



West Virginia
Comprehensive Behavioral
Health Commission

Status Report

November 1, 2007

Submitted to

*West Virginia Legislature
Joint Committee on Government & Finance
Legislative Oversight Commission on Health &
Human Resources Accountability*

Submitted by

*Martha Y. Yalker, Chair
Cabinet Secretary, WV Department of Health & Human Resources*

*Note: This status report reflects the work of the Commission through
November 1, 2007 and serves to provide an update on the Commission's
work progress since the June 2007 report.*

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Background

For your information and acknowledgement of progress being made regarding H. B. 4488 to create a Comprehensive Behavioral Health Commission, I am providing this update report from the Comprehensive Behavioral Health Commission for your review. As described in the June update, it is important to note the process approach adopted by the Commission. The Commission determined early in its work that a collaborative process that engaged those most involved in the system from across the state would be vital to the long-term acceptance of any 'new' or improved system. Therefore, the Commission previously spent more time, up front, developing an approach that would garner the volunteer resources and assistance of 'experts' from every facet of the current behavioral health system. We have been very gratified at the response and active involvement of over 150 professionals from higher education to rural-based clinicians.

The Commission and its Advisory Board continue to work hand in hand to maintain a working environment that brings out the best in working relationships among the participants and that will hopefully bring lasting positive change. I am very pleased with the on-going dedication of the many professionals who are volunteering their time to be part of the working groups. Our data shows approximately a dozen or more attend each working group meeting. Further, through leveraging technology, there is significant e-mail, on-line surveys and fax traffic that helps keep more people engaged.

Senator Jon Blair Hunter and Delegate Bobbie Hatfield continue to provide support to the Commission's work. Having legislative representatives staying involved is vital to our overall success. As Chair of the Advisory Board, Dr. John Linton continues to work diligently to bring a diverse set of opinions together. Our Commission co-Chair, Dr. Ahmed D. Faheem, also is very active, not only in the Commission meetings, but with the working groups as well. We appreciate all Commission and Advisory Board members for their commitment.

The leadership of BHHF, under Commissioner John Bianconi, has also contributed to all the working groups in support of Commission work. As mentioned in June, concurrent with the Commission work, BHHF has been undertaking a number of targeted initiatives focused on improving the behavioral health system within state government. Note: Please see the later section in this report that lists some of this work.

This report is intended to provide an update since the June Status Report. Highlights from that report will be summarized.

Commission Meeting Schedule

Since forming, the WVCBHC has held seven full meetings with the Advisory Board attending including a special 'kick-off' meeting for its working groups. The meeting dates were: October 11, 2006; January 9, 2007; February 13, 2007; March 13, 2007; May 8, 2007; July 10, 2007; and, September 26, 2007.

For additional information including notes from meetings, position papers, research, etc., visit the Commission's website at www.wvcbhc.org.

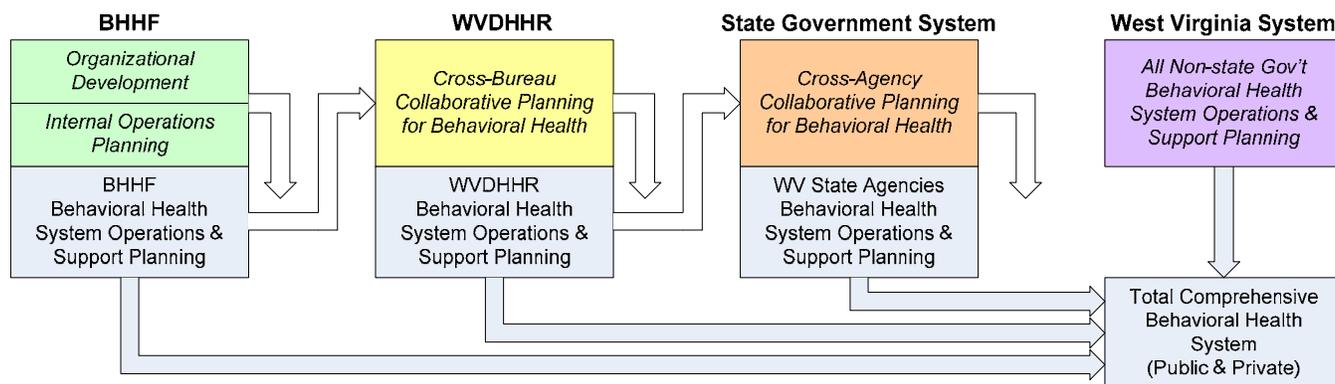
The WV Behavioral Health System

In assembling the Commission, Advisory Board, and Working Groups, much attention and effort was given to including members of the entire West Virginia Behavioral Health System. As seen in the diagram below, this includes members of BHHF; other WVDHHR agencies; other State government entities such as Criminal Justice and the Court System along with non-government organizations such as private hospitals, practitioners, support and advocacy groups. Reflective of the actual system, less than 25% of the working group members are state employees.

