NACBH NEWS

National Association *for* Children's Behavioral Health

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National Association for Children's Behavioral Health
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EXECUTIVE DIRECTOR NOTES

Pat Johnston, Executive Director

Dear NACBH Colleagues,

As I sit down to write the last column for the year, I'm at a bit of a loss to explain or interpret the lack of political (small "p") will of Congress to fulfill its most basic functions. Would you notice if I just recycled the Executive Director Notes from a previous month? Debt ceiling increase, FY 2018 appropriations, extension of funding for CHIP, MIECHV (Maternal, Infant and Early Childhood Home Visiting program), and other important public health programs that expired September 30 – none of the above accomplished as the Republican majority rushed to put a disastrous tax bill on the President's desk before the Democratic Senator-elect from Alabama is seated. So, for a change, I'm not offering another reason why NOW they must really act! They will when they do.

Let's turn to happier thoughts and recoup some energy to pick up our advocacy in the New Year.

Earlier this month, our Emerging Best Practice conference on value-based purchasing was a resounding success, raising the bar once again for conference planning next year. A program committee will be forming soon. Please let me know if you're interested in participating, and/or send along your ideas on emerging opportunities and challenges.

In recent days, two important reports hit the top of our pile for holiday reading: the first Report to Congress of the new Interdepartmental Serious Mental Illness Coordinating Committee (highlighted elsewhere in this newsletter), and a Milliman Research Report analyzing disparities in network use and provider reimbursement rates for behavioral vs. physical health services. We look forward to reviewing their results and recommendations as we reconvene the Public Policy Committee and polish up NACBH's agenda for 2018.

The Best Practices (formerly Standards) Committee is also lining up topics and speakers for the coming months, and we'll have some terrific committee news to announce in January.

So, get some rest, have some fun, and return ready to jump back in. Happy Holidays! □

NATIONAL DRUG & ALCOHOL FACTS WEEK:

JANUARY 22-28, 2018

NACBH members are encouraged to organize and promote an educational event during National Drug & Alcohol Facts week, sponsored by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The week-long health observance is an opportunity for teens to learn the facts about drug and alcohol use and abuse from scientists and other experts.

Plan your event – 5 steps to hosting, with a teaching guide, activity ideas and toolkits, and more.

Register your event to be listed on NIDA's online map.

PUBLIC POLICY COMMITTEE REPORT

Denis McCarville, AK Child & Family, Anchorage, Alaska, Chair

Standing Monthly Conference Call: 4th Friday of each month, 2:00 – 3:00 p.m. (Eastern)*

*But not in December! The Public Policy Committee conference calls and reports will resume in the New Year.

BEST PRACTICES COMMITTEE REPORT

Jan Carson, Catholic Charities, Timonium, Maryland, Chair

Standing Monthly Conference Call: 3rd Tuesday of each month, 1:00 – 2:00 p.m. (Eastern)

All members are welcome to participate in the Best Practices Committee (formerly the Standards Committee) discussions of accreditation standards and surveys, compliance issues, peer consultation on timely hot topics, and presentations by NACBH members on program and performance improvement initiatives. Please email Jan Carson or Pat Johnston to volunteer a presentation, add an agenda item or join the committee. The roster is posted on the Members page of the NACBH website.

The November 18 call included a member report on a recent Joint Commission survey. The survey was noted to be two months past the general time frame for the unannounced survey. The facility had one surveyor for five days. The surveyor was noted to rely heavily on the Safer Matrix. The organization found it helpful to be able to track the acuity of the observations by the surveyor. Some of the topics covered during the survey included:

- Fire Safety including compliance with fire codes
- Core competencies – addressed in hiring processes and in ongoing evaluation of staff
- Infection Control – acceptance of flu vaccine; expecting to see an increase in the acceptance rate from an established baseline rate

Joint Commission's Professional and Technical Advisory Committee and Advisory Council

The Joint Commission's newly-announced revisions in the models for the PTAC and the Advisory Councils were presented. More details are expected from the Joint Commission in the coming months as they further define the roles for these two advisory groups.

Emergency Preparedness

The group continues to discuss emergency preparedness. Members are encouraged to share plans on the NACBH Member's Only Page on the website. Please email plans to Pat Johnston for posting.

