

**Transformation Team Public Comment
May 16 – May 31, 2015**

May 12, 2015

Dear Members of the Transformation Team:

Thank you for allowing me to speak to you today.

I am the mother of a 13-year-old child living with bipolar disorder and I am here today to share my story and to ask for your support in strengthening Virginia's mental health system for children and adolescents.

Like 1 in 5 children in America, my daughter has a brain disorder.

For our family, our daughter's mental illness has caused us to live in a life of instability. We never know when her illness will strike. We are hypersensitive to whether her illness might be leading us to hospitalizing her - as we have had to do twice.

It was at the end of her last hospitalization, when our family qualified for Virginia's Comprehensive Services Act funding. Through Fairfax County's intensive wraparound services we were able to receive home-based therapy, parent training and respite care.

We are the lucky ones -- we have been able to find a hospital bed when my daughter has needed it and to access CSA funding when our family has been in crisis after her hospitalizations.

But there are many families in Virginia who are not lucky.

With an estimated 100,000 children and youth in Virginia living with mental illness, we know that there are parents and children who are suffering and not talking about it.

Virginia's mental health care system needs sustained, long-term support. A comprehensive array of services — case management, outpatient, and emergency — is needed.

The draft recommendations included in the Child and Adolescent Behavioral Health Transformation Team report are a positive step in the right direction. As I have heard from families around the Commonwealth, current services are not only inadequate, but they are inconsistent.

Funding is also inadequate and inconsistent across the state. Beyond mandating core services, augmenting existing funding would ensure that additional children are reached with a more comprehensive array of services.

In particular, I am an advocate for better crisis response and intervention services for families.

Our family has twice had to call the police to our home in a crisis – because there was no crisis mobile team available at the time.

I talk to parents all the time that could also benefit from crisis intervention supports – rather than resorting to calling the police or driving to the Emergency Room with their child during a crisis.

I am also a big proponent of access to core services. In my experience I have heard from families that there is a lack of understanding of what services are available for children who have mental health disorders. Because of the stigma that surrounds these children's illness, families are also reluctant to search for help, and sometimes those they reach out to do not know how to navigate the system.

Whether this is from a lack of coordination, or the existence of a coordinated system, or confusion among those who are in a position to help these families – it needs to be addressed.

In particular, I appreciate the committee's recommendations to establish consistency in the availability, quality and accountability of core services.

I also agree with the recommendation to establish one state entity to be responsible for the needs of children with a mental illness. Finally, the recommendation to establish a statewide system of navigation for families to improve access is long overdue and needed.

As you work together to fine tune these recommendations, I ask that you remember families like mine, families with children who have a serious mental illness that will continue into adulthood. Our children need treatment NOW, while they are young, and they will continue to need support as they transition into adulthood.

With appropriate services and supports, our children can live up to their potential, be successful, and contribute to society.

Thank you for your time.

From: DeBord, Karen

Sent: Saturday, May 16, 2015 1:09 PM

To: TransformationTeams (DBHDS)

Cc: Jones, Edwin

Subject: Mental Health Transformation Team

Dear Transformation Team,

I am so pleased that the state of Virginia is reviewing the Mental Health system! Something I would like to suggest is that a close look be taken to review options for education in addition to prescribed clinical treatments. Many organizations around the state including, Cooperative Extension at Virginia Tech, are working with parents on preventative measures. So much of what parents need to know, what families need to know, and what couples need to know is educational. Not common sense, necessarily, but how relationships grow, develop, how trust is established, how self-concept emerges, how habits are formed and more.

In Cooperative Extension, we use a research-based, developmental approach to working with children and families on relationship building, human connections, learning about how to manage their resources (including debt and spending), about wellness, nutrition and health. Many of these are just the types of interventions families need in addition to, and sometimes in place of, clinical interventions. Our Masters' educated Extension Agents are located across the state and are working very hard to prevent child maltreatment, prevent community violence, to teach health practices, to engage youth, and to teach parents how to interact in positive ways with their children.

We are already serving as an educational agency for court-ordered parenting and as nutrition educators for low income families on subsidized food programs. However, in the current system, there is a barrier when it comes to using community educators to serve beyond in this sort of partnership. We are a publically funded and available entity. We do not collect third party health care payments. In fact, most parent educators are not clinicians, thus cannot be part of the solution in today's mental health system. However, we see such need in serving the vast numbers of folks on waiting lists when often what will fit their needs is found in an educational (non-credit adult education) workshop-type setting.

