# NACBH NEWS

National Association *for* Children's Behavioral Health

NOVEMBER 2017 | VOL 1 NO 6

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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,**

We're looking forward to seeing many of you – and a good number of non-members – at the Emerging Best Practices conference in St. Pete Beach! Thanks to a compelling topic, expert faculty, and a terrific program committee, we're expecting the highest number of meeting attendees in recent years.

The final program will be posted soon, adding a children's provider to the first day's agenda. Keri Eisenbeis, government relations executive for the BayCare Health System in Tampa, will fill us in on BayCare's experience in the Children's Hospital Association's CARE Award, funded by the Center for Medicare and Medicaid Innovation. The three-year, 10-hospital demonstration developed care coordination services and alternative payment models for children with complex medical conditions, to deliver better care and reduce costs. Behavioral health issues and services were very much in the mix. Keri will talk with us about how one new payment model was developed, including the use (and limitations) of Medicaid claims data to inform the project. We're delighted to have a hands-on expert from the children's health world to deepen our two-day dive into Value-Based Purchasing.

Until then, I wish all of you a very happy and delicious Thanksgiving with family and friends! ☐

# CMS UPDATES POLICY GUIDANCE ON PRTFS

The Survey and Certification group at the CMS Center for Clinical Standards and Quality has posted answers to 100 Frequently Asked Questions submitted by surveyors responsible for certifying Psychiatric Residential Treatment Facilities (PRTFs). Most of the questions relate to the use of seclusion and restraint. Other areas include plans of care, medical treatment, facility notification and reporting, staffing, education and training, and the survey process.

NACBH members who operate PRTFs are encouraged to review the FAQs, as well as the interpretive guidance issued to PRTF surveyors in 2014. ☐

# UPCOMING CONFERENCE

**NACBH 2017 Emerging Best Practices Conference**

**Getting Ready for the Next (Really) Big Thing: Value-Based Purchasing**

November 30-December 1, 2017
Don Cesar Beach Resort in St. Pete Beach, Florida

***Full details and registration at www.nacbh.org***

# PUBLIC POLICY COMMITTEE REPORT

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

The Public Policy Committee has been watching the progress – or, should I say, lack of progress – towards the reauthorization of the Children's Health Insurance Program (CHIP). On November 2, the House passed its version after combining it with extensions of community health centers and other safety net programs. But it includes partisan cost offsets that cannot gain needed Democratic support in the Senate and, while the Senate version is currently enjoying bipartisan support, it doesn't include any cost offsets. As of this writing, floor action on that side of the Capitol has not been scheduled as Finance Committee Chairman Orrin Hatch (R-UT) and Ranking Member Ron Wyden (D-OR) work on proposed pay-fors. More than a month after CHIP funding technically expired, the clock is ticking loudly in states that must begin sending families coverage termination notices soon.

For more details and timely updates on Congressional action, go to www.FamiliesUSA.org. They have great information and advocacy tools on CHIP, Medicaid, the ACA, and how the Republicans' tax reform plans set the stage for massive health care cuts.

As we head into the NACBH Emerging Best Practices conference and the holiday season, the Public Policy Committee will take a break from our standing fourth-Friday conference calls. May there be much progress to report in the New Year! ☐

# CMS ANNOUNCES NEW 1115 WAIVER GUIDELINES FOR SUD TREATMENT EXPANSION

On November 1, CMS issued a new Dear State Medicaid Director (SMD) letter, replacing earlier guidelines for states to serve enrollees with substance use disorders (SUDs) under Section 1115 waivers. The new initiative is intended to accelerate states' response to the opioid crisis and was announced on the same day that the White House Opioid Commission presented its final report to the President.

As we reported in 2015, the earlier SMD letter described new SUD service delivery opportunities. With strings attached, Medicaid reimbursement would be allowed for short-term inpatient or residential treatment in otherwise excluded Institutions for Mental Disease (IMDs). In order to cover the treatment in IMDs, states would have to offer a specific, comprehensive continuum of SUD services, which could not be limited to adult beneficiaries. Like all 1115 demonstrations, these would undergo public notice and comment during the application process, be evaluated against pre-determined criteria at the end of the waiver period, and be cost-neutral to the federal government.

