CHIPAC

Children's Health Insurance Program Advisory Committee of Virginia

Quarterly Meeting

December 7, 2023

Real-time Remote Captioning

- Remote conference captioning is being provided for this event.
- The link to view live captions will be pasted in the chatbox.
- You can click on the link to open up a separate window with the live captioning.

Meeting Notice – Public Access

- This meeting is being held virtually.
- There will be a public comment period at the close of the meeting (~3:00 PM).
- The meeting is being recorded.

Roll Call

Organization	Name
Virginia Department of Social Services	Irma Blackwell
American Academy of Pediatrics – VA Chapter	Dr. Susan Brown
Virginia Hospital and Healthcare Association	Kelly Cannon
Virginia Community Healthcare Association	Martha Crosby
Virginia Association of Health Plans	Heidi Dix
Center on Budget and Policy Priorities	Shelby Gonzales
Voices for Virginia's Children	Emily Moore
Virginia Department of Education	Amy Edwards (sub for Alexandra Javna)

Roll Call

Organization	Name
Joint Commission on Health Care	Estella Obi-Tabot (interim)
Virginia Department of Health	Jennifer Macdonald
The Commonwealth Institute for Fiscal Analysis	Freddy Mejia
Virginia League of Social Services Executives	Michael Muse
Virginia Health Care Foundation	Emily Roller
Dept. of Behavioral Health and Developmental Services	Hanna Schweitzer
Medical Society of Virginia	Dr. Nathan Webb

Leadership and Membership Update and Actions

- Discussion of committee leadership transition
- New member nominees:
  - Kenda Sutton-EL, Birth in Color
  - Sarah Bedard Holland, Virginia Health Catalyst

Meeting Agenda

- CHIPAC Business (1:00-1:15)
- Virginia Medicaid Unwinding Update (1:15-1:40)
- DMAS Policy and Program Updates (1:40-1:50)
- Cardinal Care Update (1:50-2:15)
- DBHDS Update - School Mental Health Pilots (2:15-2:45)
- Agenda Items for March 7, 2024 CHIPAC Meeting (2:45-2:55)
- Public Comment (2:55-3:00)

CardinalCare
Virginia's Medicaid Program

Virginia Medicaid:
Ending Continuous Coverage Requirements and the Return to Normal Enrollment

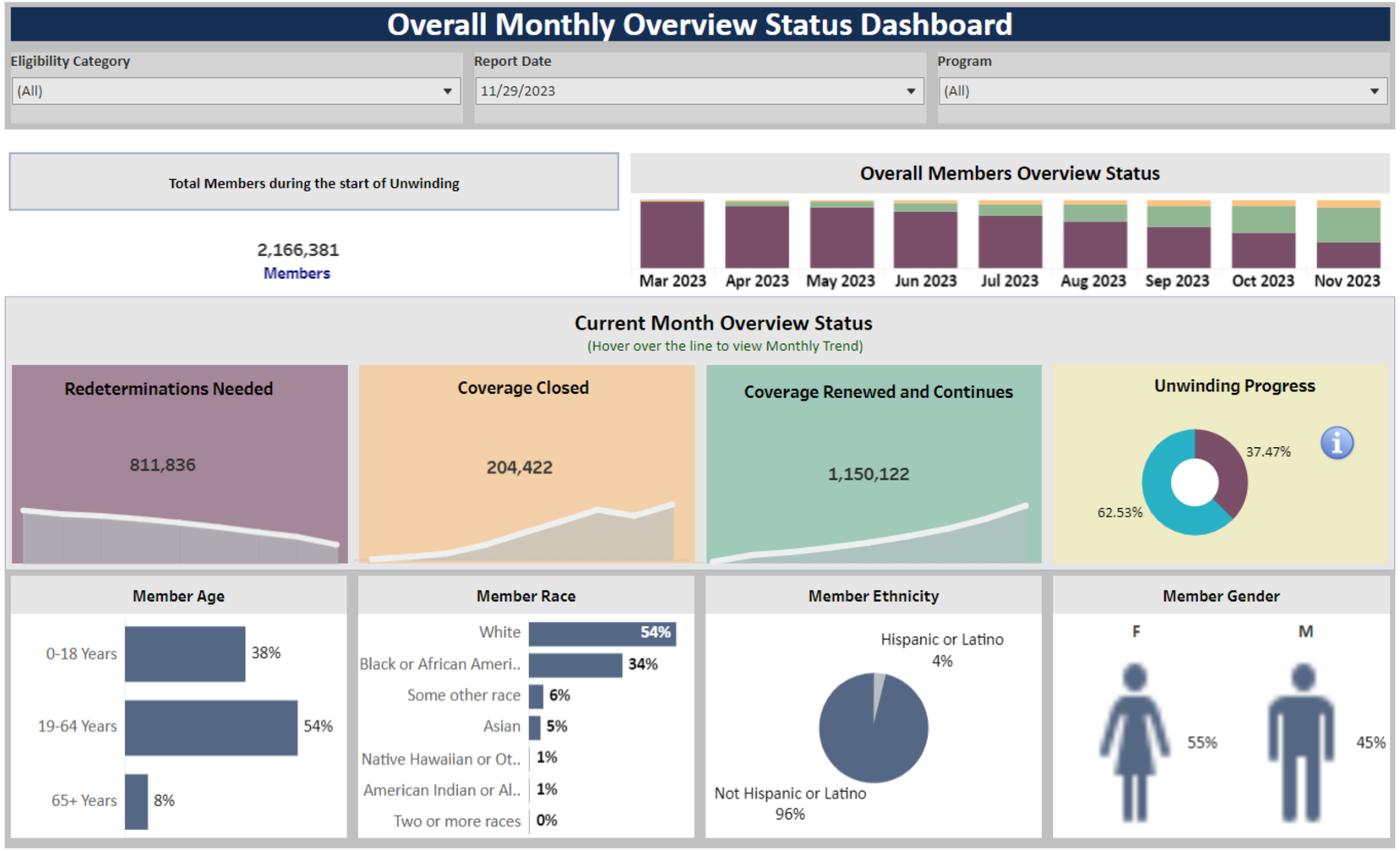
Department of Medical Assistance Services

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

COVER VIRGINIA

DMAS

Unwinding Dashboard



*** The dashboard was refreshed on 11/29/2023 – 204,422 members were closed, and 1,150,122 members were renewed with ongoing coverage.**

