Our Behavioral Health System: Joint Priorities towards a North Star

Children's Services Act Annual Conference

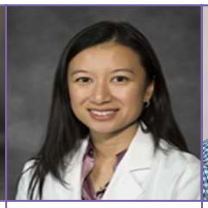
November 2, 2022

Virginia Department of Behavioral Health & Developmental Services

VIRGINIA'S MEDICAID PROGRAM DMAS

PRESENTERS TODAY:

Alyssa Ward, LCP, Ph.D
- Behavioral Health Clinical Director
- Department of Medical Assistance Services



Alexis Aplasca, MD, FAAP, FAPA
- Chief Clinical Officer
- Department of Behavioral Health and Development Services

Bill Howard, LCSW
- Acting Assistant Commissioner for Crisis Services
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Shamika Ward, MS
- Mental Health Senior Program Specialist
- Department of Medical Assistance Services

Patty Smith, MSW
- Behavioral Health Manager
- Department of Medical Assistance Services

Ashley Harrell, LCSW
- BH Senior Program Advisor
- Department of Medical Assistance Services

Laura Reed, LCSW
- BH Senior Program Advisor
- Department of Medical Assistance Services

FURTHERING THE MISSION

- Our mission is to improve the health and well being of Virginians through access to high quality healthcare.
- The Addiction & Recovery Treatment Services benefit implementation in 2017 significantly enhanced our rates and access to evidence-based care for substance use disorders.
- BRAVO was conceived in 2018 as a means to enhance our mental health services and seeks to implement effective, innovative services with reimbursement rates that match the cost of delivery.

ARTS ADDICTION & RECOVERY TREATMENT SERVICES

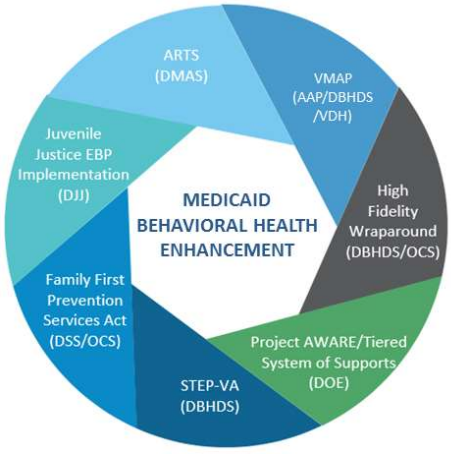
VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION · QUALITY · VALUE

PROJECT BRAVO BEHAVIORAL HEALTH REDESIGN FOR ACCESS, VALUE & OUTCOMES

THE ROLE OF SERVICES REDESIGN IN SYSTEM TRANSFORMATION

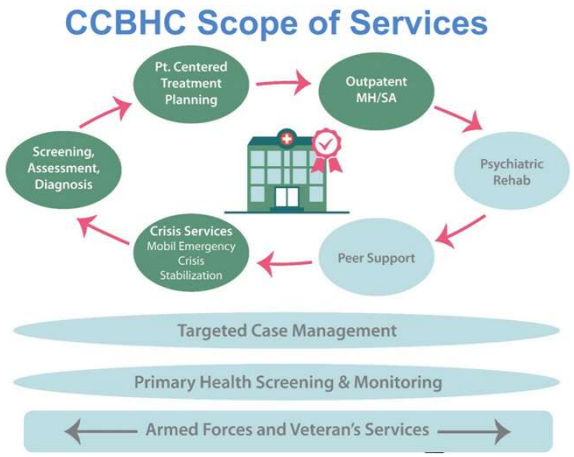
PROJECT BRAVO

- BRAVO enhances the services within the Medicaid benefit, including definitions/requirements and rates
- Medicaid is the largest payor of behavioral health services in the Commonwealth
- Enhancing and aligning Medicaid services to include innovative services paid for with general funds allows the Commonwealth to maximize the federal contribution to cover payment of these services
- Assuring we have quality services in place is a critical part of the larger transformation of how the system functions as a whole



NATIONAL MODEL & VIRGINIA MODEL

System Transformation Excellence and Performance (STEP-VA) is a long-term initiative designed to improve the community behavioral health services available to all Virginians. All 40 CSBs in Virginia are statutorily required to provide all STEP-VA services.



- Same Day Access
- Primary Care Screening
- Outpatient Services
- Crisis Services
- Peer and Family Support
- Psychiatric Rehabilitation
- Veterans Services
- Case Management
- Care Coordination

NEXT STEPS IN STEP-VA

Ongoing implementation of Crisis System Transformation, and final 3 STEPs

Step	Planning and Installation (Phase 1 Start Date)	Initial Implementation (Phase 2 Start Date)	Full Implementation/ Validation (Phase 3 Start Date)
Case Management	7/1/2021	7/1/2023	7/1/2024
Psychiatric Rehab	7/1/2021	7/1/2023	7/1/2024
Care Coordination	7/1/2021	7/1/2023	7/1/2024

Behavioral Health System Architecture

Beyond Project BRAVO lies the larger conversation of system transformation related to the structure and mechanics of how our system operates to serve the people of the Commonwealth.