I ask you to carefully consider how education about quality of life (nutrition, health, human development finances) fits into the scheme of what is needed in the realm of family mental health wellness and seek out partnerships that enhance what mental health counselors alone cannot do. Please begin to shape policy that will partner clinicians with educational partners. In Cooperative Extension, we use research-based educational information. Not all organizations do, so no matter who counselors choose to partner with, it should be expected that parenting or child development, or adult development educational information be solid, not merely based on personal opinion. We are finding that even within the medical community, many family physicians are advising on many of the items that I have named above but with 50-75 patients a day, it is most difficult to adequately address particular needs of parents and families. You might wish to reference an article I wrote several years addressing this topic < <http://ncsu.edu/ffci/publications/2007/v12-n2-2007-summer-fall/debord.php> >

Thank-you for carefully considering how this contribution can begin to shape wellness in the future. Let me know if I can respond to additional questions.

Karen DeBord, Ph.D.

Interim Associate Director for Family & Consumer Sciences

Extension Specialist, Family & Human Development

Virginia Cooperative Extension

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-----Original Message-----

Sent: Saturday, May 16, 2015 3:03 PM

Subject: Mental Health in VA, my state

Hi!

Sorry, I did not know about this forum or I'd have tried to be there! I am a consumer with far more experience in hospitals than I wish I had. Because I have had Bipolar Disorder 1 since my twenties, and now I am in my 60s, I know what it takes to be and remain stable in a free American life. I now work at PVCC in an administrative position. The process I had to go through, no one should have to go through when they are NGRI. Because the judge sided with the person who got to court that day, I was treated like a criminal and subhuman for 28 months until I earned my release into CSB-supervision in the community. I was never a criminal. I was sick, and although I became violent and gave my ex-husband 6 stitches, I was stable after 2 weeks in "The system." I would never have harmed anyone except when psychotic, which happened because my psychiatrist was on vacation when I needed him. Everyone's case is different, but it should not have taken an attack on a senator and his son's suicide to get attention to the absolutely abysmal conditions in VA, case in point: Petersburg State Hospital and Northern Virginia Mental Health Institute where I saw one patient over medicated to DEATH and was powerless to do anything about this except to draw a picture of her. I was attacked twice by insane criminals in Petersburg, and no one ever took my requests for making a police report seriously. I am sure I was the only patient with an M.A. From GU there, nevertheless, the policy of an ANONYMOUS Forensic Review Board should be abolished. If they are going to judge you, you should have a right to personally address them, or at least to write YOUR OWN letter to them, using THEIR names! I am still angry about what happened to me May 2000 - July 2003. Thank goodness I learned to display NO EMOTIONS, say very little, refused to "interact" because I journaled and wrote my one free letter daily, and kept my eye on the prize during every long day, which seemed like a year: my own FREEDOM. When counsellors would ask why I was like this, I would say, "I didn't come here to make friends, thank you!" The personnel at Petersburg were not well-qualified. There were only two employers in town: the hospital or the fish fry.

Sent from my iPad

Sent: Monday, May 18, 2015 10:22 AM

Subject: Submit Public Comments on Transformation Teams

I strongly recommend when the new Deaf/HoH patient comes to the state hospital that requires to be with the Fluently ASL user staff at the first 72 hours for patient's own safety.

Secondly, I strongly recommend the counselor requires to use fluently sign in ASL at the deaf base in the state hospital at 24 hours daily.

Sent: Monday, May 18, 2015 11:29 AM

Subject: Transformation Team Public Comment

Hello Everyone,

While reviewing some of the recommendations/comments, I realized that there was nothing related to improving communication for Deaf, Hard of Hearing or DeafBlind people. Slide 8-11 of the [Adult Behavioral Health Services Team](#) mentions 'Access' and nothing about communication access? We all know there is a large Spanish population around us and their access to skilled Spanish providers was not even noted either.

A similar issue was noted in the [Child & Adolescent Behavioral Health Team](#) presentation with a difference - nothing about communication access. The closest reference was 'Education' on slide 9 begs a question - will this be done in the child's native language? Again, the same issues noted above applies here as the clients or patients (whichever is preferable) need access in their primary language as that will help get them help faster, reduce retention and readmittance. Family members are not skilled interpreters as they have an emotional connection to the case and can not impartially interpret professionally.

