



Virginia Department of
Behavioral Health &
Developmental Services

Update: Virginia's Community Behavioral Health System

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Topics for today

- CCBHC Planning Grant Update
- Virginia “Model”: What do we need in Virginia
- Relationships/Critical Connections
 - Jail Services
 - Crisis Services
 - Housing
- Jail Waiting List Update
- TDO Data
- New Standards for Emergency Evaluators

CCBHC Planning Grant

- Service Descriptions completed for each of the 9 + 1 services, including provisions for children
- Community Needs Assessment completed
- Eight CSBs assessed for needs to be addressed for certification
- Cost information required to set Prospective Payment System rate being integrated

Service Descriptions

- **Behavioral Health Crisis Services:** crisis intervention, 24 hour mobile crisis, crisis stabilization
- **Screening, Assessment, and Diagnosis, including Risk Assessment:** Same Day Access to a standardized screening to determine level of care needed: emergent, urgent, or routine
- **Person Centered Treatment Planning, Risk Assessment and Crisis Planning**
- **Outpatient Mental Health and Substance Use Services:** Includes individual, family, and group psychotherapy and competent use of evidence based practices
- **Outpatient Clinic Primary Care Screening and Monitoring:** key health indicators are screened and monitored with coordination with physical health care providers
- **Targeted Case Management:** Linking, monitoring and coordinating needed medical, social, legal, and educational supports
- **Psychiatric Rehabilitation Services:** Emphasizes strengthening the individual's abilities to deal with everyday life and includes such services as Mental Health Skill Building, Psychosocial Rehabilitation Services, and Intensive In-Home Services for youth
- **Peer Support and Family Support, including parent peer support for children:** an effective point of engagement for individuals who otherwise may not seek services
- **Intensive Community-Based Mental Health Care for Members of the Armed Forces and Veterans :** critical access to services when distance to Veterans and Military Hospitals is prohibitive. Care is consistent with guidelines promulgated by the VHA.
- **Plus One: Care Coordination:** essential to improved care and outcomes and includes all relevant community partners

Community Needs Assessment

- Key variables included: population, health disparities, income, health factors
- Prevalence rates for mental disorders
- Provide a “penetration rate” to benchmark vs. national data. However, Virginia information is only for CSBs and does not include other providers. We are pursuing data relative to “all payors” to clarify and better assess Virginia.

Assessment Information

- Although none of the eight CSBs could be certified today:
- Preliminary draft Needs Assessment by PCG indicates all 8 CSB's are mostly ready to implement or ready to implement with remediation the 9 + 1 required services (SAMHSA rating categories)
- Can use the same established methodology to determine readiness for remaining 32 CSBs using publicly available data sets, primary source data collection, and consumer and stakeholder surveys
- Key issues related to services and access
 - Workforce and recruitment of psychiatrists and other clinical staff
 - Funding
 - Transportation

Preliminary Rankings by Service

NOTE: “Lowest Common Denominator” determines overall rating

Service Type	Readiness Assessment
Behavioral Health Crisis Services	3 – Ready to implement with remediation
Screening, Assessment and Diagnosis	3 – Ready to implement with remediation
Same Day Access to Screening	3 – Ready to implement with remediation
Person Centered Treatment Planning	2 - Mostly ready to implement
Outpatient Mental Health and Substance Use Services	3 – Ready to implement with remediation
Outpatient Clinic Primary Care Screening and Monitoring	3 – Ready to implement with remediation
Targeted Case Management	2 - Mostly ready to implement
Psychiatric Rehabilitation Services	2 - Mostly ready to implement
Peer Support and Family Support	2 - Mostly ready to implement
Intensive, Community-Based Care for Armed Forces and Veterans	3 – Ready to implement with remediation
Care Coordination	2 - Mostly ready to implement

Rating System

- 1 – Ready to implement
- 2 --Mostly ready to implement
- 3 – Ready to implement with remediation
- 4 – Not ready to implement

Areas of Greatest Concern

- 24- hour mobile crisis: 2 of 8 currently meet the CCBHC service definition. Barriers to implementation include cost, lack of staff resources, and geography.
- Same Day Access to Screening: 3 of 8 currently meet service definition. Major barrier is sufficient staff.
- Outpatient Mental Health and Substance Use Services: Services provided through CSBs and a combination of contracted providers. Major barrier is psychiatric time and certification to provide MAT. SAMHSA requires some services currently contracted to be provided by CCBHC.
- Outpatient clinic primary care screening: Screening and monitoring key health indicators will require most CSBs to hire additional medical/nursing staff.
- Peer and Family Support: Shortage of reimbursement mechanisms and “barrier crimes” rendering some ineligible.
- Care Coordination: More formal tracking of referrals, care coordination agreements with providers and connectivity for exchange of medical information is more elaborate than what is in operation currently in CSBs.

