COMMONWEALTH of VIRGINIA

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Tuesday, November 23, 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.LL of the 2021 Acts of Assembly directs the Department of Behavioral Health and Developmental Services (DBHDS) to collaborate with the Virginia Treatment Center for Children (VTCC) on strategies to relieve the high bed census at the Commonwealth Center for Children and Adolescents (CCCA). Specifically, the language states:

> *The Department of Behavioral Health and Developmental Services, in collaboration with the Virginia Treatment Center for Children (VTCC), shall examine and develop strategies to better utilize VTCC in assisting with relief for the census pressures on the Commonwealth Center for Children and Adolescents (CCCA). The strategies to be examined shall include, but are not limited to: (i) diversion strategies when CCCA is near capacity; (ii) increasing the number of Temporary Detention Order admissions; and (iii) operating as a step-down facility from CCCA. The department shall report its finding and recommendations to the Chairs of the House Appropriations and Senate Finance and Appropriations Committees and the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century by November 1, 2021.*

This report details diversion and step-down strategies DBHDS and VTCC can implement in partnership in order to alleviate the bed census at 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 G. Land, FACHE

Commissioner, Department of Behavioral Health & Developmental Services
CC:
Vanessa Walker Harris, MD
Susan Massart
Mike Tweedy

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Tuesday, November 23, 2021

The Honorable R. Creigh Deeds, Chair
Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century
Pocahontas Building
900 East Main Street
Richmond, VA 23219

Dear Senator Deeds:

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CC:
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Virginia Department of
Behavioral Health &
Developmental Services

Report on Item 320.LL of the 2021 Appropriations Act

Report on Collaboration between DBHDS and VTCC

To the Chairs of the Senate Finance and House Appropriations Committees and the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century

Tuesday, November 23, 2021

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Preface

Item 320.LL of the 2021 Acts of Assembly directs the Department of Behavioral Health and Developmental Services (DBHDS) to collaborate with the Virginia Treatment Center for Children (VTCC) on strategies to relieve the high bed census at the Commonwealth Center for Children and Adolescents (CCCA). Specifically, the language states:

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Introduction

This report details potential strategies for alleviating the high bed census at the Commonwealth Center for Children and Adolescents (CCCA) through partnership between the Department of Behavioral Health and Developmental Services (DBHDS) and the Virginia Treatment Center for Children (VTCC). VTCC recently began implementing changes to its model of care including an interdisciplinary approach that increases the clinical services available within the VCU Health System Emergency Department. VTCC has expressed interest in partnering with DBHDS in the following areas:

- Increase capacity and fully serve children and adolescents subject to a temporary detention order (TDO) who would otherwise be admitted to CCCA
- Serve as a step-down for youth clinically ready to discharge from CCCA
- Assist with preventing inpatient hospitalizations altogether for children for whom an alternative is appropriate
- Further develop innovative treatment models that address the complex needs for children's mental health

The following includes an overview of the high bed census at CCCA including more information on CCCA's patient population, VTCC's plans for shifting its model of care, and shared strategies between DBHDS and VTCC to alleviate the high bed census at CCCA and prevent TDOs and inpatient hospitalization altogether when appropriate.

