COMMONWEALTH of VIRGINIA

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December 2, 2021

The Honorable Janet D. Howell, Chair. Senate Finance Committee
The Honorable Luke E. Torian, Chair, House Appropriations Committee
The Honorable R. Creigh Deeds, Chair, Joint Committee to Study Mental Health Services in the Commonwealth in the 21st Century
Pocahontas Building
900 East Main Street
Richmond, VA 23219

Dear Senators Howell and Deeds and Delegate Torian:

Item 320.MM of the 2021 Appropriations Act directs the Department of Behavioral Health and Developmental Services to report on early psychosis intervention and coordinated specialty care for children, adolescents, and young adults. Specifically, the language requires:

> *The Department of Behavioral Health and Developmental Services, in cooperation with the Department of Medical Assistance Services, the Medicaid managed care organizations, and the Community Services Boards/Behavioral Health Authority, shall report on current efforts to provide early psychosis intervention and coordinated specialty care for children, adolescents and young adults in need of services. The report shall include a summary of current services, funding and programmatic issues to address treatment and care of this population, as well as planned efforts and recommendations to expand and improve care for this population. The report shall be provided 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 15, 2021.*

In accordance with this item, please find enclosed the report on 320.MM of the 2021 Appropriations Acts of Assembly. Staff are available should you wish to discuss this report.

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

CC: Vanessa Walker Harris, MD
Susan Massart
Mike Tweedy

Virginia Department of Behavioral Health & Developmental Services

Report on the Item 320.MM of the 2021 Appropriations Acts of Assembly

Coordinated Specialty Care Report

To the Chairs of the Senate Finance and House Appropriations Committees

December 2, 2021

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Executive Summary

First Episode Psychosis (FEP) is the initial onset of symptoms of a psychotic disorder. In these early stages of psychosis, connecting people to the proper treatment can result in changing the trajectory of their lives. Research has shown that Coordinated Specialty Care (CSC) helps individuals with FEP learn to manage their illness, provides education and support for their caregivers, and improves their overall quality of life. The CSC program treatment is a person-centered, team–based, comprehensive treatment and support service.

Currently in Virginia, there are eight community services boards (CSBs) providing CSC services. Another three programs are in development to meet the increasing needs of this population. This report will explain current services for individuals with FEP and their funding in Virginia as well provide recommendations to expanding treatment across the Commonwealth. The Department of Medical Assistance Services (DMAS), Medicaid managed care organizations (MCOs), community services boards (CSBs), and other stakeholders collaborated with DBHDS to develop this report, identifying four key recommendations to expand and improve care in this area:

1. Continue state funding for the existing eight CSBs providing CSC and allocate ongoing state general funds for the three CSC programs at CSBs.
2. Work toward sustainable funding for CSC, including providing funding to DMAS for a rate study to develop a bundled reimbursement mechanism for CSC and consideration of the development of commercial rates.
3. Support training and technical assistance for CSC, including investing in or routine fidelity monitoring, training, and technical assistance from industry experts, such as ONTrackNY and NAVIGATE.
4. Invest in data collection and reporting mechanisms to monitor CSC outcomes, and join the Early Psychosis Intervention Network (EPINET) and the EPINET National Data Coordinating Center (ENDCC) to connect to national standards.

Preface

Item 320.MM of Chapter 552 of the 2021 Acts of Assembly directs the Department of Behavioral Health and Developmental Services (DBHDS), in cooperation with the Department of Medical Assistance Services, the Medicaid managed care organizations, and the Community Services Boards/ Behavioral Health Authority to report on current efforts to provide early psychosis intervention and coordinated specialty care for children, adolescents and young adults in need of services. The language states:

> *The Department of Behavioral Health and Developmental Services, in cooperation with the Department of Medical Assistance Services, the Medicaid managed care organizations, and the Community Services Boards/Behavioral Health Authority, shall report on current efforts to provide early psychosis intervention and coordinated specialty care for children, adolescents and young adults in need of services. The report shall include a summary of current services, funding and programmatic issues to address treatment and care of this population, as well as planned efforts and recommendations to expand and improve care for this population. The report shall be provided 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 15, 2021.*

Background

First Episode Psychosis

Psychosis is a condition where people have trouble distinguishing between what is real and what is not. There is an important focus on identifying and providing evidence-based interventions for young people who experience first episode psychosis (FEP) as it may be a critical indicator of the emergence of serious mental illness.