Our system has layers of complexity across

- Numerous interacting authorities and regulations governing the practice of behavioral health
- A mix of providers including our community service boards system and private providers
- Largely unbraided funding sources with complicated rules for who can pay for what in what order
- Significant, overlapping initiatives seeking to improve access and quality of care
- Workforce availability
- Locality practice/process subcultures and variable resources

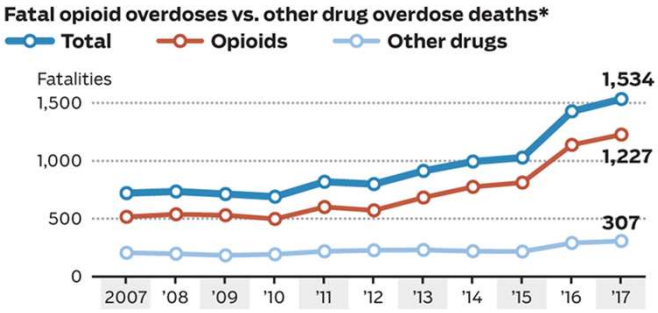
BEHAVIORAL HEALTH SYSTEM TRANSFORMATION

- Managed care implementation within Medicaid is a kind of delivery system transformation and significantly altered the landscape for our members and providers

- **Full system transformation is a bigger picture**
- It necessarily integrates numerous architectures in a plan that incorporates the needs of all Virginians
- Large scale transformation requires strategies for blending and braiding funding sources
- All stakeholders require consideration, and this can be complex in a locally driven Commonwealth
- The process involves widening access to pathways between care providers & examining where routes need revision and where detours have been paved to avoid problem zones

BACKGROUND ON VIRGINIA'S BEHAVIORAL HEALTH TRANSFORMATION

VIRGINIA'S OVERDOSE CRISIS 2007-2017



The opioid epidemic disproportionately affects Medicaid beneficiaries

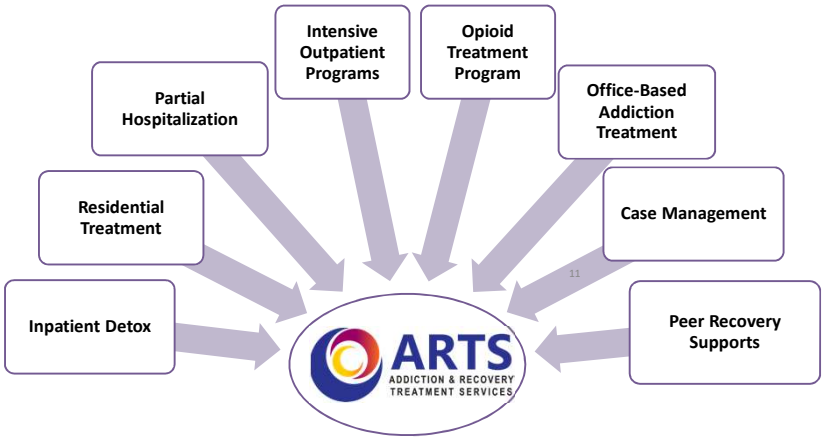
- **Medicaid beneficiaries age 18–64 have a higher rate of opioid use disorder than privately insured individuals**, comprising about 12 percent of all civilian, non-institutionalized adults in this age group but about one-quarter of those with an opioid use disorder.
- Medicaid beneficiaries are **prescribed pain relievers at higher rates** than those with other sources of insurance.
- They also have a **higher risk of overdose and other negative outcomes**, from both prescription opioids and illegal opioids such as heroin and illicitly manufactured fentanyl.

POLITICAL WILL SUPPORTING ACTION

September 2014	Virginia Governor signed Executive Order 29, creating the Governor's Task Force on Prescription Drug and Heroin Abuse, resulting in 51 legislative recommendations
July 2015	CMS State Medicaid Director's Letter announcing 1115 Demonstration option
March 2016	Virginia General Assembly mandate to transform the Medicaid SUD benefit.
November 2016	State Health Commissioner declared a Public Health Emergency for Virginia as result of the opioid addiction epidemic.
December 2016	CMS approved Virginia's 1115 Substance Use Disorder Demonstration Waiver (significant for residential services)
April 2017	Virginia Medicaid implemented the Addiction and Recovery Treatment Services (ARTS) benefit.
July 2017	Virginia Medicaid implemented the Peer Recovery Support Services benefit.

ARTS
ADDICTION & RECOVERY TREATMENT SERVICES

ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)



Goal is to ensure that members are matched to the right level of care to meet their evolving needs as they enter and progress through treatment.

ARTS offers a fully integrated physical and behavioral health continuum of care.

COVID-19 ACCELERATED OVERDOSE DEATHS NATIONALLY

Drug overdose deaths in 2020 hit highest number ever recorded, CDC data shows

By Maggie Fox, CNN
Updated 10:17 AM ET, Wed July 14, 2021

https://www.cnn.com/2021/07/14/health/drug-overdose-deaths-2020/index.html
https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm

"As we continue to address both the COVID-19 pandemic and the opioid crisis, **we must prioritize making treatment options more widely available** to people with substance use disorders."

CDC Data: Fatal overdose rates increase by 30% in 2020 –

100,306 people died in 2020

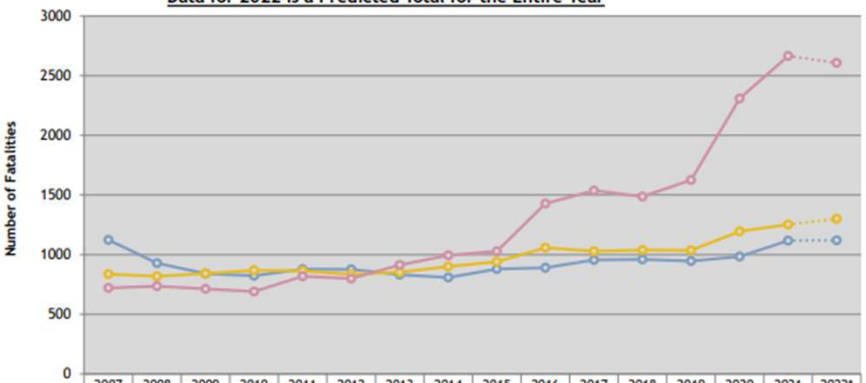
75% involved an opioid

VDH FATAL DRUG OVERDOSE REPORT

Q1 2022

Fatal drug overdose has been the leading method of unnatural death in Virginia since 2013, exceeding deaths due to motor vehicle collisions and gun-related deaths.

