

Transformation Team Recommendations

ROUND 2

FALL 2015

Virginia Department of Behavioral
Health and Developmental Services

Four focus areas of the Transformation Initiative

- Adult Behavioral Health
- Adult Developmental Services
- Children & Adolescent Behavioral Health Services
- Services to Individuals who are Justice-Involved

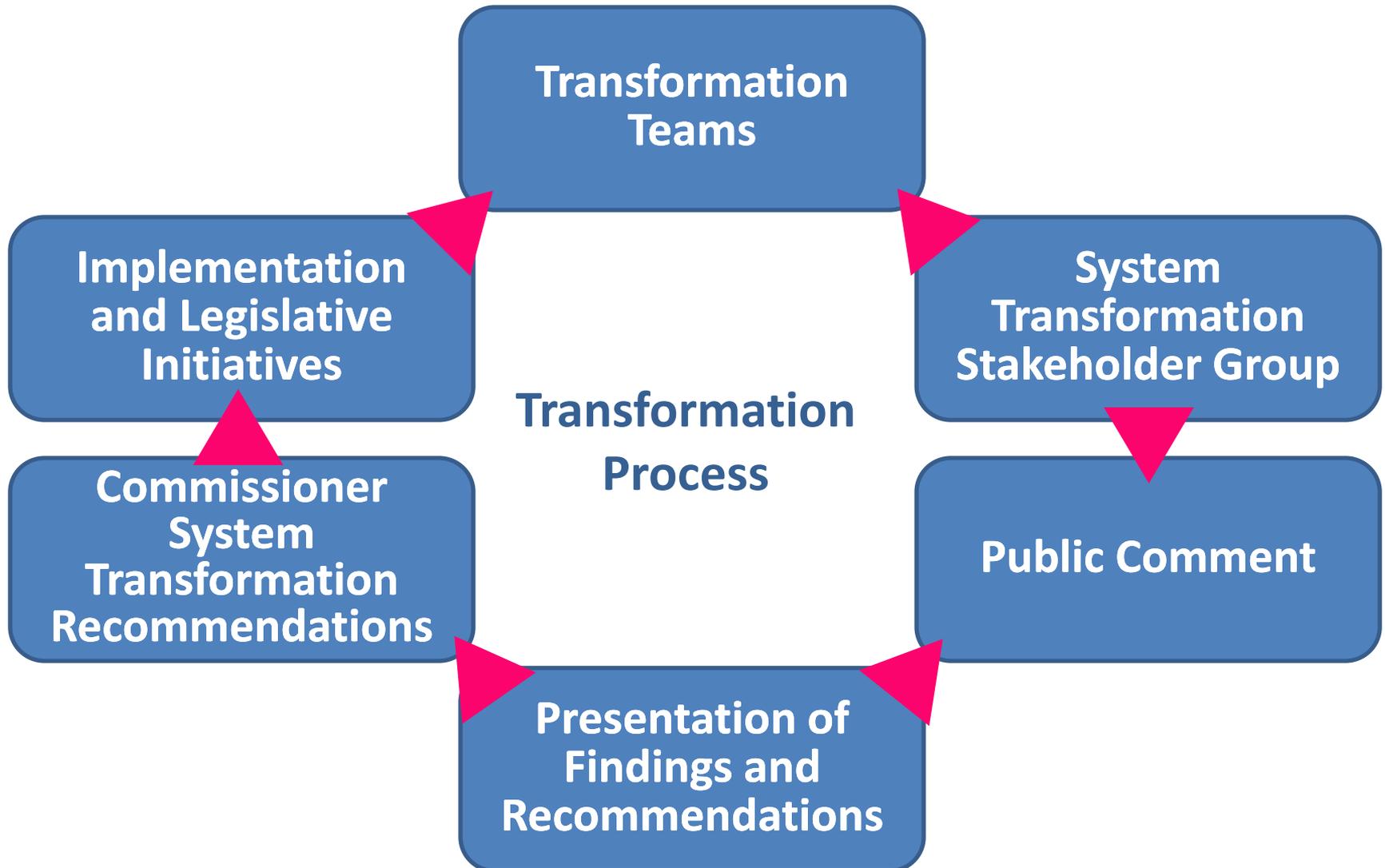
Phase Two – Stakeholder Group

- Meets with the Co-Chairs of each Transformation Team to provide input and consultation.
- Receives and reviews recommendations from the Transformation Teams.
- Offers additional recommendations.

