Virginia Department of Behavioral Health & Developmental Services

Transforming Virginia to a Stronger, More Accountable Publicly-Funded Behavioral Health System

Service Descriptions

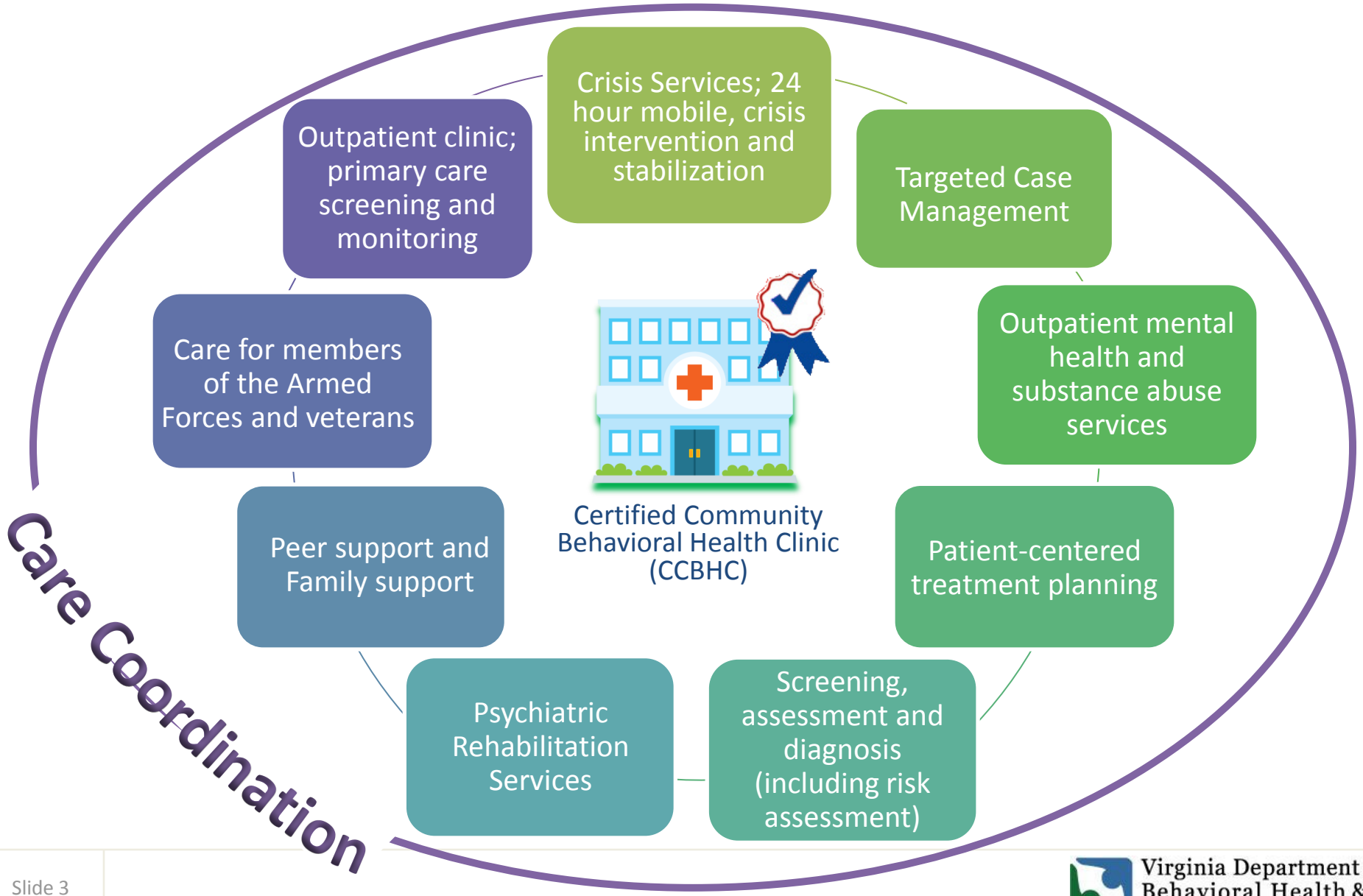
Daniel Herr, JD
Assistant Commissioner for Behavioral Health Services
Virginia Department of Behavioral Health
and Developmental Services

