COMMONWEALTH of VIRGINIA

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COMMISSIONER

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Tuesday, January 12, 2021

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 and Delegate Torian:

Item 320.GG of the 2020 Acts of Assembly directs the Department of Behavioral Health and Developmental Services (DBHDS) to report on the details of a possible memorandum of understanding (MOU) with the Children's Hospital of The King's Daughters (CHKD) for providing care to children or adolescents that may otherwise be admitted to the Commonwealth Center for Children and Adolescents (CCCA). Specifically, the language states:

> *The Department of Behavioral Health and Developmental Services is authorized to collaborate with the Children's Hospital of The King's Daughters (CHKD) to develop a memorandum of understanding (MOU) for dedicating a portion of the future bed capacity of a 60-bed mental health hospital at CHKD for use in providing treatment services to children or adolescents that may otherwise be admitted to the Commonwealth Center for Children and Adolescents (CCCA). The MOU should detail the priority populations that would be best served at CHKD and that assists the Commonwealth in reducing census pressure on CCCA. As part of the MOU the department and CHKD shall develop an estimated financial contribution for the potential benefit of such an arrangement to the Commonwealth. The department shall report on the details of the MOU to the Governor and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by November 1, 2020.*

This report details an envisioned agreement with CHKD, through collaboration between DBHDS and CHKD, to help divert admissions from CCCA and help prevent avoidable inpatient hospitalization. It also details the estimated financial requirements of this agreement. Staff is available to answer any questions.

Sincerely,

Alison Land

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

CC:
Vanessa Walker Harris, MD
Susan Massart
Mike Tweedy

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Tuesday, January 12, 2021

Governor Ralph Northam
Patrick Henry Building
1111 E Broad St.
Richmond, VA 23219

Dear Governor Northam:

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Report on Item 320.GG of the 2020 Appropriations Act

Report on an MOU between DBHDS and CHKD

To the Chairs of the Senate Finance and House Appropriations Committees and the Governor of Virginia

Tuesday, January 12, 2021

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Preface

Item 320.GG of the 2020 Acts of Assembly directs the Department of Behavioral Health and Developmental Services (DBHDS) to report on the details of a possible memorandum of understanding (MOU) with the Children's Hospital of The King's Daughters (CHKD) for providing care to children or adolescents that may otherwise be admitted to the Commonwealth Center for Children and Adolescents (CCCA). Specifically, the language states:

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Introduction

This report is a description of components of an agreement should one be developed between the Department of Behavioral Health and Developmental Services (DBHDS) and Children's Hospital of The King's Daughters (CHKD). CHKD plans to expand its capacity to provide mental health services to Virginia's youth through a 60-bed expansion and increased outpatient service capacity. This expansion would support the development of the largest community based mental health center for youth in the Commonwealth and through collaboration with DBHDS, is an opportunity within the community to help divert admissions from the Commonwealth Center for Children and Adolescents (CCCA). CHKD and DBHDS identified priority target populations that CCCA serves to inform the potential structure of an agreement. Ultimately, an agreement as described below, used to contract beds for children and adolescents who would otherwise be admitted to CCCA, and would require a financial investment on the part of the Commonwealth and an overall beneficial step for children's mental health.