Phase Three - Public Comment Period

- Recommendations posted on the DBHDS website
- Webinar to view team presentations
- Link to submit public comment
- Additional presentations to key legislative committees and stakeholder groups

System Transformation Process Design





Justice Involved Transformation Team

Co-Chairs

David Rockwell, Henrico Mental Health

Michael Schaefer, PhD, DBHDS

Team's Charge

- 1. What services delivery structure best promotes quality, access and accountability in the Commonwealth? Also, specifically address:
 - Who should provide the services?
 - What is the role of private providers?
 - How do we ensure internal, cross-system and primary care integration?
 - Where in the Commonwealth should services be targeted?
- 2. What screening, assessment and services should be standardized across the system to promote best practices?

Approach Used to Accomplish Charge

- Team met monthly
- Members were encouraged to share their thoughts/experiences with existing system
- Brought in subject matter experts as needed
- Members encouraged to transform system and create new/ideal system
- Utilized recommendations from Round One to frame discussion for this round of questions

What services delivery structure best promotes quality, access and accountability in the Commonwealth?

- General consensus was that to promote quality, access, and continuity of care it would be best if CSBs were the designated provider of services for this population
 - As many individuals are uninsured they often by default will rely on CSB for services post release
 - As recommendations for treatment services are geared towards those with SMI and/or severe impairments CSBs are logical providers of care
 - CSBs exist in all regions of the Commonwealth and serve as part of the safety net thus are well positioned to provide these services
 - CSBs operate the existing jail diversion programs thus are better situated to refer individuals for diversion
 - Having the CSB as the provider of BH services would in part address issues related to inconsistent formularies
 - Having the CSB as the provider of BH services would create natural discharge planning procedures thus decreasing risk of future decompensation/ re-arrest

What services delivery structure best promotes quality, access and accountability in the Commonwealth?

- There are some significant challenges to having the CSBs as the provider of BH services in jail
 - Sheriff/Jail Administrator has right to chose vendor & often contract for combined medical/ psychiatric services
 - Some CSBs are not staffed sufficiently to manage demand for BH care, let alone medical care
 - Some CSBs have 6-8 jails within their region and it would be extremely difficult to provide staffing in all the various jails/detention centers
 - Lack of staff with technical expertise in working in correctional setting
 - Regional jails provide services to individuals from large catchment area (crossing over many CSB jurisdictions) thus it would be confusing as to which CSB was responsible

What services delivery structure best promotes quality, access and accountability in the Commonwealth?

- Ultimately Transformation Team agreed that it was best not to dictate provider of jail/detention based services, but instead set minimum standards for services
 - Caveat #1 – Every jail should have at least one staff member who's primary job is to aid in coordinating release planning. General Assembly should fund the creation of these positions.
 - Caveat #2 – Regardless of who is providing BH services in the jail, each CSB should have at least one staff member who's primary responsibility is coordinating release planning for individuals releasing from jail and needing follow up services from the CSB. General Assembly should fund the creation of these positions.

Services Which Should Be Available to All Individuals Incarcerated/Detained

- Screening (using a validated screening instrument) upon admission for the existence of behavioral health issues by staff qualified/trained to perform screenings
- Screening(both upon admission & during the period of detention/incarceration) for suicide risk conducted by trained/qualified staff
- Mechanisms/policies/practices/resources to refer those who score (+) on behavioral health screen or suicide screen to a trained mental health professional for a more in-depth assessment and when indicated the development of a treatment plan to address the needs.
- Presence of jail/correctional/detention staff who are trained in crises de-escalation and active listening/problem solving skills
- Access to medical care, to include behavioral health care, to address any acute issues which may arise during the period of incarceration/detention.

