FY 2006, because current positions lost funding from Title IV-E, the Department has been unable to fill the new positions. The Department has seen a 34 percent increase in the number of licensed locations between FY 2002 and FY 2006. The current ratio is 1:184 staff/licensed locations, compared to 1:17 staff/location ratio for assisted living facilities and 1:17 for nursing homes. In assisting with the transformation initiative, the Office of Licensing, since July 2004, has licensed over 500 additional group home beds, additional day support services, and crisis stabilization services to replace use of local inpatient and state hospitalization.
- Increased focus on community services may increase likelihood of investigations by VOPA or media, which affects and generally increases licensing monitoring.

Anticipated Changes in Facility and Community Program Inspections and Monitoring (Office of the Inspector General)

- On a pilot basis during FY 2006, the OIG is beginning to conduct inspections and reviews of licensed community-based programs operated by community services boards and private providers.
- The OIG will begin to focus more inspections of state facilities on topical areas that enable a targeted look at specific functional areas rather than broad-based reviews of the facilities.

Agency Financial Resources Summary:

Department of Mental Health, Mental Retardation, and Substance Abuse Services funding comes from state general funds, special revenue funds, and federal grants. State general funds support the Department's 16 state facilities, finance the majority of the central office oversight functions, and fund community programs operated by Virginia's CSBs and several private not for profit organizations.

Special Revenue funds are derived predominantly from the collection of fees related to the provision of services in the Department's inpatient facilities. These revenues consist of Medicaid reimbursement, Medicare reimbursement, private insurance reimbursement, private payments, and other federal entitlement programs.

Federal funds consist of numerous grants from the federal government. The majority of the Department's federal funds consist of the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Community Mental Health Services (CMHS) Block Grant, which are passed through to CSB programs. With the exception of the National School Lunch, National School Breakfast, Education of Handicapped Children, and Virginia Department of Agriculture and Consumer Services Federal Food Distribution Program, all grants are passed through to community programs. Those not passed through are administered by some state facilities.

	<u>Fiscal Year 2007</u>		<u>Fiscal Year 2008</u>	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	\$458,455,702	\$317,189,215	\$457,808,280	\$317,836,637
Changes To Base	\$55,368,323	\$17,732,690	\$68,157,796	\$9,801,518
AGENCY TOTAL	\$513,824,025	\$334,921,905	\$525,966,076	\$327,638,155

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Agency Human Resources Summary:

Human Resources Overview

The Department depends on a full complement of 9,817 salaried, wage, and contract employees in a wide variety of classifications (over 125 roles). Of these employees, approximately 3 percent (327.5) are in the central office. The vast majority of Department employees provide direct services to individuals in the 16 state facilities, which operate 24 hours a day, seven days a week. Additionally, a considerable number of Department employees provide site support services necessary to maintain the state facility infrastructure and surrounding environments and to operate the facilities' physical plants. A demographic profile of the total Department workforce shows the following characteristics:

- Race: 47.7 percent Caucasian 52.3 percent minorities
- Gender: 75.2 percent female 24.8 percent male
- Average Age: 46.3 years
- Average Length of Service: 12.5 years

Approximately 43 percent of the Department's total workforce is employed as direct service associates. The demographic profile of this segment of the workforce shows the following characteristics:

- Race: 32.8 percent Caucasian 67.2 percent minorities
- Gender: 81.3 percent female 18.7 percent male
- Average Age: 43.3 years
- Average Length of Service: 11.0 years

This diversity of staffing skills mix, the complexity of consumer service requirements and facility and site support issues have posed a number of human resources challenges, including:

- The aging and increasing cultural diversity of the current workforce,
- Declining enrollments in key degree and specialty programs such as nursing,
- The shortage of health care professionals and direct care workers, and
- The increasing level of skills expected of the workforce in the future.

Full-Time Equivalent (FTE) Position Summary

Effective Date:	6/30/2006
Total Authorized Position level	9892
Vacant Positions	1946
Non-Classified (Filled).....	4
Full-Time Classified (Filled)	8690
Part-Time Classified (Filled)	83
Faculty (Filled)	0
Wage	885
Contract Employees	155
Total Human Resource Level	9817

Factors Impacting Human Resources

As Virginia's population increases and demands on the publicly funded MH, MR, and SA. services system increase, several major factors are expected to affect the quality, responsiveness, and effectiveness of the system's human resources.