The new guidelines remove the detailed description of what services must be included in a full array of services, while still requiring states to "indicate how inpatient and residential care will supplement and coordinate with community-based care in a robust continuum of care." New in this version are six goals and six milestones, which states will report on periodically during the five-year demonstrations as well as in their final evaluations. The SMD letter specifies that room and board in IMDs will not be eligible for federal financial participation. The 2015 letter did not include that proviso and we don't know whether room and board has been matched in SUD 1115 waivers granted between then and now. In either event, the federal cost-neutrality requirement is a challenging fixed element of new – and, particularly, expanded – service delivery design. ☐

# DULUTH'S NORTHWOOD CHILDREN'S SERVICES RECEIVES PROVIDER OF THE YEAR AWARD FROM THE NATIONAL ALLIANCE ON MENTAL ILLNESS

*L to R: Richard Wolleat, President & CEO of Northwood Children's Services; Sue Abderholden, Executive Director of NAMI MN; and John Cairns, Northwood Children's Services Board Member.*

Duluth's Northwood Children's Services (NCS), the oldest child-caring agency in Minnesota, was presented the "Provider of the Year" Award in St. Paul on Nov. 4 during the annual meeting of the state's National Alliance on Mental Illness affiliate (NAMI Minnesota).

The award "recognizes an organization that provides mental health services that demonstrate excellence, respect and best practice," according to NAMI Minnesota materials.

"Northwood has done incredible work around children's mental health. The organization offers a variety of programs with a focus on resiliency but also respect and compassion," said Sue Abderholden, NAMI Minnesota's Executive Director.

"Every time I have visited I have been impressed with how caring the staff is and the variety of ways in which you work to engage the children and youth. Northwood is about changing lives."

NCS, which was founded in 1883, has a full continuum of mental health services to include residential treatment, intensive residential treatment, diagnostic and assessment services, intensive day treatment services, school-based intensive day treatment services, a pre-school intervention program for toddlers, corporate foster care homes and community-based mental health services.

Richard Wolleat, NCS President & CEO said, "We are truly grateful to be chosen by NAMI to receive this prestigious award. To be recognized by an informed stakeholder and respected advocacy organization in the mental health field that our programs demonstrate excellence, respect and best practices is, indeed, an honor. It is gratifying to Northwood's Board of Directors, affirming to our staff for the work they do, and comforting to parents of the children and youth we serve to receive this kind of recognition. We thank NAMI's Board of Directors for selecting Northwood. We will do our best to live up to the ideals it represents."

In 2016, NCS served nearly 800 children, youth and their families throughout their various programs and services. In addition to providing these much-needed services, NCS is a large part of Duluth's economy, with 240 employees and an annual budget of $15 million.

NAMI Minnesota is a non-profit organization dedicated to improving the lives of children and adults with mental illnesses and their families. NAMI Minnesota offers education, support and advocacy. NAMI Minnesota vigorously promotes the development of community mental health programs and services, improved access to services, increased opportunities for recovery, reduced stigma and discrimination, and increased public understanding of mental illness.

Additional information about Northwood Children's Services can be found at www.NorthwoodChildren.org. ☐

# 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 October 17 call included a member report on a recent Joint Commission survey. Some of the hot topics covered during the survey included:

- the management of contract employees
- Infection Control: aggregation of data on staff declinations of the flu vaccine
- Environment of Care: fire drills in foster homes
- Competency Assessment: training for foster parents
- Suicide Risk Assessment: the assessment of protective factors against suicide

Information was shared for anyone interested in participating in COA's Advisory Panel on behavior management standards that was scheduled at the end of October.

The committee also discussed Emergency Preparedness Plans including the following areas:

- The use of September, National Emergency Preparedness Month, for training of staff
- Mock surveys
  - Practicing how to evacuate in severe weather conditions
  - Conducting mock surveys to evaluate the capabilities including: Continuity of Operations; Shelter in Place; Evacuation/ Security; and Communication/ Ability to Track Clients/Staff
- Active Shooter Plans
- Manager Training Guides
- Kaiser Permanente Hazard Vulnerability Assessment and Analysis tools

The Kaiser Permanente materials provide a good guide for periodically assessing emergency plans, and have been posted in the committee area of the Members page. We will also post Emergency Preparedness Plans and related documents shared by NACBH members. Please send them to Pat Johnston, indicating which of the Events identified in the KP assessment your emergency plan covers. This will help us organize the materials for other NACBH members' reference.

