COMMONWEALTH of VIRGINIA

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COMMISSIONER

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June 15, 2020

The Honorable Janet D. Howell, Chair
Senate Finance Committee
The Honorable Luke E. Torian, Chair
House Appropriations Committee
Pocahontas Building
900 East Main Street
Richmond, VA 23219

Dear Senator Howell:

Item 311.H of Chapter 1283 of the 2020 Appropriations Act directs the Department of Behavioral Health and Developmental Services (DBHDS), in conjunction with several other state agencies and stakeholders, to identify strategies for reducing admissions to the Commonwealth Center for Children and Adolescents (CCCA). The language states:

> *Upon passage of this Act, the Department of Behavioral Health and Developmental Services shall establish a workgroup, including stakeholders as deemed necessary by the Department, to examine and identify possible alternative treatment services and sites for minors that otherwise would be placed at the Commonwealth Center for Children and Adolescents (CCCA). The work group shall also examine underlying systemic issues that are contributing to the increase in admissions and projected admissions at CCCA and identify potential strategies and recommendations for reducing admissions to CCCA. The membership of the work group shall include representatives from the Department of Medical Assistance Services, the Department of Juvenile Justice, the Office of Children's Services, Community Services Boards, the Virginia Hospital and Healthcare Association, and other relevant stakeholders. The work group will submit its findings to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by June 15, 2020.*

Additionally, Item 321.G of Chapter 1289 of the 2020 Appropriations Act directs DBHDS to identify options for alternative private settings for inpatient care. The language states:

> *Out of this appropriation, $6,300,000 in the first year and $8,400,000 the second year from the general fund shall be used for additional capacity for children's acute inpatient care. The Department of Behavioral Health and Developmental Services shall pursue options for alternative private settings for inpatient care for children who would otherwise be admitted to the Commonwealth Center for Children and Adolescents.*

In accordance with these items, please find enclosed the combined report for 311.H of Chapter 1283 as well as the Item 321.G of Chapter 1289 of the 2020 Appropriations Act. Staff are available should you wish to discuss this request.

Sincerely,

Alison G. Land, FACHE
Commissioner
Department of Behavioral Health & Developmental Services

CC:
Daniel Carey, MD
Vanessa Walker Harris, MD
Susan Massart
Mike Tweedy

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June 15, 2020

The Honorable Ralph S. Northam
Governor of Virginia
1111 East Broad Street
Richmond, VA 23219

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Report on the 311.H of Chapter 1282 of the 2019 Acts of Assembly as well as the Item 321.G of Chapter 1289 of the 2020 Acts of Assembly

Children's Inpatient Workgroup Report

To the Chairs of the Senate Finance and House Appropriations Committees

Monday, June 15, 2020

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Preface

Item 311.H of Chapter 1282 of the 2019 Acts of Assembly directs the Department of Behavioral Health and Developmental Services (DBHDS), in conjunction with several other state agencies and stakeholders, to identify strategies for reducing admissions to the Commonwealth Center for Children and Adolescents (CCCA). The language states:

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Executive Summary

The purpose of this report is to provide a summary and recommendations from the Children's Inpatient Workgroup, to the General Assembly of Virginia, based on the collective views of Virginia's child-serving system of behavioral health care in addressing the rising census of the only state hospital for children in Virginia, the Commonwealth Center for Children and Adolescents (CCCA). Over the past three years, CCCA has experienced a rapid growth in admissions. In FY2019, there were over one thousand admissions, the highest reported number of admissions in the history of CCCA. While the majority of other states have reduced the capacity or completely eliminated their state psychiatric hospital for children, in Virginia, CCCA experiences enormous pressure – at times operating over census capacity – to meet the acute behavioral health crisis needs of children.

The population of children served by CCCA has shifted over the past several years. CCCA now serves nearly exclusively acute, involuntary admissions. Claims data from Virginia Medicaid (FY 2017-2019) indicates that CCCA serves as the first point of entry for inpatient psychiatric care for three-fourths of children covered by Medicaid. In addition, disparities exist among the population served by CCCA, such that 64 percent of CCCA admissions are male, and while African American youth constitute 19 percent of the child population of Virginia, they represent 40 percent of the CCCA admissions. Thirty percent of the children have diagnoses of intellectual disability, autism, or developmental disabilities, and 25 percent of children admitted are in the custody of the Department of Social Services.[1]

To address the systemic causes for the rising CCCA census and identify solutions for alternative private settings for inpatient psychiatric care, from February 2020 through May 2020, the Department of Behavioral Health and Developmental Services (DBHDS) convened and led the Children's Inpatient Workgroup and the findings and recommendations will aid DBHDS in developing a Request for Proposal for children's psychiatric inpatient services. Workgroup participants included representatives from 31 distinct stakeholder groups including state agencies; advocacy, provider, and professional organizations; hospital systems; and health care payers (i.e. managed care organizations and the behavioral health service administrator). While many different perspectives were discussed, a view that was shared by nearly all participants is that Virginia still needs a state hospital for children to serve as the safety net for youth with the highest and most complex behavioral health conditions. However, children need a more robust system of behavioral health care that allows for earlier intervention so that the safety net is not the only net.

The vision for Virginia's behavioral health system is to provide high-quality, evidence-based, cost-efficient services in the least restrictive environment, appropriate to the child's need, in the community where the youth resides. This includes the integration of trauma-informed care principles across the continuum to empower individuals to build resiliency and overcome the impact of adverse experiences so that they can lead meaningful, productive lives in the community. The terms "least restrictive environment" and "appropriate to meet the child's

[1] DBHDS State Hospital Data, FY 2019.

needs" originate from the Federal Individuals with Disabilities Education Act (IDEA), which is intended to ensure that children with special needs, including behavioral health needs, are integrated with their peers and receive the services they need. As importantly, the Federal Early Periodic Screening and Diagnostic Testing (EPSDT) program supports that a behavioral health system for children must include prevention and early intervention of mental health problems to allow each child the chance to reach their full developmental potential. Significant work has been underway toward that vision through System Transformation Excellence and Performance – Virginia (STEP-VA), which stakeholders widely cited as needing continued and full support for complete implementation. In addition, the proposed Medicaid Behavioral Health Enhancement is seen as an opportunity to build out services absent from the current system of care, and ongoing investment is needed to address the systemic issues that drive inpatient admissions. Virginia must better meet the behavioral health needs of children. Combined effort across the child-serving systems of Virginia will ensure that children's mental health remains a priority.

Key findings from the workgroup are:

- Increasing the number of inpatient psychiatric beds across the Commonwealth was not seen as the only avenue to address the systemic issues contributing to the increasing admissions to CCCA.
- The "Bed of Last Resort" legislation (§37.2-809) was cited as an important factor contributing to the increasing admissions at CCCA. However, the majority of participants felt that the period for the Emergency Custody Order for minors was adequate.
- Adolescents presenting with acute behavioral aggression pose a challenge to community private psychiatric hospitals due to an increased need for staffing to maintain safety for staff and other patients.
- Children and adolescents with an intellectual disability or developmental disability pose a challenge to community private psychiatric hospitals due to a need for specialized programming and therapies that match the individuals' needs and level of functioning.
- Greater investment in a comprehensive continuum of child and adolescent behavioral health services ranging from prevention, early intervention, treatment, and recovery that is well-coordinated across state agencies is needed to fully address the systemic causes that drive inpatient admissions.
- Investments are needed to increase behavioral health workforce capacity serving children and adolescents in all areas of Virginia through possible loan forgiveness or training programs.
- Person- and family-centered care should drive the funding, priorities, and processes that address the mental health needs of children and adolescents rather than availability and eligibility for services. This can be accomplished by including family voice and active involvement in service planning along with Family Support Partners who have lived experience navigating the children's behavioral health system.
- The top three most effective solutions identified to divert from admission to CCCA were:
    1. Community-based Mobile Crisis Services and intensive community-based treatment (Multisystemic Therapy, Functional Family Therapy, Partial Hospitalization Programs, and Intensive Outpatient Programs);
    2. Crisis stabilization units;

3. Intensive care coordination using High Fidelity Wraparound.
- The top three most effective solutions identified to effectively step-down individuals from CCCA were:
  1. Intensive care coordination using High Fidelity Wraparound;
  2. Short-term residential or group home settings;
  3. Expansion of telehealth treatment modalities.