- The average age of the Department's current workforce continues to increase. This trend is expected to continue over the next six years. The average of the Department's current workforce of nearly 10,000 employees is now 46 years old. The average age of Department nursing positions is now 49 years old.
- Just over 10 percent of the Department's workforce will be eligible to retire in the next five years and in some facilities, this increases to 14 percent to 17.1 percent, many in this group are nurses. This loss of experienced and well-trained staff could have an adverse effect on patient care and safety. Significant

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recruitment and succession planning will be required for many occupational groups.

- Demand for health care workers continues to rise, estimating in Virginia that by 2030, the traditional caregiving workforce (women aged 25 to 44) will increase by 15.9 percent. With the vacancy rate in state facilities as of the end of fiscal year 2006 at 9.0 percent coupled with the statewide average turnover rate of 23.7 percent and ranging as high as 36 percent to 52.3 percent in some of our facilities, the system faces a significant challenge in providing services to our consumers. Vacancies and turnover will likely worsen as the population continues to age and the "care gap" between those needing care and those available to care for them will continue to widen.
- Department vacancy and turnover rates continue to increase while available workforce resources decline. The exhaustive effort of recruitment and retaining staff with lagging compensation and inadequate career mobility opportunities has resulted in a revolving door scenario, creating extensive overtime and limiting the Department's ability to be a viable competitor in the marketplace. While the Department is evaluating alternative or non-traditional training and educational programs for nursing and direct care staff, this will not be sufficient. Additional resources will be needed if the Department is to successfully recruit and retain a workforce with the skills necessary to address the needs of individuals served by its facilities.
- New technologies and increasing service demands will create a health care market that requires highly skilled and well-educated workers. In addition to technical or clinical skills and expertise, well-honed communication and reasoning capabilities will be needed.

Anticipated Changes in Human Resources

- Demand for jobs in seven of the 25 fastest growing occupations will be in health care positions utilized within the MH, MR, and SA services system. These include: personal and home care aides, nurses, physical therapists, residential counselors, human services workers, teachers of special education, and other health service workers.
- To expand the pool of workers, the services system at all levels must begin to adapt to a situation in which workers in general, and particularly skilled and motivated workers, are likely to be in short supply. The Department's vacancy and turnover rates are expected to continue to increase while the general availability of workforce resources declines. This will likely exacerbate staffing shortages and increase demand for overtime.
- It will be necessary to increase compensation to attract, retain, and motivate individuals into the system and encourage higher productivity of existing employees by providing incentives more closely connected to performance. Competitive base salaries complemented by the use of bonus systems that reward employees for demonstration of desirable behavior and the application of needed competencies is necessary.
- Training is important to employee satisfaction, productivity, and growth. As increasing numbers of employees retire, many of the new workers who replace them will require training to develop needed core competencies. Workforce training in new service technologies and evidence-based practices also will be critical to increasing the productivity of existing employees and maintaining the quality of services. Such training can occur through tuition reimbursement, web based distance learning, and on-site formal education.
- Career progression and pathways also will be critical to recruit and retain health care and direct support professionals. Career ladder models that support employee advancement through the attainment and application of successively higher levels of competencies will be increasingly important. Employees who can create and apply sophisticated new technologies will be rewarded.

Agency Information Technology Summary:

Current State / Issues

In the Spring of 2006, the Department, in collaboration with the Virginia Association of Community Services Boards, developed the following Partnership Information System Vision and Values for the Commonwealth's MH, MR, and SA system.

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As partners, we envision the development and maintenance of health information systems that support the core values of recovery, self-determination, resilience, empowerment and participation; meet the information needs of providers and funding sources; and promote a culture of information sharing. Health information includes consumer, service and billing information. Together, we will develop health information systems that all partners are capable of implementing, and that are supported by a commitment of the partners, a dedicated management infrastructure, widely available user training, and appropriate hardware and software. In keeping with our vision, health information systems must incorporate the following values and principles:

Functionality: Information systems:

- Are comprehensive
- Support decision making
- Conform to established standards
- Enable shared understanding of data elements
- Are accessible to users
- Support multi-level user portability

Flexibility: Information systems are:

- Adaptable to multiple environments
- Interoperable

Usefulness: Information systems are capable of:

- Producing information and reports that describe consumers and services
- Improving decision making
- Improving services for consumers

Accuracy: Information systems use data to produce information that is:

- Valid
- Succinct
- Consistent
- Reliable
- Compliant with state and federal statutes, regulations, and policies