It's important to note that the Commission believes the Legislature's intent, as contained in H.B. 4488, was to look at a comprehensive behavioral health system, not just the state portion of it. Therefore, the working groups are reviewing all aspects of behavioral health in West Virginia.

Realizing Our Potential: Transforming West Virginia's Behavioral Health System

Comprehensive System through Collaborative Planning



Working with Principles

The Commission continues to focus on the initial set of values regarding the West Virginia behavioral health system. As outlined early in its work, the Commission stresses these values as the foundation of the comprehensive behavioral health system for West Virginia:

1. Quality, above all, and in every aspect of the system.
2. A collaborative, integrated and fully-accessible system that promotes true inclusiveness.
3. Sincere respect for the consumer with no place for stigma.
4. A holistic approach, body & mind, that positions behavioral health within overall health status.
5. Strong community-based presence across all aspects of the system.
6. Care provided in the most appropriate settings for the identified need.
7. A responsive system that observes open communication in all directions.
8. Financial resources that assure a viable system for all, especially those in need.
9. Evidence-based practices as a cornerstone of an effective and productive system.
10. Accountability through appropriate performance measurements and outcomes reporting.

Working Group Progress

The working groups have continued working after reporting analysis of the current system in May. Since the June update, the working groups held an average of 2-3 meetings each in order to accomplish their immediate goals to: 1) extract and prioritize the most important issues/opportunities to be addressed; and, 2) develop recommendations for an improved, comprehensive behavioral health system in West Virginia. The People/Populations and the Program/Clinical working groups have been meeting jointly since a number of issues overlapped.

Guest Speaker Presentation: Ron Manderscheid, PhD

Dr. Ron Manderscheid provided significant content at the Joint Commission/ Advisory Board meeting in July. Dr. Manderscheid has extensive background in the area of mental health and gave a well-received, detailed overview of the current state of Behavioral Health framed within the work the Commission is undertaking. He responded to questions and helped lead a discussion on a number of topic areas. A copy of his background and power point presentation can be found on the Commission's website.

Dr. Manderscheid also provided some key references that have been uploaded to the Commission's website or referenced on the site. Going forward, he offered his assistance to the Commission, as appropriate.

Commission Related or Influenced Activities

A number of activities and initiatives related to the efforts of the Commission and working groups are also gaining momentum. Some of these are the result of the overall attention from the Commission on the topic areas. A brief description of selected activities follows:

1. Public Consulting Group (PCG) Studies

- Behavioral Health System Redesign: Quality Management (final draft report submitted September 2007 and is currently being reviewed).
- A report on West Virginia's state facility psychiatric inpatient bed crisis and options for developing forensic placement alternatives has been drafted and is being reviewed.

2. Strategic Planning Process for BHHF/OBHS (Joint Team of PCG and CESD)

- Design and Oversight Planning Team (DOT) - nominated by BHHF Leadership Team - Representatives from the facilities/divisions/support staff started meetings in August.
- Explore the best design for carrying out an effective organizational development and strategic planning process. This will assess the changes needed in BHHF for the future based on Commission recommendations by engaging the entire organization in the process.

3. Behavioral and Primary Health Care Together: Illustrations of how it's done in West Virginia

- Behavioral Health/Primary Care Integration Forum was held September 18th and 19th - Phil Schenk (Advisory Board member).
- Partnership between Primary Care Association; Behavioral Health Providers Association; BHHF

Target Audience - Commission/ Advisory Board; State Legislators; Health Policy Makers; Persons in Behavioral Health and Primary Care

4. *Two Proposals Exploring Integration*

- West Virginia Pilot Integrative Primary Care/Community Mental Health Clinic Care
- Collaboration of West Virginia University School of Medicine/Psychiatry and Valley Health Care Systems in Morgantown

5. *Meeting with Senior Advisor to HRSA (Human Resource Service Administration) and Director of Public Health Corp to discuss proposal (Ron Manderscheid, John Bianconi, Dr. Jim Stevenson & Scott Graham)*

6. *Forum on Evidence-Based Practices (held at Civic Center in Charleston)*

- Approximately 170 participants discussed definitions and the key components of evidence-based practices. The perspective and expectations of stakeholders were a part of this work which looked at different models and projects regarding evidence-based practices.