Recommendations for reducing admissions to CCCA:

- The General Assembly, Administration, and various state agencies should develop a shared definition of the role of CCCA, as a state hospital, including specific admission criteria, to establish clear expectations around utilization as the facility of last resort for children.
- Direct funding for inpatient psychiatric services to increase the total number of beds in the system and to enhance the existing beds by investing in therapeutic programs, services and supports, staffing models, and training to reduce the use of seclusion and restraints.
- Direct funding and resources toward community services that divert from or step-down from acute inpatient psychiatric treatment.
- Direct initial investments for community services toward step-down levels of care including mobile crisis stabilization, intensive care coordination using evidence-based practices such as High Fidelity Wraparound, and intensive community-based services such as Multisystemic Therapy, Functional Family Therapy, Partial Hospitalization Programs, and Intensive Outpatient Programs. Residential treatment and therapeutic group homes are additional potential step-down options, however these levels of care should be further developed to ensure they are effectively utilized as short-term treatment settings.
- Decrease the racial, socio-economic, and geographic disparities that are disproportionately represented among those served by CCCA by increasing resources across public and private stakeholders to include population health initiatives.
- Expand access to evidence-based mental health treatments that decrease long-term morbidity due to mental illness via services such as Virginia's Coordinated Specialty Care, a program for individuals ages 15-25 years old who have experienced first episode psychosis.
- Develop comprehensive crisis services throughout Virginia including 24/7 mobile crisis in all localities as well as additional crisis stabilization units for children and adolescents in additional areas of Virginia.
- Integrate crisis mental health services within schools and other non-traditional mental health settings through the 24/7 support line, which is being created through the Crisis Step of STEP-VA, and align Medicaid rates with the care provided to help increase availability of these services.
- Increase systemic coordination by directing resources to expand the availability of training to facilitate diverting admissions from CCCA while someone is under an ECO. For youth who are admitted to CCCA, actively begin discharge planning at the time of admission, involving all supports and services in the process, including the use of peer services.
- Examine the applicability of value-based care models for behavioral health care for children to comprehensively address preventive services as well as acute care needs.

Background

The Importance of a Comprehensive Continuum of Behavioral Health Services

Inpatient psychiatric treatment is only one component of a comprehensive system of care and should be used only when other community-based services have been unsuccessful or when a child's immediate needs cannot be safely served by a community-based alternative. This can only happen if there is a comprehensive system of care across the state without geographic, financial, or administrative barriers for families to access services rapidly and at the right time and the appropriate level of service. Virginia's over-reliance on inpatient care is more costly to the state and has long-term implications for children and families including disrupted attachments, trauma, and disruptions in education and social-emotional development. The complete implementation of System Transformation Excellence and Performance (STEP-VA) which provides nine essential, core service types will support the necessary enhancements and transformation of the public community behavioral health system which is administered by the 39 community services boards and 1 behavioral health authority across the Commonwealth. In conjunction with STEP-VA, the proposed Medicaid Behavioral Health Enhancement illustrates a model for a continuum of behavioral health services for children (see Appendix A). [2] Implementation of these two critical initiatives works to address both the development of services and the long-term financial sustainability of those services. Implementation of the complete continuum is multi-phase, however, the development of services to avoid unnecessary inpatient hospitalizations can be prioritized now.

Inpatient Psychiatric Care for Children and Adolescents in Virginia

There are approximately 365 licensed inpatient psychiatric beds for children under age 18 years old in Virginia (see Figure 1).[3] The majority of children's acute inpatient psychiatric care is provided by private psychiatric hospitals, who serve nearly 100 percent of voluntary admissions and in FY 2019 served 55 percent of all children's involuntary admissions (admissions served under a Temporary Detention Order, or TDO). However, over the past five years, the number of involuntary admissions served by private hospitals have decreased by nearly 15 percent (see Figure 2). One reason offered to explain this shift was that overall the state may be experiencing higher total numbers of admissions, of which the majority are voluntary and therefore not served by the state hospital.

[2] Virginia Department of Medical Assistance Services, Virginia Department of Behavioral Health and Developmental Services, & the Farley Health Policy Center. Virginia Medicaid Continuum of Behavioral Health Services. December 2018.

[3] § 37.2-308. Data Reporting on Children and Adolescents. April 30, 2019 – June 30, 2019.

Figure 1: Children's Psychiatric Hospitals in the Commonwealth

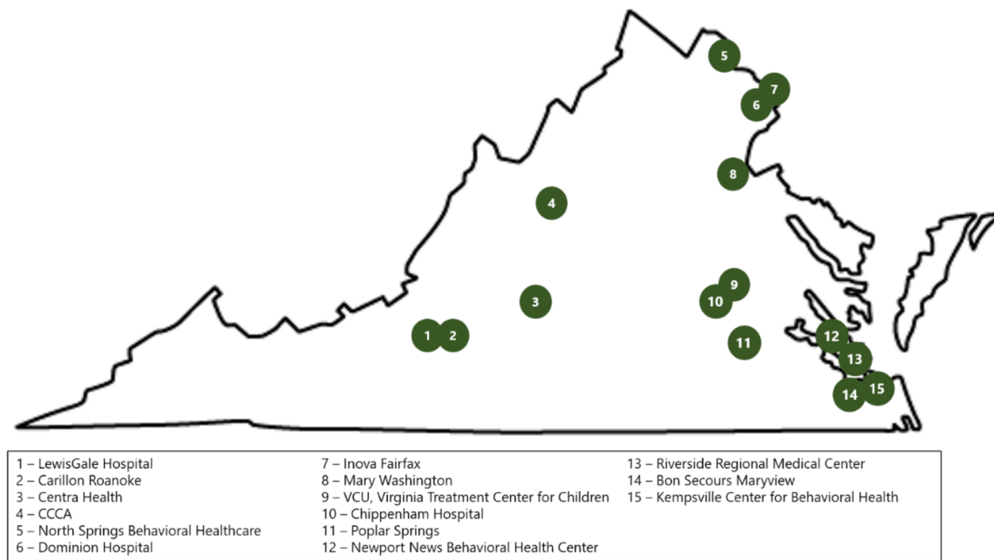
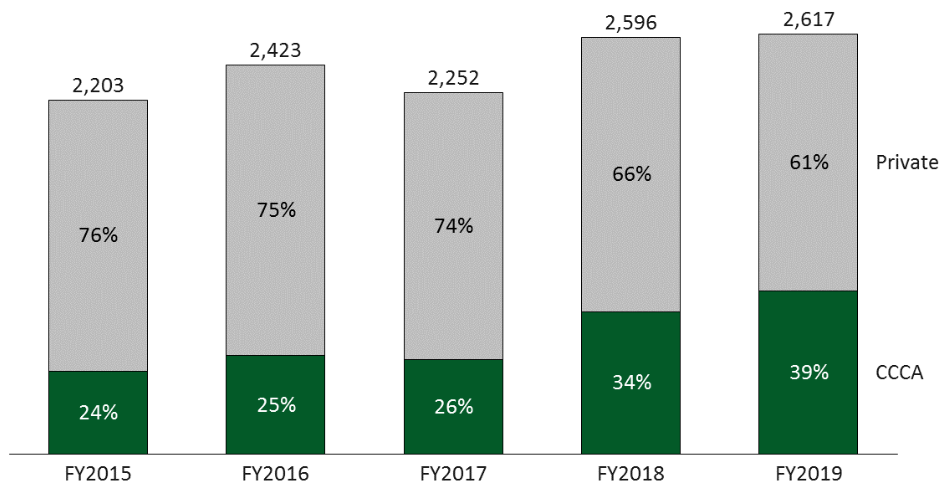