Services Which Should Be Available to Individuals with Serious Mental Illnesses (SMI), ID, DD, and TBI

- Admission Behavioral Health Assessment (by qualified/trained staff) conducted within a maximum of 72 hours post screening with indication of potential behavioral health issues
 - Assessment should identify current behavioral health treatment needs
 - Assessment of feasibility for diversion
 - Assessment of needs to decrease risk of re-offense
 - For those identified as being SMI, prompt notification of the CSB as likely these individuals will require significant post-release services
 - For those identified as being at risk to self or others or at risk of harm to self due to inability to care for self, CSB should be immediately contacted to evaluate for need for inpatient care pursuant to §19.2-169.6
- Mechanism for the prompt notification of community treatment providers that client has been arrested and mechanism for the prompt sharing of treatment records from community providers with the jail/detention center treatment provider

Services Which Should Be Available to Individuals with Serious Mental Illnesses (SMI), ID, DD, and TBI

- Psychiatric Assessment by psychiatrist or psychiatric nurse practitioner or psychiatric physician assistant within 5 days of the Admission Behavioral Health Assessment
 - For those who were prescribed medications in the community – a mechanism to continue those medications until the individual can be seen by the jail mental health provider
 - For those who were prescribed medications in the community – access to those psychotropic medications which have been found to be effective in addressing individual's behavioral health issues (should the jail mental health provider deem them clinically indicated)
 - For those not prescribed medications in the community – a formulary sufficiently broad to allow the jail/detention center psychiatrist, nurse practitioner, or physician assistant sufficient treatment options for the individual.

Services Which Should Be Available to Individuals with Serious Mental Illnesses (SMI), ID, DD, and TBI

- Sufficient availability (either live or via telepsychiatry) of psychiatrist, psychiatric nurse practitioner, or psychiatric physician assistant to meet both the acute and chronic behavioral health needs of the individuals within the facility.
 - For those experiencing acute issues – access should be no less frequent than once per month
 - For those experiencing chronic issues (who's mental status is at baseline) – access should be no less frequent than once every three months
- Ongoing case management services throughout the period of incarceration/detention
 - CSB should maintain an open case for this population
 - For those not previously opened to the CSB, a case should be opened
 - Frequency/duration of case management will be dependent on individual's needs
 - Caseloads will be determined by acuity of clients served, however, every CSB should have at least one designated staff member who's primary responsibility is case management for those involved in the criminal justice system

Services Which Should Be Available to Individuals with Serious Mental Illnesses (SMI), ID, DD, and TBI

- Evidenced based treatment (either individual or group)
- Access to jail environment which supports psychiatric/behavioral stability
 - Non-lockdown environment for those who don't require isolation
 - Access to structured activities
 - Ability to interact with staff and peers
 - Environment, which to the degree possible, does not re-traumatize individual
- Prompt access to inpatient psychiatric care (either at a DBHDS facility or a designated facility) when the need arises
- Access to trained forensic peers and/or WRAP facilitators
- Presence of jail/correctional/detention staff that are trained in crises de-escalation, active listening/problem solving skills, and trauma informed care.

Services Which Should Be Available to Individuals with Serious Mental Illnesses (SMI), ID, DD, and TBI

- Discharge planning services
 - Include application for resumption of benefits
 - Include assistance in locating affordable, safe housing
 - Aftercare appointment for mental health services with strong preference for same day access
 - “Warm” handoff from jail to community treatment provider
 - Care navigator who ensures individual links with community provider
 - Follow up for those who don’t make appointment
 - Treatment summary from jail mental health provider should be given to community provider prior to scheduled follow-up appointment
 - Sufficient supply of discharge medications/scripts to bridge until next appointment
 - Address transportation issues to minimize risk of follow-up no show
 - Funds to purchase services to minimize risk of relapse/ re-offense

How do we ensure internal, cross-system and primary care integration?

- By hiring both a jail based release planner and a CSB discharge planner we can improve both internal and cross system collaboration/ integration
- By developing a system for prompt exchange of information both coming in and going out of jail/detention we can improve collaboration/ integration
- Virginia's movement towards establishment of CCBHCs will enhance primary care integration which hopefully will infuse into treatment in justice involved settings.

Where in the Commonwealth should services be targeted?

- As meeting these standards is a large undertaking, Transformation Team recommends selection of several (up to 8) pilot sites so we can learn what works/ doesn't work
 - There needs to be a mix of urban and rural
 - There needs to be a mix of regional and local jails
 - There needs to be a mix of CSB as provider of jail based services and private provider as provider of jail based services.
 - There needs to be geographical diversity given the different regional cultures/service delivery systems



Adult Behavioral Health Transformation Team

Co-Chairs

Mike O'Connor, DBHDS

Becky Sterling, DBHDS

What service delivery structure best promotes quality, access and accountability in the Commonwealth?