Agenda for December 19:

1. Follow-up from the discussion on Emergency Preparedness at the NACBH conference in early December.
2. Begin to discuss questions for Julia Finken, Executive Director for Behavioral Health Accreditation, Joint Commission, who will join our call in February.
3. Joint Commission's Special Report on Suicide Prevention, November 2017. Available to Joint Commission accredited organizations at the following link: https://customer.jointcommission.org/contentPublishing/Lists/PerspectivesGallery/JCP-11-17.pdf. □

CMS TO STREAMLINE SECTION 1115 DEMONSTRATIONS, 1915 WAIVERS AND SPA PROCESS

Two new Informational Bulletins from the Center for Medicaid and CHIP Services (CMCS) describe plans for streamlining the review and management of certain waivers and State Plan Amendments (SPAs).

Among all of the Medicaid waiver authorities, Section 1115 demonstrations offer states the greatest flexibility to experiment with their service and reimbursement plans, and also require the highest level of public notice and comment. Last March, then-HHS Secretary Tom Price and CMS Administrator Seema Verma announced that more flexibility and a faster approval process would be forthcoming. The November 6 Informational Bulletin outlines a number of steps CMS will take to expedite the process, including:

- Simplifying the application template
- Providing states with technical assistance in defining their demonstrations
- Implementing a coordinated team approach across CMCS for multiple policy experts to weigh in
- Developing parameters for expedited approval of plans or elements of plans that are substantially similar to those approved in other states
- Approving less-complicated elements for longer periods of time than more-complicated elements that will require closer monitoring
- Establishing a fast track process to extend existing 1115 demonstrations that have proven outcomes

In addition, CMS will reduce the frequency of reporting for demonstrations that meet certain performance requirements. Details of each of these tasks are yet to be determined. A primary question for stakeholders is how the expedited waiver processes will align with the robust public comment requirements currently in regulation.

The second Informational Bulletin describes the steps CMS has taken and plans to take to expedite reviews for SPAs, 1915(b) waivers for managed care, and 1915(c) waivers for home and community-based services. Reviews can take many months to make their way through the system, both "on the clock" while CMS acts, and "off the clock" while CMS waits for states to provide requested additional information (RAI). The average time that pending SPAs have been on RAI status, for example, is two years, and some have been pending for nine years. The current backlog of SPAs and 1915 waiver actions on RAI status exceeds 350.

To get new reviews off to a faster start, CMS has instituted preliminary phone calls with states within 15 days of receipt of each new SPA or 1915 request, to review the intent of the request, identify incomplete information and flag any known major policy issues. CMS has also compiled a package of available tools including templates, checklists, and other guidance to assist states in preparing complete submissions. Additional tools will be added.

To reduce the backlog of SPAs, CMS will partner with states to resolve outstanding reviews in batches, beginning with the 75 oldest, and to initiate disapproval of SPAs with unanswered RAIs sooner in order to move them along or close them out. To prevent more SPAs from becoming backlogged, CMS will expand the types of SPAs that can be processed through the web-based system that is currently used only for SPAs related to health homes and MAGI-based eligibility administration. □

CMS ISSUES GUIDANCE ON ACCESS TO CARE FOR FFS REQUIREMENTS

The Center for Medicaid and CHIP Services (CMCS) has issued a Dear State Medicaid Director (SMD) letter clarifying its policy on implementation of the Medicaid access regulations that went into effect in January 2016.

The regulations require a transparent, data-driven process for states to document whether Medicaid payments are sufficient to enlist providers and assure beneficiary access to a core group of covered services, including mental health and substance use disorder treatment, at least once during each three-year cycle. States submitted their initial access monitoring review plans to CMS in October 2016 after public review and comment, and will update the plans every three years. States are also required to consider the data from access reviews before submitting a State Plan Amendment (SPA) that proposes to restructure or reduce provider reimbursement for the identified services. (Please email Pat Johnston to receive a full description of the regulatory requirements.)

The November 16 SMD letter clarifies that the regulations apply only to fee for service (FFS) payments made by states or counties to providers, not to FFS reimbursement through Medicaid managed care plans. It also describes circumstances "which are unlikely to result in diminished access, and therefore, where states would not be required to conduct the analysis and monitoring procedures specified in the regulation." One example is the imposition of federal upper payment limits and financial participation limits for which the state is not exercising discretion. Other examples are related to the proposed Medicaid reimbursement's comparability to Medicare payment rates.

