Virginia Association Of Community Services Boards, Inc.
Making a Difference Together

Premier Mental Health, Developmental, and Substance Use Disorder Services in Virginia's Communities

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Remarks to the Joint Commission on Health Care
Behavioral Health Subcommittee
Jennifer Faison, Executive Director, VACSB
20 August 2014

The Virginia Association of Community Services Boards (VACSB) remains committed to its mission which is to achieve a publicly-funded system of quality services in Virginia that:

- is responsive to the needs of individuals with behavioral health and developmental disabilities and their families;
- focuses on community-based, person-centered supports;
- ameliorates and prevents disabling conditions and;
- promotes resilience, independence, recovery.

Continuum of Care

While the recent focus has rightfully been on the public crisis response environment, there are a multitude of other points along the continuum of care where the safety net of public and private providers can have an impact on an individual's ability to remain stable and in a community setting. The continuum has services and interventions along a spectrum from low-intensity, social and community services to high-intensity, medical and behavioral health specialty treatment modalities. At the low-intensity end of the spectrum, we know that peer support, support for self-directed care and continuing care for substance use disorders have proven to be effective in helping individuals adhere to their treatment plans, maintain stable housing and obtain and maintain meaningful employment.

The intermediate range of the spectrum includes engagement, medication management and physical health care coordination services and supports. Medication management, service planning (especially crisis planning and family education) and general health screenings can help an individual create and maintain natural family supports and engage additional professional expertise, all of which can help to ensure that s/he stays engaged in treatment, has a plan for avoiding crisis and, ideally, one for when a crisis does occur, and feels a sense of responsibility for self-management of both physical and emotional health.

The most intensive end of the spectrum includes crisis stabilization, partial hospitalization, intensive community treatment and mobile crisis. The objective is to use these interventions to avoid inpatient hospitalization, when possible, which aids in appropriate utilization management of the finite number of state and community psychiatric hospital beds.

VACSB Officers
Chair: Al Collins, Rappahannock Area Community Services Board
1st Vice Chair: F. Gibbons Sloan, Chesterfield Community Services Board
2nd Vice Chair: Debbie Burcham, Chesterfield Community Services Board
Secretary: Linda R. Drage, Piedmont Community Services Board
Treasurer: James F. Bebeau, Danville-Pittsylvania Community Services Board
Executive Director: Jennifer Faison

Of note is that the more "medical" types of services at the more intensive end of the spectrum are very commonly available as Medicaid State Plan services and conversely, the services on the lower-intensity end of the spectrum are more commonly covered as waiver services. It is uncommon to find the more "social" types of services in the Medicaid State Plan and, without that funding source, these services are often underdeveloped and underutilized. An emphasis on early intervention, prevention and health promotion will go a long way toward ameliorating the conditions that cause behavioral health crises, and dedicated, sustained funding across all areas of the spectrum will allow for the creation of more robust community services which are evidence-based, person-centered and accessible to all who need them.

Care Coordination and Integration

In addition to focusing on those intersections along the continuum of care where there are opportunities for diversion from hospitalization, care coordination and integration is critical for helping individuals with behavioral health issues to remain stable and healthy in the community.

Longstanding research indicates that individuals with behavioral health issues die 25 years before individuals without behavioral health diagnoses. Virginia has taken a number of steps to attempt to address that issue, two of which have been the creation of A New Lease on Life (ANOL) grant-funded integrated care projects and another is the Commonwealth Coordinated Care demonstration project. Both of these steps puts Virginia in an excellent position to make the next logical move which is a move toward a system of care that allows individuals with behavioral health issues to designate and entity, specifically a CSB, as his or her health home.

There were initially 8 ANOL projects in which CSBs set up community partnerships and infrastructure to allow physicians to see individuals on site at the CSB and, in some cases, to allow a behavioral health specialist to work in a physician's office, serving as a resource to physicians with patients who have behavioral health needs. The grant funding for these projects has been expended, but part of the grant request process required the CSB to lay out a plan for sustainability. There are currently 24 CSBs who have integrated care projects of some kind.

Commonwealth Coordinated Care is a demonstration project that came online in the spring of 2014 and holds great promise for those individuals who qualify. Participation in the project is open to individuals who are dually eligible for both Medicare and Medicaid. CSBs, DMAS, CMS and three managed care organizations have partnered to coordinate behavioral and primary health care through the case management and interdisciplinary care team infrastructures that exist in the CSBs and the managed care organizations respectively. The project will last for three years and we believe there will be positive outcomes in terms of:

- Increased access to & participation with BH/medical service providers
- Improved coordination among prescribers and reduced medication-related waste
- Improved adherence to medications
- Improved psychiatric stability
- Reduced frequency/duration of high-end treatment services (hospitalization and inappropriate us of ERs)
- Improved functional status

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There is interest on the part of the Governor's office for this type of initiative and CSBs are interested in continuing the dialogue in this very positive direction.