There are laws about communication access on the state and federal levels. For the Deaf, Hard of Hearing and Deafblind community, many refer to the Americans with Disabilities Act (of 1990, later updated in 2010). There is a similar law on the state level known as [The Virginians with Disabilities Act](#) - you can see a list of common disability laws at <http://www.easyaccess.virginia.gov/legalrights.shtml>. Essentially the laws state that the most effective method of communication should be used, whether it be American Sign Language, Spanish Sign Language, or some other form of sign language.

Communication access should be included in your focuses as THEY do save you MONEY in the long run! I have met people who returned for the same services that they got already because they did not fully understand why everything was done to them or why it was important. In some cases, they did not take their prescription medicines and later had health complications that brought them back to you or died at local hospitals. This is an obvious strain on our overall resources, which is why communication access for ALL should be included in your recommendations.

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Virginia Network of Private Providers, Inc.
Building Meaningful Lives for Extraordinary People

Thank you for the opportunity to comment on the work of the Transformation Team Recommendations; we appreciate the tremendous effort that has gone into the development and the vetting of the recommendations.

We offer the following comments for your consideration:

- Providers, both public and private, will continue to be the essential catalyst to drive the changes proposed and they need to do so from a position of strength and secure/adequate funding, supported and valued by the Executive Branch agencies and full participants in all aspects of this transformation.
- Strengthening the provider workforce, implementing best practices, requiring organizational selfassessments, establishing quality standards for each core BH service and simplifying documentation are, among other items listed, all good goals. The provider community has the capacity and commitment to implement these as long as there is adequate funding.
- We, as providers and advocates, are concerned that the effort to “transform” will over-shadow the very basic elements of providing adequate support for the system already in place. While access to services is partly a function of identifying the “right services for the right person at the right time” it is equally a function of supporting the services both with funds and with policies/regulations that facilitate rather than hamper.
- The emphasis on the provision of Case Management is understandable, but it is fair to say that current requirements, especially for I/DD Case Managers, have rendered them ineffective in doing most of the tasks listed. They have become, instead, sub-regulatory monitors, collectors of data, and movers of paper!
- We are concerned about the lack of specific recommendations to reduce the waitlist for Waiver services. As the wait list increases, more individuals and families experience urgent crises and our system needs supports to assist them. Additionally, we are concerned that the transformation relies heavily on Medicaid funding which does not address those individuals who are ineligible for Medicaid funding. We recommend a commitment to also support these individuals.
- We are concerned, as is evident in the comments above, that it will be difficult to sequence the various recommendations to coincide with funding requested from and approved by the General Assembly while also managing the ongoing need for funding for expanded BH crisis capacity, reducing the ID/DD Waitlists, funding the revised rate structure for I/DD services, etc. It is our grave concern that mandates and/or expectations for transformation will be imposed without the support and funding being in place.

Again, thank you for the opportunity to comment.

May 18, 2015

Sent: Tuesday, May 19, 2015 10:48 AM

Subject:

8000 on our waiting list and 5000 patients on urgent need. I read this in our paper yesterday. My 87 year old mother required services when she was on Hospice care and just wanted to let go. A week of services that were unbelievable for her, me and our state. I believe the Creigh Deeds law should have not applied to my mother and others like her. Time and expense for her took away from someone in

need. This simple word change in the law, under Hospice care, would have helped your department and my mother. If you want to talk further about this I would be happy to.

From: Leigh Wion [mailto:lwion@vaneurocare.org]

Sent: Tuesday, May 19, 2015 11:29 AM

To: TransformationTeams (DBHDS)

Subject: Transformation Team Public Comment

My name is Leigh Wion and I am the Program Administrator at The Bridge Line and manage High Street Clubhouse in Charlottesville. In addition to High Street Clubhouse, our non-profit organization provides community based supports and services to brain injury survivors in a residential home-like setting in Downtown Charlottesville. We also provide information and referral to individuals, families, and professionals seeking resources.

When a person we serve experiences a mental health crisis, crisis services and supports are available through Region 10 CSB's crisis hotline, local police department, and at University of Virginia Hospital respond. However, the long term availability and access to ongoing mental health supports is often not readily available due to provider wait lists and no Medicaid Waiver for adults with brain injuries. Even brain injury survivors who meet the criteria for services under the DD Waiver because their injury occurred before the age of 22 experience long waiting periods of 5 years or more before funding becomes available.