Operational: Information systems:

- Are available to all users
- Are user friendly
- Support interoperability
- Are state of the art
- Are secure (but not paralyzed)
- Are easy to maintain
- Are fully funded

To implement the vision statement and these values and principles, we (the Department and CSBs) need to address the following strategic themes, which include a variety of challenges and opportunities:

Implementation of an Electronic Health Record

- Developing Regional Health Information Organizations (RHIO)
- Constructing a framework for interoperability
- Expanding the comprehensiveness of data collected
- Enabling the migration of data
- Facilitating the transfer of consumer service record text to data

Availability of IT Resources

- Replacing outdated or inadequate IT infrastructure
- Acquiring and maintaining adequate numbers of skilled IT staff
- Acquiring adequate financial resources

Responsive to the Diversity of the Services System

- Overcoming incompatibilities among IT systems
- Dealing with agency-organizational fragmentation in how data is managed

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- Encouraging consistency among and responsiveness of vendors
- Facilitating the applicability of the system to all ranges of organizations (small to large, simple to complex)

Enhancing Data Quality

- Increasing the shared understanding of software development (design and control) processes
- Increasing shared ownership of data and user buy-in
- Addressing, reducing, or making bureaucratic demands more consistent

Commitment to Information Systems

- Supporting the full costs of IT systems (e.g., for development and maintenance activities)
- Assigning a high priority to the development and maintenance of IT systems
- Instituting a culture of data that assures the availability of high quality data and uses it for

decision-

making and service management

Current Department IT Operation: The Office of Information Technology Services is comprised of 15 classified positions and three P14 positions. One 15 classified position is vacant but recruitment to fill is underway. These positions support application development activities in the central office and in the 16 state facilities. The Department's technology environment and staff are transitioning from supporting legacy applications using older technologies to one that develops and supports new applications with current technology. This includes establishing a structured applications development environment, standardization of development tools, and provision of adequate training and support for IT staff.

The Department maintains 25 production application IT systems and currently has one application that is in active development. One project is in the analysis and design phase and several projects are just being initiated. All development projects now have objective outcome measures (project plan, monitoring, scheduling, and budget) and are utilizing best business development practices (primarily VITA standards). Examples of current IT applications and projects follow.

- The state facility consumer information system (AVATAR), which was developed in 2003 to ensure compliance with the federal Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Sets Privacy Rule, is in production and producing monthly reimbursement billing on schedule.
- The Community Consumer Submission (CCS) application, developed by the Department in partnership with the CSBs to extract data from CSB information systems required to comply with federal and state reporting requirements, has been successfully implemented. A project to re-architect the entire data reporting process for CSBs was initiated in March 2006. The redesign should be completed in December 2006 with implementation by July 2007.
- A web-based application to track Sexually Violent Predators was implemented on July 1, 2006. This is the first fully functional web-based application.
- A project is underway to move the hosting of the Infants and Toddlers Online Tracking System (iTOTS) application from a third party to the central office was initiated in June 2006 and is scheduled for implementation on March 1, 2007. This should allow the Department to better meet reporting requirements and provide local providers with tools to better manage their caseloads.
- The Department, in partnership with the Department of Medical Assistance Services, has initiated a project to develop a web-based application to manage the MR Home and Community-Based Waiver program. This initiative will be implemented in conjunction with the Medicaid Systems Transformation Grant awarded in September 2006.
- The FMS Migration from the HP3000 platform to Windows/SQL Server was completed on June 30, 2006 as scheduled. Several interfaces are currently being rewritten and those should be operational by the Spring 2007, which would close out this project.
- Work on porting PRAIS data from the HP3000 platform to Windows/SQL Server continues with a scheduled completion date of March 31, 2007.

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Electronic Health Record: The Department serves thousands of individuals each day in the 16 state facilities. In order to properly manage the care provided, clinical data in the form of thousands of transactions per facility per day needs to be collected, stored, and analyzed. A priority activity of the Department is the development of an electronic medical record for the state facilities with individualized electronic patient data such as:

- Treatment Planning
- Physician Orders
- Infection Control
- Discharge Planning
- Seclusion and Restraints
- Ancillary Service Orders
- Pharmacy
- Assessments
- Nutrition and Diet
- Critical Incidents.