Virginia “Model”?

- Would represent integration of Transformation Team recommendations and national CCBHC model
- Would, if accepted, require building over several biennia beginning with Same Day Access and Primary Care Screening
- Would, in our thinking, encompass the 9 + 1 services with the following additions (not required for the CCBHC grant):
 - Medication Assisted Treatment for opiate addiction can be contracted
 - In-home children’s services
 - Housing, employment, education, and Social Services as well as Primary Care for true care coordination
- Would, if accepted, provide critical support for individuals at risk for incarceration, those in crisis, and those in need of stable housing

Relationship to Jail Services

- Key provisions of the Justice-Involved Transformation Team include: diversion, screening, assessment, and release planning
- Most inmates, or potential inmates, lack coverage and BH needs will fall to the CSBs
- Diversion and planning for services post release both require that services are accessible and sufficiently comprehensive to meet individual needs

Jail BH Services

In addition to establishing opportunities at each intercept point for diversion from the criminal justice system:

- Every jail should have at least one staff member who's primary job is to aid in coordinating release planning.
- Each CSB should have at least one staff member who's primary responsibility is coordinating release planning for individuals
- Standardized screening (using a validated screening instrument) upon admission
- Screening(both upon admission & during the period of detention/incarceration) for suicide risk
- 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.
- 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

Jail BH Services (Cont.)

- Psychiatric Assessment by psychiatrist or psychiatric nurse practitioner or psychiatric physician assistant within 5 days of the Admission Behavioral Health Assessment
- A formulary sufficiently broad to allow the jail/detention center psychiatrist, nurse practitioner, or physician assistant sufficient treatment options for the individual
- 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
- Ongoing case management services throughout the period of incarceration/detention
- Access to jail environment which supports psychiatric/ behavioral stability
- 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.
- Release planning services

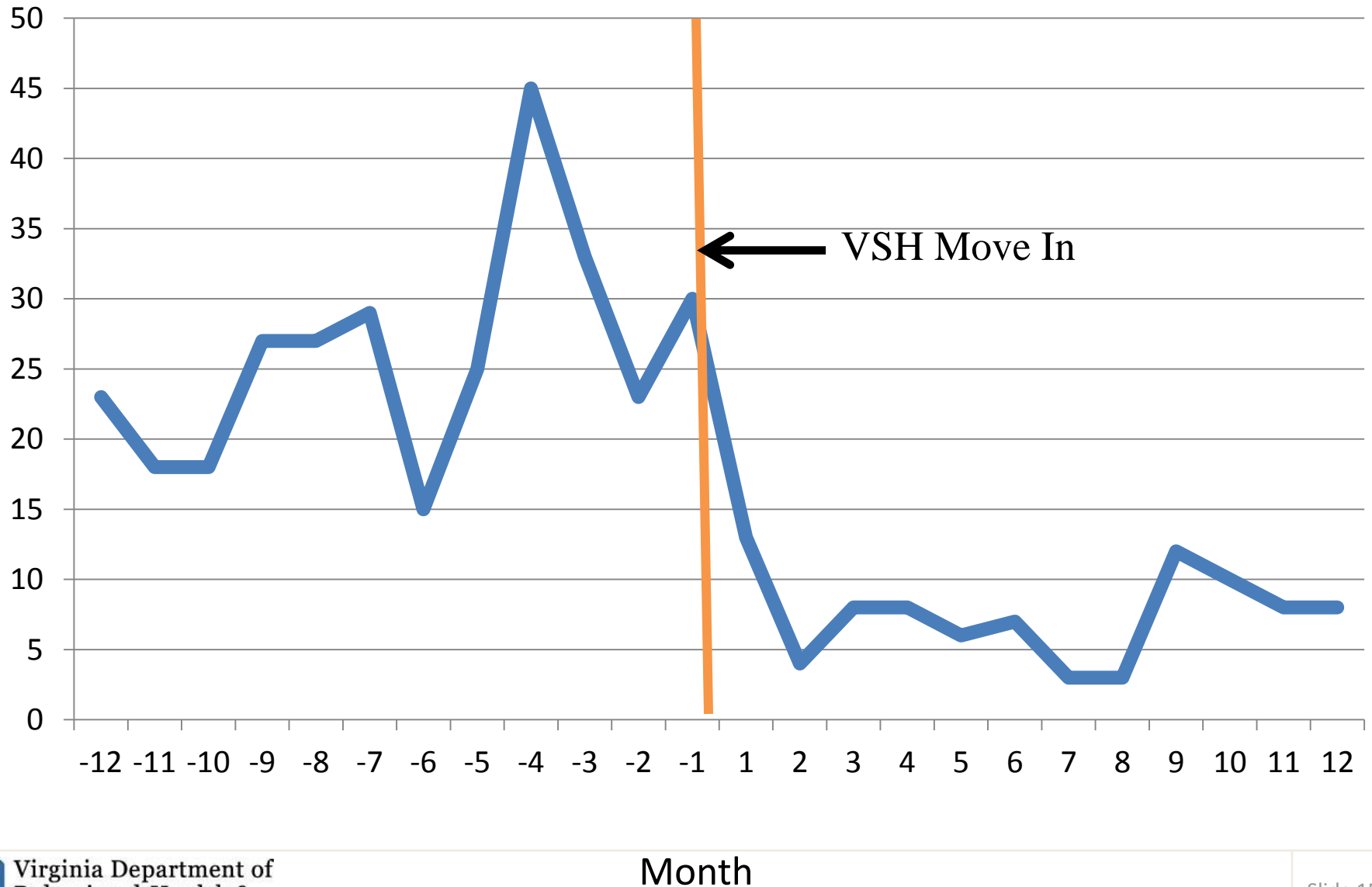
Relationships (Crisis Services)