We would like to be part of the solution to assure access and funding is readily available to all individuals regardless of their disability.

Thank you.

PLEASE NOTE THE NEW E-MAIL ADDRESS BELOW! E-MAIL WILL FORWARD FROM THE OLD E-MAIL ADDRESS OF [LWION@VANEUROCARE.ORG](mailto:lwion@vaneurocare.org) FOR THE NEXT 3 MONTHS.

Leigh Wion, CTRS

Program Administrator

The Bridge Line

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The Bridge Line administers High Street Clubhouse, a Clubhouse model program for persons with brain injury in Charlottesville and the surrounding counties of Albemarle, Greene, Louisa, Nelson, and Fluvanna.

Sent: Tuesday, May 19, 2015 8:53 PM

Subject: Townhall Meeting May 20,2015

To Whom It May Concern: I am sending this email to the townhall meeting with a concern for the deaf and mental health of the people in this area that have these problems and are all but forgotten as far as services that are offered to assist them in becoming the people they could be with the right services to help guide and teach them responsibility and how to manage their finances to the best of their ability to make them self reliant I have a family member that is deaf and has some mental issues and he is very **intelligent on some levels and lacks skills in communicating** as his first language is sign language and very very few people in this area know sign language and as far as I can tell there is not alot of staffing in the VA Department of Behavioral Health that knows sign language and has a hard time finding interpreter's when needed for the deaf. It seems to me that if you are not a government or state employ its hard to get anything in our area. I don't understand all this and I hope that just maybe someone will take an interest in our deaf and intellectual disabled citizens and set up some services to help them feel self worth, everyone deserves to feel that. Thank You, Your help would be appreciated.

Sent: Wednesday, May 20, 2015 1:16 PM

Subject: Transformation Team Public Comment

Dear Sirs,

I attended the meeting in Wytheville this morning and want to f/u with some comments.

As a caveat, I will say that I am a former employee of Mount Rogers CSB, having worked there as a counselor for almost 13 years. My comments come from my experience of having worked there but I do not represent the CSB.

You will recall that Lisa Moore, Director of Mount Rogers, noted during the meeting that SUD is a significant problem in the 5 counties that Mount Rogers serves. This includes Bland, Wythe, Grayson, Smyth, Carroll, and the city of Galax. These are for the most part involuntary clients. They enter into the

CSB by way of crisis services, aftercare services, probation, VASAP, employer-mandate, or because a family member has pressed them to come. They may have presented themselves during or immediately after an acute episode but the motivation for sustained rehabilitation is lost after the acuity has subsided.

As a counselor to these clients, I have found that the first obstacle to overcome in serving this population is their mistrust issues. They know that, regardless of the satisfaction with the service or service provider they have in one agency, each agency has communication with every other agency. There may be reluctance, for example, to discuss in a group counseling session, something that may get back to the probation officer, although there are expressed reassurances that staff will honor confidentiality. Staff can not provide reassurances that other group participants will honor the rules of confidentiality.

As for recommendations, I believe it would be helpful and “person-centered” to serve the SUD and other involuntary people by way of walk-in clinics. These should be strategically located in a shopping center accessible to other services and where transportation is already available.

In Wytheville, for example, the Commons Shopping Center is where the WalMart is located. Many of the CSB clients shop there because the local transportation buses have scheduled routes there. They will often pay more for some things because it is the one-stop-convenient- shop that they need to make. My point-establish a walk-in clinic where the people already are.

There are other involuntary population groups as well, which I am sure you know of. There is no reason why the walk-in clinic can not serve these population groups as well. If you want to integrate the medical model in with medical care, made this walk-in clinic one that serves more general needs. By doing so, this will reduce the stigma of someone walking into the “mental health clinic” for services. These clinics can be staffed by a team of one internist, one psychiatrist, one nurse, two crisis staff, two case managers, and perhaps two support staff.

As for meeting the needs of children and families, there is a need here in Wytheville/Wythe County (and I presume the other areas within the Mount Rogers service region) for recreation. I have received numerous complaints through the years that there is “nothing to do”. The local recreation center is available to those who can pay fees for their services, which CSB clients can not afford. Perhaps these could be made available within the school facilities. Funds for staff to provided these programs will need to be allocated, as responsibility for this should not fall on teachers or other staff of the schools.