The VACSB and its member Community Services Boards stand ready to assist the Joint Commission in whatever ways it deems appropriate and I look forward to continuing our work together.

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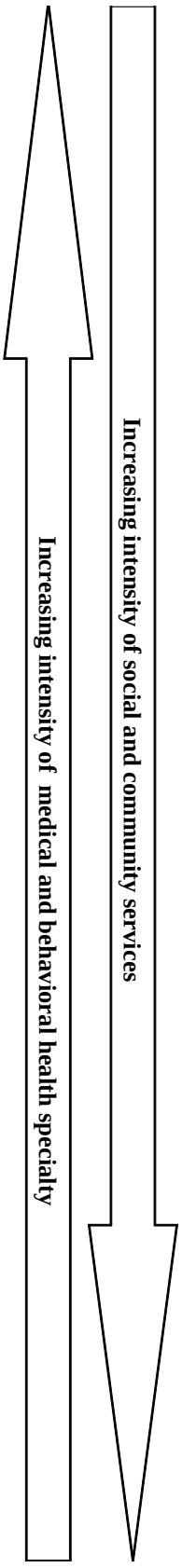
Figure 3-1 Good and Modern Addictions and Mental Health Service System

Acute Intensive Services	Mobile crisis Medically monitored intensive inpatient Peer based crisis Urgent care 23 hour crisis stabilization 24/7 crisis hotline
Out-of-Home Residential Services	Crisis residential/stabilization Clinically managed 24-hour care Clinically managed medium intensity care Adult mental health residential Children's mental health residential services Youth substance abuse residential Therapeutic foster care
Intensive Support Services	Substance abuse intensive outpatient, Substance abuse ambulatory detoxification Partial hospital Assertive community treatment Intensive home based treatment Multi-systemic therapy Intensive case management
Outpatient Services	Individual evidence based therapies Group therapy, family therapy Multi-family therapy Consultation to caregivers
Healthcare Home/Physical Health	General and specialized outpatient medical services Acute primary care General health screens, tests, and immunizations Comprehensive care management Care coordination and health promotion Compressive transitional care Individual and family support Referral to community services
Medication Services	Medication management Pharmacotherapy (including MAT) Laboratory services
Engagement Services	Assessment Specialized evaluations (psychological, neurological) Service planning (including crisis planning) Consumer/family education Outreach
Prevention (including Promotion	Screening, brief intervention, and referral to treatment Brief motivational interviews Screening and brief intervention for tobacco cessation Parent training Facilitated referrals Relapse prevention Wellness recovery support Warm line
Community Support (Rehabilitative)	Parent/caregiver support Skill building (social, daily living, cognitive) Case management Behavioral management Comprehensive community support Supported employment Permanent supported housing Recovery housing Therapeutic mentoring Day habilitation
Other Supports (Habilitative)	Personal care Homemaker Respite Supported education Transportation Assisted living Recreational services Interactive communication technology devices
Recovery Supports	Peer support Recovery support coaching Recovery support center services Supports for self-directed care Continuing care for substance use disorders



Commonwealth Coordinated Care
Medicare & Medicaid working together for you

Commonwealth Coordinated Care Update – August 2014

Beginning August 1, 2014 there are 11, 176 Virginians enrolled in the Commonwealth Coordinated Care (CCC) program. This includes 2,825 individuals who have opted in to the CCC program across the five CCC regions. Approximately 13, 000 individuals are scheduled to auto-enroll in CCC on September 1, 2014 in the Central Virginia area.

Timeline for Beneficiary Notification:

- Central Virginia beneficiaries received letters with their automatic assignments by July 1, 2014 and received a second, 30-day notice by August 1st.
- Beneficiaries in the Charlottesville and Roanoke regions received their automatic assignment letters by August 1st and will receive a follow-up letter by September 1, 2014. Automatic coverage in these regions will become effective October 1, 2014.
- As a reminder, Northern Virginia automatic coverage will become effective November 1, 2014 and beneficiaries in this region will receive notification of their automatic assignment by September 1, 2014.