08.22.2016

What Virginia Must Solve

ACCESS	• Must improve access to services across Virginia • Over-reliance on crisis services • ~50% of people served by CSBs lack coverage • Health disparities (geographic, socioeconomic)
QUALITY	• Over reliance on costly institutional care • Consistent implementation of best practices • Meeting Olmstead/ADA - Requiring integrated services
CONSISTENCY	• CSB services vary considerably across Virginia • Size, geography, local funding, reimbursement disparities, local priorities, etc.
ACCOUNTABILITY	• Outdated data infrastructure and reporting • Variances in governance, related to funding streams • Quality/Performance/Engagement

CCBHC "9 (plus 1)" Components of Excellence



Virginia Department of Behavioral Health & Developmental Services

Same Day Access

Same day access to screening, assessment and diagnosis, including risk assessment:

- Provides the tools and resources to make access to care more timely.
- Addresses revenue losses due to no-show appointments.
- Institutes performance improvement measures across the board.
- Increases engagement in treatment by reducing the time it takes to enter care.
- Quick access to care improves continuity and more quickly engages individuals.
- Encompasses the 9 (plus 1) service "screening, assessment and diagnosis (including risk assessment)."

Behavioral Health Crisis Services

- **Emergency Crisis Intervention Services:** Available 24/7; may include preadmission screening and evaluation, short term crisis counseling, triage, disposition determination and/or referral assistance provided over the phone or face-to-face.
- **24-hour Mobile Crisis Teams:** Major goal is to support the individual to remain in the least restrictive environment and provide access to supports needed to stabilize the crisis situation.
- **Crisis Stabilization Services:** Goals are to avert hospitalization or re-hospitalization, provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in crisis, and mobilize the resources of the community support system, family members, and others for ongoing rehabilitation and recovery.
- **Emergency Crisis Intervention and Withdraw Management:** Goal includes providing withdrawal management according to the American Society of Addiction Medicine (ASAM) criteria to people experiencing a crisis at the time of the crisis.

Outpatient Clinic Primary Care Screening and Monitoring

- Agencies will be responsible for screening and monitoring of key health indicators and health risk, including but not limited to:
  - Adult Body Mass Index (BMI) Screening and Follow-Up
  - Weight Assessment and Counseling for Nutrition
  - Physical Activity for Children/Adolescents
  - Blood Pressure

- Agencies will link individuals to primary health care providers when health risks are identified and assist with barriers to primary care services.

Person-Centered Treatment Planning

- Engages the individual and family through emphasizing the uniqueness of each person and his or her right to self determination.
- Is based on principles of wellness, recovery, and hope and seeks to discover strengths that each individual possesses.
- Is the road map for the work done by the individual, family, and provider and addresses:
  - Strengths, needs, abilities, and preferences of the individual
  - Balancing strengths with barriers
  - The individual's life vision by incorporating his/her hopes, dreams, and goals
  - The integration of prevention, medical and behavioral health needs
  - Safety and crisis planning
  - All services required to help meet the identified goals
  - Individual's advance wishes related to treatment and crisis management

Outpatient Mental Health and Substance Use Services

- Includes individual, family, and group psychotherapy and competent use of evidence based practices.
- Evidence based practices include but are not limited to:
  - **Trauma Informed Care**
  - **Person and Family Centered Care**
  - **Recovery Oriented Care**

  } **Foundation for all services provided by the agency**

  - Motivational Interviewing
  - Cognitive Behavioral Therapies (Trauma informed CBT for children)
  - Prescription long-acting injectable medications for mental and substance use disorders
  - Tobacco Cessation
  - American Society of Addiction Medicine (ASAM) Criteria
  - Medication Assisted Treatment

Targeted Case Management

- Assisting individuals in sustaining recovery, and gaining access to needed medical, social, legal, educational, and other services and supports
- Supports for persons deemed at high risk of suicide, particularly during times of transitions such as from an ED or psychiatric hospitalization

- Identifying and reaching out to individuals in need of services
- Assessing needs and planning services
- Linking the individual to services and supports
- Assisting the individual directly to locate, develop, or obtain needed services and resources
- Coordinate services with other providers
- Enhancing community integration
- Making collateral contacts
- Monitoring service delivery
- Advocating for individuals in response to their changing needs

Psychiatric Rehabilitation Services

- Psychiatric Rehabilitation Services provide:
  - Assessment
  - Medication education
  - Opportunities to learn and use independent living skills
  - Enhance social and interpersonal skills
  - Family support and education
  - Vocational and educational opportunities
  - Advocacy to individuals with mental health, substance use, or co-occurring disorders in a supportive community environment focusing on normalization

- It emphasizes strengthening the individual's abilities to deal with everyday life rather than focusing on treating pathological conditions.
- Specific services to be provided include **Mental Health Skill Building Services, Psychosocial Rehabilitation Services, and Intensive In-Home Services** as defined in the current Virginia State Medicaid Plan.