Background

The High Census at CCCA

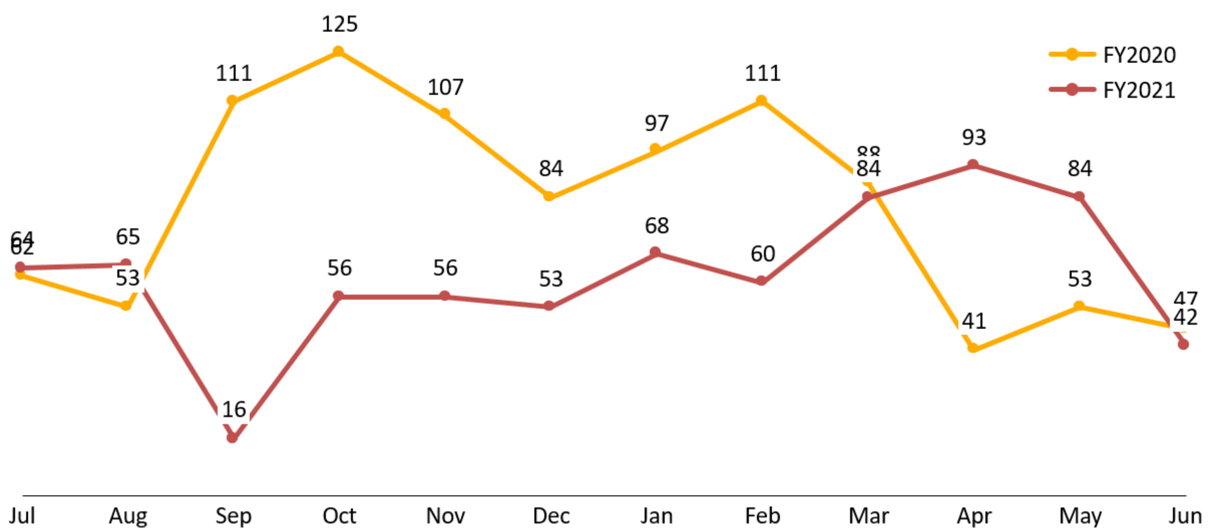
CCCA is the only state facility in Virginia for children under 18 years old and has a capacity of 48 beds across four 12-bed units. Admissions to CCCA have increased significantly in recent years. Between FY 2017 and FY 2020, admissions increased by 34 percent, reaching over 1,000 in FY 2019. Additionally, 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 2020, CCCA admitted 38 percent of all minors under a TDO compared to 28 percent in FY 2017.[1]

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 2020 and FY 2021, which is a reflection of the impact of the COVID-19 pandemic. CCCA experienced a COVID-19 outbreak that resulted in decreased staff capacity, limiting the number of available beds to 18. Additionally, the impact of stay-at-home orders and the shift to a largely virtual public education during this time changed

[1] Note that FY 2020 data is often used as a point of comparison in this report as data from FY 2021 CCCA admissions reflects disruption from the COVID-19 pandemic including temporary closures due to virus outbreaks, staffing shortages, and offline beds.

the typical seasonal distribution seen in other years. Typically, 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. 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, FY20 and FY21*



*Admissions dropped temporarily in FY20 and FY21 due to COVID-19 and staffing shortages, but this trend is not expected to continue in future years.

CCCA Patient Demographics

Sixty-nine percent of CCCA patients are age 14 and up, which reflects the age of objecting and incapable minors in Virginia. Over a quarter (27 percent) are 17 years old and another quarter are children under age 14 years old (30 percent). Gender and racial disparities exist among the population served by CCCA, such that 57 percent of CCCA admissions are male, and while African American youth constitute 19 percent of the child population of Virginia, they represent over 40 percent of the CCCA admissions.[2]

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.[3] Individuals

[2] DBHDS State Hospital Data, FY 2021.
[3] DBHDS State Hospital Data, FY 2019.

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.

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.[4]

About the Virginia Treatment Center for Children

In 2013, the General Assembly allotted funding for the purpose of constructing a new facility for the Virginia Treatment Center for Children, or VTCC.[5] VTCC offers children and adolescents both inpatient and outpatient mental health services in Richmond, VA.

Effective May 2021, VTCC began implementing several changes to its model of care and is taking steps to improve throughput in its Pediatric Emergency Department and reduce length of stay on inpatient units (more information available in Appendix B). In addition, VTCC has made extensive changes to its traditional exclusionary criteria with the intent of providing care to more children and continuing to accept TDO admissions. New leadership at VTCC has implemented an interdisciplinary approach to care – in particular, by more fully integrating social workers, case managers, and advanced practice nurses. These clinicians are now embedded throughout the care continuum for pediatric patients, with the goal of ultimately reducing the need for child and adolescent inpatient hospitalization. This increase in clinical services available throughout the care continuum, including in the VCU Health System Pediatric Emergency Department, should help to decrease overall hospitalization rates by providing psychiatric triage and case management services necessary to mitigate their risk and stabilize the patient and family support network.