Under the CCC program, automatic assignment to a Medicare-Medicaid Plan (MMP) will only occur in those localities where there are at least two MMPs approved to offer services. If one MMP is available, eligible beneficiaries in that area may elect to opt-in to that MMP, but will not be automatically enrolled until a second MMP is available in that locality. Due to this program requirement, the localities listed below will not participate in automatic assignment at this time. Please note, additional network submissions are due from MMPs in August and it is likely that this list will change:

1. Western/Charlottesville Region:
    a. City of Harrisonburg
    b. City of Staunton
2. Southwestern/ Roanoke Region:
    a. Henry County
    b. City of Martinsville
    c. City of Radford
    d. Wythe County

Stakeholder Advisory Committee

The Stakeholder Advisory Committee met July 17th at DMAS. During this meeting, the Committee recommended DMAS share information about the resolution of a previous concern.

In the first weeks of CCC automatic assignment in Tidewater, beneficiaries that opted out of CCC continued to show they were enrolled in CCC for their Part D plan. The systems with Medicare and Medicaid have been updated to ensure both systems are showing congruent and accurate Part D information.

Another recommendation of the Stakeholder Advisory Committee is to notify beneficiaries to keep their Medicare and Medicaid cards in a safe place after enrolling in CCC. Due to the flexible and voluntary nature of the CCC program, DMAS recommends beneficiaries not discard their Medicare and Medicaid cards when they receive the CCC insurance card from their chosen MMP. If the beneficiary chooses to opt-out of CCC in the future, they may need to begin using their existing Medicare and Medicaid cards again. DMAS is asking all Stakeholders assist us to share this information with beneficiaries you may know and work with. Thank you for your partnership in this communication.

Success Stories from the Field:

The Medicare-Medicaid Plans continue to receive feedback from their members and contracted providers communicating positive outcomes that have resulted from participation with CCC. A few of these stories are shared with CCC stakeholders below:

Humana

A member in their 40's joined Humana's CCC plan. This member was identified as receiving behavioral health treatment through the DMAS Medical Transition File. The member has a history of Bipolar II disorder and PTSD as well as painful endometriosis and uncontrolled diabetes. The Member is receiving Targeted Case Management (TCM) services through a Community Services Board (CSB).The behavioral health (BH) care manager facilitated the comprehensive and behavioral health assessment in collaboration with the care team and the TCM team from the CSB. During this process, the BH care manager discovered several gaps in this Member's medical care, the primary issue being that the Member had not seen her PCP for over 8 months due to transportation issues and a change in the PCP's participation with the Member's prior health plan. The Member revealed that she was extremely anxious and in a great deal of pain due to her medical condition and that her plan was to go to the emergency room for care to help deal with her pain. She felt like she had no other options and expressed feelings of hopelessness related to managing her pain and her ability to get to medical appointments.

Following the comprehensive medical and behavioral health assessments, the clinician connected the member and the BH care manager to a customer service representative to find a PCP near the

member's home. The new PCP was able to schedule an appointment to see the member the next day, with transportation arranged by the BH care manager. There was excellent coordination and responsiveness from Logisticare. The new PCP is two blocks from the Member's home and in walking distance. The Member and her TCM both report the Member is happy with her new doctor and has already kept a follow-up appointment to help her begin to manage her medical conditions. The Member and her BH care manager will continue to work with the community-based services through TCM as well as the Humana medical care team to ensure her care plan addresses all of her needs and that all available supports are in place.

Virginia Premier

Our recent success story stems from an opportunity to educate a Skilled Nursing Facility on CCC and build a stronger relationship with that provider.

The provider had a LTC member residing in their facility but was unsure about CCC, in particular Virginia Premier's CompleteCare and the Care Management process. The facility's concern stemmed from an intention of protecting the best interest of their resident, and Virginia Premier was able to meet with the facility to discuss the Commonwealth Coordinated Care Program. What began as a skeptical interaction, resulted in a beneficial conversation for both Virginia Premier and for the Skilled Nursing Facility.

The facility reports they now have a good understanding of the CCC program, Virginia Premier's participation, and how Care Coordination through CCC can benefit members. Both parties involved walked away from the conversation with a positive feeling and understanding of how to work together moving forward. There is now an excellent opportunity to build on this new relationship.

Anthem Healthkepers

Anthem Commonwealth Coordinated Care MMP plan has a 62 year old woman enrolled in the program who qualifies under the EDCD waiver. The member had a stroke, was in chronic pain, was experiencing weight loss and had painful and increased swelling in both of her legs.

The Member lives alone, however, her daughter lives nearby and is involved in the care and treatment of her mother. Under the Medicaid EDCD waiver, she had an authorization for a personal care worker approved for 6 hours per day. Upon enrollment into CCC, the Anthem CCC Care Coordinator visited the member and her daughter in the member's home. The initial assessment revealed physical problems with longstanding, poorly managed pain and leg

swelling. The Member had not ever had a mammogram or a colonoscopy screening. When speaking with the Member's daughter, she voiced frustration with the current PCP due to poor communication with the PCP office and felt her mother's needs were not being addressed despite multiple visits for the same issues.