Total Number of Motor Vehicle, Gun, and Drug Related Fatalities by Year of Death, 2007-2022*
Data for 2022 is a Predicted Total for the Entire Year



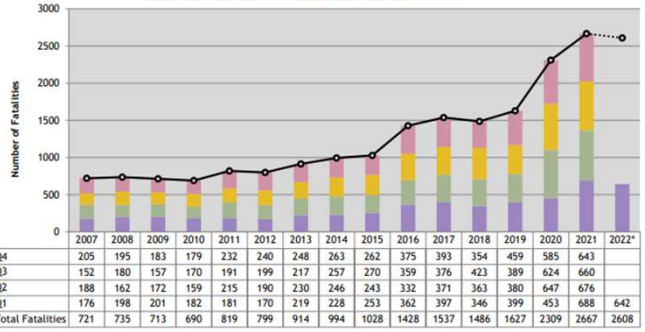
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022*
Motor Vehicle Related	1124	928	841	823	878	877	832	808	879	890	955	960	947	984	1117	1121
Gun Related	836	818	843	868	863	835	852	901	940	1058	1028	1038	1036	1195	1253	1301
Fatal Drug Overdose	721	735	713	690	819	799	914	994	1028	1428	1537	1486	1627	2309	2667	2608

VDH FATAL DRUG OVERDOSE REPORT

Q1 2022

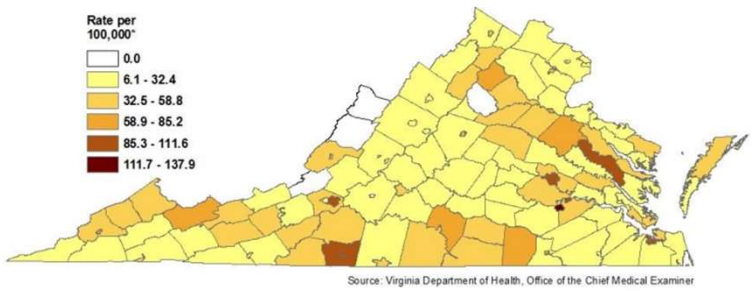
All Drug Overdoses

Total Number of Fatal Drug Overdoses by Quarter and Year of Death, 2007-2022*
Data for 2022 is a Predicted Total for the Entire Year



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022*
Q4	205	195	183	179	232	240	248	263	262	375	393	354	459	585	643	
Q3	152	180	157	170	191	199	217	257	270	359	376	423	389	624	660	
Q2	188	162	172	159	215	190	230	246	243	332	371	363	380	647	676	
Q1	176	198	201	182	181	170	219	228	253	362	397	346	399	453	688	642
Total Fatalities	721	735	713	690	819	799	914	994	1028	1428	1537	1486	1627	2309	2667	2608

Rate of All Fatal Drug Overdoses, All Substances, by Locality of Overdose, 2021



Source: Virginia Department of Health, Office of the Chief Medical Examiner

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RISK FACTORS FOR ADOLESCENT SUBSTANCE USE

- Family history of substance use
- Favorable parental attitudes towards the behavior
- Poor parental monitoring
- Parental substance use
- Family rejection of sexual orientation or gender identity
- Association with delinquent or substance using peers
- Lack of school connectedness
- Low academic achievement
- Childhood sexual abuse
- Mental health issues

High Risk Substance Use in Youth | Adolescent and School Health | CDC

YOUTH WITH SUBSTANCE USE DISORDER 2022

Mental Health American ranks Virginia 10th in the country with 3.71% of youth report having a substance use disorder in the past year.

Nationally, 62% of teenagers in 12th grade have abused alcohol. 50% of teenagers have misused a drug at least once.

- In Virginia, 44,000 or 6.96% of 12- to 17-year-olds report using drugs in the last month.
  - Among them, 77.27% report using marijuana in the last month.
  - 0.32% report using cocaine in the last year.
  - 0.16% report using methamphetamines.
  - Up to 0.08% used heroin (data is limited).
  - 2.37% report misusing pain relievers.
  - 9.01% of all 12- to 17-year-olds used alcohol in the last month.

Youth data 2022 | Mental Health America (mhanational.org)
https://drugabusestatistics.org/teen-drug-use/#virginia

	% with any SUD	% with OUD	% with AUD	% with cannabis diagnosis	% with stimulants diagnosis
All Medicaid members	6.1%	2.5%	2.3%	1.7%	1.4%
Age					
12-21	2.2%	0.3%	0.5%	1.5%	0.3%
22-34	10.3%	4.9%	2.9%	3.7%	2.7%
35-44	13.5%	7.1%	4.5%	3.5%	3.5%
45-54	14.3%	6.0%	6.5%	2.9%	3.5%
55-64	13.4%	4.1%	7.7%	2.1%	2.6%
65+	5.5%	1.9%	3.0%	0.4%	0.5%
Race/ethnicity					
White, non-Hispanic	7.7%	3.6%	2.7%	1.8%	1.7%
Black, non-Hispanic	5.6%	1.5%	2.3%	2.0%	1.4%
Hispanic	2.5%	0.8%	0.9%	2.1%	0.5%
Other	2.6%	0.8%	1.2%	0.4%	0.5%
Aid category					
Medicaid expansion	10.8%	4.7%	4.3%	2.9%	2.7
Other non-disabled adults	9.1%	5.2%	2.1%	2.3%	1.9%
Pregnant members	6.0%	2.3%	0.7%	2.4%	1.1%
Low-income children	0.8%	0.1%	0.1%	0.3%	0.1%
Aged	4.9%	1.7%	2.7%	0.4%	0.5%
Blind/disabled	13.5%	5.0%	6.0%	3.7%	3.3%