Lastly, I will make an overarching comment about anything and everything that has anything to do with the transition. Limit the paperwork to the bare minimum. With the use of electronic records now, there is no need for staff to beat a dead horse by writing the same thing again and again when someone from another agency (i.e. Medicaid) can go into the database and pull up whatever it is that they want. Allow staff to have the time with clients instead of doing paperwork. A treatment plan, for example, should include something on the order of "In the event that [client] is hospitalized, then this [intervention] will happen". This will eliminate the need for an entirely new treatment plan upon discharge, another Program Eligibility Form, etc...

I

In the event that a walk-in model is adopted, there will be little need for ongoing monitoring, as people will not be considered "clients", but perhaps people who have made "serial contacts". The emergency rooms of our hospitals are not burdened with monitoring the clients they see with annual treatment plans, with quarterly reviews, etc..., so why should the staff of walk-in clinics?

The staff of these proposed walk-in clinics can continue to encourage clients to greater stability of functioning and can continue to make referrals to other clinicians/providers, but the clients will continue to express their desire for services in whether or not they use them, regardless of how they are



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May 20, 2015

Commissioner Ferguson,

The Arc of Northern Virginia is pleased to see the work you are doing at DBHDS to lead the agency towards a strong, community-based system for people of all abilities. As an organization focused on people with intellectual and developmental disabilities and their families, we are particularly interested in the Transformation plans related to Developmental Services and the intersection of Developmental Services with the other areas of focus.

There were several highlights from the May 12, 2015 presentation of the Transformation ideas that struck us as innovative. For one, the shift towards focusing on futures planning is a key to moving our system forward. We are currently so bogged down by waiting lists and a service system with limited flexibility that we see families constantly putting out little fires as crises arise rather than coming up with long term strategies for success.

Ensuring that everyone has access to case management and that this service is mandatory for people receiving state services is critically important. To live a truly integrated life, people with

disabilities have so many separate areas to navigate (e.g. housing, transportation, education, employment, community engagement, and advocacy) and it is impossible to do that effectively without well trained case managers who can assist them in identifying savvy support staff and appropriate resources.

We were heartened to see renewed commitments to reducing the waiting list for services, implementing meaningful Waiver Redesign, and promoting Early Intervention. Though these ideas are not new, they are the bedrock of any possible future success.

Lastly, we have seen a dramatic and frightening increase in negative interactions between people with I/DD and the criminal justice system. The Transformation Teams' ideas related to educating judicial professionals, implementing training for corrections staff on the I/DD population, and adding jail-based screening for developmental disabilities and mental health needs is critically needed. Monitoring of the implementation to ensure a decrease in negative interactions with the justice system would also be important.

Though the Justice Team did an excellent job of including the I/DD population in their comments, we found that the Behavioral Health Team focused on mental health and substance abuse needs. There is significant overlap between the I/DD population and the mental health population that was not addressed by the Team. As the system stands today, mental health services often see a primary diagnosis of I/DD and do not focus on treating the mental health needs that also exist. This must change if we are to ensure we are implementing effective, person-centered supports.

Finally, we applaud the mission of the teams to "think big," but without any regard to the very real limits on system funding, it seemed that many of the ideas were concepts that would never come to fruition. We are aware that these services will soon be converted to a system of managed care that is driven by cost savings and we must take that into account as we do any planning for the future.

We hope to see the positive ideas presented in action in the near future alongside the full inclusion of people with disabilities in all realms of the state and community support network.

Sincerely,

A handwritten signature in black ink that reads "Rikki Epstein". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Rikki Epstein
Executive Director
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REpstein@TheArcofNOVA.org

Sent: Wednesday, May 20, 2015 10:26 PM

Subject: Recommendations

I have been dealing with mental health services for my son for the last 15 years. There is a need for walk-in services. When my son is agreeable to an appointment with a psychiatrist for a new prescription, he needs same day service. My son has antisocial personality tendencies, diagnosed social anxiety and depression. He like so many other individuals suffering from mental illness, is non-compliant and lacks the ability to plan. There are not enough willing psychiatrists and they don't seem to care. My son is 26 years old and is currently homeless, feeling hopeless and full of despair, with some suicidal ideation, -no plan to carry out. He has a history of drug addiction with reluctance to enter treatment program due to social anxiety. He completed 4 days of the 30 day program approximately 1 year ago. There have been no criminal charges for the past 8 years. He has no friends, decreasing support from family due to a history of stealing from family members. He can not hold a job... Sounds like high risk for suicide. Would be nice to have some support from the CSB's suicide prevention campaign.