Key Issues Development

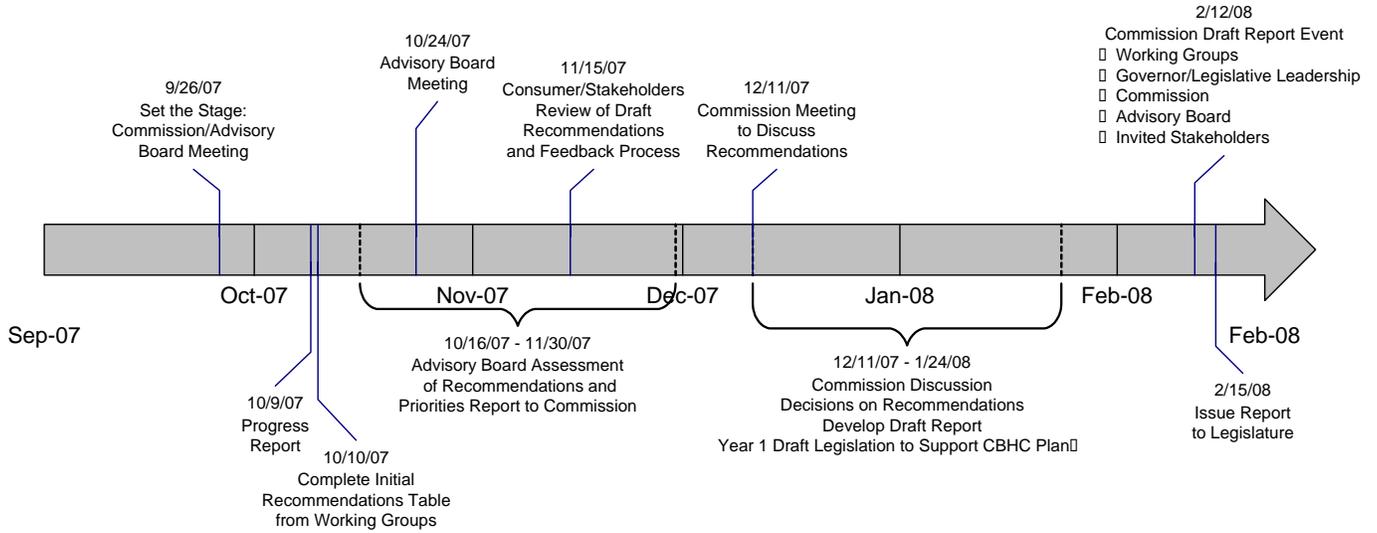
Based on the general trends in behavioral health, the visioning and guiding principles work of this Commission and key issues emerging from the Commission's working groups, a special *Key Issues Discussion Handout* (see attachment 1) was prepared and distributed to those present at the July meeting. In table format, this document identifies a critical topic or issue and lists discussion points for each. As explained to those in attendance, the purpose of the discussion table was to encourage Commission and Advisory Board members to begin to learn more about key areas needing attention as part of the outcomes of the Commission. The topics/issues listed in some cases contrast with what is in place today or there may be more than one approach to implementation. The topics/issues were further discussed in the September 2007 meeting.

Next Steps

Recommendations are being developed by each working group through a combination of facilitated online surveys, conference calls, email exchanges, and meetings. Working groups were given substantial flexibility in terms of the number and timeframe for their recommendations.

As seen in the diagram below, the Commission expects to issue its report to the Legislature in February 2008. To reach that point, the working groups will provide their recommendations to the Advisory Board. The Advisory Board will then review, incorporating comments, and prepare a "Priorities Report" to the Commission. The Draft Report will bring together the working group members and other stakeholders for a review of the report prior to its issuance to the Legislature.