Members Determined as of 11/29/2023*

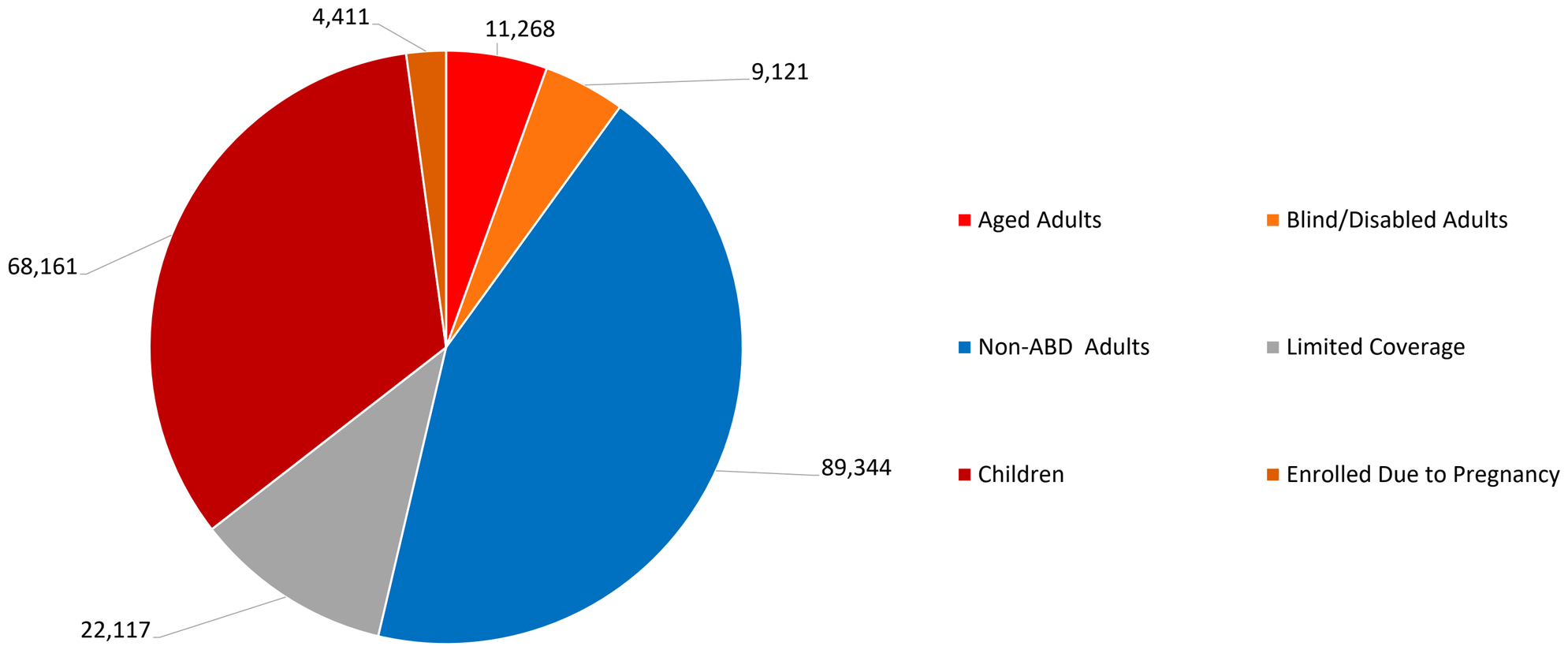
Completed by Member
2,166,831
2,000,000
1,900,000
1,800,000
1,700,000
1,600,000
1,500,000
1,400,000
1,354,544
1,200,000
1,100,000
1,000,000
900,000
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000

More than 62% of members have been determined, with 53% of members remaining enrolled.

Top Closures by Eligibility Grouping:

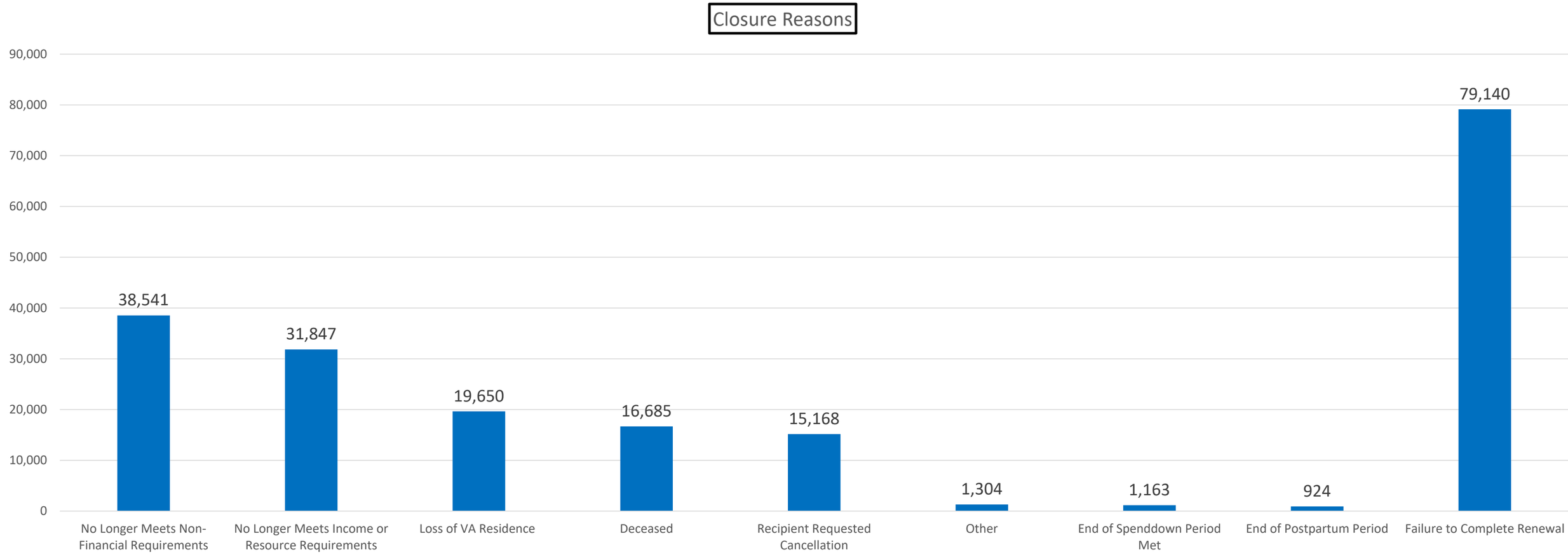
Closures through 11/29/2023

The highest closures have occurred among non-disabled adults between the ages of 19-64, followed by children, and then those enrolled in limited coverage such as Medicare Savings Plans, Plan First (family planning coverage), Incarcerated Coverage, and Emergency Medicaid.



Top Closure Reasons – Closures through 11/29/2023

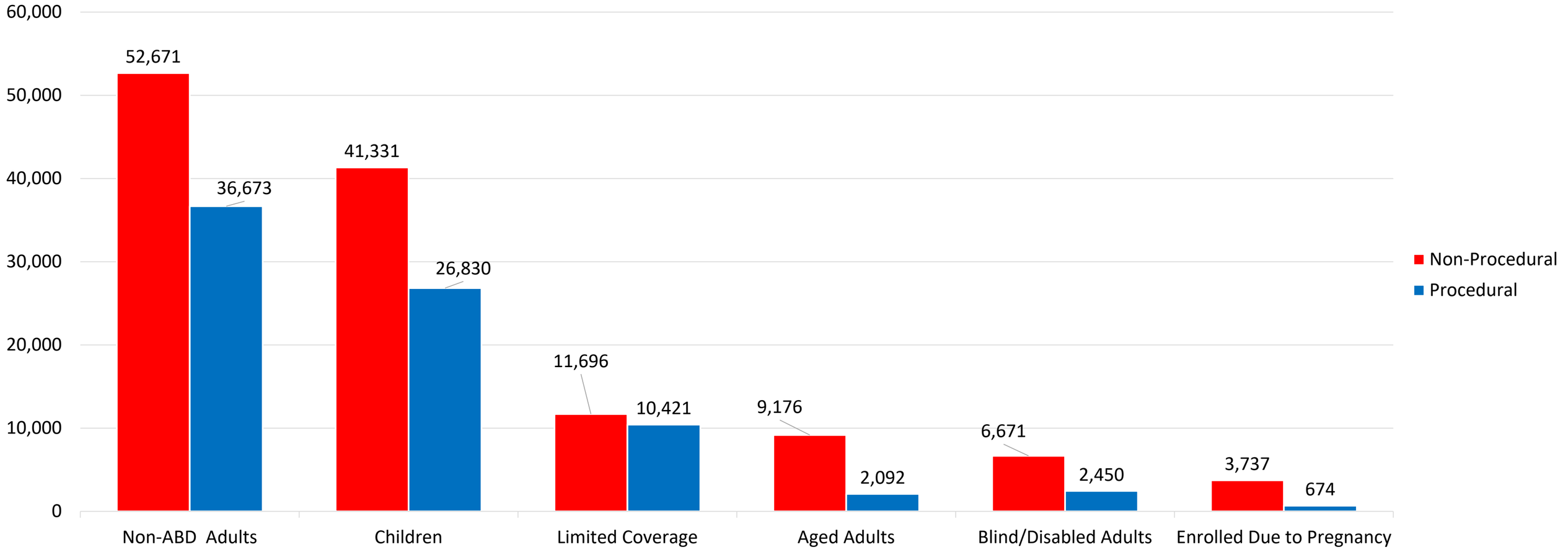
While November marks the ninth month of unwinding, the first month renewals were due in Virginia was May 2023. Redeterminations that were received in April were processed, however, April did not include closures for failure to return Medicaid renewal packets. As of 11/29/2023, 125,282 members were closed for non-procedural reasons (ineligible) and 79,140 members were closed for procedural reasons (did not return a renewal form or verifications needed to determine eligibility). This total is through unwinding out of the 2,166,381 members identified in the unwinding cohort.