IN VIRGINIA

PREVALENCE OF DIAGNOSED SUD, BY MEMBER CHARACTERISTICS, SFY 2020

ADDICTION DEFINED: AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM)

Addiction is a **treatable, chronic medical disease** involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

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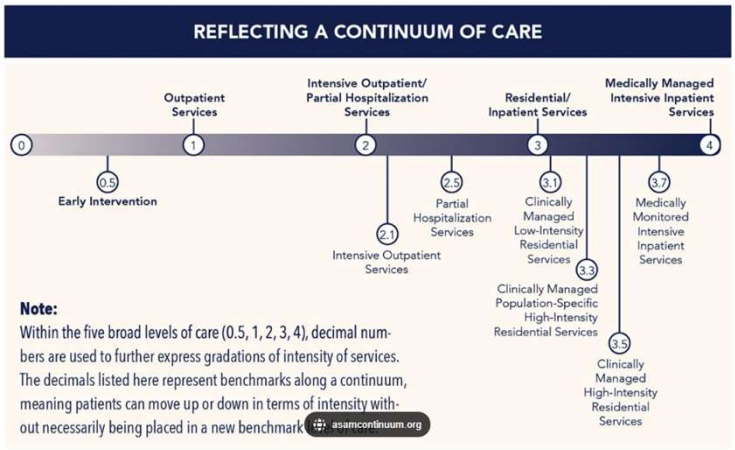
Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

Adopted by the ASAM Board of Directors September 15, 2019

TREATMENT DEFINED: AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM)



The ASAM Criteria is the most widely used and comprehensive set of guidelines for placement, continued stay, transfer, or discharge of patients with addiction and co-occurring conditions.

CASE EXAMPLE

GROUP DISCUSSION

10 MINUTES

Which Medicaid service do you think is the most appropriate to meet this child's needs?

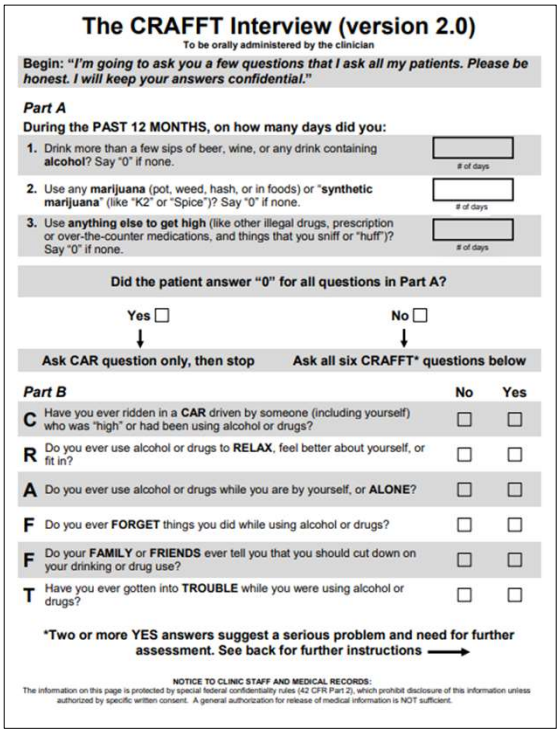
Carl is a 15 y.o. African American male whom you suspect meets DSM-5 criteria for Alcohol Use Disorder-Mild and Cannabis Use Disorder – Moderate. He reports no withdrawal symptoms but then he really doesn't think he has a problem, and you are basing your tentative diagnosis on reports from the school, probation officer, and older sister.

Carl has been arrested three times in the past eighteen months for petty theft/shoplifting offenses. Each time he has been acting intoxicated but denies use. The school reports acting up behavior, declining grades, and erratic attendance, but no evidence of alcohol/drug use directly. They know he is part of a crowd that uses drugs frequently.

Yolanda, Carl's 24 y.o sister, has custody of Carl following his mother's death from a car accident eighteen months ago. She is single, employed full time and has a three y.o daughter she cares for. She reports that Carl stays out all night on weekends and refuses to obey her or follow her rules. On two occasions she has observed Carl drunk. On both occasions he has been verbally aggressive and has broken furniture. A search of his room produced evidence of marijuana which Carl claims he is holding for a friend.

ASAM LEVEL 0.5

SCREENING FOR ADOLESCENT SUD



The CRAFFT Interview (version 2.0)

To be orally administered by the clinician

Begin: "*I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential.*"

Part A

During the PAST 12 MONTHS, on how many days did you:

1. Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Say "0" if none. ☐ # of days
2. Use any **marijuana** (pot, weed, hash, or in foods) or "**synthetic marijuana**" (like "K2" or "Spice")? Say "0" if none. ☐ # of days
3. Use **anything else to get high** (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff or "huff")? Say "0" if none. ☐ # of days

Did the patient answer "0" for all questions in Part A?

Yes ☐ → **Ask CAR question only, then stop**

No ☐ → **Ask all six CRAFFT* questions below**

Part B	No	Yes
C Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
R Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
A Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
F Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
F Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
T Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

***Two or more YES answers suggest a serious problem and need for further assessment. See back for further instructions →**

NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:
The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.