Having an electronic medical record supported by a complete suite of clinical applications has the potential to improve quality of care and patient satisfaction. It also will greatly reduce risk and increase operational efficiencies, resulting in cost savings to the agency. The Department also is working with the CSBs to jointly develop a common data dictionary for use by the CSBs as they embark on local EHR initiatives.

Security: The HIPAA Security Rule, published in the Federal Registrar on February 20, 2003, has had a profound impact on Department operations. The Rule focuses on the following areas:

- Security and confidentiality practices
- Sanctions
- Access Controls
- Physical security and disaster recovery
- Risk assessment
- Education and training programs
- User authentication
- Audit trails
- Remote access points

The Department has published guidance and procedures for the implementation of IT security standards in the central office and state facilities. These procedures and an accompanying technical manual address all technical aspects of the HIPAA Security Rule as well as procedures of the Virginia Information Technologies Agency (VITA). The Department has hired a security officer to manage the security rule implementation as well as other security-related activities.

IT Best Practices and Infrastructure: Over the past year, the Department has made considerable progress in establishing measures to track IT productivity and develop and implement best business practices and procedures that comply with VITA standards for new projects and application maintenance activities. These practices and procedures address productivity and documentation requirements for project planning activities and include:

- System Development Life Cycle (SDLC) - Completed (Per VITA standards)
- Project Proposals - Completed (Per VITA guidelines)
- Documentation requirements for each phase of the SDLC - Completed
- Project Planning Requirements - Completed (per VITA guidelines)
- Customer approvals - Completed
- Change control - Completed (June 30, 2006)
- Testing - Completed (June 30, 2006)
- Progress reporting - Under development (December 2006)
- Security - Under development (December 30, 2006).

A standard automated problem and resolution-tracking system was put into production for several applications in September 2005. Starting April 3, 2006, problems and issues related to all supported applications are being tracked with this system.

The following IT infrastructure issues and requirements must be addressed if the Department is to provide secure and adequate support to staff and patient needs:

- Applications within the Department are not well integrated. This impairs data reporting and analysis efforts as well as applications maintenance and enhancements that must be done by technology staff.

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- A significant amount of state facility data must be migrated from an obsolete hardware platform so that critical reporting functions will not be interrupted. Two opportunities for integrating stand-alone applications with AVATAR have been identified.
- The Department needs to formalize processes to assist in measuring how well ITS staff achieves desired outcomes. Business customer surveys have not been conducted. Service level agreements for services are not in place.
- The Department's technology infrastructure requires upgrading. A number of facilities need to upgrade hardware, software, and network cabling. Supporting this infrastructure is very difficult.

Factor Impacting Information Technology

- The Department's IT activities will be affected by the uncertainty, potential costs, and possible administrative requirements associated with the proposed VITA service-base fees.
- Federal reporting requirements for outcome measures will require changes to the Department's information technology services applications, particularly the CCS application.
- Federal requirements for an electronic health record are being planned. Implementation of these requirements would require investment in technology to address existing needs in state facilities and CSBs.
- Requirements for medication management will require the Department to upgrade or replace its automated pharmacy system in the state facilities and Community Resource Pharmacy. This includes medication bar coding.
- Security management (HIPAA, Homeland Security) will require additional resources in the central office and in state facilities.
- Staffing resources continue to pose problems for the information technology program at the agency. Development, maintenance and support for the needed application continue to be problematic with limited staff. The issues exist for both central office and the state facilities.

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Anticipated Changes / Desired State

- The Department will use the values and principles embodied in the Information System Vision and Values for the Services System to guide efforts to establish a culture of data within the mental health, mental retardation, and substance abuse services system. It will provide a statement of what culture of data means and how data can be used as a ally and valuable resource for fulfilling the vision of a consumer-driven system of services based on self-determination, empowerment, recovery, and resilience.
- The Department will continue its efforts to establish a structured information technology applications development environment. This includes employing standard development and maintenance procedures and a standard set of development tools. Staff training and retraining continues be a priority. This effort should result in more consistent applications that lend themselves to better integration and a more productive staff. It will also address some of the issues created by the VITA transition.
- The Department will initiate a project to obtain an application to meet the requirements of the electronic health record in the state facilities and will continue to work with the CSBs, as they implement electronic health records, to assure interoperability.
- The Department will initiate a project to upgrade for replace existing pharmacy applications in the state facilities and in the Community Resource Pharmacy to meet requirements.
- The Department will design and develop a set of applications to address the outcome measurement requirements for MH, MR, and SA services. These applications will be integrated with the community consumer submission (CCS) application.
- The Department will implement enhancements to data reporting and analysis processes to integrate data from multiple sources, such as data warehousing and data migration from obsolete platforms.
- The Department will pursue ways of prioritizing and coordinating application development in the central office and state facilities and will continue to look at the feasibility of and opportunities for sharing application development staff.