- While the goal of having accessible, consistent services across the state would be to decrease the number of individuals in crisis a robust crisis system is essential,
- A Crisis System that relies on Inpatient beds or Crisis Stabilization Units is expensive and not recovery oriented.
- A true crisis system has the capacity to make acute medications available, next-day referrals for assessment and establishment of a plan of care, emergency housing, direct referrals for social supports, and the like – all of which requires a robust community BH system that is well integrated with the crisis response system.
- We need a crisis resolution system rather than just a crisis response system.

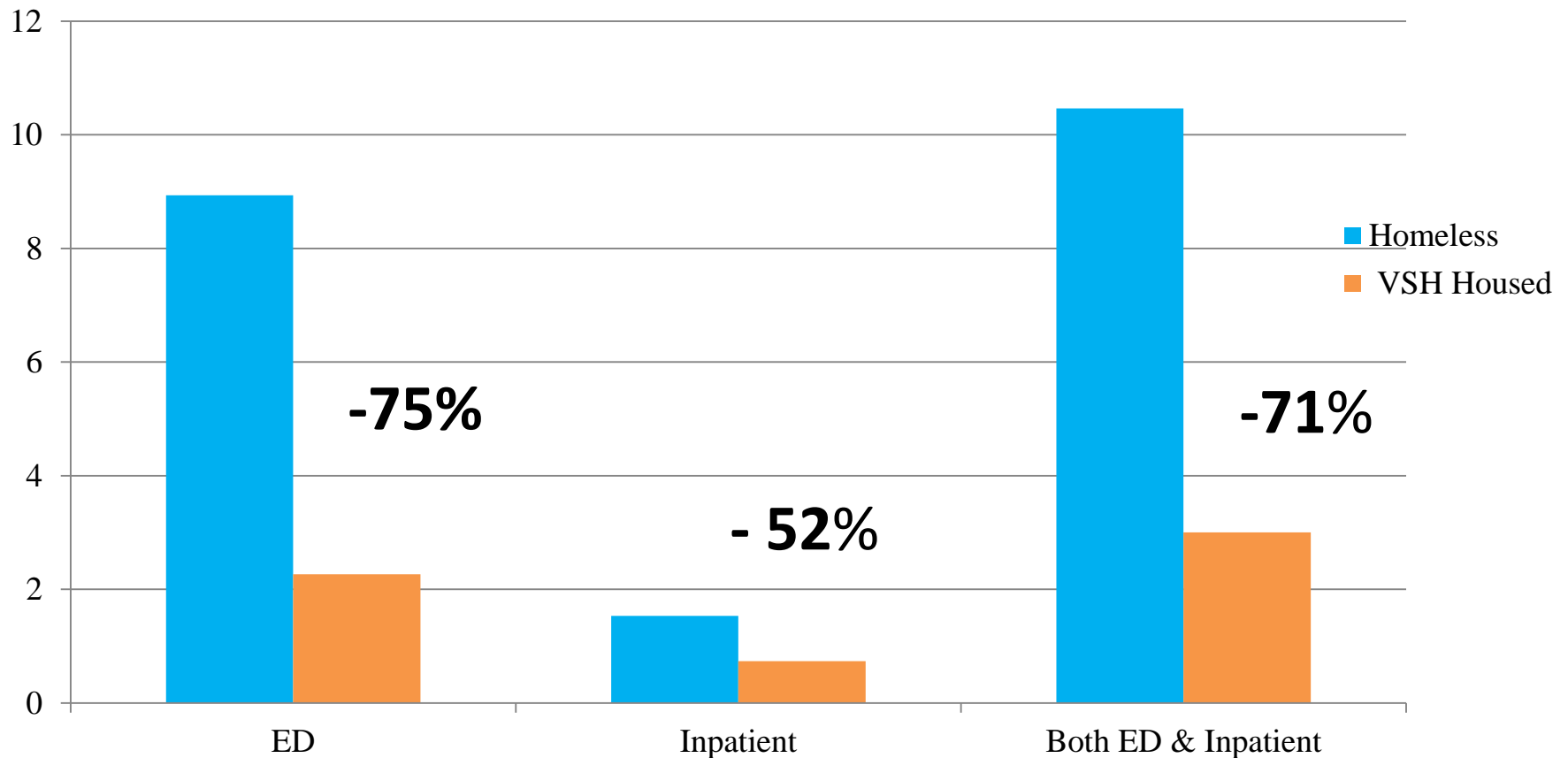
Relationships (Housing)