Estimates of incidence of FEP among those ages 15-29 range from about 86 to 107 per 100,000.[1] Other studies indicate that the incidence may actually be much higher, particularly among the Medicaid population – a recent study out of New York cited incidence rates of 272 per 100,000 among this population.[2]

Evidence indicates that high intensity interventions provided at this stage of illness change the long-term trajectory of the disorder toward reaching recovery goals effectively. Psychosis is treatable, and many individuals who experience FEP will never experience another one. For others who experience chronic psychosis, early treatment is a foundational component to mitigate the negative impacts of serious mental illness.

The FEP program that has the most robust evidence is Coordinated Specialty Care (CSC). CSC is a team-based, collaborative, recovery-oriented approach to treating FEP. The goal of CSC is to identify and engage young people and their caregivers in a youth-specific treatment which includes low-dosage medications, cognitive and behavioral skills training, supported employment and education, case management, and family psychoeducation. Youth participants are empowered through shared decision-making to address their unique needs, preferences, and recovery goals.

Team-based, recovery-oriented approaches to FEP, such as CSC, have been found to be successful in both improving outcomes for individuals and reducing overall cost of care. One study found a team-based treatment approach as opposed to general community services improved quality of life scores for individuals with FEP and was more cost-effective.[3] Another study found that early intervention services for individuals with FEP were effective in reducing hospitalization and severity of symptoms.[4] CSC has also been found to increase education and employment rates from 40 to 80 percent and decrease hospitalization rates from 70 to 10 percent from baseline to follow up within one year.[5] Targeting services to this population can pay dividends in reducing the incidence of serious mental illness and overall costs to Virginia's behavioral health system.

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[1] Simon, et al. "INCIDENCE AND PRESENTATION OF FIRST-EPISODE PSYCHOSIS IN A POPULATION-BASED SAMPLE". (2017). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5811263/

[2] Radigan, et al. "A New Method for Estimating Incidence of First Psychotic Diagnosis in a Medicaid Population." (2019).

[3] Rosenheck, et al. "Cost-Effectiveness of Comprehensive, Integrated Care for First Episode Psychosis in the NIMH RAISE Early Treatment Program". (2016).

[4] Bird, et al. "Early intervention services, cognitive-behavioural therapy and family intervention in early psychosis: systematic review". (2010).

[5] Nossel, et al. "Results of a Coordinated Specialty Care Program for Early Psychosis and Predictors of Outcomes." (2018).

Coordinated Specialty Care in Virginia

In 2014, Department of Behavioral Health and Developmental Services (DBHDS) released a request for proposals to community services boards (CSBs) to solicit applications for funding to develop and implement evidence-supported early intervention models designed to address the behavioral health needs of young adults, including those experiencing FEP. This funding supports the provision of CSC for two to three years for individuals between the ages of 16 and 30 years of age experiencing symptoms. Exceptions are made for individuals diagnosed with psychosis before the age of 15 years old. The request identified eight CSBs and developed the CSC programs to introduce the evidence-based practice to Virginia. The following CSBs currently provide CSC services:

- Alexandria Department of Community and Human Services
- Fairfax-Falls Church Community Services Board
- Henrico Area Mental Health & Developmental Services
- Highlands Community Services Board
- Loudoun County Department of MH, SA, & Developmental Services
- Rappahannock-Rapidan Community Services Board
- Prince William County Community Services Board
- Western Tidewater Community Services Board

In addition to the eight CSBs, there are three new teams being formed at Blue Ridge Behavioral Health, Mount Rogers, and Arlington CSBs. Additional services that can be applied universally include but are not limited to early identification, high-quality assessment, monitoring, and treatment. Early engagement and integration of treatment planning with natural support can enhance an individual's strengths while promoting resilience.