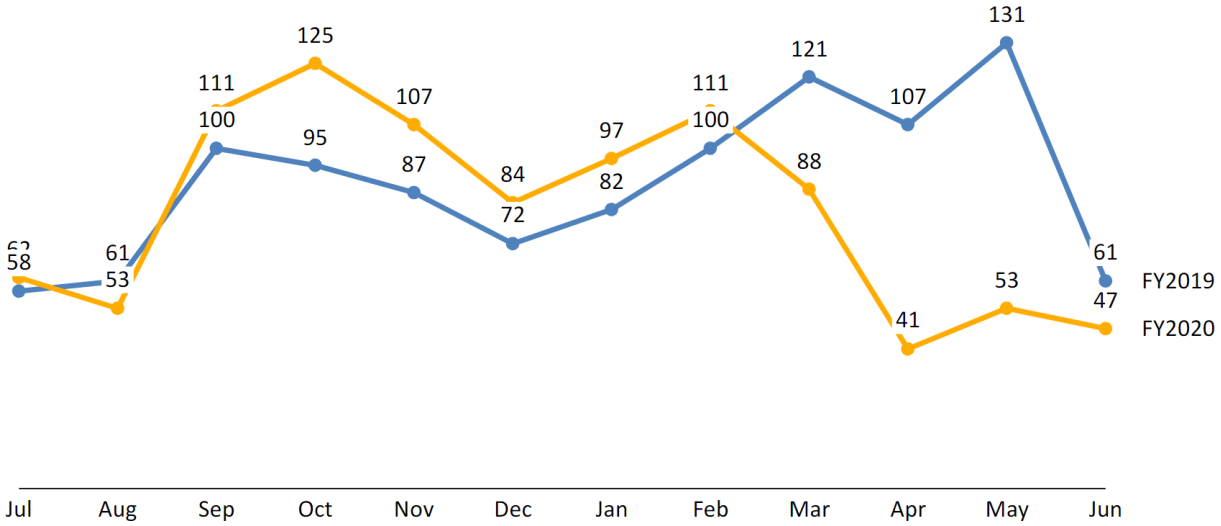
Background

Census at CCCA

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 2020, admissions increased by 34 percent, 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 2018, CCCA admitted 39 percent of all minors under a TDO compared to 28 percent the year before.

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. Figure 1 displays monthly admission patterns in FY 2019 and FY 2020. 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, during these peak times children may have to wait in emergency departments (EDs) or other medical units until a bed is available at CCCA. 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 trends in admissions, it is estimated that CCCA would need an additional 30 beds by FY 2022 in order to safely serve all incoming patients during those 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.

Figure 1: CCCA Admissions by Month, FY19 and FY20*



**Admissions dropped temporarily in FY20 due to COVID-19, but this trend is not expected to continue in future years.*

CCCA Patient Demographics

The average age of CCCA patients is 14 years old, which reflects the age of objecting and incapable minors in Virginia, nearly a quarter (23 percent) are 17 years old and another quarter are children under age 14 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.[1] 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.

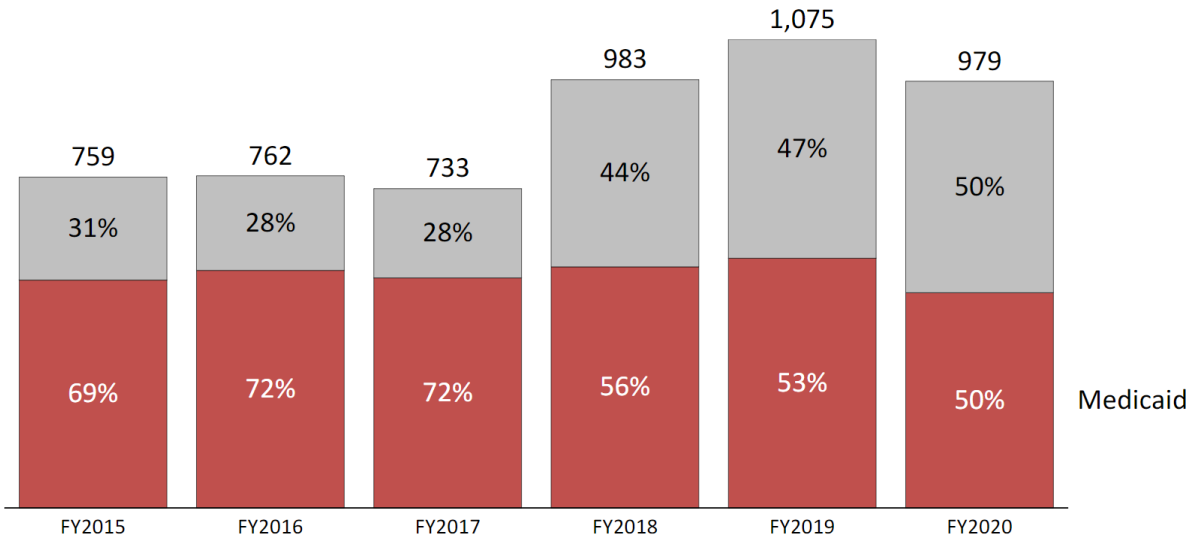
Approximately 30 percent of admissions are patients with a primary or co-occurring diagnosis of autism or intellectual or developmental disability. Due to their individual behavioral needs related to aggression, inability to fully integrate into a general milieu setting, or maladaptive behaviors such 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. Often, aggressive behavior is a deterrent to admission in a private facility, even years later.