The Care Coordinator helped arrange an appointment with the Member's PCP and the care coordinator accompanied the member to the appointment for the interdisciplinary team meeting. Prior to the appointment, the Care Coordinator met with the family to prepare a list of current unresolved issues and any concerns. The member and the Care Coordinator discussed the list with the PCP and helped explain the Member's medical concerns. Collaborating with the PCP, new orders for home health were issued, pain medication was changed to better meet the member's needs, and a referral was written for a mammogram. The physical exam also revealed shingles as a main source of the Member's pain.

Next, a referral and visit to a nephrologist was also arranged to investigate whether renal problems are contributing to the worsening leg swelling. In addition, the mammogram was completed which proved significant by identifying an issue that may require future treatment. During the weekly follow up visit, the Member reported the medication change from the PCP brought relief for her pain. Upon further discussion, the Member's personal care hours were increased due to increased weakness in her swollen legs. This additional support will provide added security for the Member when her daughter is not available.

Evaluation Update

During July, the evaluation team interviewed staffed at the MMPs and continued drafting the second *Notes from the Field* update focusing on DMAS' implementation of the CCC Program. The team also developed a plan for partnering with the Virginia Association of Centers for Independent Living to conduct a series of enrollee focus groups around the state. Individuals interested in the evaluation should direct inquiries to Gerald A. Craver, PhD (DMAS lead evaluator: gerald.craver@dmas.virginia.gov).

CCC Quality

The CCC Quality Learning Collaborative has been rescheduled to September (Date TBD). DMAS continues to seek dual eligible beneficiaries who have enrolled in CCC and their caregivers to participate and share their CCC experience with our Quality Collaborative! If you

know of a CCC enrollee or their caregiver who might be interested in participating, please email Fuwei Guo at (fuwei.guo@dmas.virginia.gov).

Outreach and Education

An **educational event on CCC** is scheduled in the **New River Valley** area of the Roanoke Region for **Tuesday, August 12th.** This event will feature a morning CCC overview and Q&A for all provider types followed by a focused training for Long-term Supports and Services (LTSS) and Nursing Facility providers (9:30am-12:30pm). An afternoon session (1:30-3:00pm) will focus on CCC overview for beneficiaries, their family members and advocates. The training is located at the **Carilion New River Valley Medical Center: Fireside Conference Center**. Seating is limited, to register for this event, RSVP to: Barbara Via at 540-633-6533 or Janet Brennend at 540-980-7720. For more information, contact Tina King: New River Valley, Area Agency on Aging 540-980-7720.

September dates and details for upcoming trainings in Central Virginia, Charlottesville, Roanoke and Northern Virginia will be available very soon.

DMAS and the MMPs continue to host weekly calls for providers. Providers can email CCC@dmas.virginia.gov to be added to the email distribution lists to receive the weekly Q&A logs. The schedule of calls & call information is below:

Monday Provider Calls (LTSS)		Friday Provider Calls	
Adult Day Services	1:30-2p Conference Line 866-842-5779 Conference code 7143869205	Hospitals and Medical Practices	11-11:30am Conference Line 866-842-5779 Conference code 8047864114
Personal Care, Home Health & Service Facilitators	2-2:30p Conference Line 866-842-5779 Conference code 8047864114	Behavioral Health	11:30am-12pm Conference Line 866-842-5779 Conference code 8047864114
Nursing Facilities	2:30-3p Conference Line 866-842-5779 Conference code 7143869205		

Commonwealth Coordinated Care
Medicare & Medicaid working together for you

Community outreach efforts continue with ongoing presentations to stakeholder groups and regular conference calls with Enrollee/Advocate groups. As a reminder, calls for Beneficiaries and their advocates are held as follows:

CCC Conference Calls for Beneficiaries & their Advocates
Tuesdays at 12:30pm & Fridays at 10am
Dial-In Information: 1-866-842-5779
Pass Code: 6657847797#

If you would like to invite the CCC Outreach Team to provide your group with a CCC overview presentation, please let us know by contacting us at: CCC@dmas.virginia.gov.

Contact information for the MMPs is updated on the DMAS website monthly. Providers and other stakeholders may visit the DMAS website http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx to find MMP contacts for their regional care coordination leads, plus lead staff for behavioral health, billing, authorizations, and more.

NEXT STAKEHOLDER ADVISORY COMMITTEE MEETING:

Medicare/Medicaid Financial Alignment Demonstration Advisory Committee

October 22, 2014

1:00 to 3:00 pm

Conference Room 7A&B

Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219