- Who should provide services?
- What is the role of private providers
- How do we ensure internal, cross system and primary care integration?
- Where in the Commonwealth should services be targeted to address service inequities?

What must be done to enhance substance use disorder services across the Commonwealth?

Reduce fragmentation of services and implement strategies to create a single system of care.

- Formally define the rolls of CSB's and private providers
- Formally define the relationship that needs to exist between local CSB's and private providers in their areas
- For adults needing multiple publicly funded long term services require a single person-centered plan of care that includes CSB Targeted Case Management

Primary Desired Roles for CSB's

- Assure availability of core/mandated services in all areas of the state
- Collaborate with private providers to expand service options, promote choice and assure service coordination
- Assure prompt 24/7 emergency access to a range of interventions
- Serve as safety net provider for all regardless of insurance status
- Promote local planning, financial support and local partnerships
- Collaborate in regional activities to assure development of high cost/lower incidence services and effective utilization of inpatient and other services

Primary Desired Roles for Private Providers

- Develop and provide quality services to expand access and choice
- Expand culturally and linguistically competent services
- Develop and provide specialized services
- Collaborate with CSB's to expand service options, promote choice and assure service coordination
- Participate in quality measurement and improvement activities
- Participate in local service planning activities

Improve Use of Data

- Develop single data system to measure key performance indicators across all providers of publicly funded services [Currently data is at DBHDS, DMAS/Magellan, HMO's.]
- Create data outcome measures in which both public and private providers participate

Pay for Outcomes and System Improvement

- Move to a more outcome based payment system
- Exploit Medicaid innovations such as DSRIP for critical infrastructure related to data and IT at state, local and provider level
- Incentive payments for outcomes and improvements/best practices
- Continue strategies to expand the use of best practices, promising practices and evidence based practices

Address Specific Workforce Shortages

- Develop credentialing standards that are specific to the work being performed
- Develop criteria for psychiatric nurses to qualify as pre-screeners and crisis providers

Expand the Availability of a Range of Housing Options

- Engage with state agency partners to develop a broad strategy for expanding housing options for public clients
- Partner with private organization or other public agencies to develop SRO options
- Expand funding to provide on going rent subsidies based on the Section 8 model

Expand Employment Opportunities

- Develop funding initiatives for evidence based individual placement and support employment services
- Clarify which activities that support and ready people for employment can in fact be supported by Medicaid
- Use additions to the state plan or a waiver to support services such as job finding, intake and assessment and follow along supports from an employment specialist

Rebuild Underdeveloped SUD Services

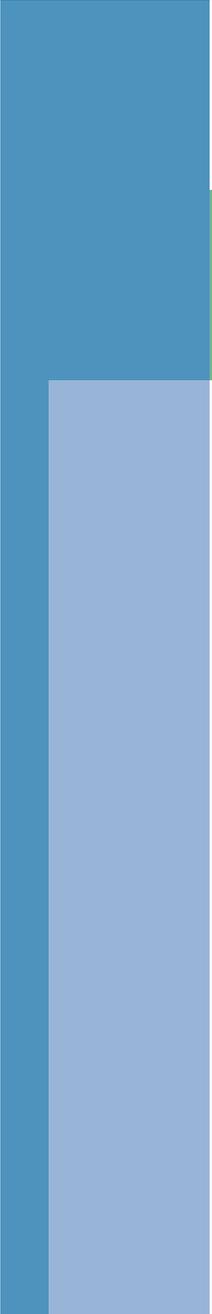
- Funding for outpatient services for the uninsured to include peer support
- Funding medication assisted treatment
 - Funding for uninsured
 - Adjusting Medicaid rates to a level that attracts providers
 - Require private insurance to have this as a covered benefit

Rebuild Underdeveloped SUD Services

- The following are also felt to be essential to an effective SUD system but the two items on the previous slide are the highest priority
 - Housing supports
 - Residential and detox services
 - Targeting young adults
 - Employment services

Support Service Consistency by Targeting Funding Both to Best Practices and to Under Resourced Areas

- Adopt a two pronged approach to new funding
 - Grant fund best practices and to fill service gaps. Allow reasonable flexibility to allow rural areas to compete
 - Develop an allocation formula:
 - Include such variable as population, household below 200% FPL, # uninsured residents, Medicaid enrollment, and adjust for cost of living and other available resources. Areas with fewer than a base population [e.g. 50,000 or 100,000 receive a set minimum based on available funding.