Figure 2: DBHDS TDO Admission Trends for Minors at Private and State Facilities



The Commonwealth Center for Children and Adolescents (CCCA) is the only state facility in Virginia for children under 18 years old and has a capacity of 48 beds across four 12-bed units. Admissions to CCCA have increased significantly over the past three years. Between FY 2017 and FY 2019, admissions increased by 41 percent (see Table 1), reaching over one thousand in FY 2019. Additionally, since the "Bed of Last Resort" legislation (§37.2-809) passed in 2014, CCCA primarily admits minors under a TDO with a nominal number who are admitted without a TDO, including individuals who are in custody of the Department of Juvenile Justice (DJJ). Across the entire private and public inpatient child psychiatric system, in FY 2019, CCCA admitted 39 percent of all minors under a TDO compared to 28 percent the year before (see Figure 2).

Table 1: **CCCA**

	FY 2017	FY 2018	FY 2019
Admissions	733	983	1,075
Average Daily Census	22.1	25.7	29
Median Length of Stay	8	7	6
Readmission Rate (12 months)	25%	29.5%	30.9%

Admission Data FY 2017-FY 2019

Child and adolescent inpatient psychiatric hospitalizations exhibit a seasonal pattern that aligns with the school year, a known pattern due to related social and emotional stressors. During peak times of the year from September through June, the inpatient census of CCCA is largely sustained above 85 percent and at times reaches or exceeds 100 percent. Due to the "Bed of Last Resort" legislation, despite lacking bed availability, CCCA must accept any minor under a TDO when no alternative placement can be found. As a result, children have been kept in emergency departments (EDs) until a bed is available. Often youth who are admitted to CCCA are hours from home, which impedes family engagement in treatment and discharge planning and makes care coordination more challenging. Based on current admissions trends, it is estimated that CCCA would need an additional 30 beds by FY 2022 in order to safely serve all incoming patients during peak times. However, many of these youth can be served in alternative settings if made available, such as intensive community-based services including mobile crisis, crisis stabilization units, Partial Hospitalization Programs, and Intensive Outpatient Programs.

Patient Demographics

The average age of CCCA patients is 14 years old, which reflects the age of objecting and incapable minors in Virginia, and nearly a quarter (23 percent) are 17 years old. Gender and racial disparities exist among the population served by CCCA, such that 64 percent of CCCA admissions are male, and while African American youth constitute 19 percent of the child population of Virginia, they represent 40 percent of the CCCA admissions. Individuals in DSS custody are disproportionately represented in the CCCA population, comprising 18 percent of

admitted patients but 33 percent of all inpatient bed days.[4] Individuals in foster care tend to experience longer lengths of stay and are more frequently referred out of CCCA to residential treatment centers or group homes. Ten percent of admissions come from juvenile detention centers, which is unchanged over the past five years. Approximately 30 percent of admissions are patients with a diagnosis of autism or intellectual or developmental disability. Due to their individual behavioral needs related to aggression, inability to fully integrate into a general milieu setting, or maladaptive behaviors such as self-soothing (i.e. head banging) or sensory seeking (i.e. socially inappropriate self-stimulation) behaviors, there is a high utilization of one-to-one staffing, which requires one direct care staff assigned to a single individual patient around the clock. While the presenting behavior in ninety-five percent of CCCA admissions is aggression, after admission less than 20 percent of children require any form of seclusion or restraint.

CCCA Medicaid Admissions

Medicaid admissions increased from Federal Fiscal Year 2017 to 2018, and then decreased in FFY2019 (Table 2), when behavioral health benefits became a managed care benefit, a promising indication of improved coordination of medical and behavioral health services. Additional analysis revealed that CCCA serves as the first point of entry for inpatient psychiatric care for three-fourths of children covered by Medicaid, as only 23% of enrollees admitted to CCCA had a prior inpatient admission to another institution. After an admission to CCCA, only 15 percent had a subsequent admission at another inpatient facility, an illustration of a path toward the reliance on the state institution. On the day of admission, the data revealed the broad range of providers that are providing crisis services, in the absence of a fully developed comprehensive crisis system for children. Services such as intensive in home treatment and behavioral therapy were highly utilized. Behavioral therapy, often provided to children with IDD, was more commonly utilized for children admitted to CCCA than it was for children admitted to other hospitals.

Table 2: Virginia Medicaid Admissions to CCCA (claims data by federal fiscal year)

	FFY17	FFY18	FFY19
Total Admissions	714	1,060	1,082
Medicaid CCCA Admissions	369	606	575
% Medicaid Admissions	51.7%	57.2%	53.1%

Workgroup Charge and Outcomes

In February of 2020, DBHDS convened and led a workgroup representing state agencies, provider associations, advocacy groups, managed care organizations, and hospitals offering children's inpatient psychiatric services in the Commonwealth. A full list of workgroup members

[4] DBHDS State Hospital Data, FY 2019.

is in Appendix C. The workgroup met in-person on two occasions, February 20, 2020 and March 3, 2020. Due to the COVID-19 public health emergency, no additional in-person meetings were conducted and further information was gathered from the workgroup participants via electronic survey. A conclusion meeting to review the summary of the workgroup findings was held via teleconference.

The workgroup was charged with the following goals:

- Examine the underlying systemic issues contributing to the increase in admissions and projected admissions at CCCA
- Recommend comprehensive strategies for reducing CCCA admissions
- Examine and identify possible alternative treatment services and sites for children and adolescents who would otherwise be placed at CCCA
- Identify the best use of funds to increase the availability of inpatient services for children and adolescents at private entities across the Commonwealth

The workgroup was divided into three sub-groups to discuss the successes and challenges in alleviating the CCCA census:

- *Clinical*: Examine the inpatient clinical needs for children and adolescents with a focus on aggressive children and children with intellectual or developmental disabilities (IDD)
- *Operations and Finance*: Examine the factors needed to make community inpatient services for children and adolescents sustainable
- *Systems of Care and Policy*: Identify strategies to improve the full continuum of services for children and adolescents

The survey asked respondents to rate the importance of various causes of the high census at CCCA and the likely efficacy of proposed solutions that were identified during the in-person workgroup meetings. The survey was administered in Qualtrics via e-mail, and thirty-one unique responses were received. Some of the respondents were representing the views of multiple individuals within the same stakeholder group. The quantitative responses were tabulated in summary tables and visualized with charts, while DBHDS staff reviewed the free-text responses. The subsequent sections in this report describe the detailed findings of the workgroup from which the recommendations were formulated. The full survey appears in Appendix B.