[1] DBHDS State Hospital Data, FY 2019.

CCCA Medicaid Admissions

Medicaid admissions increased from Federal Fiscal Year 2017 to 2018, and then decreased in FY 2019 and FY 2020 (Figure 3), 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 percent 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. An analysis of services received on the day of admission 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.

Figure 3: Percentage of Admissions with Medicaid



CHKD Expansion Plans

CHKD is undergoing an expansive mental health transformation initiative which is anticipated to help alleviate some of the census concerns at CCCA over time should children and adolescents who would otherwise be admitted to CCCA be diverted to CHKD. This initiative includes:

- 60-bed inpatient psychiatric hospital (Norfolk, Virginia)
    - This facility is anticipating 2,100 admissions annually, providing general inpatient acute psychiatric care as well as mental health treatment for patients with comorbid emotional and physical illness and services for young patients with Autism Spectrum Disorder (ASD). CHKD broke ground on this facility in September 2019 and anticipates opening the facility in late 2022.

- Intensive Outpatient (IOP) and Partial Hospitalization (PHP) programs (Virginia Beach, Newport News, and Norfolk, Virginia)
    - These programs would provide intensive services for children and adolescents. CHKD anticipates serving 315 patients annually per location, beginning sometime between September 2021 and 2022.
- Expanded outpatient and telemedicine services (Virginia Beach, Norfolk, Newport News, and Chesapeake, Virginia)
    - CHKD anticipates an additional 18,500 outpatient mental health therapy visits and 8,300 psychiatry consults beginning sometime between September 2021 and 2022.
- Recruitment of at least 10 additional child and adolescent psychiatrists and development of a Child and Adolescent Psychiatry Fellowship with Eastern Virginia Medical School is planned for fall of 2023.

CHKD and DBHDS began discussion in the summer of 2020 around how to leverage CHKD's anticipated new capacity to plan for diversion of children and adolescents who would otherwise be admitted to CCCA. Discussion centered around the long-term impact of CHKD's expansion of intensive services (IOP and PHP) and outpatient services on diverting admissions over time as well as the potential for securing a portion of CHKD's inpatient beds to serve children who would otherwise be admitted to CCCA and helping to alleviate the high census pressure at CCCA.

Agreement for CHKD Future Bed Capacity

Priority Patient Populations

CHKD's goal with their planned expansion is to serve children who are unable to receive the care they need when they need it because of lack of access to pediatric mental and behavioral health services. CHKD intends to fully serve the youth in their surrounding community as well as any youth in Virginia that is in need of their services. CHKD plans to fill critical gaps in state-available services at a time when many families are in crisis and searching for help.

Approximately a quarter of admissions to CCCA are children under 14 years old and this aligns with CHKD's plans to focus on children age 12 and under, with a particular focus on various sub-populations. CHKD intends to build intensive, family-centered services for young children for whom inpatient care is a service of last resort. Additionally, CHKD plans to specialize in care for children with neurodevelopmental disorders including Autism Spectrum Disorder (ASD) through a dedicated 4-bed unit. Children with co-occurring mental health and neurodevelopmental disorders, including moderate to severe ASD, are often unable to find care in their communities as the need for crisis stabilization and care has risen in Virginia. CHKD has planned its 4-bed ASD unit with those children in mind and with priority to children in the greater Norfolk area.

As previously described above and in the Children's Inpatient Workgroup report, many private inpatient psychiatric facilities do not have the resources to meet the needs of children with moderate to severe intellectual disability/developmental disability, or youth with co-morbid

complex medical conditions.[2] As a result, many of these youth are directed to CCCA for admission through the Bed of Last Resort. CHKD intends to be part of the solution to meet these needs and build capacity to accept children and adolescents under TDO with these conditions.