Since March 1, 2021, VTCC has hired three new child psychiatrists. At present, however, VTCC, much like the rest of the Commonwealth, is significantly impacted by capacity limitations due to the shortage of the mental health workforce, which is further exacerbated for specialists in child mental health. Nursing recruitment in particular remains a challenge and is being prioritized at every level. With the necessary decrease of inpatient beds due to the workforce mental health shortage, VTCC was able to maintain a consistent average daily census and has created a tiered plan to increase bed capacity (Table 1). This increased capacity plan is dependent on patients' acuity, severity of illness and scope of services that needs to be provided.

[4] Children's Inpatient Workgroup Report. DBHDS. (2020). Available at: https://rga.lis.virginia.gov/Published/2020/RD215/PDF
[5] Item C-39.40 of the 2013 Appropriations Act.

Table 1: Plan to Increase Capacity at VTCC

	Restore beds	Total beds
11/1/2021	4	20
12/1/2021	4	24
2/1/2022	4	28
Spring 2022	4	32

Based on specific needs expressed by DBHDS and other partners, VTCC intends to implement its planned operational changes by focusing capacity building to meet the inpatient, diversion, and step-down needs of the following priority patient populations:

- Children and adolescents under custody of the Department of Social Services (DSS)
- Children and adolescents with developmental disabilities (excluding non-verbal developmental disabilities)
- Youth with first episode psychosis

It should also be noted that by first focusing on enhancing support for the aforementioned patient populations, VTCC will not immediately be capable of meeting the inpatient needs of other specialized populations, such as patients with eating disorders or a primary diagnosis of a substance use disorder. Eventually, however, VTCC has expressed its commitment to partnering and possibly assisting with these patient populations as well.

Partnership Opportunities between DBHDS and VTCC

This report details several diversion and step-down possibilities, categorized by in terms of immediate, short-term, intermediate, and long-term goals based on necessary resources such as capital investments or changes, hiring, and training. The proposed programs set forth in this report would require additional financial support from the Commonwealth to ensure appropriate staffing – both in numbers and in skill sets.

Immediate Opportunities for Partnership

CCCA's immediate needs include partners willing to admit children and adolescents that would otherwise be admitted to CCCA. VTCC continues to accept TDO admissions on a limited basis. By Spring 22, it anticipates increasing its current capacity by 12 beds to a total of 32 beds.

Table 2 outlines FY2020 data for CCCA admissions in general. This data was used to calculate estimated cost avoidance for the state should VTCC agree to take a proportion of CCCA admissions.

Table 2: FY 2020 CCCA Data	
Total Admissions	979

Total Bed Days	9,945
Statewide Average LOS	11.8
Cost per Bed Day	$1,660.78
Total Admissions from Region 4*	181
Total Bed Days from Region 4*	1,837

**See Appendix A for a map of DBHDS regions*

Should VTCC agree to admit a proportion of individuals admitted to CCCA from Region 4 who fall under the priority patient populations described above (namely, individuals with a diagnosis of ID/DD or psychosis and individuals under DSS custody), the immediate anticipated outcome for the strategies outlined in this report would be a decrease in CCCA admissions for the target populations 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.

Table 2 displays estimated annual bed days for Region 4 CCCA admissions in the priority patient populations identified.