Child & Adolescent Behavioral Health Transformation Team

Co-Chairs

Janet Lung, LCSW, DBHDS

Stephany Melton-Hardison, NAMI

Team Process

- Eighteen members included state child-serving agencies, CSBs, private providers, family and advocacy groups, universities.
- Monthly meetings were held on site at children’s agencies that hosted and gave an overview of their services:
 - **United Methodist Family Services**
 - **Saint Joseph’s Villa**
 - **NAMI’s Virginia Family Network**
 - **Hampton-Newport News CSB**
- The team addressed the charge questions as follows:

What services delivery structure best promotes quality, access and accountability in the Commonwealth?

- **DBHDS should implement the Certified Community Behavioral Health Center structure in as many areas of the state as possible.**
 - CSBs that cannot accomplish this structure could become DCOs of the closest CCBHC. This structure offers an ideal structure for promoting quality, access and accountability.
 - The CCBHC credentialing standards would ensure a standardized set of services provided by all CSBs, complete with the integration of primary healthcare/pediatric services and other child-serving systems.
 - CCBHCs should function as the behavioral health component of the system of care and support the overall children's system of care.
- **Require and fund a set of mandated behavioral health services to be offered consistently across the state:**
 1. Prevention and Wellness
 2. Case Management
 3. Crisis Response (including but more comprehensive than prescreening)
 4. Psychiatric services (including child psychiatry, psychiatric nurse practitioners, physician assistants, and telemedicine approaches)
 5. Parent Peer Support
- **Other services, determined through a local planning process, would also be provided to meet the specific local population's needs.**

What services delivery structure best promotes quality, access and accountability in the Commonwealth?

- Functions such as the **Part C Early Intervention** local lead agency role should be provided by the CCBHC or CSB to increase consistency. This would reduce fragmentation, as well as administrative and contracting costs that currently exist in the system.
- DBHDS should develop policy and procedures requiring all service delivery entities (Community Services Boards and private providers) to follow a **System of Care** Approach. This should be accomplished through mandatory training sessions comprised of all Community Service Board staff and other child service delivery partners providing services through public funding. Initial training in this model should be followed by periodic booster training sessions and reviews of this model to ensure consistent compliance with established policy and procedures.

Who should provide the services and what is the role of private providers?

- Services other than the ones that are required of the CCBHC, and emergency services required by code to be provided by CSBs, should be provided by the public or private provider that can provide the best quality service to meet the child and family's needs. Services should include peer and parent peer support providers.
- Use the CCBHC structure to assist with the urgent care, larger psychiatric pool, and crisis stabilization, link consumers back to the CSBs/private providers in their area. A partnership of public and private providers would allow for a seamless referral services delivery structure. Providers should be certified by DBHDS to ensure their adherence to evidenced based practices and System of Care principles.
- Private providers provide many of the services needed by children. There must be a structure that oversees quality, consistent access and accountability for services provided by private and public providers.
- CSBs should establish partnerships and contracts with qualified private providers for many services including Intensive In-Home, psychiatry, outpatient counseling, psychological evaluations, etc.
- Request DMAS to review children's services within the state Medicaid Plan (Intensive In-Home, Crisis Intervention, Crisis Stabilization) with respect to rate structure, provider qualifications, quality review, claims history and other factors to determine if revisions are warranted to avoid unintended consequences.

How do we ensure internal, cross-system and primary care integration?

- **Create an Assessment Center** at each CSB or CCBHC. A Behavioral Health Navigator would
 - meet families and discuss their needs
 - Link them with public or private evidence based services
 - Follow them on a minimum weekly basis to ensure services are being provided in the system of care model
 - A Parent Peer Support Partner would be assigned to each family
- **Workforce Development** – an effective workforce development initiative should include:
 - Strategies to increase the number of professionals in the following disciplines
 - child psychiatrists
 - nurse practitioners
 - physician assistants
 - licensed mental health clinicians (LCSW, LPC, LCP, etc.)
 - Parent peer support partners (oversight by the Virginia Family Network)
 - Regular training opportunities delivered according to a strategic workforce development plan. These should be free to the participants and provide continuing education certificates to support licensing requirements.
 - Incentives for tuition reimbursement for those employed at CSBs after graduation.
- **Use the system of care principles** to guide services that are strengths based, supportive, culturally and linguistically competent, community based, timely and appropriate, and provided in the least restrictive environment.