The **CRAFFT** is an efficient and effective health screening tool designed to **identify substance use, substance-related riding/driving risk, and substance use disorder among youth ages 12-21**.

https://crafft.org/use-the-crafft/

ADDITIONAL TRAINING RESOURCES FOR CLINICIANS WORKING WITH ADOLESCENTS WITH SUD

SUD Treatment for Adolescents	ASAM Criteria Assessment Dimensions 1 & 2	ASAM Criteria Assessment Dimensions 3
ASAM Criteria Assessment Dimensions 4	ASAM Criteria Assessment Dimensions 5 & 6	SUD & LGBTQ+ Clients
SUD and The Family	SUD & Cultural Humility	Screening and Assessment for SUD

https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/support-act-grant/

DETAILS ON BRAVO SERVICES

7/1/2021

- ASSERTIVE COMMUNITY TREATMENT (ACT)
- INTENSIVE OUTPATIENT (IOP)
- PARTIAL HOSPITALIZATION (PHP)

12/1/2021

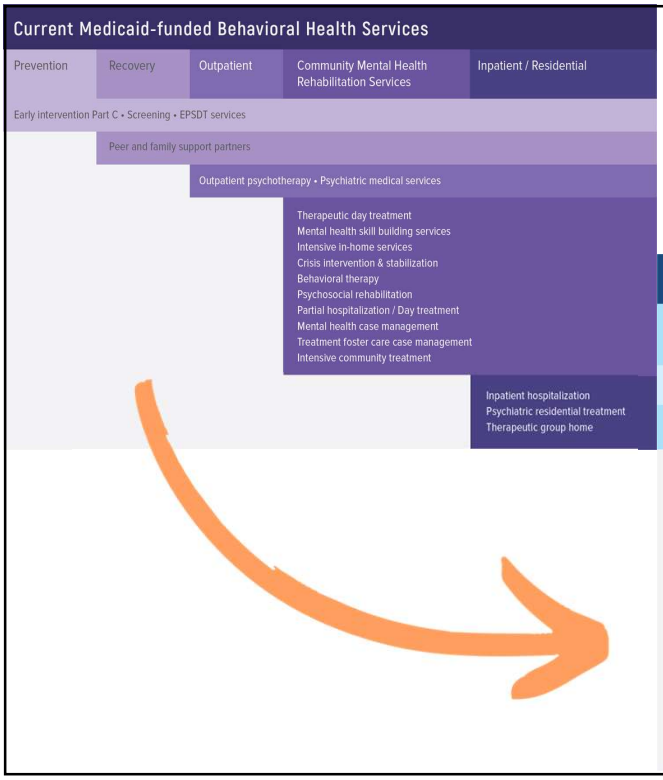
- COMPREHENSIVE CRISIS SERVICES
- MULTISYSTEMIC THERAPY (MST)
- FUNCTIONAL FAMILY THERAPY (FFT)

year 1 accomplishments

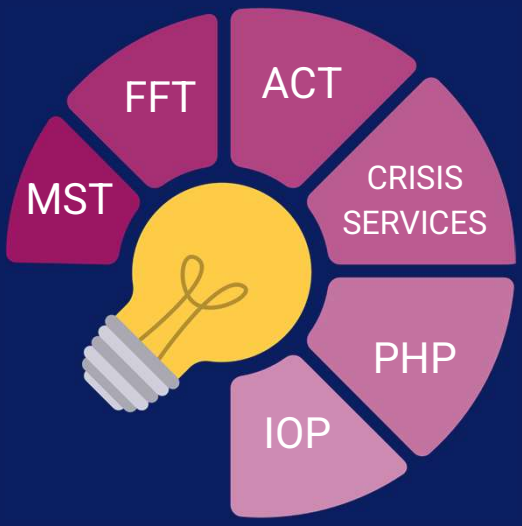
- Met implementation deadlines on time with Managed Care Organization (MCO) partners on timeline shortened to half by pandemic delays in funding
- Maintained close partnerships with Behavioral Health (BH) associations and providers through MCO Resolutions Panel to identify authorization and claims issues and work on solutions
- Development of the Center for Evidence Based Partnerships with Virginia Commonwealth University (VCU)
- DMAS BH Dashboards Launched

year 1 challenges

- Limited training dollars has hampered ability to prepare workforce for new services
- Workforce crisis has limited the expansion of services & networks
- Complexity of crisis system infrastructure and Medicaid reimbursement



2021



WHAT COMES NEXT

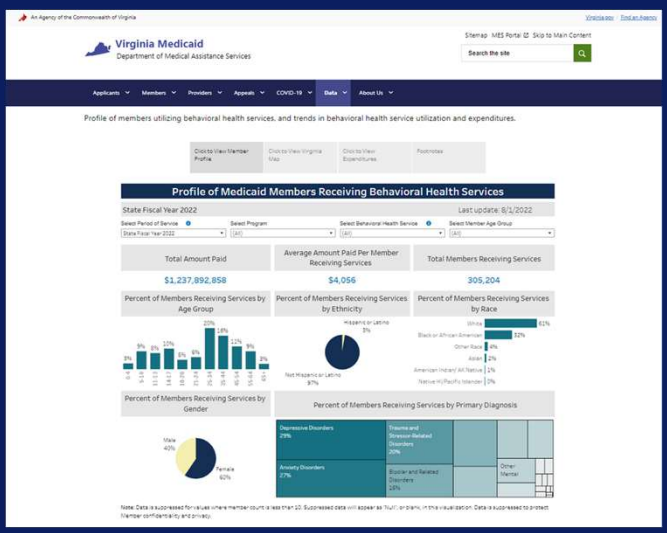
01 Service learning collaboratives

02 Build out of crisis system

03 Metrics & Evaluation

04 Explore Opportunities for Expansion

BEHAVIORAL HEALTH DASHBOARDS



- Utilization data by State Fiscal Year, Program, Service and Member Age Filters
- A tool to begin hypothesis testing around behavioral health utilization; interpretation should be contextual
- Geographic "heat map" tool
- Overall expenditures trends
- 6-9 months of claims lag
- Substance Use Disorder (SUD) diagnoses included here, but ARTS services are not yet fully integrated

https://www.dmas.virginia.gov/data/behavioral-health/behavioral-health-service-utilization-and-expenditures/

Emerging Priorities

VIRGINIA'S MEDICAID PROGRAM
DMAS

PROJECT BRAVO

BRAVO expansion

Continuous improvement process for both recently implemented and proposed services

ARTS & BRAVO INTEGRATION

Greater integration of policy and practice across MH and SUD, starting within our division

Workforce Crisis

A big focus of interagency collaboration

Substance Use and Co-Occurring Mental Disorders

Researchers have found that about half of individuals who experience a SUD during their lives will also experience a co-occurring mental disorder and vice versa.