Systemic Issues Contributing to the CCCA Census

The rising census at CCCA is a symptom of a larger systemic problem – a lack of available and effective alternatives to inpatient treatment. The workgroup identified that the "Bed of Last Resort" legislation was an important factor contributing to the CCCA census. It disproportionately affects CCCA admissions since children and adolescents under TDOs must be admitted when no other facility is able to provide treatment. The legislation itself is not problematic, but it exposes gaps in the behavioral health system, since in a time of psychiatric crisis there are few alternatives to inpatient care. As such, the majority of participants felt that the period for the Emergency Custody Order for minors was adequate and changes to this would not significantly impact the CCCA census. The workgroup participants identified a wide range of factors contributing to the CCCA census, which fell into three main categories: community

services, coordination of care, and the admissions process. Insufficient investment in community-based alternatives that serve as diversion or step-down from inpatient treatment, and the resulting limited access to those services, was the highest-ranked systemic issue contributing to the CCCA census (Figures 3 and 4). Among all of the factors identified, the lack of inpatient beds was the lowest ranked as a contributing factor (Figure 5), as participants did not see that increasing the number of inpatient beds across the Commonwealth would address the rising CCCA census.

Factors Contributing to the High Census at CCCA

Figure 3: Factors related to community services

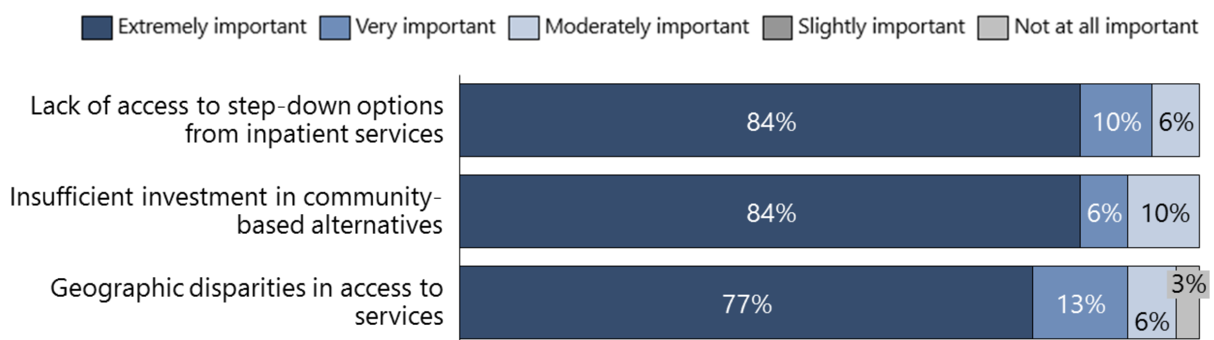


Figure 4: Factors related to coordination of care

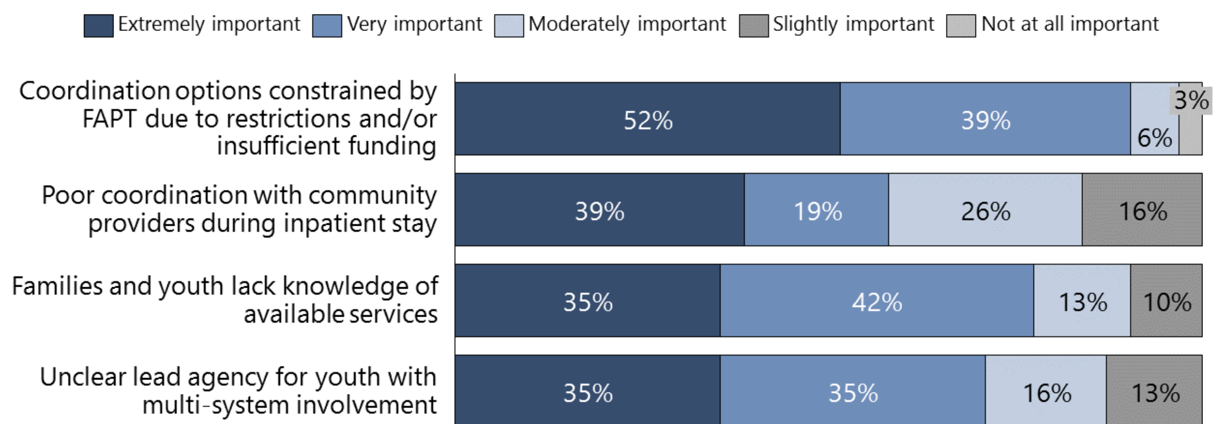
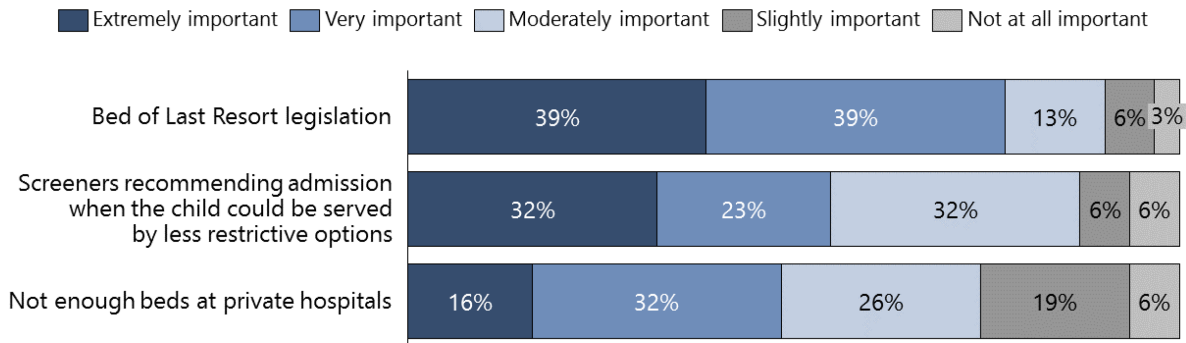


Figure 5: Factors related to the admissions process



Factors Contributing to Diversion to CCCA

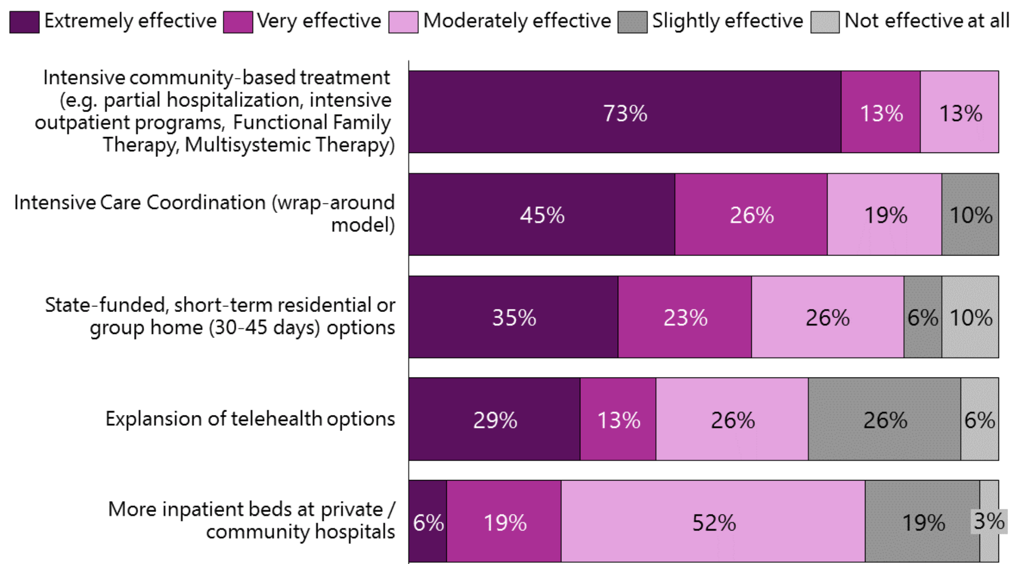
One of the primary reasons why a child may be admitted to CCCA over an alternative facility is the challenge associated with youth presenting with aggressive behaviors. Aggression is a common symptom in children with behavioral health disorders and can be caused by a myriad of diagnostic and developmental reasons including trauma, mood disorders, and developmental delays. To manage aggression in an acute psychiatric inpatient setting, the workgroup identified that there is a need for specialized staff training, higher staff to patient ratios, separate units, specialized therapeutic programs, and in the most severe instances, the use of seclusion or restraints. Lastly, the symptom of aggression was noted as a contributing factor that may increase lengths of stay due to a lack of transition options to community-based services. One participant also noted that bed registry data may not always give an accurate, real-time picture of available, private beds based on the specific time of day, the specific patient's clinical needs, and other factors. This unclear picture of bed utilization may prevent maximizing placements in community inpatient settings.