- The lack of stable housing reflects psychosocial distress and impedes individuals from getting past it.
- Housing Is A Key Determinant Of Health.
- People Who Are Homeless Are At Greater Risk For Poor Health.
- Homelessness Is Correlated With High Health Care Costs. The high proportion of complex health needs and co-occurring health and behavioral health disorders increases the number, intensity, and scope of the services. Homelessness also increases the likelihood of excessive use of the hospitals and crisis services.
- In addition to the relationship to poorer health outcomes and higher costs, lack of housing can be a key factor in recurrent arrests, loss of sobriety, and lack of adherence to prescribed medications for psychiatric or medical reasons
- Access to housing is integral component to a community BH system

Total Monthly VCUHS ED + INPT Visits Before and After Move In for Highest Utilizers (n=30)



Annual Average VCUHS Visits Per Virginia Supportive Housing Clients



	ED	Inpatient	Both
Homeless	8.9	2.3	10.5
VSH Housed	1.5	0.7	3.0

Jail Waiting List Update

Facility	# waiting	# waiting longer than 7 days	Notes
CSH	6	0	<u>Five</u> of the individuals waiting are being assessed by and/or treated by HPR V Jail Team
ESH	13	10	
WSH	2	1	Delay is related to transportation issues at the jail
SWVMHI	0	0	
SVMHI	0	0	
Catawba	0	0	
PGH	0	0	
NVMHI	0	0	
Total	21	11	

TDO Data FY 16 through 5/31/16

	<i>July</i>	<i>Aug</i>	<i>Sept</i>	<i>Oct</i>	<i>Nov</i>	<i>Dec</i>	<i>Jan</i>	<i>Feb</i>	<i>Mar</i>	<i>Apr</i>	<i>May</i>
State Hospital TDOs	229	240	258	267	221	191	263	278	297	376	444
Total TDOs Executed	2,147	2,205	2,208	2,100	1,989	2,001	2,010	1,999	2,271	2,229	2,353
Percent State Hospital Admits	10.7	10.9	11.7	12.7	11.1	9.5	13.1	13.9	13.1	16.9	18.9

- FY16 (thru May)**

TDO total	23,514	2137/month (12.4%)
TDO private	20,448	1859/month (4.9%)
TDO state hospital	3,064	278.5/month (116.9%)

- For reference FY15:**

FY15 TDO total	22,804	1900/month
FY15 private	21,263	1772/month
FY15 state hospital	1,541	128.4/month

New standards and processes for Emergency Evaluators (July 1, 2016)

- Joint effort between DBHDS and VACSB
- All new hires Masters or Doctorate
- All supervisors licensed and two years experience
- 24/7 access to licensed emergency clinician
- Certification required
- Required minimum 12 hours supervision annually
- Required minimum 16 hours continuing education
- Formal QA monitoring
- Recertification every two years
- Evaluators lacking new educational requirement must have eight years experience to continue

Conclusion

- We must continue to focus on building a system of responsive, consistent community based services that go beyond responding to each crisis.
- The system we build needs to connect to critical partners in housing and the criminal justice system as well as be closely integrated with crisis services.
- The basic framework of the CCBHC model, tailored to meet current and future needs of the Commonwealth will give us the opportunity to build, over time, the system we need.