Peer and Family Support

- Peer Support and Family Support, including parent peer support for children provides access to:
  - Peer specialists
  - Recovery coaches,
  - Peer counseling,
  - Family/caregiver supports including parent peer support partners.

- Peers will be certified through the DBHDS certification process.
- WRAP (Wellness Recovery Action Plan) or equivalent planning will be provided through peer and family support services.
- Recovery support services include:
  1. **Emotional support –** Includes peer mentoring, peer coaching, and peer-led support groups;
  2. **Informational support –** Includes peer-led life skills training, job skills training, citizenship restoration, educational assistance, and health and wellness information;
  3. **Instrumental support –** Includes connecting people to treatment services, providing transportation to get to support groups, child care, clothing closets, and filling our applications or helping people obtain entitlements; and
  4. **Affiliational support –** Offers the opportunity to establish positive social connections with other recovering people.

Armed Forces and Veterans

- Intensive Community-Based Mental Health Care for Members of the Armed Forces and Veterans are not always easily accessible. Clinics will provide services when Armed Forces members located 50 miles or more (or one hour's drive time) from a Military Treatment Facility and veterans living 40 miles or more (driving distance) from a VA medical facility.
- Services are to be informed by SAMHSAs 10 guiding principles of recovery:
  - Hope
  - Person-driven
  - Many pathways
  - Holistic
  - Peer support
  - Relational
  - Culture
  - Addresses trauma
  - Strengths/responsibility
  - Respect
- Clinics will work to identify members of the armed forces and veterans upon intake to be sure they receive appropriate support and services.

Care Coordination

- Care coordination includes but is not limited to:
  - Department of Social Services
  - Physical health care providers
  - Schools
  - Employment
  - Housing resources

- Care coordination for youth in the CCBHC model is crucial given the many different entities serving children and adolescents and their families including physical health providers. The intensity of care coordination should be appropriate to the level of need and include the High Fidelity Wraparound model when needed.

Care Coordination

Four key activities are to be included in care coordination provided by the CCBHC:

1. Assume accountability including a referral and transition tracking system.
2. Provide individual and family support during the referral and transition process.
3. Build relationships with community providers serving the same population and develop formal care coordination agreements with those providers.
4. Develop connectivity wherever possible for ease in exchange of medical information.

Community Needs Assessment

- Establish community demographics, prevalence rates, penetration rates, and relevant social indicators including a community self-assessment of need.
- Identify units of service needed for each service based upon demographic data and self-assessment.
- Document existing units of service for each category and the gap between the existing services and the population needs including barriers to access.
- Identify timeframe for developing and implementing those services.
- Create a matrix for costs of developing and implementing additional services.

Preliminary Rankings by Service

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

NOTES:

- "Lowest Common Denominator" determines overall rating
- Any rating below "ready to implement" (2-4) is related to funding.