Other populations CHKD is targeting include:

- Children and adolescents with both emotional and physical illness, including eating disorders, somatic symptoms, and related disorders with significant functional impairment, and chronic medical conditions with co-occurring mood, anxiety, and/or behavioral symptoms.
    - These patients would be admitted to a specialized inpatient psychiatry unit that is also able to meet the patient's unique medical needs.
    - Step-down treatment could continue, if appropriate, in their associated partial hospitalization program, where the child would participate in a highly structured program during the day and then return home in the evening.
    - Medically complex children or children with more than one significant chronic condition, with co-occurring mental health diagnosis, would be treated by CHKD's interdisciplinary mental health team in collaboration with pediatric specialists as indicated.
- Children newly placed in the foster care system, who have recently experienced trauma and/or neglect, to provide specialized services to meet their unique needs.
- Children with serious medical conditions or those who have had medical procedures, where it was experienced as a traumatic event, and as a result develop acute or post-traumatic stress disorder. This is defined as medical trauma, which is a set of psychological and physiological responses of children and their families to pain, injury, serious illness, medical procedures, and invasive or frightening treatment experiences.[3]

As mentioned above, approximately 95 percent of CCCA admissions present with aggressive behaviors upon admission. Often, this behavior can serve as a deterrent to admission at a private facility, even years later. As such, DBHDS is also prioritizing identifying alternative services for patients presenting aggressive behavior. Caring for children who present with aggressive behavior can be challenging and difficult for staff to manage in a general inpatient milieu-based model without significant support, and often the behavior requires intensive outpatient support in the community after discharge from an inpatient setting. CHKD intends to work with the state to assist in managing the younger population of children 12 and under with identified aggressive behavior in an attempt to support CCCA with diversion when clinically appropriate.

Partnership Structure

An agreement between DBHDS and CHKD would need to outline the various obligations of both parties as well as admissions and bed day authorizations and a structure for billing and compensation. Overarching responsibilities of CHKD would include:

- Meeting the staffing and service requirements

[2] Children's Inpatient Workgroup Report. (June 2020). Available at: https://rga.lis.virginia.gov/Published/2020/RD215

[3] "Medical Trauma". The National Child Traumatic Stress Network.

- Communication and coordination with local CSB's to ensure joint treatment and discharge planning
- Communication and coordination with CCCA related to diversion of admissions
- Regular reporting requirements including utilization management and financial expenditures
- Ensuring the standards of care and quality are met and monitored

Overarching responsibilities of DBHDS would include:

- Contract administration to ensure that the agreement fulfills the required elements that meet the needs of the Commonwealth
- Providing resources to meet the needs of the target population including financial resources, training, and technical assistance
- Timely payment for services rendered
- Maintaining and reporting data related to the impact on the bed census at CCCA

It is important to note that contracting with private inpatient settings is one of DBHDS's key strategies to alleviating the census at CCCA and ensuring children and adolescents receive needed care. Should the General Assembly direct DBHDS and CHKD to formulate an agreement, the method for procurement or agreement should be addressed specifically in the authorizing language. Without this specific language, in order for DBHDS to enter into an agreement with any entity, DBHDS must go through a procurement process. A competitive bid is required in order to enter into an agreement, which precedes a contract detailing payment for services rendered. Additionally, any agreement that DBHDS develops with a private provider must fit into certain financial parameters, namely, that funding agreements do not duplicate payments received by CHKD through Medicaid or other insurance sources and that all CMS, state, and federal regulations are followed.

Financial Considerations

Should DBHDS enter into an agreement with CHKD, the anticipated outcome is that DBHDS will experience a decrease in CCCA admissions for the population identified, allowing for CCCA to admit other child and adolescent populations. CCCA incurs costs for youth who are uninsured and when the child continues to remain at CCCA after the child's clinical situation no longer meet the medical necessity criteria for continued stay as defined by Medicaid or another insurer. For the purposes of this report, DBHDS used this financial data to inform what a potential cost avoidance benefit would be for CCCA that could be used in contracting with CHKD should an agreement be implemented, paying for services otherwise not reimbursed through Medicaid or a private insurer.

The following tables outline FY2020 data for CCCA admissions and sub-categories that reflect target population by age and the region where CHKD is located and the anticipated cost avoidance based on this data, also reflecting that CHKD prefers a per diem /per bed payment method.

FY2020 CCCA Data

Total Admissions	979
Total bed days	9945
Statewide average LOS	10.15
Cost per bed day	$1,660.78
Total admissions from Region 5	202
Total admissions from Region 5 who were under 12*	34
Total statewide admissions who were under 12*	207

*at time of admission

For every child that does not go to CCCA, there is a cost avoidance benefit for CCCA.