Procedural vs. Non-Procedural Closures by Eligibility Grouping:

Closures through 11/29/2023

The highest closures have occurred among non-disabled adults between the ages of 19-64, followed by children, and then those enrolled in limited coverage such as Medicare Savings Plans, Plan First (family planning coverage), Incarcerated Coverage, and Emergency Medicaid.



Additional Unwinding Data – Automated Ex Parte Rates

Baseline numbers are pre-March 2020.

	Baseline		March 2023		April 2023		May 2023		June 2023	
	Cases	Members	Cases	Members	Cases	Members	Cases	Members	Cases	Members
Number Picked Up	64,000	80,000	121,604	210,145	96,521	168,173	115,260	200,604	119,444	218,310
Number Successful	32,000	40,000	83,776	135,402	25,541	44,931	29,493	52,438	32,549	57,641
Percent Successful	50%	50%	68.9%	64.4%	26.5%	26.7%	25.6%	26.1%	27.3%	26.4%
Packets Sent*	32,000		36,488		68,377		82,872		83,669	

	July 2023		August 2023		September 2023		October 2023		November 2023	
	Cases	Members	Cases	Members	Cases	Members	Cases	Members	Cases	Members
Number Picked Up	113,542	205,374	110,909	181,751	103,551	163,215	92,263	152,878	88,279	154,456
Number Successful	47,747	78,786	61,040	94,139	62,566	105,565	43,745	82,117	38,657	79,995
Percent Successful	42%	37.8%	55%	51.8%	60.4%	64.7%	47.4%	53.7%	43.8%	51.8%
Packets Sent*	63,802		47,968		39,366		46,021		47,534	

*One packet is sent per household including all members.

Thank you to all partners across the Commonwealth who are working to support the efforts to ensure a smooth transition back to normal processing.

12 Month Continuous Eligibility (CE) for Children

- Effective January 1, children in Medicaid and FAMIS will remain enrolled for a 12-month protected coverage period, regardless of changes in circumstance.
- Limited exceptions:
  - Turning age 19,
  - Moving out of state,
  - Member/representative requests termination of coverage,
  - Eligibility erroneously granted due to agency error or fraud/abuse/perjury,
  - Death of the enrolled child.
- Medicaid children remain in Medicaid and may not be moved to FAMIS during the CE period.
- FAMIS children may be moved to Medicaid coverage if they qualify, but they cannot be disenrolled during the CE period.
- Obtaining other qualifying health coverage is not an exception to the CE requirement for FAMIS children.

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CARDINAL CARE MODEL OF CARE OVERVIEW AND COMPARISON WITH CURRENT PROGRAM RULES

December 2023

Presented by Lynne Vest and Jeannette Abelson

VIRGINIA'S MEDICAID PROGRAM
DMAS

Cardinal Care is a single brand encompassing all health coverage programs for all of Virginia's Medicaid members.

Background

- As part of the 2021 Appropriations Act, DMAS was directed to merge our two managed care programs, Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus), in a manner that links seamlessly with the fee-for-service program.
- DMAS's strategy to achieve these legislative directives was implemented in phases, including the initial phase to rebrand as Cardinal Care in January 2023, while working closely with the Center for Medicare and Medicaid Services (CMS) to receive federal approval to consolidate the two managed care waivers and contracts.
- Cardinal Care is DMAS's program name that includes all Medicaid, FAMIS, and Plan First members, and includes members served through managed care and fee-for-service delivery systems.
- DMAS received approval from CMS to consolidate the Medallion 4.0 and CCC Plus programs under Cardinal Care Managed Care – effective October 1, 2023.
- Cardinal Care Managed Care provides a strong foundation for the Governor's priority initiatives, including *Right Help Right Now* and the managed care procurement.

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Facts about Cardinal Care Managed Care

- Cardinal Care Managed Care (CCMC) includes all existing managed care populations and services.
- Medallion 4.0 and CCC Plus enrolled members have already transitioned seamlessly to CCMC.
- CCMC Members remain enrolled with their current managed care organization (MCO) and can continue to see their doctors and other providers.
- Full implementation of CCMC may require up to 60 days from October 1, 2023.
- DMAS will phase-out use of the CCC Plus and Medallion 4.0 managed care program names over time.
- The CCC Plus home and community-based services (HCBS) Waiver will continue to operate as the CCC Plus HCBS Waiver.
- CCMC improves continuity for members who will no longer need to transition between two managed care programs.
- Overall, this continuity will result in greater efficiency; full alignment may require process changes as described in the next slides.

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Cardinal Care Managed Care Benefit Alignment

Coverage under Medallion 4 and CCC Plus varied slightly for the services listed below. CCMC will align coverage for these services effective November 1, 2023. Providers should follow the existing process for the following services, until November 1, 2023.

1. Hospitalized At Enrollment – Under Medallion 4 rules, managed care enrollment was delayed until the member was discharged from the hospital. CCMC aligns with CCC Plus rules, and CCMC eligible members who are in the hospital at the time of initial MCO enrollment will enroll in CCMC managed care. Hospitals continue to bill inpatient DRG admissions as they do today, i.e., claims should be submitted to the entity (FFS or MCO) with whom the member is enrolled at admission; the entity at admission is responsible for hospital DRG from admission to discharge.
2. Newborn Enrollment – Under CCC Plus, newborns of CCC Plus mothers were first enrolled in fee-for-service prior to enrolling in managed care. CCMC aligns with Medallion 4.0, so that newborns of CCMC mothers will have coverage through the birth mother's MCO for at least the birth month plus two-additional months timeframe, which has been in place under Medallion 4.0 for many years.
3. LTSS and Hospice Services – Under Medallion, members who needed LTSS or hospice were disenrolled from the MCO to fee-for-service before re-enrolling in managed care. CCMC aligns with CCC Plus so that managed care populations who elect hospice benefits or enroll in long-term care programs will not be disenrolled as they were in Medallion 4.0.

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Cardinal Care Managed Care Populations

Includes the same populations participating in the CCC Plus and Medallion 4.0 Programs

Nearly 2 million managed care members

- Newborns
- Infants
- Children
- Pregnant women
- Caretaker adults
- Older adults
- Disabled children
- Disabled adults
- Medicaid expansion adults
- Individuals with Medicare and Medicaid (full-benefit duals)

Excludes the same populations who are excluded from the CCC Plus or Medallion 4.0 programs

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Cardinal Care Managed Care Services

Includes the same services provided in the CCC Plus and Medallion 4.0 Programs

Medical, preventive and behavioral health services; addiction and recovery treatment services (ARTS); maternal, newborn, and infant services; transportation; hospice; and long-term services and supports (LTSS) in community and nursing facilities.

Participants in the Developmental Disability (DD) Waivers are included; however, DD Waiver services are carved-out and paid through DMAS

Continues to carve out dental services, school health services and LTSS screenings.

Excludes psychiatric residential treatment services

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Cardinal Care Managed Care Improvements

Single Managed Care Contract and Waiver

Preserves Continuity of Managed Care Enrollment

Responsive Model of Care

Aligned Open Enrollment

Enhanced Accountability & Oversight

Cardinal Care Branding & Communications

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Provider Contracting and Billing

- Providers will continue to contract with same six MCOs.
- Continue to use the same service authorization and billing processes for fee-for-service and MCOs, unless notified of a specific change.
- Continue to check Medicaid eligibility. As we transition to Cardinal Care, the program names (CCC Plus and Medallion 4.0) will be phased out starting on January 1, 2023. DMAS eligibility verification systems (ARS and Medicall) will reflect managed care enrollment as “MCO.” The member’s MCO information on ARS will not change.