Rating System

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

The Way Forward: Transformation Teams

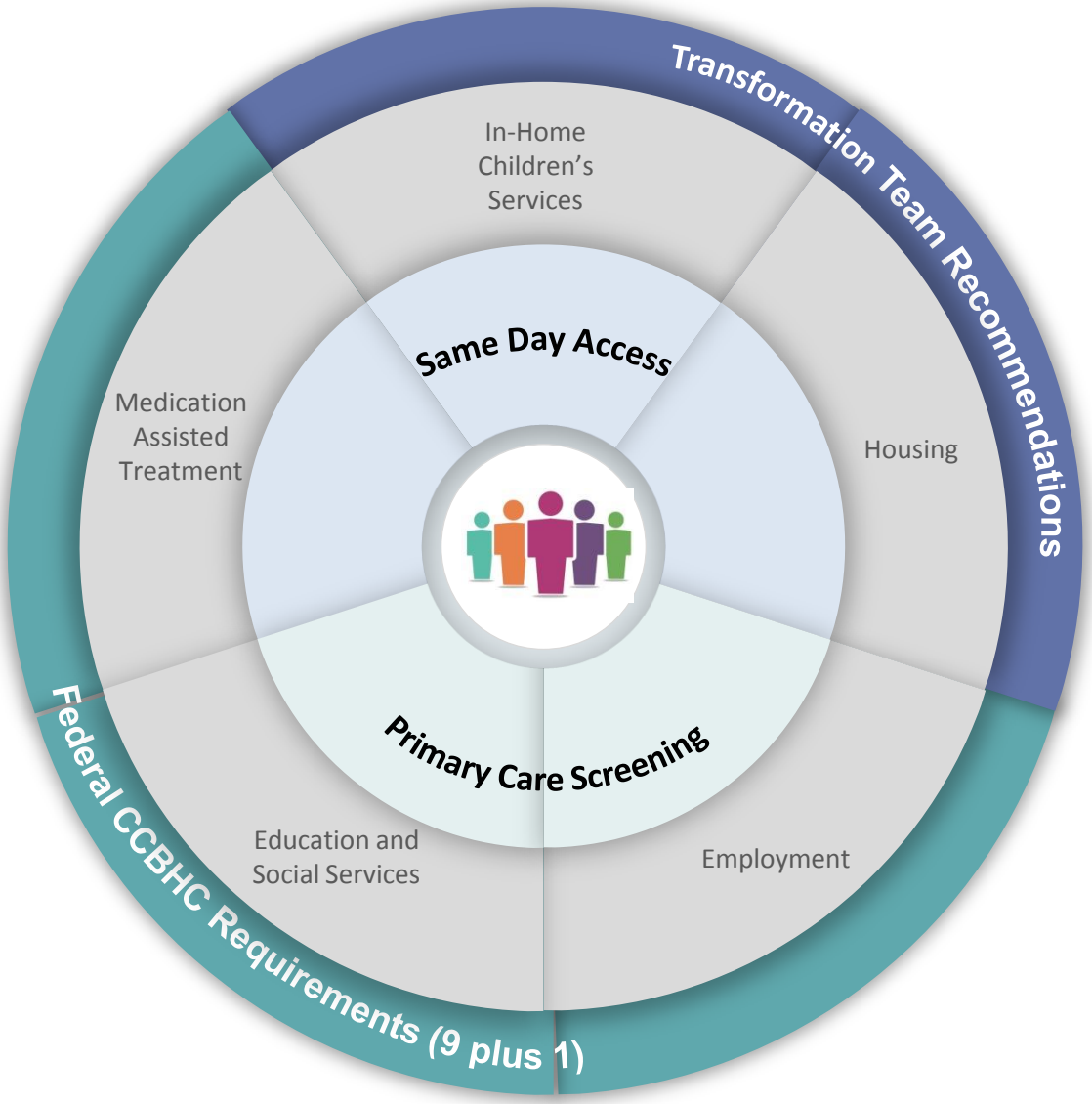
DBHDS Transformation Teams: Full-scale transformation effort with system stakeholders, including state agency partners, CSBs, private providers, advocates, individuals receiving services and family members. The teams' work has been completed, some recommendations already implemented, and DBHDS is working on a plan to implement remaining recommendations. The teams include:

- Child and Adolescent Behavioral Health Services
- Adult Behavioral Health Services
- Justice Involved Services
- Developmental Services

Note: More information on the transformation team process and their recommendations can be found at the following link: www.dbhds.virginia.gov/about-dbhds/commissioner-transformation-teams

Virginia's Path Forward

- The new system must be made of responsive, consistent community services that do more than address each crisis.
- Builds on federal CCBHC requirements and transformation team recommendations with services Virginians need.
- Would provide critical support for individuals at risk of incarceration, those in crisis and those in need of stable housing.
- The result is Virginia-specific to meet current and future needs of Virginians with mental illness and their families.



Virginia Department of Behavioral Health & Developmental Services

2015 Federal Planning Grant for CCBHCs – Accomplishments

The CCBHC planning grant provided a vehicle to push access, quality, consistency and accountability in Virginia. Major accomplishments include:

- ✓ Developed a comprehensive definition of core services for Virginia, including best practices
- ✓ Developing cost models to provide specific services at each of eight CSBs
- ✓ Conducted community needs assessment to establish prevalence and penetration rates, identify units of service needed and document gaps
- ✓ Conducted an IT needs assessment relative to data collection and reporting capability required for accountability
- ✓ Delineated service requirements to integrate physical and behavioral health while screening all clients for medical conditions and same day access
- ✓ Solidified agreement for consistent, standardized services easily accessible to all individuals as a shared value and priority for the behavioral health system
- ✓ Demonstrated the DBHDS value of transparency, candor, and purposeful collaboration to CSBs and stakeholders