WVCBHC Recommendations/Report Timeline



Draft as of 9/26/07

Closing

While there is still much work to be done, I am genuinely pleased with the progress, energy and dedication of so many individuals. One significant outcome of the Commission's work will be the lasting working relationships being built as part of this process.

Attachment 1
Key Issues Discussion Handout

Topic/Issue	Topic/Issue Background Information
1. Evidence-based practices	<p>The groups support the evolution of evidence-based practices and promising practices in the provision of behavioral health services statewide. In general, it is felt that facilities and providers utilizing properly framed and implemented evidence based and promising practices should be encouraged both by policy and reimbursement.</p> <p>State investment in differential reimbursement of qualified use of evidence-based practices and payment for non-medical-model supports and services would be beneficial. At the same time, reimbursement of pharmacological management and pharmaceuticals could be increased, particularly for those providers willing to utilize evidence-based medication algorithms.</p>
2. Holistic approach	<p>A holistic approach to health care is supported by the working groups. Integration of behavioral health into primary care and other health care settings is one model of service provision. Other models can also be functional. Regulatory and reimbursement barriers to primary care/behavioral health integration need to be addressed.</p>
3. Prevention and early intervention	<p>Prevention and early intervention programs are an investment in the health of our future generations. Prevention activities, early identification programs and school-based mental health activities need to be available and accessible across the state. More emphasis should be placed on funding these programs and rebalancing health care investment.</p>
4. Community based	<p>Behavioral health care needs should be identified at a local level and unique to each community. Health care policy and investment decisions should be local but based on data derived from reliable and valid sources.</p> <p>Investments in health care need to be community investments derived from a variety of sources including state, federal, and local entities. The State should carefully consider its appropriate role in service provision. Services which can be more skillfully and economically provided by the private sector should be operated as such. The State is, however, the default provider of services and should be prepared to assume that responsibility as necessary.</p> <p>The State should begin to identify resources for community-based treatment of children and families and older persons. The State should investigate practices that force it to take custody of children simply to afford them access to Medicaid or IV E reimbursed residential services. Families, as they are able, should have participation in decisions regarding children and in the therapy of the children/youth. Early identification and intervention is essential, which would require adequate funding of school-based programming. Older persons will require social day care, respite, and other support services in order to remain in their home environments amidst their families. In the long term, this will result in reduced usage of extended care in residential facilities and therefore cost savings.</p>

Topic/Issue	Topic/Issue Background Information
5. Electronic health records	Electronic health records (EHR) may be the basic unit of communication between health care providers of the future. The State should make an investment in the development of infrastructure at all levels and should be proactive in inclusion of the private practice community in such development. Regulatory issues should be addressed in facilitating and requiring capacity for EHR for all health care providers.
6. Workforce	<p>The State of West Virginia’s behavioral health system is facing a serious workforce crisis at all levels of training and expertise, including nursing, medicine, direct care, and professional therapy. The State should invest in training the providers of the future. Cost effective methods of providing quality services should be identified. Regulatory barriers to efficient use of personnel resources should be addressed. Some entry level job positions requiring less training and investment may be necessary. Peer support reimbursement should be explored.</p> <p>A survey conducted by members of the Workforce Development working group revealed that low salaries and low morale in the workplace are also issues that should be addressed.</p>
7. Alternate funding sources and integrated funding	Government agencies should work collaboratively in order to take advantage of all available funding sources and manpower resources. Creative, outcome-based approaches to braiding and blending funding sources, manpower resources, and treatment modalities should be utilized, which will require changes in regulatory and fiscal strategies.
8. Accountability	The Department should hold contract agencies and Medicaid-enrolled providers accountable for providing treatment and supports that result in improved quality of life for consumers. This will require alterations in reimbursement, monitoring and data management activities.
9. Integrated programs	The Department of Health and Human Resources (DHHR) should work in concert with the Supreme Court of Appeals, Juvenile Services and the Division of Corrections to identify and appropriately manage individuals with behavioral health needs who come to the attention of the court system. Community based Drug Courts, Mental Health Courts and Day Reporting Centers are resources to be encouraged statewide, which will likely require Legislative funding for many communities as these programs are currently fiscally dependent on transient federal and local funding and judicial interest. It may be recommended that a state forensic facility be funded and developed for individuals found incompetent to stand trial or not guilty by reason of mental illness and those in the correctional system experiencing treatable behavioral health problems.
10. Co-occurring disorders	Co-occurring substance abuse, health and mental health disorders should be screened for, identified and addressed in all treatment environments. The State and its consumers of health services should address the separate treatment silos for mental health, health and substance abuse disorders. This approach should extend to all provider types including primary care and private health practitioners, as much as possible. All should be trained and sensitized to mental health and substance abuse issues. Funding silos should be addressed.