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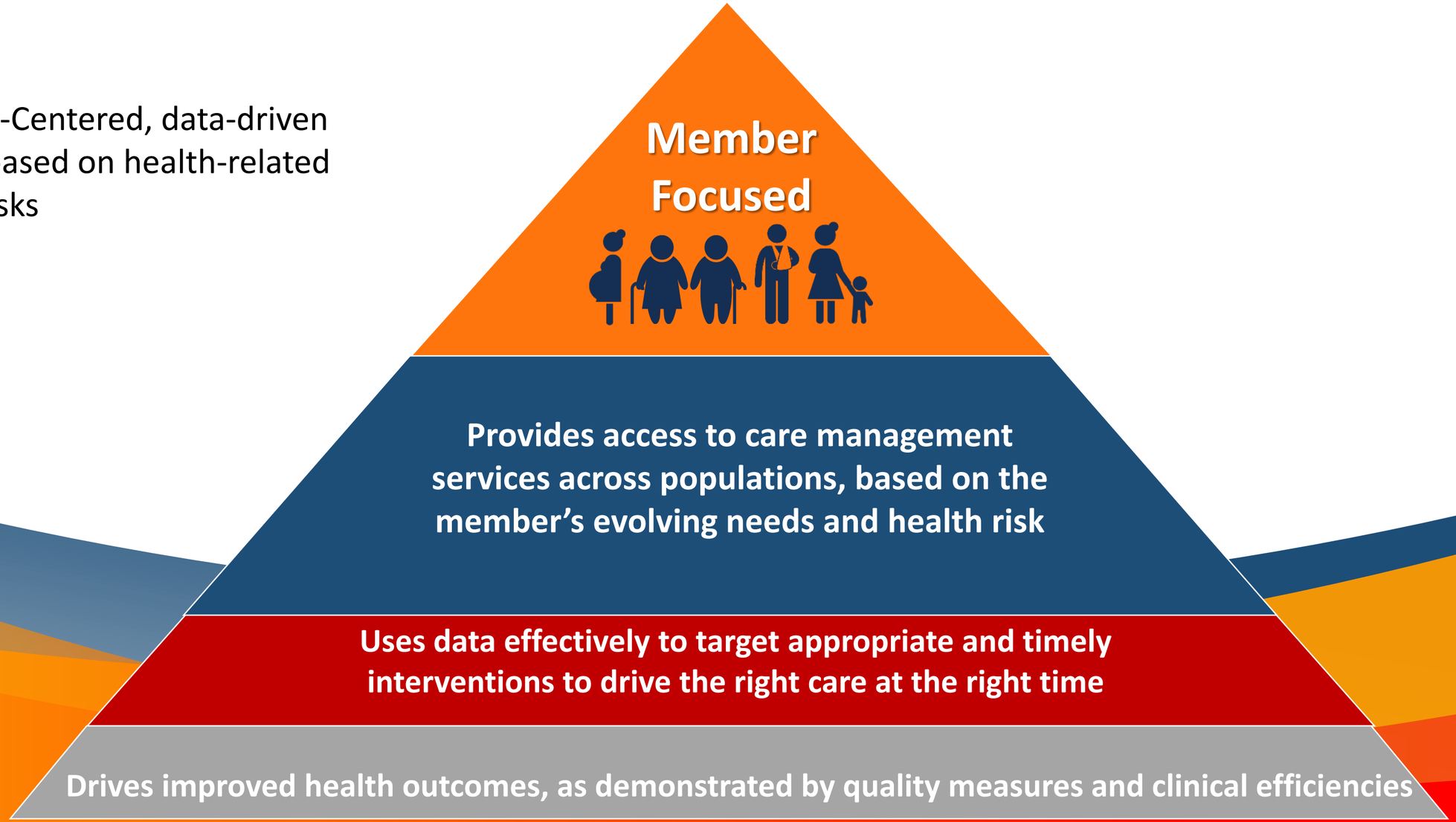
Cardinal Care Model of Care

Responsive Model of Care

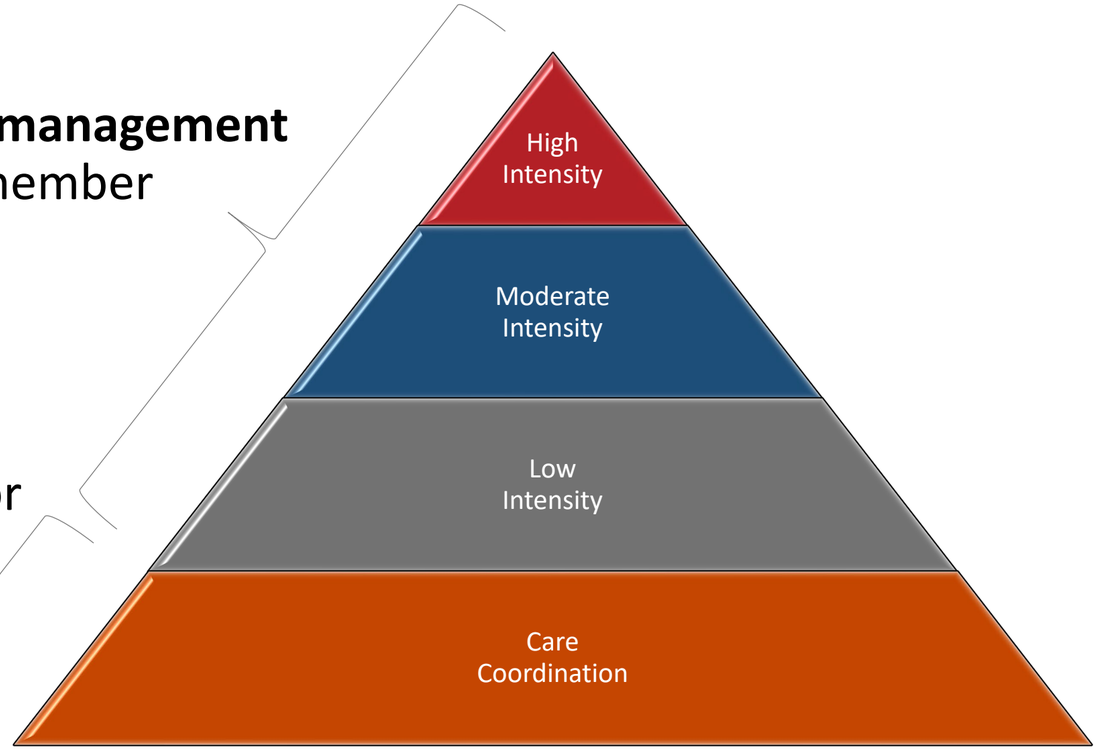
Member-Centered, data-driven model, based on health-related needs/risks



Care Management Intensity

Three levels of care management intensity based on member needs/risks

Care coordination for members with minimal needs



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Care Management Components

MCO care managers partner with providers on behalf of members with significant health needs to:

- Support the member's choice to reside in the least restrictive environment
- Facilitate successful transitions between levels of care and settings
- Provide comprehensive health risk assessments
- Develop comprehensive member-centered care plans
- Provide for interdisciplinary care team collaboration, participation and communication
- Engage the provider's expertise/ability to promote quality, etc.
- Collaborate with involved parties to ensure the member's health, safety and welfare
- Establish wrap-around community support services, addressing social determinants of health

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Overview of the Cardinal Care Model of Care Design