NACBH does not agree that Medicare rates, regulated under a separate federal law, would necessarily meet the Medicaid statute's requirement that states "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." There is no formal mechanism for commenting on SMD letters. Nonetheless, NACBH has written to the CMCS Director, copying the relevant Congressional committees, to (1) object to the exclusion of Medicare-comparable rates from Medicaid access reviews, and (2) emphasize that reimbursement rates for pediatric services should never be excluded from review on the basis that they are sufficient for senior adult and geriatric populations. □

NACBH MEMBER SPOTLIGHT:

RACE IN AMERICA THE FOCUS OF STARR COMMONWEALTH'S GLASSWING PROGRAM

Practically since the Civil Rights movement of the 1960s and the official ending of segregation in the country, there has been talk of America moving away from a society that excludes based on race, to a fully blended populace where all are accepted. The reality, all these years later, is still much different than those utopian visions, and our views of race still affect much of the way things work in modern American life.

It's within that reality that Starr Commonwealth, based in Michigan, works to educate and provide some evolution within the framework of their racial healing and equity seminars and community work.

It all began in 1913, when Floyd Starr purchased property in Albion, Michigan, and founded the commonwealth as a refuge for "homeless, dependent, neglected and delinquent boys."

"Mr. Starr's belief that 'There is no such thing as a bad boy,' was not a common understanding for most people in 1913," said Elizabeth Carey, President and CEO of Starr Commonwealth. "He believed there is goodness and greatness in all kids, and we as adults have to help them find it. Today, 104 years later, not only do we still believe what he believed, but we've proven it over and over again."

With that mission at the core, a watershed moment in Starr Commonwealth's history happened in the early 1990s. Officials from Starr Commonwealth heard lecturer Nathan Rutstein speak about his book "Healing Racism In America: A Prescription For The Disease." The lecture caused Starr Commonwealth's leadership to consider

how they could really understand what racism has done to America and the healing we have got to do in order to better serve each other, particularly the kids.

"We were serving kids in residential treatment on multiple campuses, we had foster care services and in-home services," Carey recalled. "We were in two different states and serving lots and lots of kids, seeing more students of color, in our treatment programs and particularly in residential treatment where we were getting large numbers from urban settings."

They brought Rutstein to Albion and with his help formed an internal program to help understand the effects of racism in America. They studied topics like slavery and redlining, and learned more about what those practices from an earlier time had led to in today's society. By 2000, Starr Commonwealth had established a formal external program called Glasswing Racial Healing, a program that serves as a safe place for people to discuss issues related to race. The intent is for participants to have an individual transformation, from their heads down to their hearts, and better understand the oneness of humankind.

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While most people would not consider themselves racist or biased, the seminars teach participants about unconscious ways that our brains can classify people we meet based on their appearance.

"If you're able to slow that down and question what you believe about people, it allows for an opening of your own self toward having deeper understanding of and deeper relationships with people. It shifts the way you look at someone and the internal thought process," Carey said, adding that the positive end result is a better working relationship with kids and adults. "If I am working in a program with colleagues who all come from different backgrounds with different experiences, I am more likely to have a better and more open team-related relationship with them if I am open to who they are."

In its earliest incarnation, the seminars primarily focused on race relations between Caucasian Americans and African Americans, but that is evolving as society is changing. They currently work with Native American communities throughout North America, with LGBT advocates and Arab American leaders. They work with law enforcement and while still offering the popular two-day seminars, have adjusted the curriculum and format to meet the needs of potential attendees.

"A lot of working professionals can't commit to two days, but we can get them to a three-hour workshop where they can learn one part of the curriculum," said Derek Allen, vice president of programs and a senior facilitator of the seminar. "Through that process Glasswing has evolved in a really powerful way and we are impacting more people."

Starr Commonwealth is internationally recognized as a leader in transformational programs for children, families, schools and communities with an annual budget of about $20 million. Their community-based programs, residential treatment services, educational services and professional training represent the international standard of excellence in identifying, treating and healing trauma and pain-based behavior and building resiliency in children and adolescents. But Carey feels it's the people, not the budget or payroll, which matter most.

"It's less about the number of employees we have, or the size of our budget and more about the people we serve and the impact we have in the community. We can count thousands of adults who have shifted the way they work and relate to people," Carey said. "We still run a residential treatment program, we still have in-home mental health programs and still do youth assistance programs, and together, the impact of our direct services and our professional training create an incredible impact over time."

To demonstrate, she points to the original vision of Floyd Starr, and how that manifests itself a century later.

"We're really proud of the way a 100-year-old belief system has transformed tens of thousands of kids' lives and had transformed the practice of thousands and thousands of professionals," Carey said. "And we only see room for more influence and impact as we go forward."