On November 30, during NACBH's conference in Florida, interested members will gather informally during the lunch break to continue the conversation about emergency planning. We will ask conference registrants to RSVP in advance so that the hotel restaurant will be ready to accommodate.

Agenda for November 21:

- Report from a member on a recent Joint Commission survey
- Follow-up on Emergency Preparedness Planning and Implementation. ☐

# NACBH MEMBER SPOTLIGHT:

## MISSION DRIVES CCSWW'S WISe APPROACH

When the Department of Social and Health Services in the State of Washington was facing an EPSDT lawsuit, demanding that they offer more and better community-based services for families and at-risk children, plaintiffs' attorneys first did their homework. Studying the data, as well as services offered throughout the state, they discovered two sizeable counties with substantially better results than elsewhere. In those counties, children and youth with the most complex needs and highest risk behaviors were nearly always able to remain in their own homes with their own families, receiving intensive family-based services, rather than entering out-of-home care or residential treatment. Outcomes were highly successful.

Those two counties were places where the Family Behavioral Health System (FBH) of Catholic Community Services of Western Washington (CCSWW) was providing intensive in-home services and wraparound care, with 24/7 access to clinicians, behavioral supports and peer counselors.

"In those two sizeable counties, it was very rare for children to enter residential treatment and there were very few children hospitalized for acute psychiatric needs," said Mary Stone-Smith, Vice-President of Family Behavioral Health with CCSWW. "Instead, intensive in-home services were provided with air-tight safety planning, 24/7 crisis response and a child and family team approach including care coordination. Attorneys spent substantial time learning about our approach in those two counties and made the establishment of a similar service statewide the primary requirement in their settlement with the state."

CATHOLIC COMMUNITY SERVICES
CATHOLIC HOUSING SERVICES
OF WESTERN WASHINGTON

The result was development of a groundbreaking approach called Wraparound with Intensive Services (WISe).

"There are three main components to WISe: Intensive in-home/ community services, crisis response and stabilization 24/7, and care coordination with a wraparound planning team process. WISe provides intensive services in the home at times that are most convenient to the family, which means a good portion of our services occur on evenings and weekends," Stone-Smith said.

"The intensity can range anywhere from 20 hours per month to 100 hours per month or more. There's no real limit, it's based on the needs of the youth and family, and strategies employed are highly flexible and creative."

WISe is also based on the CCSWW mission, rooted in faith, which clearly advocates keeping youth with their families and keeping families together. In circumstances where it is not possible or feasible for a youth to live with a birth parent, staff complete Family Search and Engagement work to connect with

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relatives who can be involved and potentially take the youth into their own home.

Constant reminders of that family-centered mission are on display throughout their 12 offices (11 in Washington and one in Oregon). Banners reminding staff that "Families know their children best," "Never Give Up" and "Families need their children and children need their families" are displayed to reinforce their mission goals of strength based, unconditional, family-driven and youth-guided approaches.

"I have worked with CCS for over 20 years through positions with the county and state, and the reason I came to work here is that everyone at CCS is mission driven," said Lin Payton, Intensive Services Care Manager, who worked with the state of Washington for many years before joining the FBH team. "That comes from being part of the larger Catholic Community Services. They have found a way to embrace the values of Catholic Charities and bring them to a very welcoming and open place."

The typical WISe team consists of a masters-level Clinician, a bachelors-level Family Support Specialist, a State Certified Peer Counselor and a half-time Youth Peer Counselor. Each team serves about 10 families. They currently have around 60 WISe teams, but Stone-Smith explains they need 20 to 25 more, so interviewing and hiring talented people with a heart for this work is a highly-selective but never-ending process.

"We are recruiting and hiring day and night, seven days a week. And with that we've learned that it's important, no matter how urgent the need to expand and serve more families, that we hire well," said Tiffany Radonich, Site Director in the Westside office in Pierce County. "So we take a lot of time in the beginning with potential candidates to talk about who we are, what we do and how we're different. We make sure people really understand the importance of the values we have. We look for genuine alignment with those values."