Strengthening the Behavioral Health Services Continuum

A key theme throughout the course of the workgroup was the critical importance of investing in a comprehensive continuum of care accessible to children and adolescents in the Commonwealth regardless of geographic region or insurance status. Workgroup participants were asked to provide input and recommendations on strategies for strengthening the child-serving system in Virginia, focusing on the acute services within the continuum, to identify specific solutions to alleviating the CCCA census and rate how effective each solution would be. The vast majority of workgroup respondents highlighted the importance of intensive community-based treatment such as Partial Hospitalization, Intensive Outpatient Programs, Functional Family Therapy, Multisystemic Therapy, mobile crisis, and crisis stabilization units (see Figure 6). Another potentially effective solution was intensive Care Coordination (ICC) in the High Fidelity Wraparound (HFW) Model, which provides a structured approach to care coordination that is designed for families and youth who are in or at risk of an out-of-home placement. These are youth with complex, challenging behavioral health issues who typically represent the upper 10-20 percent of a "severity pyramid". States that have implemented ICC/HFW experience a significant return on investment. For example, 82 percent of youth who received wraparound services moved to less restrictive, less costly environments, compared with 38 percent of the

comparison group and total net Medicaid spending is reduced by 28 percent for youth served through HFW, even as home and community based services increased. These cost reductions occurred as a result of a 43 percent drop in the use of psychiatric inpatient treatment and a 29 percent decrease in the use of residential treatment. [5,6]

Figure 6: Potential Solutions for Reducing the CCCA Census



The Need for Comprehensive Crisis Services

The workgroup emphasized the need for comprehensive crisis services. This includes mobile crisis and stabilization teams – available 24 hours a day, 7 days a week – that serve children in their homes and communities and divert children from out-of-home placement (such as hospitalization or arrest) when a lower level of care is a safe and effective alternative. Mobile crisis can also help reduce the number of visits to hospital EDs, improve ED service delivery, and better meet the needs of children and families.[7] States with comprehensive, fully accessible mobile crisis programs have seen savings by diverting from inpatient hospitalizations. In Connecticut, in FY 2013, EDs referred to mobile crisis services 1,121 times, and 553 of these

Kempsville Center for Behavioral Health has a "Call Us First" campaign, a 24/7 support line staffed by licensed mental health professionals that was raised as an initiative helping to reduce CCCA admissions.

[5] Return on Investment in Systems of Care. National Technical Assistance Center for Children's Mental Health,

...ity Profiles, Center for Health Strategies, July 2014.

...ectors. Making the Case for a Comprehensive Children's

Regional Educational Assessment Crisis Response and Habilitation (REACH) was hailed as an example of an initiative that has diverted admissions particularly through the use of crisis stabilization units for children and adolescents in Regions III and IV, Southwestern and Central Virginia.

referrals were coded as "inpatient diversions". Of those, 60 percent were Medicaid beneficiaries, resulting in a cost savings of $4 million. Within a crisis continuum, mobile crisis and crisis stabilization services can effectively deescalate, stabilize, and improve treatment outcomes. These services are specifically designed to intercede before urgent behavioral situations become unmanageable emergencies.[8]

Crisis stabilization units can be leveraged both to prevent CCCA admissions as well as offer a step-down from inpatient care. In many cases they also serve as a valuable alternative to inpatient psychiatric admission. To improve access, participants recommended expanding the service eligibility criteria, increasing reimbursement, and funding workforce recruitment and retention.

Care Coordination and Access to Intensive Community Based Treatment

As noted above, the workgroup emphasized the importance of further developing the network of community-based providers to develop alternatives to inpatient treatment across all localities in Virginia. The specific needs identified by the workgroup were:

- Funding to increase the behavioral health workforce, particularly in underserved areas of Virginia, with a particular focus on psychiatrists and nurse practitioners
- Higher reimbursement rates to reflect the intensity and effectiveness of the service provided for Multisystemic Therapy, Functional Family Therapy, Partial Hospitalization Programs, and Intensive Outpatient Programs, and Applied Behavior Analysis
- Increased expertise on specific populations, including the IDD population, among community-based providers in all regions of the Commonwealth

The need for improved care coordination for many children and adolescents was also raised. One participant, for example, stressed the importance of eliminating the paper chart and sharing up-to-date information electronically with a child's care team. Another highlighted the need for targeted case management and statewide care coordination, to ensure that the services a child is referred to will meet their need.

Northern Virginia Regional Projects Office was praised as an example of a local initiative helping to divert CCCA admissions in their Regional Utilization Group Meetings which includes CSBs and community providers.

The workgroup highlighted the fundamental importance of implementing a patient-centered discharge plan in conjunction with the child's family and or legal guardian. This is critical to reducing length of stay and preventing readmissions. The workgroup also noted that peer supports for both youth and families, Family Support Partners and Youth Support Partners, can help families navigate care, follow plans of care, and connect the family to needed resources.[9] Additionally, specialized training for parents and guardians could help them better navigate the child-serving system and meet their children's behavioral health needs. In order to reduce

[8] *ibid.*

[9] Office of Children's Services, Building a Family Support Partner Program: Tools and Tips for Agency Readiness and Hiring, 2015.

inpatient length of stay and ensure that children are served in the least restrictive environment, discharge planning must start at the time of admission.

Serving more youth in their communities or in psychiatric inpatient care that is closer to home better allows for family engagement. In addition to peer services, increased coordination with the managed care organizations around care coordination can assist with after-care and identify what other resources are needed to prevent readmissions. Stakeholders also cited the need for better coordination when there were multiple agencies involved in a child's case. Participants noted that there are particular challenges identifying appropriate step-down services in community-based settings, especially for children and adolescents in Department of Social Services (DSS) custody. Telehealth was a modality highlighted to address geographic barriers such as when a child's case manager or family are not able to be physically present. Another participant thought it was important for transportation to be provided for parents and guardians to attend discharge planning meetings.

Increasing Services for Prevention and Early Intervention for Mental Illness

Pediatric care is grounded in principles of prevention and early intervention of childhood illness and disorders, and the workgroup strongly voiced the need to support this application to behavioral health. Supporting youth wellness and earlier identification of mental health conditions, prior to an acute crisis, would impact the long-term need for inpatient psychiatric care. An example of a high-intensity treatment that has demonstrated ability to change the long-term trajectory of serious mental illness in Virginia is the Coordinated Specialty Care program, an evidence based, standardized treatment delivered in a team-based model. Coordinated Specialty Care is aimed at transitional age youth ages 15-25 years old who have experienced first episode psychosis.