Co-occurring disorders can include anxiety disorders, depression, attention-deficit hyperactivity disorder (ADHD), bipolar disorder, personality disorders, and schizophrenia, among others.

Common risk factors include genetics, stress, trauma

Mental disorders can contribute to substance use and SUD.

Substance use and SUDs can contribute to the development of other mental disorders.

Importance of co-occurring treatment and integration of Mental Health and ARTS services…

Building the bridge to recovery

Effective Behavioral Therapies for Individuals with Co-Occurring Disorders

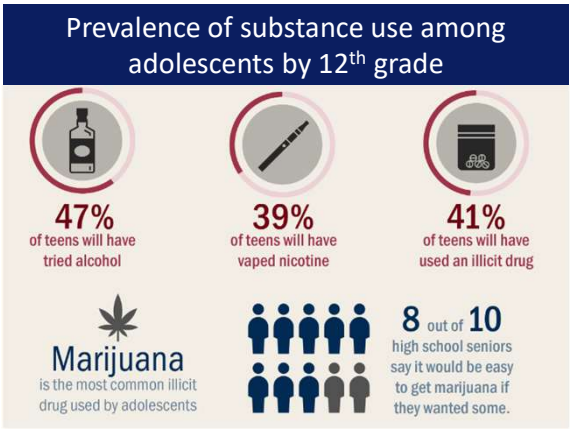
Assertive Community Treatment

- A high-intensity, team-based treatment delivered in the community for individuals with serious mental illness. Referred to as "hospital without walls."
- ACT is a highly coordinated set of services offered by group of medical, behavioral health, peer recovery support providers and rehabilitation professionals in the community who work as a team to meet the complex needs of individuals with severe and persistent mental illness.
- An individual who is appropriate for ACT requires this comprehensive, coordinated approach as opposed to participating in services across multiple, disconnected providers, to minimize risk of hospitalization, homelessness, **substance use**, victimization, and incarceration.
- Required team member includes a Substance Use Disorder Specialist that must have skills to treat individuals with co-occurring disorders.

Effective Behavioral Therapies for Individuals with Co-Occurring Disorders

Multisystemic Therapy and Functional Family Therapy

- Intensive family and community-based treatments for adolescents which address the externalizing behaviors of youth with significant clinical impairment in disruptive behavior, mood, and/or substance use.
- MST and FFT are integrated into our Mental Health Services Manual: Intensive Community Based Support – Youth
  - A youth may have primary diagnosis of Substance Use Disorder, risk of involvement or involvement with the legal carceral system



Teen Drug Use Infographic (mstservices.com)

Effective Behavioral Therapies for Individuals with Co-Occurring Disorders

Comprehensive Crisis Services

- A full set of evidence-based crisis services that would involve regional call centers to dispatch public and private providers to conduct mobile crisis intervention and ongoing, community-based crisis stabilization. Would also provide appropriate reimbursement for crisis stabilization units (residential crisis) and include 23-hour observation beds.
- Learn more about the model: https://crisisnow.com/
- Any diagnosis within the current DSM, **including SUD**
- Eventual goal is to have Mobile Crisis Response teams that **specialize in responding to individuals with SUD**.
- **Both 23-Hour Crisis Stabilization and Residential Crisis Stabilization Units** are **equipped to treat individuals with a primary diagnosis of SUD**.

A Crisis Response May Be the Only Opportunity to Help Someone with an Addiction

Nearly 38% of people living with a substance use disorder have a mental illness.

Those dependent on alcohol or drugs are at a 10-14 times greater risk of suicide, with roughly 22% of suicides involving alcohol intoxication.

Information on the current statewide crisis system is available on the DBHDS website.

A UNIFIED VISION:

THE COMMONWEALTH CRISIS SYSTEM

PROJECT BRAVO

Objective: The development of a community-based, trauma-informed, recovery-oriented crisis system that responds to crises where they occur and prevents out-of-home placements.

HIGH TECH CRISIS CALL CENTERS

24/7 MOBILE CRISIS RESPONSE

CRISIS STABILIZATION PROGRAMS

ESSENTIAL PRINCIPLES & PRACTICES

CRISIS IN COMMUNITY

Individual in crisis who calls 988 or another number that is directed to 988

1 **CRISIS RESOLVED BY CALL CENTER**
No additional intervention needed

2 **MOBILE CRISIS DISPATCH**
Crisis resolved and person connected back with EXISTING PROVIDER

3 **MOBILE CRISIS DISPATCH**
Crisis resolved, no existing provider, referral to COMMUNITY STABILIZATION until other service provider available

4 **MOBILE CRISIS DISPATCH**
Crisis resolved, person connected with other service provider who is immediately available

5 **ESCALATION IN CARE**
Mobile Crisis determines need for initiation of ECO/TDO, 23 hr, RCSU or hospital Emergency Room

Emergency Custody Order/Temporary Detention Order

CRISIS CALL CENTER

"Someone to Call"

24/7 Staffing
(LMHP, QMHP, Peers, Volunteers)

>

Mobile Crisis Response, Crisis Receiving Centers, Hospitals

of calls resolved on the phone

remaining are core referrals to the other crisis services

MOBILE CRISIS RESPONSE

"Someone to Respond"