Table 3: Estimated Annual CCCA Bed Days

	Region 4 CCCA Admissions	Estimated Annual CCCA Bed Days
ID/DD Diagnosis	63	743
Psychosis Diagnosis	5	59
DSS-involved youth*	176	2,079
TOTAL	244	2,882

**CCCA cites 18 percent of admissions are DSS-involved youth*

For the purposes of this report, DBHDS used this data to inform what a potential cost avoidance benefit would be for CCCA that could be used in contracting with VTCC should an agreement be implemented, paying for services otherwise not reimbursed through Medicaid or a private insurer. The below table details approximate bed days and costs for CCCA admissions from Region 4 with three of the target patient populations developed with VTCC. Estimated cost avoidance to the state would depend on VTCC capacity to take on these youth. Table 4 outlines estimated cost avoidance based on varying diversion levels of the priority populations.

Table 4: Estimated Cost Avoidance based on Varying Diversion of the Priority Populations

% Diversion	Estimated Bed Days Diverted	Estimated Annual Cost Avoidance

50%	1,440	$ 2,393,015
75%	2,161	$ 3,589,522
100%	2,881	$ 4,786,029

Based on the above estimates, should VTCC agree to accept 50-100 percent of CCCA admissions from Region 4 with a diagnosis of ID/DD or psychosis or who are DSS-involved, it would lead to an annual cost avoidance to the Commonwealth between $2.3 and $4.7M.

Short-term Opportunities for Partnership

Mental Health Services for Children and Adolescents in Foster Care (DSS Custody)

Youth in custody of the Department of Social Services (DSS) remain at risk for serious emotional and behavioral health disorders due to a complex biopsychosocial history that often includes parental history of mental health and substance use disorders, a personal history of trauma, frequent disruptions from school and residential environment, and changes in guardians. Frequent environmental disruptions results in fractured and lack of comprehensive and continuous medical and behavioral health care. Several opportunities exist to: 1) improve the overall assessment and treatment for youth in foster care; 2) maintain foster care youth within their local communities; 3) and expand both diversion and step down alternatives for youth who would likely be placed at CCCA.

VTCC is well positioned to serve this multidisciplinary need for foster care youth due to their expertise in child mental health and relationship with the Children's Hospital of Richmond at VCU, which is the Central Region's expert in pediatric care. In the Children's Inpatient Workgroup, it was noted that many children in DSS custody who are subsequently admitted to CCCA often do not have a clear plan or path and that prior to the "Bed of Last Resort" legislation, CCCA served as a service location where youth with complex needs would receive a more comprehensive evaluation rather than just crisis intervention and stabilization.[6] Many stakeholders indicated that a similar site for youth in foster care is still needed in the system. In response to this, two specific levels of care can be developed for youth in custody of a DSS office located in the Central Region.

Diagnostic unit – Comprehensive Evaluation and Treatment

Given the complex biopsychosocial history of many children in foster care, the presentation of a behavioral health crisis that requires acute inpatient psychiatric treatment is a point in time where a high quality, comprehensive assessment can change the treatment trajectory and break the cycle of repeat hospitalizations. Such assessment may include: a psychiatric and social assessment, observation in a structured environment, assessment and screening of medical needs, assessment of outcomes to previous therapies and medications, consultation on psychiatric diagnosis and complex psychopharmacology, and recommendations related to the psychiatric, medical, educational, and therapeutic interventions individual to the child.

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

In this proposed model of care, youth in foster care could spend up to 30 days at VTCC to receive a comprehensive assessment as well as to develop a transition plan to community-based services. Any inpatient days beyond what is determined to be medically necessary as determined by the insurer could be paid for by the Commonwealth. If it is clinically determined that a longer length of stay is appropriate, the youth may be transferred to CCCA for ongoing treatment. This service allows for thorough evaluation and multidisciplinary treatment of youth while involving the caregivers. At the end of the hospitalization, a comprehensive report outlining diagnostic findings and treatment recommendations would be provided.