The integration of mental health services into non-traditional settings has also proven to be effective. Representatives from the Department of Juvenile Justice noted that having mental health personnel on staff in juvenile correctional centers has helped minimize the need for CCCA. The Virginia Mental Health Access Program has effectively trained pediatricians to identify and treat mental health issues in youth before times of crisis. The importance of working with schools was raised as a vehicle for both prevention and treatment. One participant recommended specialized mental health training and technical assistance for school resource officers (§ 9.1-101) to help with early identification and connect children and adolescents to community-based treatment. The workgroup recommended better collaboration between providers and schools to develop prevention models and expand treatment access.

As with any issue related to meeting the behavioral health needs in the state, workforce was broadly discussed. Participants highlighted the need to invest in increasing behavioral health workforce capacity serving children and adolescents in all areas of Virginia through adequate reimbursement rates and loan forgiveness programs. As it pertains to inpatient psychiatric care, participants noted the need to invest in the training of the child mental health workforce to

"Community-based providers also need to increase their use of evidence-based treatment programs, and there needs to be more efficacy data for services."

provide trauma-informed, high quality, effective treatment grounded in evidence-based principles.

Identifying Alternative Community Inpatient Settings

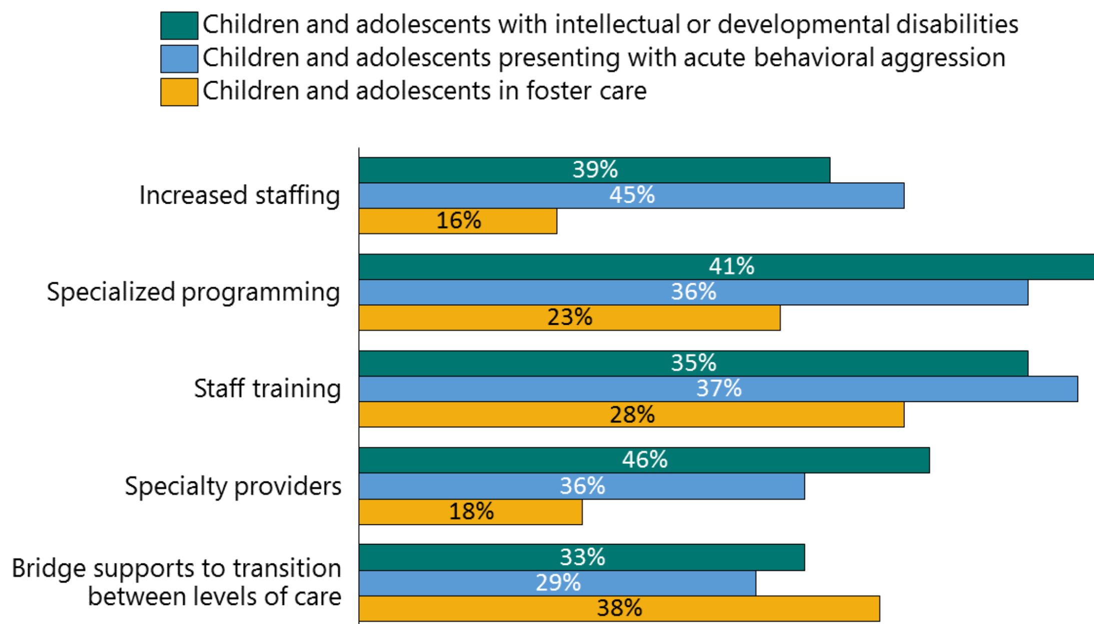
Children should receive care in the communities in which they reside, including inpatient treatment, when needed. Treatment and recovery for children includes the integration of family, education, and social supports in the community. When a child is admitted to CCCA, hours from their home, the care and resources are simply not optimal. Specific strategies were identified by the private hospitals that participated in the workgroup, whereby if supported, would increase

> *"Our client population is not homogenous, and we will need a variety of specialty programs and approaches to meet their needs."*

their capacity to more effectively serve as an alternative to CCCA.

When asked about the particular clinical needs to enable community psychiatric inpatient units to more adequately care for the IDD population and youth presenting with aggressive behavior, specialized programming and staff training were ranked the highest, above specialty providers, increased staffing, and bridge supports to transition between levels of care (see Figure 7). For children and adolescents in foster care, staff training was rated the highest, followed closely by bridge supports.

Figure 7: Clinical Needs of Specific Child and Adolescent Populations



Funding is a key resource for alternative inpatient settings to increase the number of beds and also to ensure an adequate staff to patient ratio to appropriately care for children and adolescents. One participant noted that the process for bringing online new youth inpatient psychiatric beds could have a more streamlined process for the Certificate of Public Need. Many participants noted that reimbursement rates for inpatient psychiatric hospitalization should reflect the level of staff training and staffing ratios necessary to care for particularly complex children and adolescents. Staff training is also critical. One participant noted a need for training in Functional Behavioral Assessment and Applied Behavior Analysis, practices that specifically have been utilized for individuals with IDD. Others stressed the importance of training in trauma-informed care as well as training specific to particular patient populations based on diagnosis and age group in order to best treat those patients via evidenced-based practices. Staff training around suicide prevention and intervention was also an area in need of enhancement to address crises and mitigate risk of readmission related to this concern.

To better understand how funding can be directed to adequately address identified barriers, the private hospitals were asked to describe a potential financing structure to either increase inpatient bed capacity or implement changes to their current practice to move toward a culture whereby children seeking inpatient treatment are not denied private hospital admission due to the common exclusion criteria: aggression, IDD, or concerns about long-term placement. One-hundred percent of hospital respondents to the survey workgroup selected infrastructure funding for needs such as increased staffing, specialized services, and milieu development as preferred in a possible fee structure (see Figures 8 and 9).

Figure 8: Strategies for Increased Utilization of Alternative Inpatient Settings

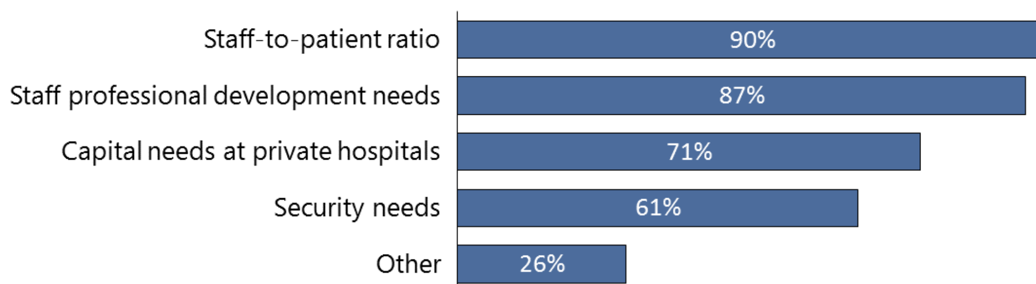
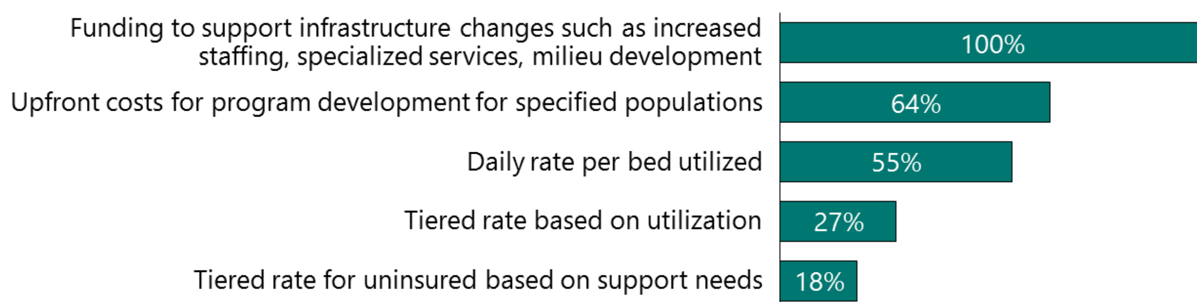


Figure 9: Key Financing Components Identified by Hospital Workgroup Survey Respondents



Lastly, the workgroup highlighted the need for more data-driven solutions. This includes the use of efficacy data to track outcomes and better understand alternative care models and the evidence-based practices that work for particular populations as well as a comprehensive examination of readmissions data by patient type and clinical needs to determine key risk factors.