Key Features of the Model of Care

- ✓ Includes **priority populations** from CCC Plus and Medallion
- ✓ Leverages MCOs **advanced analytics** and methods to target data-informed solutions for identifying and stratifying populations by member need/level of risk.
- ✓ Allocates care management resources **equitably across populations** based on the member's need and risk level, with special attention to the Commonwealth's most vulnerable populations (such as vent-dependent populations)
- ✓ Supports right care, right place, right time
- ✓ Maximizes use of limited care management resources
  - Assigns elements of care coordination (MMHS, HRA, ICP/ICT, etc.) as appropriate **by need and risk level**
  - **Makes ICT meetings required only on an as-needed basis (at a Member's or Care Manager's discretion) for members in low and moderate intensity care management**
  - Considers **movement of members between risk and intensity levels**, especially based on health related, triggering events as a member's needs evolve over time
  - Allows MCOs the flexibility to use an abbreviated HRA in response to triggering events or interim contacts
  - Allows MCOs the flexibility to use telephone or video conference to administer the MMHS, HRA and develop the ICP. The MCO is, however, required to conduct the HRA in-person for Members in High Intensity CM
  - Provides flexibility to not require the assigned care manager to do the HRA for in-person visits (except for vent dependent members)
- ✓ Broadens staffing qualifications for most Care Managers to include a range of social worker and mental health professional designations (to include LMHPs, RN/LPNs, QMHPs, LMSWs, LBSWs, MSWs or BSWs, as appropriate); continues to allow bachelors in health and human services
- ✓ Links with quality outcomes and clinical efficiencies

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Summary of What Changed/Stayed the Same

SAME

- Focus is on the same vulnerable populations from CCC Plus and vulnerable complex populations from Medallion
- Same covered services
- Same Screening (MMHS)
- Same HRA elements
- Same ICP process
- Maintains the unable to contact provisions (plans are not held accountable for member behavior, such as unable to locate/refusal)
- Maintains person-centered care planning
- Maintains face to face for certain LTSS populations; allows for interim / subsequent contacts to be in person, telephone, or video conference.

Less stringent

- Relaxes *Face to Face* requirements for members receiving care management except for high intensity populations and nursing facility and waiver members. (For others populations receiving care management, face-to-face contacts are based on MCO discretion.)
- Decreases ICT requirements; for moderate and low intensity, where ICT is permitted as needed or at Member request;
- Broadens staffing qualifications for most Care Managers to include a range of social worker and mental health professional designations (to include LMHPs, RN/LPNs, QMHPs, LMSWs, LBSWs, MSWs or BSWs, as appropriate).
- Provides flexibility for health plans to manage the care management intensity
- Provides flexibility to not require the assigned care manager to do the HRA for in-person visits (except for vent dependent members)
- Provides flexibility to use an abbreviated HRA

Different

- Simplifies to three levels of Care Management intensity, customized based on member need/risk
- Standardizes terminology and definitions
- Allocates care management resources equitably across populations **based on the member's need and risk level.** Example: PDN, foster care, high risk pregnancy, other complex conditions have been treated differently under CCC Plus and Medallion.
- Leverages MCOs advanced analytics and methods to target data-informed solutions for identifying and stratifying populations by member need/level of risk
- Modifies ICP timeframes to be respective of members risk level (high, moderate, low)
  - 7 days for high intensity
  - 30 days for moderate intensity
  - 60 days for low intensity
  - *Prior it was 6 months, but was required for all CCC Plus populations)*
- Streamlined design that links with quality outcomes and clinical efficiencies

Process for Identifying Members for Care Management

- MCOs use a risk stratification and scoring methodology to identify:
  - **Mandatory High Priority Populations**
  - **Mandatory Priority Populations** (*including members who fit into this category and which **CM intensity level** is most appropriate for each member*)
  - **MCO Determined Priority Populations** (*including members who fit into this category and which **CM intensity level** is most appropriate for each member*)
  - **Other members** who may benefit from CM and at which **CM intensity level**
- MCOs conduct restratification of all Members quarterly.

The MCO's risk stratification/scoring methodology use, as available, the following data sources*:

- MCO's advanced analytics and predictive modeling;
- Claims history/analysis;
- Aid category;
- LTSS level of care;
- Previous CCC Plus enrollment;
- Medicaid Application medical complexity attestation question;
- MCO screening (MMHS);
- Pharmacy data;
- Immunizations;
- Lab results;
- Admission, Discharge, Transfer (ADT) feed information;
- Provider referrals;
- Referrals from social services;
- Member's zip code;
- Member's race and ethnicity;
- Member or caretaker self-referral; and
- Referrals from other sources, such as CILS, AAAs, CSBs, Department of Corrections, Public Defender's Office, etc.

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REVISED 5/9/23 - Cardinal Care Priority Populations; Person Centered Care Management		
1) Mandatory High Priority Populations; members must receive high intensity Care Management	**2) Mandatory Priority Populations; members must receive care management, MCO determines intensity (high, moderate, low)**	**3) MCO-Determined Priority Populations; MCO Determines Care Management and appropriate intensity (high, moderate, low)**

• **CCC Plus Waiver members receiving PDN**
• **Children receiving PDN through EPSDT**
• **Ventilator-dependent members**
• **Members transitioning from a NF to the community** (for a minimum of 3 months prior to the transition and 6 months after the transition, or longer if determined necessary by the MCO)
• **Foster Care / Former Foster Youth**:
  ○ Members in foster care or former foster youth for 3 months after enrollment into the Medicaid program, the child welfare system or a new foster care home
  ○ **Members in foster care 3 months prior to aging out of the child welfare system**
  ○ Former foster youth for the first 3 months after aging out of the child welfare system
• **Very Vulnerable Infants:**
  ○ Substance-exposed infants for first 3 months of Medicaid enrollment;
  ○ Neonatal abstinence syndrome infants(following diagnosis or identification as part of this population, whichever is later) for first 3 months of Medicaid enrollment
  ○ Infants admitted to the NICU Level 3 for first 3 months of Medicaid enrollment
	Members Enrolled in Waivers or with I/DD
	• CCC Plus Waiver members (not receiving PDN)
	• Members enrolled in the DD Waivers (Building Independence (BI), Community Living (CL), and Family and Individual Supports (FIS) waivers)
	• Members with intellectual/developmental disabilities (I/DD)
	Members in Hospice, Nursing Facilities or with Dementia
	• Members receiving hospice benefits
	• Nursing facility members (except for members in the "Mandatory High Priority Population")
	• Members with cognitive or memory problems (e.g., dementia)
	Members with brain injuries
	Members with SMI or SED
	• Members with serious mental illnesses and serious emotional disturbances (institutional and community dwelling);
	• Members who receive Mental Health Services, as reflected in the Cardinal Care Summary of Covered Benefits Chart
	• **Individuals in foster care and former foster youth who are not in the "Mandatory High Priority Population"**
		Pregnant Women and Children with High Needs/Risk
		• Members with a high-risk pregnancy, as defined by the Contractor
		• Children and Youth with Special Health Care Needs
		• Children identified as at risk for developing developmental disabilities or delays (early intervention program)
		Members with Other Complex/Chronic Conditions
		• Members with other complex or multiple chronic conditions (e.g., respiratory conditions, heart disease/heart failure, diabetes, cancer, etc.)
		• Members with end stage renal disease
		• Members with physical or sensory disabilities
		Members Meeting Utilization-Based Criteria
		• Patient Utilization Management and Safety (PUMS) Program Members
		• Members with 3 or more ED visits or hospitalizations related to their chronic medical, physical health condition in the past 90 calendar days
		• Members with 1 or more ED visits or hospitalizations related to their behavioral health or substance use condition in the past 3 months;
		• Members 18 years of age or older who have had 2 or more falls resulting in an ED visit, hospitalization, or physician office visit within the past 90 calendar days
		Members with Behavioral Health (BH/SUD)
		• Members with behavioral health and substance use disorders
		Members with High Social Needs
		• Members who are experiencing homelessnes
		• Justice-involved populations (includes individuals who have a history of incarceration, probation or parole supervision)
		• Members who have other, high social needs that pose a significant risk to their health, safety and welfare
		Other Populations Based on MCO Determination

Care Management Pathway

Maximizing use of data and care management to improve the pathway to better health outcomes.