- Rapid response, assessment and early intervention to individuals experiencing crisis
- Provided 24/7
- Purpose:
  - Prevention of acute exacerbation of symptoms,
  - Prevention of harm to the individual or others,
  - Provision of quality intervention in the least restrictive setting,
  - Development of immediate plan of safety to help avoid higher level of care

COMMUNITY STABILIZATION

"Bridge to community care"

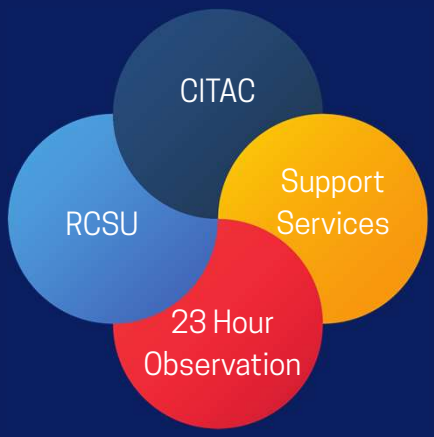
The goal of Community Stabilization services is to stabilize the individual within their community and support the individual and/or support system during the periods

- between an initial Mobile Crisis Response and entry in to an established follow-up service at the appropriate level of care
- as a transitional step-down from a higher level of care if the next level of care service is identified but not immediately available for access or
- as a diversion to a higher level of care

SHORT TERM
NATURAL ENVIRONMENT
REFERRAL AND LINKAGE
COORDINATION
ADVOCACY AND NETWORKING

CRISIS RECEIVING CENTERS

"Somewhere To Go"

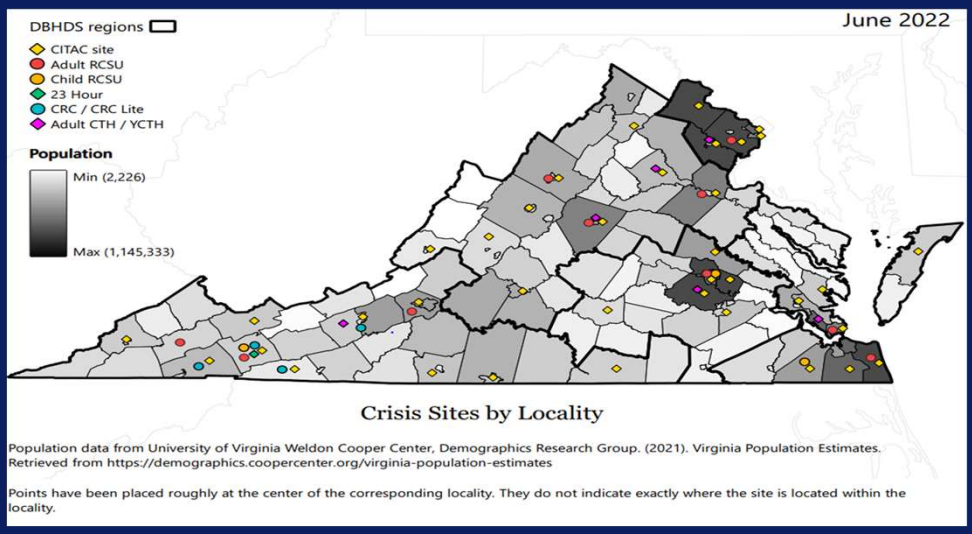


These centers may hold multiple services and act as "behavioral health urgent care" for individuals seeking crisis supports, or for law enforcement drop off for individuals they have in their custody

ASSESSMENT
PSYCHIATRIC EVALUATION
NURSING ASSESSMENT
CARE COORDINATION

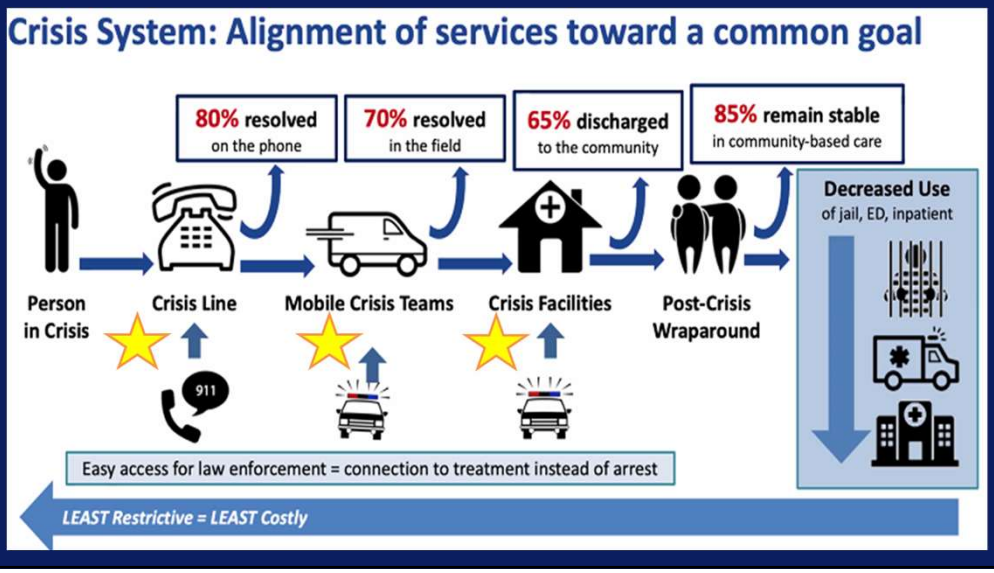
CRISIS SITES BY LOCALITY

System status June 2022



CRISIS TRANSFORMATION

Expected Outcomes



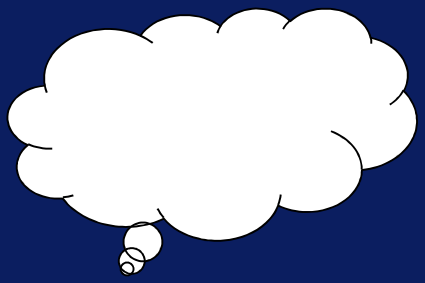
RESIDENTIAL TREATMENT

AN ENVIRONMENT RIPE FOR CHANGE

- There were no changes to the system since inception in 2001.
- DMAS was at risk of losing Federal Financial Participation because there was no assurance that existing teams met CMS requirements.
- Admission, care coordination, and discharge processes did not embrace best practice, focus on client outcomes, or align with Systems of Care principles.