The Role of CCCA in a Comprehensive System of Behavioral Health Care for Children

All workgroup participants recognized that CCCA serves a critical role in Virginia's system of children's behavioral health care, and more than half of the respondents of the survey described CCCA's role as a facility serving the acute inpatient needs of children and adolescents in Virginia. Nearly all respondents stated that CCCA should serve as the facility of last resort for children in need of acute psychiatric hospitalization and thus as a true safety net for children. However, investment in the range of community services, from inpatient to outpatient treatment, is essential.

> *"CCCA should serve as a short-term acute psychiatric hospital for the foreseeable future. That will only work as part of a continuum of services that includes much more robust community-based alternatives that prevent many children from ever getting to CCCA and provides a step-down for those who do go when they get discharged."*

A subset of participants noted that CCCA should also be used to serve longer-term, residential, and voluntary cases with complex behavioral health needs. In this role, other strategies may be employed such as coordination between CCCA and private hospitals for planned transfers of patients who require complex, longer-term treatment. As an example, these transfers may be at a ratio of one to three CCCA patients for every one child transferred from a private hospital. While a consensus was not determined by the workgroup, participants noted that defining the role of CCCA, including the admission criteria, in the overall system of care is a key aspect of addressing the census so that there are clear expectations around the use of a state hospital for children.

Conclusion

Children and adolescents with behavioral health disorders are a distinct population that require specialized health care to address the complex interplay of their social, emotional, academic, and developmental needs. The systemic issues contributing to the rising census of CCCA identified by the Children's Inpatient Workgroup have circled back to a theme previously visited by the stakeholders in other similar workgroups: Virginia needs a comprehensive continuum of behavioral health services for children, ranging from prevention to acute treatment. Services are missing, and those that exist are fragmented, resulting in significant gaps for which CCCA has been left to fill in times of acute psychiatric crisis.

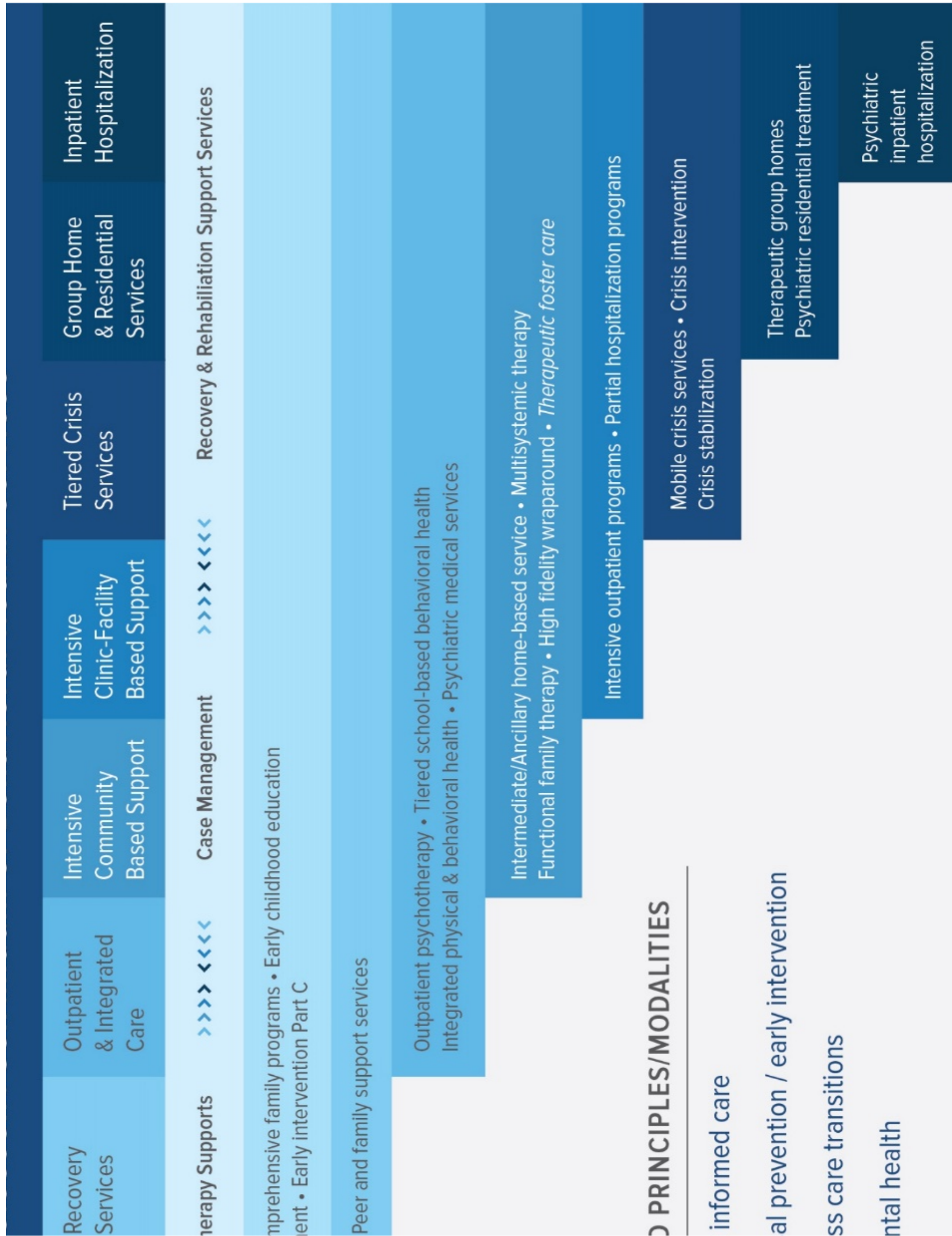
Fortunately, the growing evidence base for effective, high intensity services for children is becoming more available, and the next step forward is to ensure they are accessible to all children who need it. This includes addressing availability, workforce, training, and financial

sustainability. To immediately target the behavioral health needs of children in acute crisis, the priority investments should be in the highest levels of care in the community, especially comprehensive crisis services, which divert from and allow the step-down from inpatient care.

The Children's Inpatient Workgroup, charged with identifying issues contributing to high census at CCCA as well as strategies for alleviating that census, noted the importance of balancing short-term and long-term goals. As such, additional inpatient capacity and enhancement to the existing capacity through service development is essential while the simultaneous work to fill gaps in the child-serving system across Virginia occurs. Striking a balance of addressing the current census problems and addressing the root cause is important. However, shifting the balance may be the only way to realize the results the system aims to achieve.

