Behavioral Health Care Subcommittee
October 5, 2016 @ 1:40 PM
Senate Room A - General Assembly Building

Members Present

Delegate David L. Bulova
Delegate T. Scott Garrett
Delegate Riley E. Ingram
Delegate John M. O'Bannon
Senator George L. Barker
Senator Charles W. Carrico, Sr.
Senator Rosalyn R. Dance
Senator Siobhan S. Dunnavant
Senator David R. Suetterlein

Members Absent

Delegate Kaye Kory
Delegate Christopher P. Stolle
Delegate Patrick A. Hope
Senator L. Louise Lucas

Staff Present

Michele L. Chesser
Paula Margolis
Andrew Mitchell
Stephen Weiss
Agnes Dymora

CALL TO ORDER

Senator Dunnavant called the meeting to order. Secretary Hazel stated that the ER Diversion Project is moving along and that harm reduction can be done through treatment. Dr. Chesser then summarized the agenda.

PRESENTATIONS

Prescription Drug and Heroin Task Force Update

Ms. Jodi Manz started her presentation with data on overdose deaths from 1999 to 2016 showing a significant increase. She highlighted a program called angel wings which aides in treatment for addiction and spoke about Virginia starting similar programs. A state website which will aid in steps to take with addiction and recovery was discussed. She also spoke about suboxone and how it is used as a tool for treatment and recovery; She mentioned that counseling also needs to be provided in conjunction with suboxone. Finally, Ms. Manz summarized the focus areas of harm reduction, treatment, illicit use prevention, prescription abuse prevention and culture change. In conclusion, she provided upcoming task force meeting dates.

DBHDS Updates

Dr. Barber started his presentation by summarizing some improvements to Virginia's Behavioral Health System pertaining to hospital operations, jail waiting lists and prevention. He went on to state that Virginia's health spending is higher than the rest of the country. The overall number of state hospital admissions rose 54% since 2013 due to private hospitals refusing patients with specific diagnosis. Credentials for emergency evaluators were discussed. Dr. Barber then spoke about updates on the Certified Community Behavioral Health Clinics (CCBHC) program. He presented a chart of participating CSBs and what services they need to provide to meet CCBHC standards. He stated that in order to have all services ready, $6.52M would be needed and then $38.02M to continue the operations. During the Federal Planning Grant there were a few issues that were discovered such as access to care, quality, consistency and accountability. He presented a model of services that need funding over the next 10 years highlighting same day access as a priority. Requests for prioritization and cost of services was made by JCHC members.

Integrating Mental and Physical Health Care Services

Paula Margolis presented a study on Integrating Behavioral Health and Physical Health Care Services. She talked about how often common behavioral health conditions go unrecognized by primary care providers, and medical conditions go unrecognized by behavioral health providers. Services for physical and behavioral health care and substance use have historically been financed and delivered under separate systems. Fragmentation can impede access to care and result in poor health status, inappropriate use of services and increased costs. Integrating physical and behavioral health has been shown to reduce fragmentation and promote patient-centered care. Integration can occur along a continuum from coordination and referral, to co-location of services and health homes, through fully-integrated multi-disciplinary teams that share administrative and financial functions, as well as patient care. Reimbursement can also occur along a continuum from fee-for-service, to bundled or episode-based payments to capitation and global payments.

Barriers to integration must be overcome, payments must be adequate to cover the expense of creating an integrated practice and information systems are required. Billing issues may pose problems and sustainability of funding is required. There are several avenues of integration, including managed care, health homes, accountable care organizations. There are opportunities for grant funding, such as the Accountable Health Communities, State Innovation Model grants, and the Delivery System Reform Innovation Program. The Integration of behavioral and physical health services is an emergent model. In order for integration to occur, new treatment paradigms must be adopted by providers, resources for restructuring provider systems are needed, and there is a need for additional behavioral health professionals in Virginia. Integration is a process and it will take several years for systems to mature and results to be achieved.

Prepared by: Agnes Dymora