For more information about Starr Commonwealth and the Glasswing program, please visit their website: www.starr.org. □

INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE ISSUES FIRST REPORT TO CONGRESS

The Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC), created by the 21st Century Cures Act passed late last year, released its first Report to Congress on December 14.

The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers, sets the stage for the committee's work in the coming years. Their role is to report on research advances, evaluate the effect of federal programs, and make specific recommendations for federal actions to better coordinate service delivery.

Some of the 45 recommendations included in this initial report are:

Focus 1: Strengthen Federal Coordination to Improve Care

1.2. Develop and implement an interdepartmental strategic plan to improve the lives of people with SMI and SED and their families.

1.4. Harmonize and improve policies to support federal coordination.

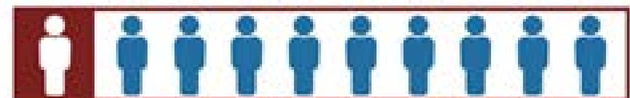
1.6. Use data to improve quality of care and outcomes.

1.7. Ensure that quality measurement efforts include mental health.

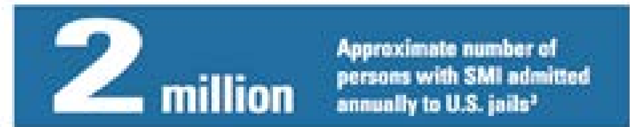
Mental Illness continued on page 8

The Health Care System Has Failed to Address the Needs of Persons With Serious Mental Illnesses (SMI) and Serious Emotional Disturbances (SED)

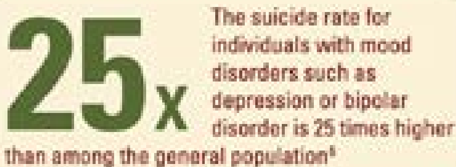
Percentage of the adult population, age 18 and over, living with SMI in the past year[1]



One in ten youths in SAMHSA's Children's Mental Health Initiative had attempted suicide prior to receiving services[2]



Sources
1 CBHSQ, 2017a
2 CMHS/SAMHSA, 2018
3 Steadman et al., 2009
4 CBHSQ, 2017b
5 SAMHSA, 2015
6 HHS, 2013
7 Ibid.



Mental Illness continued from page 7

Focus 2: Access and Engagement: Make It Easier to Get Good Care

2.5. Establish standardized assessments for level of care and monitoring of consumer progress.

2.6. Prioritize early identification and intervention for children, youth, and young adults.

2.7. Use telehealth and other technologies to increase access to care.

2.8. Maximize the capacity of the behavioral health workforce.

2.9. Support family members and caregivers.

2.10. Expect SMI and SED screening to occur in all primary care settings.

Focus 3: Treatment and Recovery: Close the Gap Between What Works and What Is Offered

3.1. Provide a comprehensive continuum of care for people with SMI and SED.

3.2. Make screening and early intervention among children, youth, transition-age youth, and young adults a national expectation.

3.4. Make trauma-informed, whole-person health care the expectation in all our systems of care for people with SMI and SED.

3.5. Implement effective systems of care for children, youth, and transition-aged youth throughout the nation.

3.8. Develop a priority research agenda for SED/SMI prevention, diagnosis, treatment, and recovery services.

Focus 4: Increase Opportunities for Diversion and Improve Care for People with SMI and SED Involved in the Criminal and Juvenile Justice Systems

4.2. Develop an integrated crisis response system to divert people with SMI and SED from the justice system.

4.3. Prepare and train all first responders on how to work with people with SMI and SED.

4.6. Require universal screening for mental illnesses, substance use disorders, and other behavioral health needs of every person booked into jail.

4.7. Strictly limit or eliminate the use of solitary confinement, seclusion, restraint, or other forms of restrictive housing for people with SMI and SED.

Focus 5: Develop Finance Strategies to Increase Availability and Affordability of Care

5.2. Adequately fund the full range of services needed by people with SMI and SED.

5.3. Fully enforce parity to ensure that people with SMI and SED receive the mental health and substance abuse services they are entitled to, and that benefits are offered on terms comparable to those for physical illnesses.

5.4. Eliminate financing practices and policies that discriminate against behavioral health care.

5.5. Pay for psychiatric and other behavioral health services at rates equivalent to other health care services.

NACBH will continue to review the report and communicate with the ISMICC on key issues for children, adolescents and their families. Please share your thoughts with Pat Johnston, and watch this space for future opportunities to participate in the public discussion. □

UPCOMING CONFERENCE

Watch this space for plans in 2018!