Further discussion and contractual details would be needed to operationalize this, with specific attention to clinical presentation and when there are competing demands on both the state hospital and VTCC to accept youth under a TDO. For example, it may be beneficial for DBHDS and VTCC to discuss if a certain portion of beds at VTCC should be reserved or earmarked to ensure continuous availability for the DSS-involved population. This would require a specific funding allotment as well as additional conversations the specific needs of this population. From there, DBDHS and VTCC could work to identify a right-sized budget, including the appropriate complement of providers (e.g., MD/Psychologist/Social Worker). Ultimately, this treatment model would allow the child to remain within the community where services, supports, education, and potential family reunification or kinship placement is intended to remain in line with the mission and values of DSS.

Urgent Outpatient Assessment and Treatment Bridge to Services

This model of care is similar to the above in regards to achieving timely access to high-quality, comprehensive assessment. However, this model would be through the outpatient setting. While a behavioral health crisis may precipitate a need for more intensive services, more often, if interventions can be provided in a timely manner, the need for acute inpatient hospitalization can be completely avoided.

This model provides the same day evaluations for patients in crisis and urgent appointments within 72-hours for referrals from the emergency department or inpatient unit. The program will work closely together with the High Fidelity Wraparound Service.

This service aims to prevent youth with behavioral problems from the need to utilize the ED and subsequent hospitalizations. Bridge services would also include crisis therapeutic service and connection with an ongoing provider at VTCC or facilitation of this connection in their community. Funding provided by the Commonwealth would support the professional time of the psychiatrist to be available within the required timeframe and any physician and other providers' services not otherwise covered by the insurer. Funding would also support additional psychologists, social workers and behavioral health counselors that would be needed to complement the work of the psychiatrist. This

outpatient clinic would serve as a diagnostic evaluation and treatment recommendation service location for youth in foster care in Central Virginia.

Trauma Recovery Center of Excellence

To effectively meet the needs of the foster care population in the services proposed, VTCC will utilize best practices and evidence-based therapies such as trauma-focused cognitive behavior treatment (TF-CBT), which has been proven to significantly improve outcomes of youth with traumatic experiences. VTCC will also monitor treatment outcomes. These may include community tenure, decreased hospital admissions, and successful in-home placements for youth with a history of state hospitalization or repeat hospitalizations and out-of-home placements.

Having a dedicated trauma center will ensure that children in foster care that experienced traumatic events will receive the evidence-based treatment they need to succeed. Opening this center will require training of staff in TF-CBT and providing ongoing supervision to ensure proper adhering to the model. In addition, VTCC will provide training and supervision as needed to CCCA staff, to meet intended shared outcome metrics.

Intermediate Opportunities for Partnership

<u>Youth with First Episode Psychosis</u>

First episode of psychosis is often an indicator of the emergence of serious mental illness such as schizophrenia, and evidence indicates that high intensity interventions provided at this early stage of illness change the long-term trajectory of the disorder and help youth reach recovery goals effectively. Programs that provide early intervention for severe mental illness, such as schizophrenia and bipolar disorder, are needed to reduce long-term morbidity associated with these conditions, such as repeat psychiatric hospitalizations and recurrence of severe episodes of symptom exacerbation.

One such program Coordinated Specialty Care (CSC), an evidence-based, standardized treatment for first episode psychosis, which is currently provided by eleven CSBs to transitional age youth, ages 16-25 years, who have an emerging serious mental illness. Virginia uses a combination of Mental Health Block Grant set-aside funds and state funds to support CSC programs. For the Commonwealth to achieve statewide expansion, the development of a Medicaid rate is critical.[7] The impact of evidence-based, high intensity treatments for early stages of SMI will result in decreasing the overall burden on inpatient psychiatric facilities.[8]

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[7] Item 320.MM of the 2021 Appropriations Act requires DBHDS to develop a report including recommendations to expand and improve services for individuals with first episode psychosis by November 15, 2021.

[8] 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.