While WISe is relatively new in its current form, FBH within CCSWW has been using this approach for decades, initiating this work in Pierce County since 1990. Nolita Reynolds, Site Director of the original (and largest) FBH site, located in Pierce County, has worked intensely as WISe in her site has grown from 30 to 90 staff dedicated to intensive services, with a need for many more. She has successfully mentored and trained countless clinicians, supervisors and clinical managers, creating numerous opportunities for staff to prepare for new responsibilities.

FBH has a long history of partnership with other child-serving systems such as mental health and child welfare. System partners also clearly believed in keeping families together, and treating children in the community, rather than in a residential setting, whenever feasible. The logic of that drive was reinforced when they replicated this approach in Olympia, and then Vancouver, Washington, and subsequently across the Columbia River in Oregon as well as in several other Washington counties.

"The more we worked with children and youth and transitioned them out of residential settings and back to family, it became apparent that they could do quite well in the community with their families if they had the right level of support," said Gary Romjue, Director and Trainer. "Oregon Behavioral Health funding entities began to think differently about the kinds of services that would benefit families. Though they continue to have a number of residential treatment providers, they made a significant service culture switch and began investing as well in intensive community-based services."

The FBH team speaks with great pride about success snapshots, telling stories of a woman overwhelmed trying to raise her grandson with aggressive and complex behavioral issues. Though he was on a waiting list for residential treatment in a community several hours away, through WISe they received the intensive help they needed and she was able to keep her family together. And there was the story of a young boy who shut down emotionally and was nearly impossible to handle after his mother was incarcerated. Diagnosed with childhood schizophrenia, he was placed in one of FBH's therapeutic foster homes where the foster parent was unable to manage his behaviors without FBH staff in the home constantly. The team worked with the mother in prison who helped them locate her sister in the east. The aunt was fearful of flying, so FBH staff provided the help she needed to travel by bus all the way to Seattle to take care of her nephew. The young boy was able to live with his aunt very successfully until his mother's release years later.

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The FBH system employs 450 staff currently, with a need for many more due to growth in WISe. With a total staff organization-wide of over 3,500, CCSWW is one of the largest human services organizations in Washington, second only to the state of Washington itself. While "Catholic" is in their name, which Stone-Smith explains helps to fully support highly mission-driven work, CCSWW welcomes staff who are of all faiths or of no particular faith, and they serve individuals throughout Western Washington regardless of their personal beliefs.

"For us, it's about social justice, to work with families who are most in need, and most often living in poverty with children and youth suffering through complex needs and severe behavioral issues. We work on several different levels, on a 'one family at a time' basis, on a broader community and state-wide basis, as well as on a national level," she said.

For more information about CCSWW and the WISe approach, please visit their website or email Gary Romjue at GaryR@ccsww.org. ☐

# HHS PROPOSES NEW RULES FOR HEALTH INSURANCE MARKETPLACES

The Department of Health and Human Services issued a proposed rule on November 2 which threatens patient protections and coverage under the Affordable Care Act, beginning with the 2019 plan year. The changes would affect individual and small business plans offered on the state-based insurance exchanges.

The rule would give states greater flexibility in defining the 10 essential benefits (EHBs) that plans must cover, in multiple ways. States could change their EHB-benchmark plan every year, choose from the 50 EHB-benchmark plans used by their own and other states versus the existing 10 in-state options, mix and match benefits described in one or more EHB categories from the larger pool of benchmark plans, or otherwise select a set of benefits that is roughly equal to a typical large employer plan but not more generous than comparison plans.

Sounds like a race to the bottom for states that may prioritize the cost of premiums over the extent of coverage in the 10 essential categories: mental and behavioral health, rehabilitative and habilitative, prevention and wellness, outpatient, inpatient, emergency care, prescription drugs, laboratory, pediatric, and maternity and newborn care.

HHS acknowledged that "consumers who have specific health needs may be impacted by the proposed policy."

Not immediately apparent is how the flexibility in defining EHBs would interact with parity requirements. Another question is whether it is legal to allow states to define EHBs; the ACA instructs the HHS Secretary to establish them.

The proposed rule also increases the threshold for a mandatory premium increase review from 10% to 15%, broadens the terms for medical loss ratio, and eliminates requirements that state exchanges have at least two Navigator entities and that one of them must be a community- and consumer-focused nonprofit group.

Much more is included in the 97-page Federal Register notice. NACBH will work with our national coalition partners to understand the more complicated implications and respond with public comments by the November 27 deadline. ☐