The Department will continue to seek opportunities to collaborate with CSBs and other state agencies in providing technology solutions.

- The Department recognizes that all applications will require regular maintenance, including upgrades to operating systems, software, services, and networks. A continuing emphasis on training at all levels will be required.

Agency Information Technology Investments:

	<u>Cost-Fiscal Year 2007</u>		<u>Cost-Fiscal Year 2008</u>	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Major IT Projects	\$0	\$100,000	\$0	\$100,000
Non-Major IT Projects	\$0	\$175,000	\$0	\$175,000
Major IT Procurements	\$0	\$0	\$0	\$0
Non-Major IT Procurements	\$0	\$0	\$0	\$0
Totals	\$0	\$275,000	\$0	\$275,000

Agency Capital Investments Summary:

Current State / Issues

The Department operates 16 facilities in 12 geographic areas, with 412 buildings encompassing about 6.5 million square feet. The average age of all state facility buildings is 49 years, with a median age of 55 years. Maintenance and renovation funding has not been adequate to prevent a gradual decline in the condition of state facilities over the years. Most buildings require replacement of their HVAC, fire alarm and electrical systems and are generally in poor condition. State hospitals and training centers will continue to be essential components of Virginia's publicly funded services system. The Department is committed to achieving a best practices balance between community and state facility services. As such, the Department must ensure that state facilities are safe, efficient, well maintained, and appropriately

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designed to meet the needs of patients and residents receiving services.

Factors Impacting Capital Investments

As the census of most state facilities has dropped, consumer profiles have changed dramatically. Historically, state hospitals provided long-term care, using a custodial model. With increased availability of community-based programs, state hospitals are now providing shorter term, more intensive, and active treatment - with the goal of returning consumers to their home communities as soon as clinically appropriate.

Similarly, the population currently served in training centers has changed, with the majority of current residents functioning at severe and profound levels of mental retardation. A large proportion is non-ambulatory, requiring specialized wheelchairs or significant staff assistance to walk. Many have multiple complex medical conditions such as seizures, scoliosis, gastro-intestinal problems, hearing or visual deficits or loss, and speech impairments that require specialized equipment and accommodations. These medical needs are projected to increase in the years to come as the training center population ages. Training centers also are experiencing greater demands to serve persons who have mild or moderate mental retardation but also have challenging behaviors that require significant behavioral interventions.

Many currently occupied state facility buildings lack accessible space needed to accommodate adaptive equipment and programming required by persons who are receiving facility services. The Department also must bring existing state facility living areas up to current life safety standards. Some buildings lack current fire detection systems and others lack early detection safety systems. A number of buildings require major renovations to bring them into compliance with current codes and certification requirements. Many of these buildings also are inefficient to operate.

Capital Investment Alignment

The Department's Capital Improvement Plan has two essential components: the first proposes projects necessary to keep operational buildings in use for the next two biennia, including roof, utility, HVAC, and food service repairs and environmental hazard abatement; the second is a phased program of facility replacements. Training centers that do not meet code requirements and are not appropriately configured to meet the needs of their current populations will be replaced with new facilities. Some that currently operate in numerous buildings over hundreds of acres will be replaced with fewer, more efficient and effective buildings at reduced operating costs. Sprawling state hospital campuses will be replaced with smaller, more effective and efficient single-building facilities.

The 2006 General Assembly provided construction funds for ESH and planning funds for WSH, SEVTC, and CVTC. Construction of the new state-of-the-art 300-bed Eastern State Hospital is underway and the Department is working closely with Staunton city officials to plan for the future location of Western State Hospital and the future use of the property. The capacity of WSH will essentially stay the same to accommodate projected future demand for forensic beds, particularly from Northern Virginia. The new SEVTC will have 100 beds and CVTC will have 300 beds. The Department has developed a facility design planning process that engages all stakeholders in the next phase of planning for the new replacement facilities. The Department also is working closely with the regions to expand community services capacity in the areas served by these facilities.

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Agency Goals

Goal #1:

Fully implement self-determination, empowerment, recovery, resilience, and person-centered core values at all levels of the system through policy and practices that reflect the unique circumstances of individuals receiving MH, MR, or SA services.