In addition to the current lack of Medicaid reimbursement, another significant limitation to expanding CSC programs is workforce training and outcome monitoring. VTCC has a long history serving as a training location for psychiatrists, pediatricians, social workers, psychologists, nurses, nurse practitioners, and psychiatric pharmacists, and are overall part of the VCU Health System and the Children's Hospital of Richmond at VCU where they also have access to medical services. They provide services onsite, in-person, and have the capacity to provide telehealth services. VTCC faculty are also part of the VCU School of Medicine, and therefore have access to educational resources, research, and grant funding. VTCC is uniquely positioned to partner with the Commonwealth to build capacity and expansion of CSC programs through the training of qualified workforce. While the impact on CCCA would be indirect, this program would help to bend the curve on the rising rates of state psychiatric hospitalization.

Long-term Opportunities for Partnership

Mental Health Services for Children and Adolescents with Developmental Disabilities

Youth with developmental disabilities (DD) present with a wide range of intellectual, adaptive, and functional abilities. Due to their varying ability to cognitively and emotionally react to stressors, many youth with DD present with a maladaptive behavioral response such as aggression toward self, others, or their surrounding environment. Not all behavioral episodes are due to a co-occurring psychiatric condition. However, it can be challenging during an acute crisis to fully assess the root cause of the exacerbation. In addition to psychiatric conditions, behavioral changes in youth with DD can be a result of medical conditions or medication side effects, physical pain, a change to their daily routine, unfamiliarity with a new environment or setting, or frustration due to limited ability to communicate effectively. Unfortunately, when these behaviors lead to inpatient psychiatric hospitalization, youth with DD may be further triggered due to the restrictive inpatient environment. Youth may further escalate their behavioral response in this setting, resulting in prolonged hospitalization and difficulty transitioning back into the community, a scenario often seen at CCCA.

To meet current needs to specifically serve youth with DD at the point of a behavioral health crisis, the development of short-term, crisis services at VTCC would help to divert from state hospitalization. In alignment with Project BRAVO, which details the enhancement of behavioral health services offered through Medicaid, development of the following DD specific services at VTCC could be explored:

1. **Applied Behavioral Analysis (ABA)**
   ABA means the practice of behavior analysis as established by the Virginia Board of Medicine in § 54.1-2900 as the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. ABA services includes the following four characteristics:

a. An objective assessment and analysis of the client's condition by observing how the environment affects the client's behavior, as evidenced through appropriate data collection.
b. Importance given to understanding the context of the behavior and the behavior's value to the individual, the family, and the community.
c. Utilization of the principles and procedures of behavior analysis such that the client's health, independence, and quality of life are improved.
d. Consistent, ongoing, objective assessment and data analysis to inform clinical decision-making.

ABA is a highly evidence-based modality of therapy for youth with DD. Currently, ABA services are limited to being only provided in an outpatient or clinic-based setting, however, this therapy can provide continuity of supports when also applied in an inpatient setting if needed. To be able to fully support youth with DD in acute psychiatric settings at VTCC, ABA therapy can be integrated as part of this treatment modality. VTCC has proposed partnering with a community partner, such as the Faison Center, in exploring what such an integrated care model might look like. As services are further developed to support individuals with DD, VTCC could recruit as part of their inpatient and/or crisis teams, ABA therapists.

Since ABA services are not covered by Medicaid when provided in an inpatient setting, should funding be allotted for this purpose by the General Assembly, DBHDS could develop a contract to cover costs to support ABA services provided in the inpatient setting.

2. 23-Hour Crisis Observation for youth with DD

23-Hour Crisis Stabilization provides a period of up to 23 hours in a community-based facility that provides assessment and stabilization interventions to individuals experiencing a behavioral health crisis. This service should be accessible 24/7 and is indicated for those situations wherein an individual is in an acute crisis. 23-Hour Crisis Observation requires a safe environment for observation and assessment prior to determination of whether admission to an inpatient or residential crisis stabilization unit setting is necessary. This service allows for an opportunity for thorough assessment of crisis and psychosocial needs and supports throughout the full 23 hours of service to determine the best resources available to for the individual to prevent unnecessary hospitalization.

Implementing this program at VTCC would require significant new staffing resources, and therefore should be considered as a long-term goal, after current workforce shortages are addressed.