TEST YOUR KNOWLEDGE OF THE IACCT

WHAT DOES IACCT STAND FOR?



- INDEPENDENT ACCESS TO CARE AND COORDINATION TEAM
- INDEPENDENT ASSESSMENT, CERTIFICATION AND COORDINATION TEAM
- INDEPENDENT ACCESS TO CERTIFICATION AND COORDINATION TEAMS
- INDEPENDENT ASSESSMENT, CARE COORDINATOR TEAMS

TRUE OR FALSE?

THE IACCT WAS DEVELOPED TO SERVE AS A SINGLE POINT OF ENTRY FOR YOUTH AT RISK OF ADMISSION TO RESIDENTIAL TREATMENT.

- TRUE
- FALSE

WHO CAN SUBMIT AN IACCT INQUIRY?

- YOUTH'S PARENT/GUARDIAN
- ALL OF THESE
- YOUTH'S PRIVATE PROVIDER
- YOUTH'S SCHOOL
- AGENCIES/SOURCES INVOLVED IN THE YOUTH'S LIFE (I.E. DSS, FAPT/CSA)

MAGELLAN RESIDENTIAL CARE MANAGERS ARE RESPONSIBLE FOR....

- COMPLETING THE IACCT ASSESSMENT
- COMPLETING THE CERTIFICATE OF NEED
- ACTS AS A LIAISON BETWEEN THE FACILITY AND THE FAMILY
- ASSISTING YOUTH, FAMILY/GUARDIAN WITH THE IACCT FROM INQUIRY TO PLACEMENT

TRUE OR FALSE?

RECOMMENDATION MEETINGS ARE HELD FOR EACH IACCT REQUEST.

TRUE

FALSE

WHICH OF THESE IS *NOT* AN IACCT SPECIAL CONSIDERATION?

OUT OF STATE RESIDENTIAL PLACEMENT

RETRO SPECIAL CONSIDERATION

INPATIENT SPECIAL CONSIDERATION

ER FOSTER CARE PLACEMENTS

TRUE OR FALSE?

1:1 SUPPORTS ARE A MEDICAID REIMBURSABLE SERVICE.

TRUE

FALSE

TRUE OR FALSE?

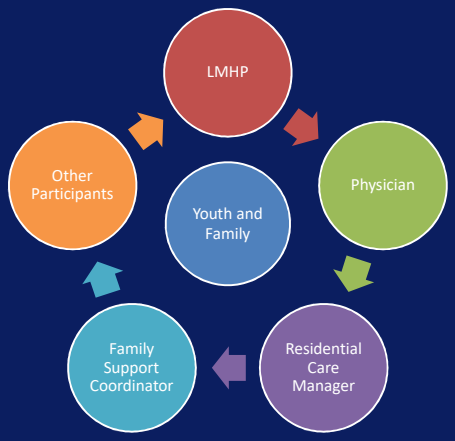
PRTF PROVIDERS CAN NEGOTIATE THEIR CONTRACTED PER DIEM RATE.

TRUE

FALSE

INDEPENDENT ASSESSMENT, CERTIFICATION AND COORDINATION TEAM PROCESS

- Established in 2017 as the single point of entry for youth as risk of admission to residential treatment.
- Youth and family focused system that will match future Managed Care administration structures, oversight and contracting requirements.
- Efficient service model that yields better outcomes to Medicaid recipients using shorter lengths of stay and higher intensity services.
- High touch care coordination that ensures effective programming and a successful return to the community and home settings.
- Involvement of youth and family in all aspects of care; essential to achieving long term outcomes.
- Promote community engagement and tenure, residential needs to be individualized, short-term, and focused on comprehensive discharge plan.



TRANSITION TO NEW FFS VENDOR

CHANGES AND EXPECTATIONS

- DMAS is preparing for the sunset of the current BHSA/FFS contract.
- New FFS vendor's primary focus will be on service authorizations.
- Other functions will be facilitated by DMAS staff.
- Contract has yet to be awarded; provider community will be informed once updates are available.

FEEDBACK ON THE IACCT PROCESS

WE WANT TO HEAR FROM YOU

1. What has been your experience/role with the IACCT process?
2. DMAS submitted a budget package which includes a rate study to re-determine the IACCT rate, what enhancements to the IACCT do you think can add value to the process?
3. What elements of the IACCT works well for you and your team?
4. What elements of the IACCT have you experienced difficulty with and would like more information/training on?

Questions & Feedback

Thank you for your partnership, support and participation.

Additional Questions?

Please contact us at:
Mental Health: enhancedbh@dmas.virginia.gov
ARTS: SUD@dmas.virginia.gov
DBHDS: crisis_services@dbhds.virginia.gov

RESOURCES

Naloxone Resources

- Get trained now on naloxone distribution
  - REVIVE! Online training provided by DBHDS every Wednesday
  - http://dbhds.virginia.gov/behavioral-health/substance-abuse-services/revive/lay-rescuer-training
  - https://getnaloxonenow.org/
    - Register and enter your zip code to access free online training
- Medicaid provides naloxone to members at no cost and without prior authorization!
- Call your pharmacy before you go to pick it up!
- Getting naloxone via mail
  - Contact the Chris Atwood Foundation
  - https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422
  - Available only to Virginia residents, intramuscular administration