MCO Advanced Analytics and Care Management System

- Advanced Analytics
- Member Screening
- Health Risk Assessment
- Individualized Care Plan
- Integrated Care
- Ongoing Monitoring
- Utilization Trends
- Quality
- Provider Performance
- Member Satisfaction

Care Management Interventions

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Virginia's Medicaid Program

More Information

DMAS Cardinal Care Member Page
https://www.dmas.virginia.gov/for-members/cardinal-care/

DMAS Cardinal Care Provider Page
https://www.dmas.virginia.gov/for-providers/cardinal-care-transition/

Sign up to get the latest news from Virginia Medicaid at: https://www.dmas.virginia.gov/

Cardinal Care Questions: ccmccontract@dmas.virginia.gov

DMAS EPSDT epsdt@dmas.virginia.gov
DMAS Early Intervention M4earlyintervention@dmas.virginia.gov; CCCplusearlyintervention@dmas.virginia.gov
DMAS Foster Care fostercare@dmas.virginia.gov
DMAS Baby Steps BabyStepsVA@dmas.virginia.gov

Questions?

School-Based Mental Health Services Pilots Update

CHIPAC Full Committee Meeting

December 7, 2023

Katharine Hunter, MSW
Acting Director
Office of Child and Family Services
Bern'Nadette Knight, PhD
Child and Family Program Specialist
Office of Child and Family Services

Budget Language

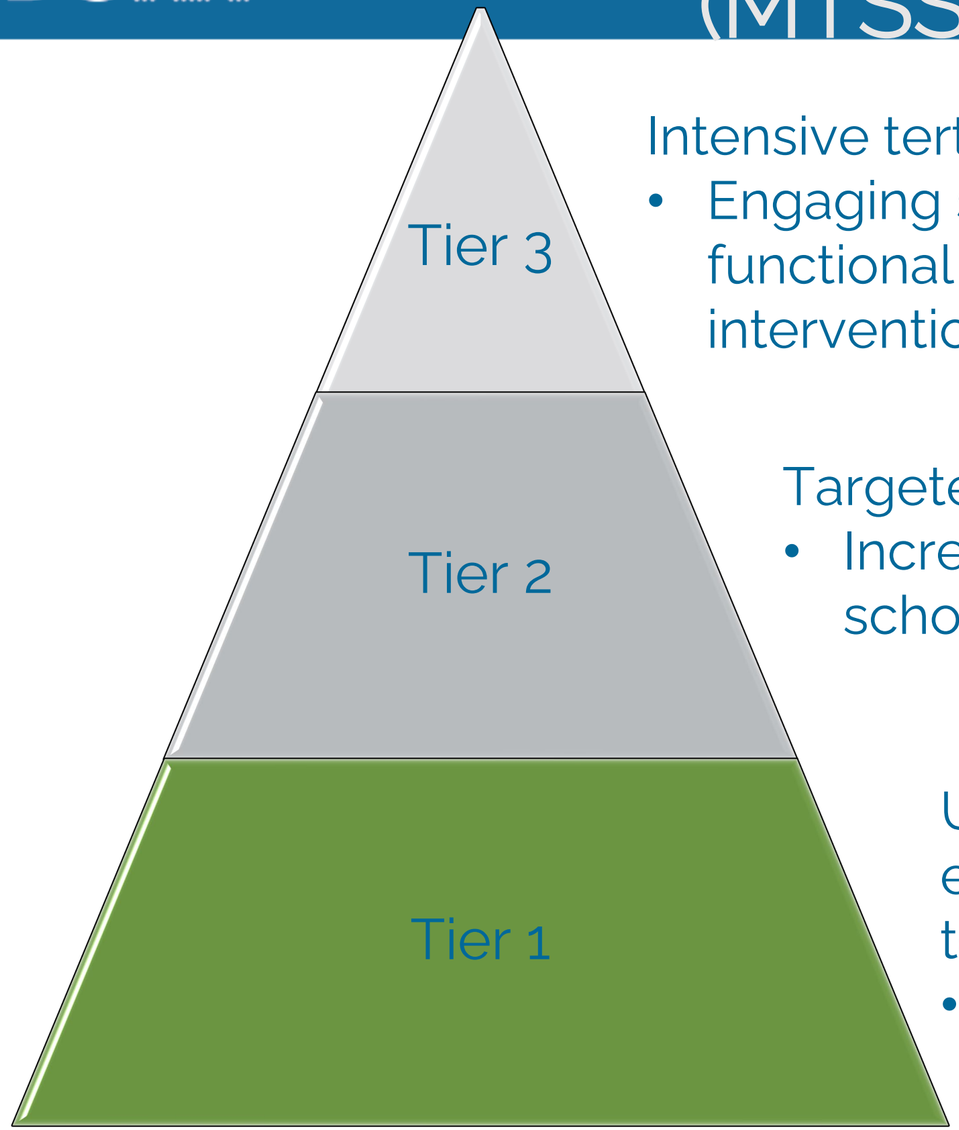
"II. Out of this appropriation, $2,500,000 the first year from the general funds is provided for:

1. ***Technical assistance (TA)*** to school divisions seeking guidance on integrating mental health services
2. ***Grants to school divisions*** to contract for community based mental health services for students from public or private community-based providers
3. ***Report back to the GA*** on the success of the pilot and identify recommendations and resources to continue these efforts by Sept. 1, 2023.

Right Help, Right Now

School based mental health programs are critically important in addressing youth mental health needs as they overcome many known barriers including access, transportation, missed school days, enhance the youth and families' natural supports in school, and needs can be identified early.

Multi-Tiered Systems of Supports (MTSS) Framework



Intensive tertiary intervention (1-5%)

- Engaging students, educators, and families in functional behavioral assessments and intervention planning

Targeted secondary intervention (10-15%)

- Increasing access to academic support and school/family communication

Universal primary Intervention supports everyone across all school settings (includes teachers, school personnel and students)

- Assessing and improving school climate and staff well-being

Source: National Center for School Mental Health (NCSMH, 2020). School Mental Health Quality Guide: Mental Health Promotion Services and Supports (Tier1).

National Center for School Mental Health (NCSMH, 2020). School Mental Health Quality Guide: Early Intervention and Treatment Services and Supports.

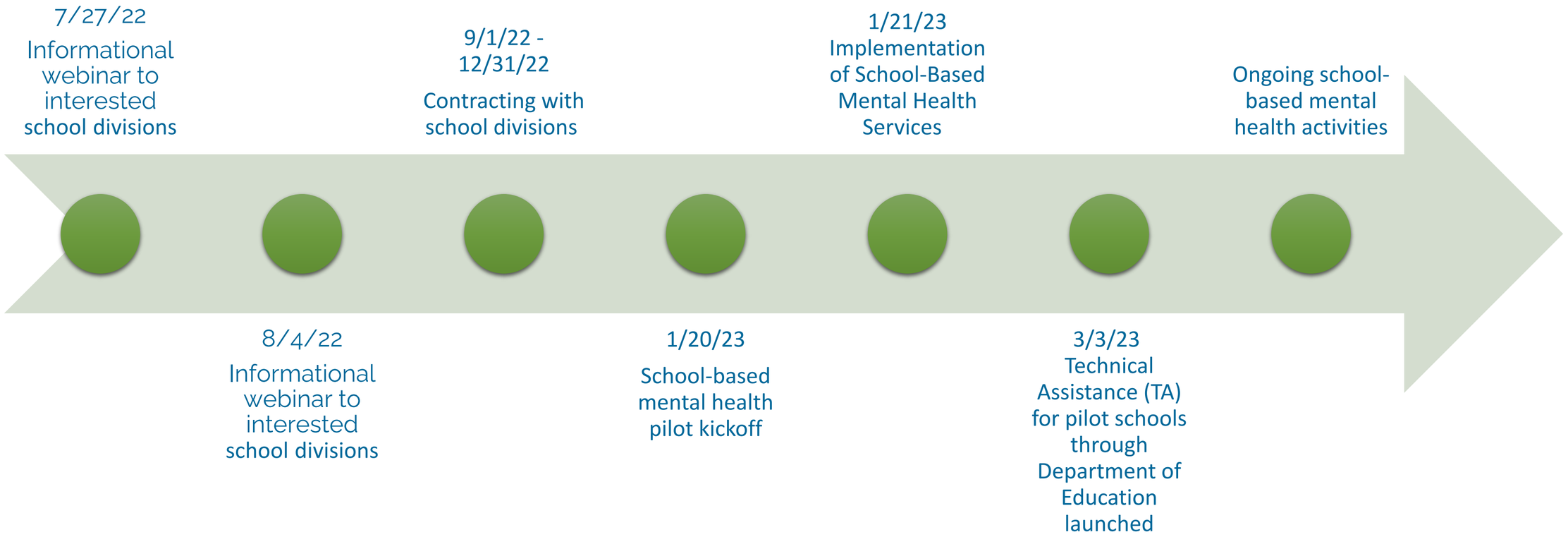
Technical Assistance

- Universal: TA for all Virginia schools and providers
  - Development of asynchronous modules for school leaders, community mental health providers, and specialized student support personnel