Appendices

Appendix A: Child and Adolescent Continuum of Behavioral Health Services



Appendix B: Children's Inpatient Workgroup Survey

What do you see as the role of CCCA in the comprehensive system of behavioral healthcare for children in Virginia? [Free text]

Factors causing the high census at CCCA

The workgroup discussed a broad range of factors that may be contributing to the increase in admissions and projected admissions at CCCA. Please rate the importance of each factor. (Scale: Extremely important, very important, moderately important, slightly important, not at all important)

Factors related to admissions process

- Pre-screeners recommending admission when the child could be served by less restrictive options
- Not enough beds at private hospitals
- Bed of Last Resort Legislation

Factors related to community services

- Insufficient investment in community-based alternatives
- Geographic disparities in access to services
- Lack of access to step-down options from inpatient services

Factors related to coordination of care

- Coordination options constrained by FAPT due to restrictions and/or insufficient funding
- Families and youth lack knowledge of available services
- Poor coordination with community providers during inpatient stay
- Unclear lead agency for youth with multi-system involvement

Do you feel that the ECO time frame for children and adolescents is:

- ☐ Too short
- ☐ Just right
- ☐ Too long

Are there any other causes not listed above that we should consider? [Free text]

How effective do you believe each of these potential solutions would be in reducing the census at CCCA? (Scale: Extremely effective, very effective, moderately effective, slightly effective, not effective at all)

- More inpatient beds at private / community hospitals
- State-funded, short-term residential or group home (30-45 days) options
- Expansion of telehealth options
- Intensive Care Coordination (wrap-around model)

- Intensive community-based treatment (e.g. Multisystemic Therapy, Functional Family Therapy, Partial Hospitalization Programs, and Intensive Outpatient Programs)
- Other (not listed above)

What is a specific example of an initiative that has resulted in diversions from CCCA in your region or locality? [Free text]

How can we improve the discharge process from inpatient to step-down placements such as crisis stabilization units, residential treatment, or other community-based services? [Free text]

What else, if anything, is needed to build out the crisis continuum in the Commonwealth? [Free text]

What are the clinical needs to enable current community psychiatric inpatient units to more adequately care for **children and adolescents with intellectual or developmental disabilities?** Please select all that apply.

- ☐ Increased staffing
- ☐ Specialized programming
- ☐ Staff training
- ☐ Specialty providers
- ☐ Bridge supports to transition between levels of care
- ☐ Other (please specify)

What are the clinical needs to enable current community psychiatric inpatient units to more adequately care for **children and adolescents presenting with acute behavioral aggression?** Please select all that apply.

- ☐ Increased staffing
- ☐ Specialized programming
- ☐ Staff training
- ☐ Specialty providers
- ☐ Bridge supports to transition between levels of care
- ☐ Other (please specify)

What are the clinical needs to enable current community psychiatric inpatient units to more adequately care for **children and adolescents in foster care?** Please select all that apply.

- ☐ Increased staffing
- ☐ Specialized programming
- ☐ Staff training
- ☐ Specialty providers
- ☐ Bridge supports to transition between levels of care
- ☐ Other (please specify)

The workgroup discussed the true cost of care and operational supports needed to provide inpatient psychiatric treatment to all children in the communities in which they reside. The following questions aim to better understand how to make inpatient services available and sustainable in the community where the child resides.

If funding were available to divert children and adolescents from inpatient admission at CCCA, which programs should be prioritized for the funding? Please RANK the items with 1 being the top priority.

- Intensive Care Coordination (wrap-around model)
- Intensive community-based treatment (e.g. partial hospitalization, intensive outpatient, Functional Family Therapy, Multisystemic Therapy)
- Crisis stabilization units
- Mobile crisis services (community-based)
- Increased capacity at private hospitals (inpatient)
- Other (please specify)

What factors should DBHDS consider in establishing a possible fee structure to increase the availability of inpatient psychiatric services for children and adolescents? Please select all that would be appropriate.

- ☐ Capital needs at private hospitals
- ☐ Staff professional development needs
- ☐ Staff to patient ratio
- ☐ Security needs
- ☐ Other (please specify)

Do you represent a private hospital offering or planning to offer inpatient psychiatric services for children and adolescents?

- ☐ Yes
- ☐ No

Private hospitals only: What would you hope to see the financial / fee structure look like for accepting CCCA diversions? Please select all that apply.

- ☐ Daily rate per bed utilized
- ☐ Tiered rate for uninsured based on support needs
- ☐ Tiered rate based on utilization
- ☐ Funding to support infrastructure changes such as increased staffing, specialized services, milieu development
- ☐ Upfront costs for program development for specified populations
- ☐ Other (please specify)

Private hospitals only: How many beds, if any, would your hospital be able to devote to accepting CCCA diversions without restrictions assuming an acceptable fee structure were implemented?

- ☐ 0
- ☐ 1-3
- ☐ 4-6
- ☐ 7-9
- ☐ 10 or more

All respondents: Do you have any other comments or recommendations for strategies and policies to reduce the census at CCCA? [Free text]

Appendix C: Workgroup Participants

Participant Name	Organization
Lauren Bayes Paul Speidell	Aetna Better Health of Virginia
Andre'a Watkins Les Saltzberg	Anthem Health Keepers Plus
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Stephanie East	Centra Health
Alice Mullinany Dan Spencer Mary Margaret Gleason Stephanie Osler	Children's Hospital of the King's Daughters
Carl Seip Walid Fawaz Jennifer Sistrunk Mary McGrath	Chippenham Hospital
Laurie Cooper Quyen Duong	Department of Education
Robin Binford Weaver Dee Kirk	Department of Juvenile Justice
Alyssa Ward Brian Campbell Daniel Harvey	Department of Medical Assistance Services
Kristin Zagar Em Parente	Department of Social Services
James Higginbotham	Dominion Hospital
Catherine Stacey	Dominion Youth Services

Participant Name	Organization
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Amy Croft Tricia Van Rossum	Magellan of Virginia
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Garrett Hamilton	North Springs Behavioral Healthcare
Anna Antell Scott Reiner	Office of Children's Services
Felecia Arbuah Nelson Smith Stephen Murphy	Poplar Springs Hospital
Kim Harper Stacey Johnson	Riverside Regional Medical Center
Charles Scercy Ronae Heard	Snowden at Fredericksburg
Natalie Elliott	Virginia Association of Community-Based Providers
Lisa Beitz Paulette Skapars	Virginia Association of Community Services Boards
Michael Triggs Scott Zeiter	Virginia Coalition of Private Provider Associations
Jennifer Wicker	Virginia Hospital and Healthcare Association
Jennifer Fidura	Virginia Network of Private Providers

Dr. Vanessa Walker Harris	Health and Human Resources	Valerie Bowman Hicks Valerie Hicks	Virginia Premier
James DeMarco Michael Bogrov	Inova	Alexandria Lewis Cheryl Al-Mateen Nancy Doyle	Virginia Treatment Center for Children
Jaime Fernandez Sarah Rodgers	Kempsville Center for Behavioral Health	Ashley Airington	Voices for Virginia's Children
Michael Stokes	LewisGale Hospital		

Department of Behavioral Health and Developmental Services (DBHDS) Representatives
Commissioner: Alison G. Land, FACHE

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DBHDS Chief Clinical Officer

Jaime Bamford, M.D.
CCCA Facility & Medical Director

DBHDS Staff:

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Andrew Diefenthaler	Chief Financial Officer
Cari Hennessy	Statistical Methodologist
Heather Norton	Acting Deputy Commissioner, Developmental Services
Heidi Dix	Deputy Commissioner, Compliance, Regulatory, & Legislative Affairs
Lisa Jobe-Shields, Ph.D.	Deputy Director, Community Behavioral Health
Michael Schaefer, Ph.D.	Acting Deputy Commissioner, Facility Services
Nina Marino	Director, Office of Child and Family Services
Shannon Wilson	Financial and Policy Analyst
Pamela Fisher	Child and Family Program Specialist