CSC services provided at CSBs are funded through a combination of state general fund (GF) and federal mental health block grant (MH BG) funds (see Table 1). The federal MH BG funds require a 10 percent set aside for services for individuals experiencing FEP. In FY2021, a total of $5,712,718 was dedicated to the provision of CSC in Virginia.

Table 1: Coordinated Specialty Care Funding in Virginia (FY 2015 – FY 2021)

	GF	MH BG	Total
2021	$4,000,000	$1,712,718	$5,712,718
2020	$4,000,000	$1,869,335	$5,869,335
2019	$4,000,000	$1,535,558	$5,535,558
2018	$4,000,000	$1,293,174	$5,293,174
2017	$4,000,000	$1,315,960	$5,315,960
2016	$4,054,000	$703,939	$4,757,939
2015	$3,500,000	$703,939	$4,203,939
Total	**$23,554,000**	**$7,421,905**	**$30,975,905**

DBHDS currently supports the following individuals served through CSC across the eight CSBs, detailed in Table 2.

Table 2: Number of Individuals Served by CSC at Each Participating CSB

CSB	As of June FY21	Total # since start of CSC	CSB	As of June FY21	Total # since start of CSC
Fairfax – Falls Church CSB[6]	39	144	Loudoun CSB	41	219
Western Tidewater CSB	39		Henrico CSB	41	142
Highlands CSB	23	93	Prince Williams CSB	26	141
Alexandria CSB	26	146	Rappahannock-Rapidan CSB	8	51

DBHDS anticipates newly available data on individuals served on the three new CSC sites by the end of FY21.

In 2019, DBHDS issued a report on the first three years of available data for CSC programs in the Commonwealth (2015-2018). Preliminary data indicated that CSBs were successful in reducing the duration of untreated psychosis by admitting individuals into CSC services soon after an individual's FEP. Additionally, data reported by CSBs showed that clients improved in areas charting progress in social connectedness, movement towards healthy behavior, and avoidance of negative interferences to recovery. The greatest improvements were shown in involvement with self-help activities, knowledge, and relapse prevention planning. They also showed improvement on the Modified Colorado and Symptom Index, used to understand improvement on emotional, behavioral, and social disturbances. Finally, upon discharge from CSC, 8 out of 10 clients responded favorably to the Modified Mental Health Statistics

[6] Fairfax-Calls Church CSB focuses on schizophrenia spectrum disorders only.

Improvement Plan Consumer Survey, indicating they were pleased with the services received and that the program had an overall positive impact.[7]

Identified Challenges to Expansion of Coordinated Specialty Care

Workforce Challenges

In order to further expand CSC programs in Virginia, DBHDS recently issued a request for proposal for more CSBs to offer CSC services. The RFP opportunity offered up to $500,000 for new program start-up funding, and only three CSBs responded. This minimal response is thought to be connected to the current behavioral health workforce crisis which impedes the ability of additional CSBs to participate in the expansion of CSC programs to new localities. CSC requires mental health professionals including Qualified Mental Health Professionals (QMHP), Licensed Mental Health Professionals (LMHP), peer support specialists, medical doctors, and other support personnel. CSC's team-oriented treatment requires minimally a team leader, a psychiatric care provider, a peer specialist, a supported employment and education specialist (SEES), and a generalist mental health clinician. Enhanced (ancillary) CSC service providers such as nurses, occupational therapists, and substance use disorder specialists may also be required depending on the individual needs of the participants.

Availability of Complementary Community-Based Services

In addition to workforce challenges, there is a significant gap in available services for youth transitioning into the adult mental health system. CSC programs focus on both the child and family while also maintaining support for the youth at home and during school through addressing educational needs, family supports, access to routine outpatient psychiatric care, and crisis intervention services. The adult mental health system does not offer the same level of wrap around services, which often results in a lapse of services complementary to CSC for the individual experiencing FEP.