For all admissions from Region 5	
If CHKD covers all of these admissions (202) instead of CCCA, the expected cost avoidance will be:	$3,405,097.23
If CHKD covers half of these admissions (101) instead of CCCA, the expected cost avoidance will be:	$1,702,548.62
If CHKD covers 1/4 of these admissions (50) instead of CCCA, the expected cost avoidance will be:	$842,845.85

For admissions from Region 5 who are under age 12	
If CHKD covers all of these admissions (34) instead of CCCA, the expected cost avoidance will be:	$573,135.18
If CHKD covers half of these admissions (17) instead of CCCA, the expected cost avoidance will be:	$286,567.59

For admissions statewide who are under 12	
If CHKD covers all of these admissions (207) instead of CCCA, the expected cost avoidance will be:	$3,489,381.82
If CHKD covers 150 of these admissions instead of CCCA, the expected cost avoidance will be:	$2,528,537.55
If CHKD covers 100 of these admissions instead of CCCA, the expected cost avoidance will be:	$1,685,691.70

Short-Term Opportunities for Partnership

CHKD continues to work with DBHDS to explore potential partnership opportunities to provide immediate relief for census issues at CCCA.

- Census issues due to the COVID-19 pandemic:
    - DBHDS and CHKD have recently convened calls discussing growing concerns resulting from COVID-19 outbreaks at CCCA severely limiting capacity and staffing at the facility. Opportunities may exist to provide psychiatric care on medical units that are better able to meet the infection control standards related to COVID-19.
- Expanded capacity in their current hospital:
    - To add additional capacity at CHKD, the organizations discussed capital improvement projects at the CHKD main hospital to potentially expand the emergency department and medical floors to co-manage youth who have co-occurring medical and psychiatric needs.
- Alternatives to inpatient hospitalization:
    - CHKD and DBHDS explored the potential of using currently appropriated funding for DBHDS to pursue alternative inpatient options to state behavioral health hospital care through the establishment of two-year pilot projects that will reduce census pressures on state hospitals as a potential option to fund the projects.[4] CHKD views this a good potential framework for future financial arrangements with the state.

Additional CHKD Plans to Support the Comprehensive Continuum of Services for Children and Adolescents

CHKD's plans support the Commonwealth's mission to provide a comprehensive continuum of services to ensure that children can access the most appropriate level of care in the community in which they reside, allow for earlier intervention, and reduce the need for inpatient hospitalization over time. CHKD outpatient services will be offered to patients requiring evaluation and evidence-based treatment that includes psychotherapy, pharmacotherapy, and care coordination in an interdisciplinary and integrated team setting. CHKD will also provide sub-acute levels of care (PHP and IOP) that serve the needs of children with more intensive needs than routine outpatient care but do not require inpatient hospitalization. These programs may prevent hospitalization or serve as a step-down following inpatient hospitalization.

CHKD will continue to develop and further implement crisis services through an outpatient clinic model, a bridge clinic, which includes evidence-based therapies, care coordination, and targeted case management. These services were designed for patients following discharge from community inpatient psychiatric facilities with no follow-up care plan or timely access to community mental health services.

[4] Item 482.20 #1C

In addition, bridge clinic services will be offered to patients who present to the CHKD emergency department in crisis, requiring immediate intervention, and who are not connected to a CHKD or community provider and may not meet criteria for inpatient admission. This could potentially result in a bridge to intensive outpatient or partial hospitalization programs. These services will complement current community-based crisis services offered through the community services boards and provide coordinated care to reduce costly hospitalizations and promote stability for the patient and in the family.

Conclusion

As the census at CCCA continues to have an impact across the Commonwealth in accessing inpatient psychiatric services, DBHDS is prioritizing partnerships with private inpatient facilities such as CHKD, as well as diversion strategies including intensive services like PHP, IOP, and crisis services. Through data informed strategic planning and development, it is clear that the CCCA population has diverse needs that should be addressed in a thoughtful and targeted manner. By recognizing and collaborating with community partners to build capacity across the children's mental health system of care, the solution to the state bed census crisis will more readily be developed.

Appendix

Appendix A: Number of Youth Admitted to CCCA by County (FY20)