- Pre-Implementation: TA for new implementers
  - Facilitated exploration and installation activities such as needs assessment and resource mapping of division/community resources

- Implementation: TA for grantees
  - Peer-to-peer learning opportunities
  - Community of Practice (CoP) for providers

School-Based Mental Health Pilot Implementation

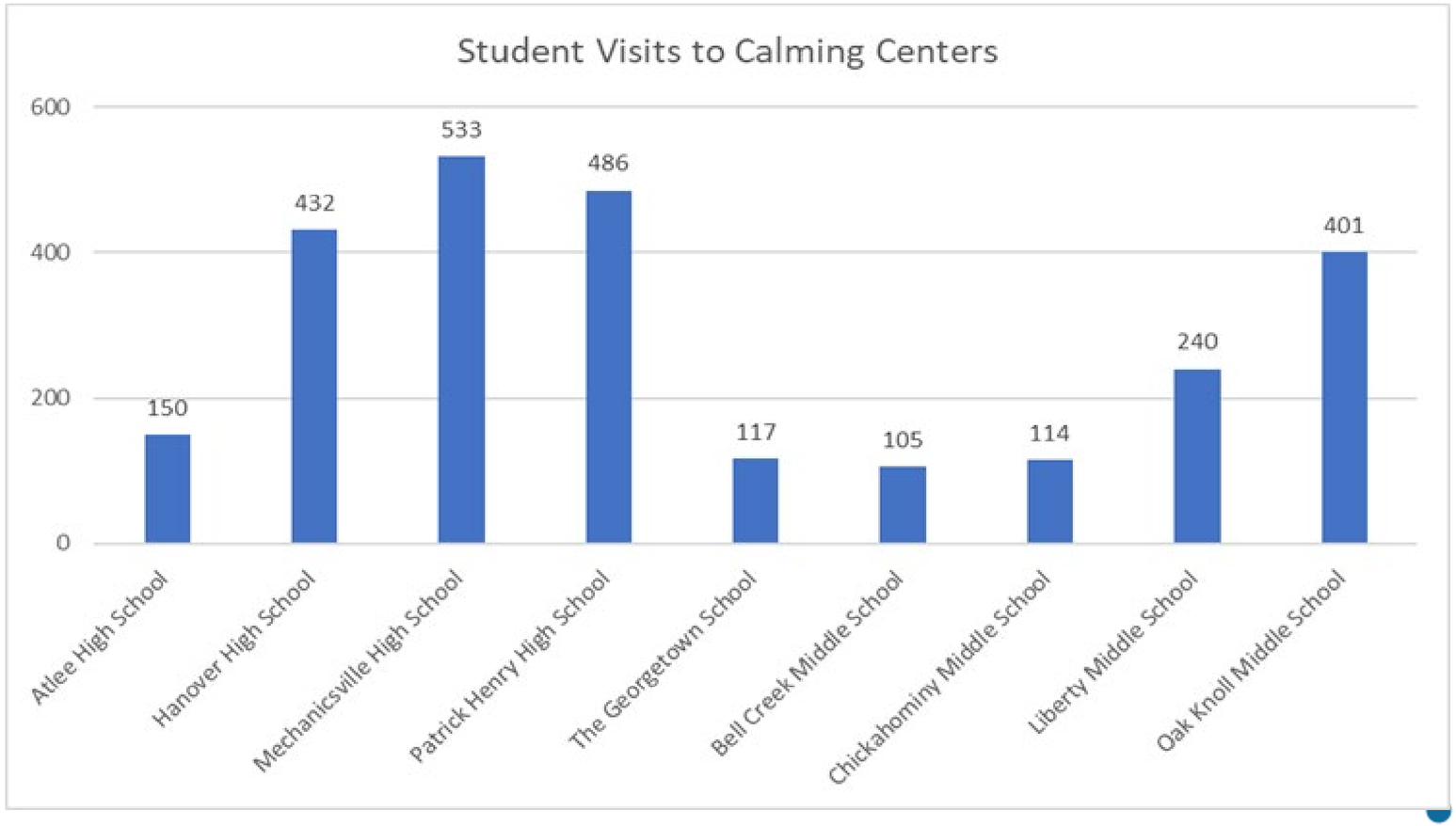


MOU Signature Date	School Division	Community Partner	Funding Amount
11/2/22	Lunenburg County Public Schools	Fulcrum Counselors, LLC	$349,822.02
11/10/22	Hanover County Public Schools	Hanover County Community Services Board	$374,850.00
11/17/22	Bristol Virginia Public Schools	Highlands Community Services Board	$213,119.55
12/19/22	Mecklenburg County Public Schools	Southside Behavioral Health	$319,822.02
1/6/23	Hopewell City Public Schools	Child Savers	$346,500.00
2/28/23	Richmond Public Schools	Richmond Behavioral Health Authority	$182,080.00
Total funding to school divisions			$1,786,193.59

Name of School Division	Children Served	Schools served with funding	MTSS Service Tiers	Type of Services Provided
Bristol Virginia Public Schools	600*	2 (both elementary)	Tier 1	Suicide prevention and mental health awareness (Thrive Line), small group interventions, crisis support
Hanover County Public Schools	91	26	All Tiers	Motivational Interviewing, Solutions Focused Brief Therapy, Cognitive Behavioral Therapy (CBT) Assessment, Brief Intervention and Referral Services, calming rooms
Hopewell City Schools	71	3 (1 elementary, 1 middle and 1 high school	2 and 3	Individual, family and group psychotherapy, group therapy
Lunenburg County Public Schools	80	5 (2 elementary, 1 middle and 2 high schools)	2 and 3	Character Strong, TEEN TRUTH Mentoring Program, No Label Mentoring Program, Hidden in Plain Sight Community and Staff support program, safeTALK suicide prevention

School-Based Mental Health Pilot Outcomes

- Hanover County used funding from the pilot to support the creation of calming rooms across 9 schools.
- Between Nov 2022 and May 2023, there were a total of 2,578 calming room visits across all schools.
- Hanover will use successes and lessons learned from calming room implementation to refine approach in future rollout.