3. **Residential Crisis Stabilization Units**

Residential Crisis Stabilization Units (RCSUs) serve as diversion facilities from inpatient hospitalization. RCSUs provide short-term, 24/7, facility-based psychiatric/substance-related crisis evaluation and brief intervention services. The service supports individuals experiencing abrupt and substantial changes in behavior noted by severe impairment or acute decompensation in functioning.

As with the 23-hour crisis stabilization proposal, above, this program would also require significant new staffing resources for VTCC to implement as well as an investment in the development of an appropriate facility.

4. **Intensive Outpatient Programs and Partial Hospitalization Programs**

To maintain the solvency of beds, CCCA utilizes therapies and interventions that provide immediate crisis stabilization and facilitate discharge. Short lengths of stay coupled with limited timely access to community-based services unfortunately result in a high rate of readmission – around 40 percent for CCCA, accounting for more than half of all bed days.

In alignment with Project BRAVO and the development of new and enhanced behavioral health Medicaid rates, VTCC would like to explore as a long-term goal the development of intensive outpatient programs and partial hospitalization programs for youth. These are highly structured, intensive programs that aim to serve youth who require more care than can be provided by routine outpatient treatment. These programs would serve as both step-down and diversion from CCCA and other inpatient settings. If implemented, VTCC would work in collaboration with CCCA to effectively step-down youth from Region 4 to prevent hospitalization, decrease the readmission rate of CCCA, and support ongoing treatment in the community.

VTCC requires additional time to examine the operational implications of this option, including changes to licensure. Additionally, financial resources would be required to support structural changes, leveraging existing space at VTCC to serve an estimated 8-10 patients in each of these programs initially. For additional expansion of these services, additional space in the community would need to be procured. Finally, adequate staffing including for case management and care coordination is critical for these services to produce positive outcomes.

Next Steps

An agreement between DBHDS and VTCC to divert admissions from CCCA or provide critical step-down services 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 VTCC would include:

- Meeting the staffing and service requirements
- Communication and coordination with local community services boards 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

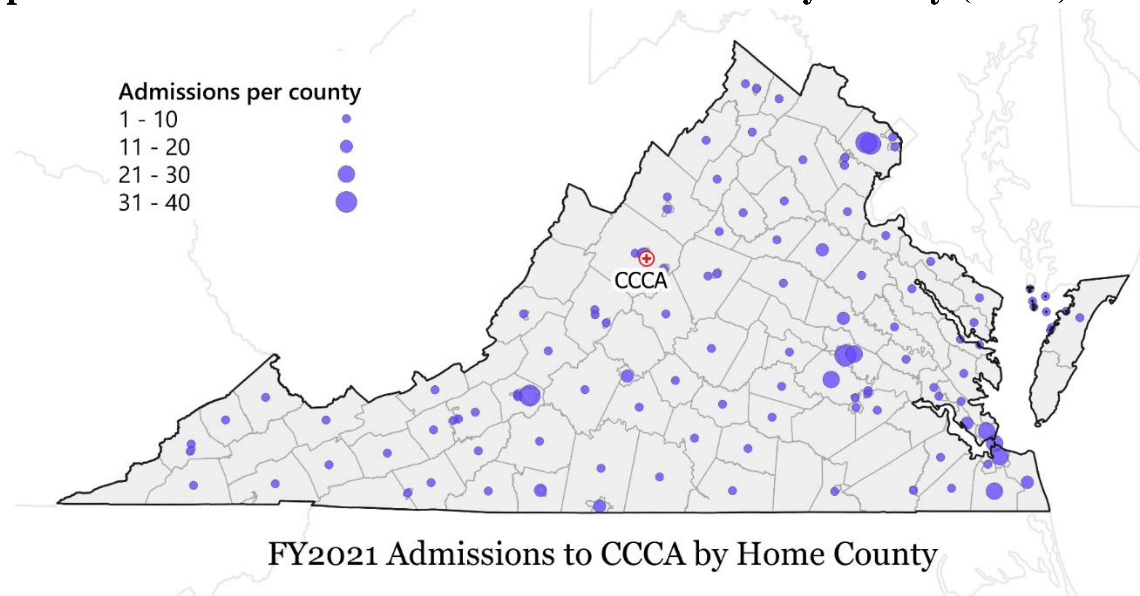
It is important to note that contracting with private inpatient settings is one of DBHDS's key strategies to alleviating the census at CCCA and ensuring children and adolescents receive needed care. Should the General Assembly direct DBHDS and VTCC to formulate an agreement, the method for procurement 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 VTCC through Medicaid or other insurance sources and that all state and federal regulations are followed.