Where in the Commonwealth should services be targeted?

- Mandate and fund the base set of services consistently everywhere in the Commonwealth.
- Review child and adolescent service availability and service need within the Commonwealth on a regular basis. Use the results to prioritize enhancement of service delivery structures and workforce development. Budget requests to add new services, or enhance existing ones, should be based on this review.
- Require regional coordination and public/private partnership in order to receive state funding. Regions should structure their services according to system of care and high fidelity wraparound principles.

What school-based services should be available for children and adolescents with behavioral health needs?

Schools provide the unique opportunity to address behavioral health prevention and intervention needs. We can serve the needs of all Virginia children and youth through a coordinated approach and collaborative partnership with each local school division.

- Establish integrated physical and behavioral health services on or very near the school grounds throughout the Commonwealth.
 - Services should use a team approach comprised of local service providers with primary care and mental health/substance abuse expertise, student support service professionals*, and administrative staff.
- Utilize the current planning process for examining the potential of mental health screening in elementary schools to inform this process.

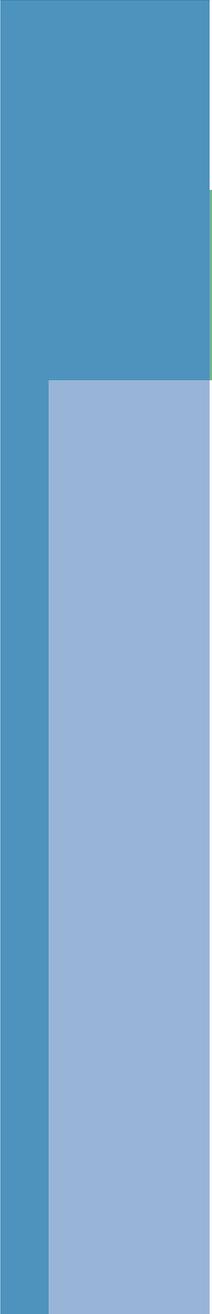
* Student support professionals are school division employees whose roles and responsibilities include supporting the behavioral health needs of students. These professionals include: school psychologists, school counselors, school social workers, and school nurses. These professionals may be QMHP for the purposes of Medicaid-billing.

What school-based services should be available for children and adolescents with behavioral health needs?

- Identify high-risk children and offer programming to build resilience on site in schools with an emphasis on positive school climate. Use existing school structures, such as the multi-tiered systems of supports, to facilitate this process. This model includes:
 - universal prevention efforts for all students,
 - targeted interventions for at-risk students, and
 - intensive interventions/wrap-around services for students with more intensive needs.
- Request the Board of Education to consider including minimum staffing requirements for all student support positions in the BOE's Standards of Quality to address the full continuum of behavioral health needs.
- Require an MOU between each local school division and the local CSB/BHA that provides a clear and streamlined referral process and supports school-based services provided by the CSB/BHA. Develop model MOU to provide guidance to local divisions/CSBs.

What school-based services should be available for children and adolescents with behavioral health needs?

- Other school-based services should include:
 - Parent peer support partners to meet with parents seeking services
 - Mental Health First Aid in schools.
 - School partnerships with local J&DR courts to divert children to behavioral health care programs to address their in-school behaviors that have resulted in criminal charges.
 - Clinical Case Management (a QMHP in Every School),
 - Therapeutic Day Treatment for every child who meets criteria for it
 - specialized treatment services for adolescent substance abuse disorders
- All school-based services should be delivered through a coordinated approach where desired outcomes are observable and measurable, clear to all providers, and progress towards those outcomes are monitored.



Adult Developmental Services Transformation Team

Co-Chairs

Katherine Olson, The Arc of Virginia

Heather Norton, DBHDS

Charge!

- How can Virginia eliminate the waiting list by 2018? Also, specifically address:
 - Who should provide the services?
 - What is the role of private providers?
 - How do we ensure internal, cross-system and primary care integration?
 - Where in the Commonwealth should services be targeted to address service inequities?
- What are the key elements of successful child crisis services?