Goal Summary and Alignment:

This goal envisions the alignment of services system policies, regulatory requirements, funding incentives, administrative practices, and services and supports arrangements with the core values of self-determination, empowerment, recovery, and resilience at the state and local levels. Opportunities for consumer and family involvement on Department policy and program committees would be increased. A statewide educational campaign and other training opportunities would help state and local government policy-makers and administrators, consumers, family members, and services and supports providers understand and have the necessary competencies and skills to employ consumer-driven, recovery, resilience, and person-centered practices. Other transformation activities would be initiated by the Department to implement recovery, resilience, and person-centered principles and practices in areas such as prevention and health promotion, consumer and family involvement and inclusion, access and engagement, continuity of care, individualized recovery and person-centered planning, recovery support and personal assistance, community inclusion, housing and work, evidence-based or best and promising practices, cultural competency, quality assurance, and performance monitoring.

Implementation of this goal is essential for transforming Virginia's MH, MR, and SA services system to one that fully realizes the Department's vision of a consumer-driven system of services and supports.

Statewide Goals Supported by Goal #1

- Engage and inform citizens to ensure we serve their interests.
- Inspire and support Virginians toward healthy lives and strong and resilient families.

Objectives For Goal #1

Objective 1.01

Increase the proportion of people served in intensive community-based services per occupied state facility bed.

Measures For Objective 1.01

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- **Measure 1.01.01**

We will increase the proportion of persons served in intensive community services versus state facilities

Measure Type: Outcome **Measure Frequency:** Annually

Measure Baseline: FY 2005: 3.52 consumers in intensive services per occupied state facility bed

Measure Target: 15 percent increase by the end of FY 2009 to 4.05 consumers in intensive community-based services per occupied state facility bed.

Measure Source and Calculation:

Data on occupied state facility beds will come from AVATAR. Data on people served in intensive community-based services (i.e., local MH inpatient, PACT, DAP, MH highly intensive residential, MR highly intensive residential, and MR Waiver services) will come from the Community Automated Reporting System (CARS) and Community Consumer Submission (CCS). Department staff will divide the number of consumers receiving intensive community-based services by the average daily census of state hospital and training center beds (excluding HDMC and VCBR) at the end of the fiscal year and will calculate the percentage change.

Goal #2:

Expand and sustain services capacity necessary to provide services when and where they are needed, in appropriate amounts, and for appropriate durations.

Goal Summary and Alignment:

This goal envisions statewide availability of a core array of recovery and resilience-oriented and person-centered services and supports that are appropriate to the needs of individuals with mental illnesses, mental retardation, or substance use disorders who are in crisis or who have severe or complex conditions, or both, and cannot otherwise access needed services or supports because of their level of disability, their inability to care for themselves, or their need for a structured environment. Every locality would have the capacity to provide, either locally or through regional arrangement, crisis access and response services 24 hours per day and seven days a week. Existing unmet needs would be addressed through a core array of services and supports choices that is available to each individual regardless of where he or she lives in the Commonwealth. These recovery and resilience-oriented and person-centered services would be flexible and provided as close to the individual's home and natural supports as possible. Natural support systems, including consumer and family networks, services, and supports, would be strengthened wherever possible and emphasis would be placed on prevention and early intervention to avoid future crises.

Implementation of this goal is essential for transforming Virginia's MH, MR, and SA services system to one that fully realizes the Department's vision of a consumer-driven system of services and supports.

Statewide Goals Supported by Goal #2

- Engage and inform citizens to ensure we serve their interests.
- Inspire and support Virginians toward healthy lives and strong and resilient families.

Objectives For Goal #2

Agency Strategic Plan

Department Of Mental Health, Mental Retardation and Substance Abuse Services

Objective 2.01

Increase the community tenure of consumers served in state facilities.

Measures For Objective 2.01

- **Measure 2.01.00**

We will reduce the percent of consumers who are readmitted to state facilities by providing community-based services and supports that respond to their individual needs

Measure Type: Outcome **Measure Frequency:** Annually

Measure Baseline: FY 2005: 23 percent of long-term consumers were subsequently readmitted to state facilities

Measure Target: 20 percent of long-term consumers are subsequently readmitted by the end of FY 2009

Measure Source and Calculation:

State facility data will come from AVATAR. The Department will calculate the percent of long-term consumers who are discharged from state hospitals and training centers and subsequently readmitted.