The CSB required my son to make several different appointments, such as an intake appointment, counseling appointment, medication appointment with psychiatrist, group therapy appointment and then he had to drive around town finding forms from the VEC to show that his wages qualified him for reduced payments, only to be billed later for the full amount of 100 dollars per appointment. I hope the perspective of a mother who loves her son will help you make patient focused recommendations that make a difference.

From: Karen Kallay

Sent: Thursday, May 21, 2015 10:18 AM

To: TransformationTeams (DBHDS)

Subject: Transformation Team Public Comment; Virginia Commonwealth

Themes and recommendations look good, but need some **prioritising of implementation strategies** because of limited resources and human nature. Based on my experience working directly with people in need *and* working at local and state advisory boards and a great deal of reading, I strongly suggest the following implementation strategies:

1. Each client have a primary facilitation home (a case manager), whether social or medical, who is responsible for facilitating the *client's main objectives in all arenas*--social, medical (and behavioral), and justice, as needed. Otherwise, everybody's business is nobody's business.

2. When client lifestyle changes are needed, and since such changes so often require near-term support and feedback, that in those cases financial and social incentives (support groups) be strongly encouraged features of recovery plans.

3. Service providers be significantly compensated by capitation rates and results, not just on contacts and procedures.

Results should be measured at least partly by client satisfaction.

Sincerely,

Karen Kallay

Member of (and not speaking for) the following: Governing Board of Rappahannock Area Community Services Board; Western State Hospital Citizen Advisory Council; Mary Washington Healthcare Citizen Advisory Council, Behavioral Health Group; Virginia Organizing; President, Recovery in Motion; Mental Health America; National Alliance on Mental Illness-Rappahannock Affiliate

Sent: Thursday, May 21, 2015 10:30 AM

Subject: Transformation Team Public Comment".

I support all of the transformation team objectives . I also suggests that we should concentrate on having a tighter communication line between doctors, therapist, and family. When my son needs his doctors, and therapist they are always busy, and I believe that when he is in a crisis, he needs immediate help and resources in order to get the necessary help that he needs as soon as possible. There should be a source that he can always rely on and not have to wait for assistance. Each person and case is different and they should be handle accordingly. Please consider how to make sure that all people with a mental disability is given priority and that this person does not feel that they are alone, and don't have the necessary infrastructure set up to best help them.

Sent: Thursday, May 21, 2015 12:27 PM

Subject: transformation team public comment

I have experience working as an RN in an acute psychiatric and emergency department, and as a "jail therapist" for a local detention center. Many times, I have evaluated psychotic individuals at the jail, and they are suffering with negative symptoms. They do not meet the criteria for "danger to self/others" but do have anosognosia. These people can be very difficult to TDO to a hospital as the law is currently written. They obviously need treatment, even long term care, but are instead in a solitary confinement cell with nothing but the clothing on their backs and a blanket for months while lawyers and judges postpone hearings because of behavior, psychiatric evaluations and so on. These and other very sick SMI individuals need hospitalization and stabilization including forced medication initially due to anosognosia. The

sooner the better, as research shows that brain tissue is deteriorating the longer the illness goes untreated.

1. There needs to be more communication between the arresting officer and the psych/medical staff in the jail because where I worked, NO information was passed on, and we were left to discover the severity of illness ourselves. Very ill people do not volunteer their demographics, history or previously prescribed meds.

2. Officers bring people to jail who are obviously suffering from altered mental status. The cause of the altered thoughts is not tattooed on the forehead of the afflicted, and therefore unknown to anyone, especially if the person has anosognosia. When brought to an emergency department, the person is cleared of any medical condition that would cause such symptoms, and then directed to a psychiatric unit. Officers however, override the medical clearance, bringing them directly to jail. Personally, I have discovered several instances where a person had medication toxicity, a brain bleed and other serious conditions when first incarcerated. They were dismissed as "nuts" and just brought in. This practice has to stop. There has to be accountability for bad outcomes of these people, and requiring medical clearance and psych. treatment prior to jail would do just this.