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 VTCC to provide needed beds as well as diversion and step-down strategies. 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 (FY21)



Appendix B: Pediatric Behavioral Health Care Management at VCU Health System

As part of continuous process improvement, VCUHS's care management department identified an opportunity for optimizing the outpatient management of pediatric behavioral health patients. This program includes collaboration between clinicians, parents, insurance providers, and state services to create individual care plans that promote high-quality, cost-effective care and reduce emergency room utilization.

Intensive care coordination (ICC) is an evidence-based collaborative planning process for developing and implementing individualized care plans for children with behavioral health challenges and their families. ICC has four goals:

1. Meet the stated needs (not services) prioritized by the youth and family
2. Improve the youth/family's ability and confidence to manage their own services and supports
3. Develop or strengthen the youth/family's natural support system over time
4. Integrate the work of all child serving systems and natural supports into one streamlined plan.

ICC recognizes that needs change and therefore a patient-centered approach must focus on support of self-management through education, coaching, and engagement of patients and families. These core competencies embrace a teamwork approach to care coordination by encouraging cross communication and transition planning. Based on best practice, VTCC's care

management model focuses on evaluating the need for hospitalization while considering safe returns home by providing wrap-around services. The wrap-around services provide a bridge until families can access consistent mental health care.

An individual behavioral health care plan is initiated after a patient is deemed safe for discharge to home by a behavioral health clinician in VCUHS's emergency department. This determination triggers a face-to-face consultation between the care manager and the patient/family/guardian to establish trust and develop the individual care plan for the next thirty days. During this visit, the care manager focuses on understanding access to services prior to their emergency encounter and creating a plan for overcoming gaps in services based on the patient's needs and social determinants of health. The care manager collaborates with the patient/family to create a care team that includes service providers, state/local agencies, community resources, school representatives, primary care, and mental health clinicians. The care plan integrates crisis stabilization strategies and when to seek emergency care. The care manager's involvement in the patient's care extends beyond the patient's emergency room discharge. The care manager remains engaged with the patient/family for thirty days post discharge and serves as a liaison between the patient and their care team. The care manager collaborates with the care team to mitigate readmissions through utilization of ambulatory based services.

As part of continuous process improvement, the VCUHS Director of Care Management has tracked population-level data since the launch of the program on June 22, 2021. To date, sixty-six pediatric behavioral health individual care plans have been implemented. Forty-five of these patients have progressed beyond the 30-day individualized care plan while the remaining twenty-one are under active care management. Of the forty-five patients, three patients (6.7%) accessed an acute care facility during their 30-day time span; only one patient was admitted while the other two were 23-hour observational status. As part of their individual health plans, each patient was contacted weekly by care management for four weeks. These interactions focused on addressing barriers to the care plan through education and facilitating navigation of the support programs available. The weekly interactions occurred via telephone with an average call time of 29 minutes (range 1-360 minutes). Some attrition did occur over the four-week period, with 43 patient contacts in week one and only 26 in week four. While less individual patient contacts occurred in week four, the average call time remained the same suggesting that patients need persisted and that attrition may reflect patients/families ability to navigate the ambulatory care network and manage their own behavioral health symptoms secondary to education and coaching provided through care management.