Feedback from Stakeholders

Focus Group Results conducted in June at the *Reimagining Mental Health for Virginia's Youth: A School-Based Approach Conference*

Focus Group Prompt	Themes
What is the top resource or support needed to implement or expand school-based mental health in your community?	➢ Consistent funding to support implementation and workforce ➢ Efficient processes which provide more time for work ➢ Technical Assistance: support, training
What do you see as the biggest benefit in having behavioral health services delivered in a school setting?	➢ Increased collaboration and communication (schools, community partner, student, and parents) ➢ Helps to decrease stigma around mental health and treatment
What do you see as the biggest barrier to successfully implementing community-based partnerships focused on school-based mental health (SBMH)?	➢ Funding not continuous to support implementation ➢ Unclear roles of providers vs. school slow or impede implementation ➢ Gaining buy-in from key stakeholders to implement SBMH
What should be the key components included in designing a partnership between school division and community agencies? What is needed for these partnerships to be successful?	➢ Clear understanding of processes for SBMH implementation ➢ Ensure staff and community partners are on the same page ➢ Sustainable funding ➢ Clear ways to measure success and outcomes

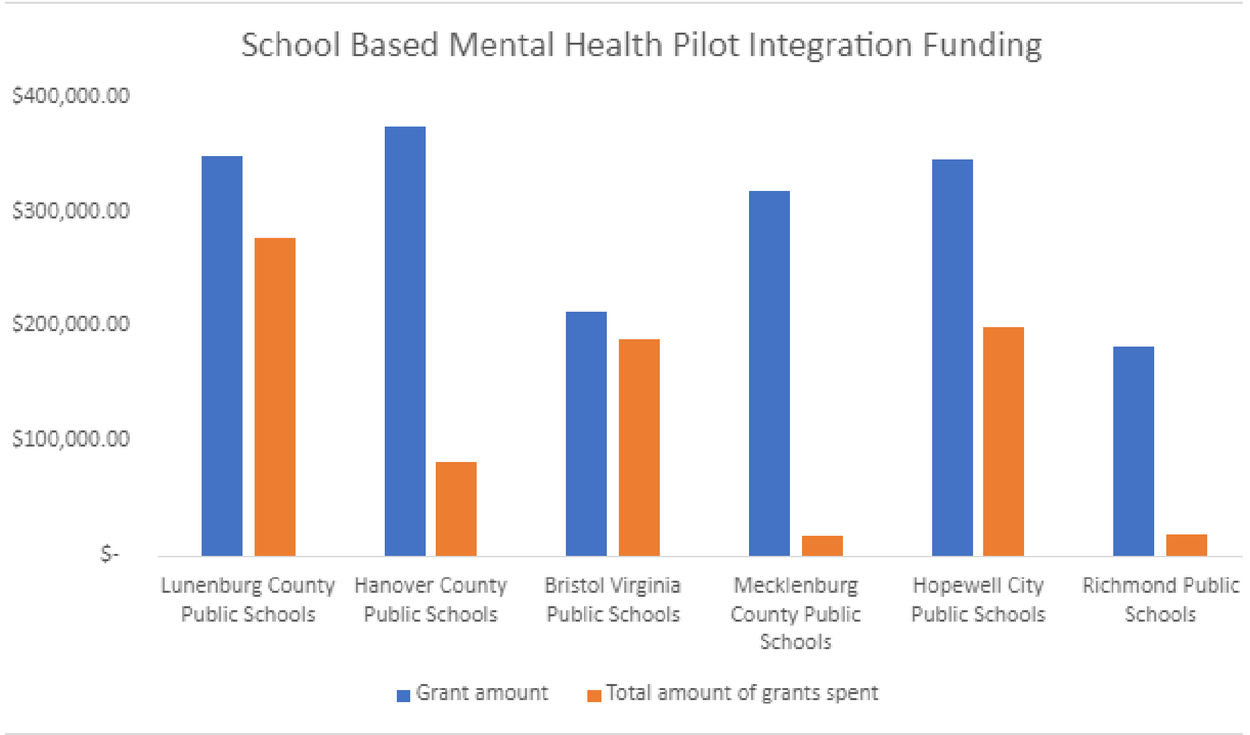
School-Based Mental Health Pilot Outcomes

Successes

- Hiring of personnel with community partners
- Provision of services to students in need
- Technical assistance support to schools

Challenges

- Full appropriation was not spent due to accelerated timeline
- Lack of available licensed behavioral staff statewide challenged community partners to hire personnel
- Uncertainty around sustainable funding impacted hiring and program implementation



DBHDS Recommendations for Implementation

Continue to build a comprehensive continuum of youth mental health care available for all Virginia youth: prevention, early intervention, and high quality, evidenced based treatment.

Enhance and support community-based partnerships with schools.

Establish shared outcome measures using goals of schools and youth mental health outcomes.

Develop targeted efforts to expand the behavioral health workforce that serves youth.

Secretaries of HHR and Education should make joint allocation decisions related to school-based mental health programming.

What's next for School-Based Mental Health

Budget Language

Out of this appropriation, $2,500,000 the first year ***and $7,500,000 the second year*** from the general fund provided for:

1. ***Technical assistance (TA)*** to school divisions seeking guidance on integrating mental health services
2. ***Grants to school divisions*** to contract for community based mental health services for students from public or private community-based providers
3. ***Report back to the GA*** on the success of the pilot and identify recommendations and resources to continue these efforts by Sept. 1, 2023.

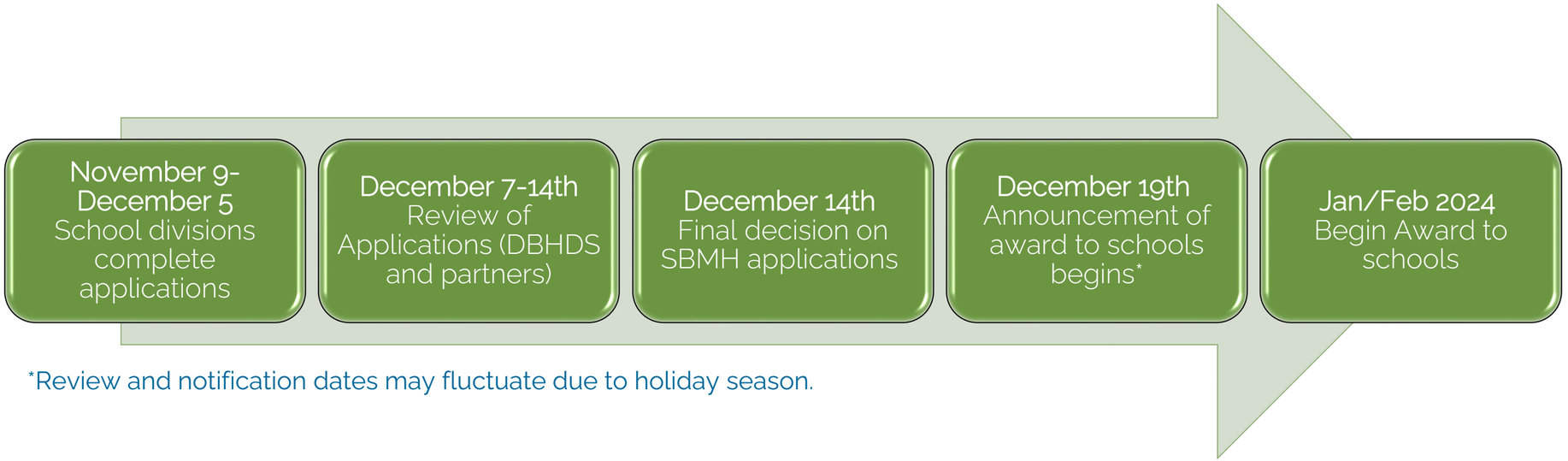
What's Next for School-Based Mental Health

- The General Assembly appropriated $7.5M to continue SBMH pilot program implementation
- An application process is underway for interested school divisions interested in funding.
- Continued collaboration with Dept of Education on data/evaluation outcomes
- Contract for data and evaluation services

Project Overview

- **Schools established a partnership** between a community-based mental health provider
- Services must fall within a Multi-Tiered System of Supports (MTSS) / Positive Behavioral Interventions and Supports (PBIS) framework
- Participate in Technical Assistance Support
- ***Funds cannot be used for Therapeutic Day Treatment and services/supports supported by Medicaid***

School-Based Mental Health Current Timeline



*Review and notification dates may fluctuate due to holiday season.

Informational webinars conducted November 11-13

Discussion of Agenda Topics for next CHIPAC meeting (in-person at DMAS offices)

March 7, 2024

Public Comment

- If you wish to submit a public comment, you can unmute yourself by clicking on the microphone icon.
- If you are joining by phone, unmute yourself by pressing *6.
- You may also submit written comments in the chatbox if you wish to do so.