Team

- Members
 - Self-Advocates
 - Professionals
 - Service Providers
 - Advocacy Organizations
 - SME's
- Bi-Monthly Meetings
 - 3 hours in length
 - System Review

Guiding Principles

- *Transparency*
- *Equitable, Need-Based Priorities*
- *Uniform, Statewide Application of Priority Determinations*
- *Data-Driven Decision-Making*
- *Family-Centered Solutions*
- *Integrated Community Supports*

Emergency Slots

- Emergency Definition:
 - Immediate service is needed as determined by the below criteria and if all other service options have been explored and exhausted (Existing CSB Slots, CRC, RST, C3T)
- Emergency Criteria:
 - Protective Services (Children or Adult) has substantiated abuse/neglect against the primary caregiver and has removed the individual from the home; or for adults, where abuse/neglect has not been substantiated but corroborating information from other sources (agencies) indicates there is an inherent risk present. There are no other unpaid caregivers available to provide support services to the individual.
 - Death of primary caregiver and/or lack of alternate unpaid caregiver coupled with the individual's inability to care for him/herself and will be dangerous to self or others without supports.

Priority One

- **Priority One:** The need shall be classified as **Priority One** if a service is needed within one year and the individual meets one of the following criteria.
- **Criteria:**
 - An immediate jeopardy to the health and safety of the individual due to the primary caregiver having a chronic or long-term physical/psychiatric condition or other conditions that significantly limits the ability of the primary caregiver (or caregivers) to care for the individual; there are no other unpaid caregivers available to provide supports;
 - There is a risk to the health or safety of the applicant, primary caregiver, or other person living in the home due to either of the following conditions:
 - The individual's behavior or behaviors present a risk to himself or others that cannot be effectively managed by the primary caregiver or unpaid provider even with generic or specialized support arranged by the case manager
 - There are physical care needs (such as lifting or bathing) or medical needs that cannot be managed by the primary caregiver even with generic or specialized supports arranged by the case manager;
 - The individual lives in an institutional setting and has a viable discharge plan in place; or
 - The individual is young adult transitioning and is no longer eligible for IDEA services. (e.g., in a foster care, residential setting, etc.). After age 27, this criteria will no longer apply. [Note: Employment should be a priority for all transition aged youth.]

Priority Two

- **Priority Two:** The need shall be classified as **Priority Two** if a service is needed between one to five years and the individual meets one of the following criteria.
- **Criteria:**
 - Likely to be future jeopardy to the health and safety of the individual due to the primary caregiver having a declining chronic or long-term physical or psychiatric condition or conditions that significantly limits the ability of the primary caregiver (or caregivers) to care for the individual; there are no other caregivers available to provide supports; and the individual's skills are declining as a result of lack of supports;
 - The individual is at risk of losing employment supports;
 - The individual is at risk of losing housing due to lack of adequate supports and services;
 - The individual has desired outcomes that, with adequate supports, will significantly improve his quality of life.

Priority Three

- **Priority Three (Active Planning):** The need shall be classified as **Priority Three** if a service is being currently sought and the system has determined that he/she may not need to access a waiver slot for more than five years as long as the current supports and services remain; however, the system should plan for future needs, as this person may present at any time.
- **Criteria:**
 - The individual is receiving a service through another funding source that meets current needs.
 - The individual is not currently receiving a service but is likely to need a service in five or more years.
 - The individual has desired outcomes that, with adequate supports, will significantly improve his quality of life.

Data Collection

- Cross System Data System that would contain common data elements
- Formalizing the data collected for individuals on the waiting list
 - Demographic Information
 - Services needed and frequency of need
 - When the services would be needed.
- Complete a biennial report summarizing who is waiting
- Annual report that discussed emergency slots

Waiting List Process

- Process is clearly defined
- Consistently implemented
- Training of CSB, DOE and Families
- Verification process
 - SIS implementation for Priority One

Center for Excellence

- Coordinated focus on transition aged youth
- Promising practices for transition aged youth
- Communities of Practice
 - COPAs
 - Regional Nurse Meetings

Children's Crisis Services

- Multi-faceted program that focuses on prevention
- Cross-system collaboration and linkages
- Respite services with appropriate therapeutic supports and services
- Mobile supports

PUBLIC COMMENT PERIOD

FEBRUARY 1 – FEBRUARY 29

Team
Presentations &
Webinar

- <http://www.dbhds.virginia.gov/about-dbhds/commissioner-transformation-teams>

Email Comments

- PublicComment@dbhds.virginia.gov