Goal #3:

Align administrative and funding incentives and organizational processes to support and sustain quality consumer-focused care, promote innovation, and assure efficiency and cost-effectiveness.

Goal Summary and Alignment:

This goal envisions adequate amounts of stable state and local funding that can be used flexibly to meet the needs of individual consumers and their families. Mental health, mental retardation, and substance abuse funding streams would be integrated to the extent possible to create individualized, recovery-oriented, and person-centered services plans. Opportunities for self-directed care would be pursued and full advantage would be taken of federal funding opportunities, including Medicaid, to implement recovery- and resilience-oriented and person-centered services. Funding allocations would include incentives for efficient and cost-effective services that are consistent with evidence-based or best and promising practices.

Implementation of this goal is essential for transforming Virginia's MH, MR, and SA services system to one that fully realizes the Department's vision of a consumer-driven system of services and supports.

Statewide Goals Supported by Goal #3

- Engage and inform citizens to ensure we serve their interests.
- Inspire and support Virginians toward healthy lives and strong and resilient families.

Agency Strategic Plan

Department Of Mental Health, Mental Retardation and Substance Abuse Services

Goal #4:

Assure that services system infrastructure and technology efficiently and appropriately meet the needs of individuals receiving publicly funded MH, MR, and SA services and supports.

Goal Summary and Alignment:

This goal envisions significant improvement in the adequacy and appropriateness of state and community capital infrastructure. State facility and community buildings would be upgraded to ensure consumer safety and provide adequate and appropriate space designed to meet the needs of consumers. State training centers would be replaced with Intensive Support Centers (ISCs) and Intensive Support Homes (ISHs), as envisioned in the MR Services and Supports Options by Level of Care Model. Large state mental hospitals on multi-building campuses would be replaced with smaller, more efficient and appropriately designed facilities. The services system also would take advantage of technologies to improve care coordination and continuity. Technologies such as an electronic health record, teletherapy and teleconsultation would be implemented to improve coordination and continuity of service delivery, support the development of promising practices, and increase access to services in underserved areas.

Implementation of this goal is essential for transforming Virginia's MH, MR, and SA services system to one that fully realizes the Department's vision of a consumer-driven system of services and supports.

Statewide Goals Supported by Goal #4

- Engage and inform citizens to ensure we serve their interests.
- Inspire and support Virginians toward healthy lives and strong and resilient families.

Goal #5:

Obtain sufficient numbers of professional, direct care, administrative, and support staff with appropriate skills and expertise to deliver quality care.

Goal Summary and Alignment:

This goal envisions a MH, MR, and SA services system workforce with leadership, technical, and collaboration (team) skills and expertise. The services system would have the resources necessary to competitively recruit and retain sufficient numbers of professional and direct care staff. The services system workforce would have appropriate skills and expertise to deliver evidence-based or best and promising practices. Public-academic partnerships with Virginia universities, colleges, and community colleges would expand the pipeline for and skill levels of hard-to-fill professional and direct care positions. Cross-training programs would be designed to develop provider skills necessary to meet the needs of the most challenging consumers, including individuals with co-occurring disorders.

Implementation of this goal is essential for transforming Virginia's MH, MR, and SA services system to one that fully realizes the Department's vision of a consumer-driven system of services and supports.

Statewide Goals Supported by Goal #5

- Engage and inform citizens to ensure we serve their interests.
- Inspire and support Virginians toward healthy lives and strong and resilient families.

Agency Strategic Plan

Department Of Mental Health, Mental Retardation and Substance Abuse Services

Goal #6:

Enhance service quality, appropriateness, effectiveness, and accountability through performance and outcomes measurement and service delivery and utilization review.

Goal Summary and Alignment:

This goal envisions statewide implementation of clinical and management practices that reflect best and promising practices and promote stewardship and wise use of system funds, human resources, and capital infrastructure. The services system would implement consistent management practices that focus on and support the delivery of recovery-oriented and person-centered services and supports. Performance and outcomes measurement systems would demonstrate quality, efficiency, and cost-effectiveness through clearly defined performance and consumer outcome expectations.

Implementation of this goal is essential for transforming Virginia's MH, MR, and SA services system to one that fully realizes the Department's vision of a consumer-driven system of services and supports.

Statewide Goals Supported by Goal #6

- Engage and inform citizens to ensure we serve their interests.
- Inspire and support Virginians toward healthy lives and strong and resilient families.