Sustainability of CSC Programs

In general, there is a relatively low incidence of FEP in the community, or about 86 to 107 per 100,000 for 15 to 29 year olds.[8] While this is still a significant portion of the population, smaller caseloads can make program sustainability difficult particularly in smaller localities. While the impact of CSC both on individual recovery and lifetime system savings is significant, the immediate costs of the wrap-around model of CSC can make it difficult to sustain case volume and maintain the treatment model. Recommendation #2 below addresses the need for sustainable funding.

Recommendations

Four key recommendations were developed in collaboration with CSBs, DMAS, the MCOs, and other stakeholders that could help strengthen and expand access to CSC services in Virginia.

1. **Continue state funding for CSC in Virginia.**
   The first recommendation is to continue funding of the existing eight and three new CSC programs. The three new CSC programs are currently funded through federal block grant

[7] Early Impacts of the Coordinated Specialty Care (CSC) Program. DBHDS. (April 2019).
[8] Simon, et al. "INCIDENCE AND PRESENTATION OF FIRST-EPISODE PSYCHOSIS IN A POPULATION-BASED SAMPLE". (2017). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5811263/

dollars and would require ongoing state general fund dollars. In addition, general investments in the behavioral health workforce is a widespread need beyond the provision of CSC services and would help CSC programs reach more Virginians in need of this services.

2. **Provide sustainable funding sources for CSC.**
   CSC is not currently a service defined or included in the Medicaid State Plan. To assure full access to the program is available, the second recommendation is to provide funding to DMAS for a rate study to develop a bundled reimbursement mechanism, similar to Assertive Community Treatment (ACT), for CSC. In alignment with Project BRAVO, CSC is a high-quality, evidence-based intervention for individuals experiencing FEP, and it is currently not covered by Medicaid. A rate study would help establish a reimbursement rate reflective of the model of care through a comparison of other states that have successfully blended state general funds with Medicaid funding.

   Medicaid funding is a critical component to expanding this service so that it is available throughout the Commonwealth, and commercial reimbursement is also critical. Further study and work with private insurers in Virginia is needed to support the development of additional support for CSC among commercial plans.

   Other states, including Washington and Nebraska, are moving in this direction by developing monthly case rates which could be used to eventually develop Medicaid and commercial rates. Monthly case rates, as opposed to general grant funding, may help to incentivize identifying and recruiting new, eligible individuals in to services.

3. **Support training and technical assistance for CSC.**
   Ongoing funding for training and technical assistance needs from recognized experts such as ONTrackNY and NAVIGATE would benefit CSC programs in Virginia. As with any evidence-based practice, training to provide services in fidelity to the model produce better outcomes. To equip the current CSBs providing CSC, training should be provided on the core components of the model routinely for fidelity monitoring.

4. **Invest in data collection and reporting mechanisms.**
   Finally, a financial investment is needed to support the development of a system for statewide data collection and reporting mechanism. This would simplify CSB reporting on CSC services in order to track outcomes and monitor progress overtime. It would also help develop a clearer picture of the return on investment of these services.

   Additionally, DBHDS is currently working to join the Early Psychosis Intervention Network (EPINET) and the EPINET Nation Data Coordinating Center (ENDCC). These are the national healthcare systems that link early psychosis clinics through standard clinical measures and uniform data collections methods across service users. The network provides large scale, practice-based research to improve early psychosis care while partnering with clients and their families. ENDCC serves as the primary coordinator for EPINET to share data with CSC programs nationwide to support early psychosis care,

quality improvement, and benchmarking. There are five aims through the ENDCC activities:

a. Serve as the central coordinating entity for Regional Hubs and facilitate the sharing of data collection strategies.
b. Curate and harmonize key assessment measures, clinical strategies, and data elements across Regional Hubs.
c. Implement a health informatics approach within and across the Regional Hubs.
d. Facilitate practice-based research.
e. Disseminate CSC resources to the broader scientific, provider, and patient communities.

DBHDS plans to continue these efforts in order to maximize CSC outcomes in Virginia.

Conclusion

FEP is best identified and treated at its onset, and the treatment services provided by the team-oriented approach of CSC can help prevent serious mental illness. Support for existing services as well as consideration of opportunities for expansion through Medicaid rates, technical assistance, and quality networks will strengthen the provision of CSC in Virginia.