Topic/Issue	Topic/Issue Background Information
11. State codes	<p>The State’s behavioral health code (Chapter 27 and others) should be revisited. Regulatory and oversight authority for the comprehensive behavioral health centers, the Bureau for Behavioral Health and Health Facilities and the Office of Health Facility Licensure and Certification should be clearly addressed.</p> <p>Issues involving commitment should be explored, particularly with regard to individuals under age 18. In addition, the Certificate of Need (CON) process should be examined with regard to behavioral health and the effect of the CON process in potentially reducing choice for consumers.</p>
12. Coordination of care	<p>The health care system is complex and difficult to navigate for consumers and families. While there should be no wrong door in terms of entering the system, resource coordinators or other mechanisms should be available to assist consumers in identifying resources and entitlements, selecting treatment providers and when necessary, completing documentation and application to obtain necessary services. The State should develop a certification process for resource coordinators, who should be independent of any provider entity. Resource coordinators could act as advisors and advocates to consumers and family members and should be knowledgeable of community and statewide resources and providers. Reimbursement mechanisms, data management and electronic health records will be extremely beneficial to fully implement this recommendation, in addition to a certification management and maintenance entity. Training of resource coordinators should occur at the university level and be continuous as new programs and funding resources emerge over time. Continuing education should be a requirement for certification.</p>
13. Consumer focused	<p>Consumers should have choices in behavioral health providers and to the maximum extent possible, should be able to select from an array of high-quality, appropriate, affordable and accessible services and supports. Peer supports and recovery-oriented treatment approaches are essential pieces in the habilitation and maintenance of individuals with enduring behavioral health challenges.</p> <p>Need smooth flow of consumers through the system.</p>
14. Forensics commitment	<p>The forensic population has increased from 16 patients in FY96 to 110+ in FY07. Ninety of these individuals are cared for in Sharpe and Bateman Hospitals with the remaining patients being cared for in transitional facilities for the forensic population or are on a “wait” list. This trend is placing the facilities in jeopardy of losing their DSH funding. Due to the increasing trend of the forensic population, it is necessary to add forensic beds to the total current bed capacity in our system.</p>
15. Civil commitments	<p>The civil commitment population has also shown increases over the years. In FY96, civil commitments were 157 and increased to 228 in FY07. Because the forensic population has increased so dramatically and because we do not “divert” the forensic population, we are required to care for those civilly committed in a “diversion facility”. This increased census is causing an over-bedding issue in our psychiatric hospitals and as well as additional fiscal responsibilities to our budget and liabilities to the State.</p>

Topic/Issue	Topic/Issue Background Information
16. MR/DD (Behavioral Health)	<p>Individuals with Mild MR/DD and Mental Illness or behavioral conditions are not eligible for services through WV's current system (ICF/MR and MR/DD Waiver). Many of these individuals need supportive services or some level of supervision to live independent and productive lives in the community. Intensive case management and other support services are not available to the individuals and they can become vulnerable to institutionalization or incarceration due to their inappropriate behaviors or manifestation of their mental illness.</p> <p>The State should develop some means of in-home supports, medication management, skills training and monitoring for this group. This could be achieved by developing a "Supports Waiver" or services under a 1915i Waiver through the DRA. This level of support would not necessarily be 24/7 in nature but have the ability to provide the supports need to keep people in the community.</p> <p>There are several individuals with MR/DD and either mental illness or severe challenging behavior who at times can be a danger to themselves or others and are currently in one of two State psychiatric facilities. They may be a MR/DD Waiver participant or have been in an ICF/MR but no current provider is willing or unable to serve them.</p> <p>The State needs to look at various options to serve these individuals, either by recruiting new providers or modifying the current rate structure to pay according to severity. The State needs to strengthen requirements for staffing expertise in Positive Behavior Supports and co-occurring MR/MH conditions.</p> <p>The State needs to better assess individuals with these conditions and also treat the individuals while at the state facilities to prepare them to function in the community.</p>