3. Just as the jail refuses critically medically ill ares-tees from an arresting officer, so should they have the authority and be REQUIRED to refuse to jail the psychotic/delusional ares-tee. Currently there is too much cronyism between police/sheriff/corrections to trust the correctional system to do a good job on their own. It has to be a policy/law requirement.

4. The jail where I worked did not employ the CSB to provide mental health care in the facility. This was a bad idea. There was poor communication between the CSB and the jail therapists, very poor, if not NO discharge planning required of the therapists. The therapists were not credentialed to be doing evaluations, (i was an evaluator with a license as an RN and a BS in health sciences) and the other person had no clinical experience whatsoever. The quality of care was despicable. The psychiatrist saw @6 or 7 patients per week for no longer than 3.5 hours, by a remote system. The very sick inmates with anosognosia were not seen because they did not seek treatment. I could not get anyone to change anything about the awful system so I left. I offered solutions and information which was supported by scholarly journals, but I was ignored.

Good luck with implementing the so badly needed changes. I'm personally hoping for an IMD exclusion repeal and enactment of the "Helping Families in Mental Health Crisis Act". Rep

Murphy met with some parents of SMI individuals in Washington yesterday and I'm hoping the madness of the system is cured real soon.

Sent: Thursday, May 21, 2015 1:11 PM

Subject: Re: Mental Health in VA, my state

Thank you.

If I can be of assistance in any way as a consumer who has been stable for 15 years, but who has also experienced the very worst of m.i. in the past, please let me know. If I can help another in any way, please also let me know.

I still have all my journals from that time in a taped up box. I shared the first one with my therapist 7 years ago, and she remarked at how lucid it all was. I replied, well, I was stabilized before I even got to the hospital. I'd had to be in the County jail for two periods equaling 50 days of utter misery prior to a bed being found for me. It was inhuman and degrading to say the least. What a ridiculous spectacle I made at my daughter's graduation from Washington-Lee H.S. in Arlington, with 4 deputies being paid, and me handcuffed and shackled when I would have sat quietly as all the other parents, whom I knew from the PTA. My daughter was valedictorian, and I am sorry she has this in her memory. It took me many, many years to overcome that with her. Our relationship was almost destroyed.

One thing I can say: I learned a great deal through my ordeal, and became a much stronger person, but I wouldn't wish it on anyone.

From: Christy Evanko [mailto:cdevanko@yahoo.com]

Sent: Sunday, May 24, 2015 9:16 PM

To: TransformationTeams (DBHDS)

Subject: Public Comment

As a Licensed Behavior Analyst, I strongly urge that Applied Behavior Analysis (ABA) services be included in all offerings for persons with developmental delays or intellectual disabilities who have Medicaid. These services would integrate with many of the core themes in the recommendations. Applied Behavior Analysis is recommended by the National Standards Project for both children and adults with autism spectrum disorders. There is a large body of research regarding ABA and its beneficial outcomes for persons with developmental delays or intellectual disabilities, as well as other persons who have challenging behaviors. In the Commonwealth, ABA must be provided by a Licensed Behavior Analyst or Licensed Assistant Behavior Analyst, and as of April, there are almost 700 licensed persons. These providers are held to strict ethical guidelines and receive extensive training. Behavior Analysts routinely provide services that are tailored specifically to the individual (i.e. person-centered) and many provide trainings to other providers. ABA needs to be an available option among the array of services, not replacing other services, but in addition to them as requested by individuals. Please strongly consider including ABA as an option in any and all service offerings from the Commonwealth. Please involve

Licensed Behavior Analysts and Licensed Assistant Behavior Analysts from the Virginia Association for Behavior (VABA) in future planning endeavors.

Thank you for your time,

Christy Evanko, BCBA, LBA

President, Virginia Association for Behavior Analysis (VABA)

Sent: Monday, May 25, 2015 12:10 PM

Subject: Transformation Team Public Comment

I applaud the Transformation Team's thorough assessment of the need to find ways to treat many more people with SMI who are not currently receiving treatment.

However, it also appears that the long term goal of treatment is to promote recovery of individuals living with MI such that many could eventually sustain employment, independence and maintain wellness using fewer public resources to do so.

To that end, I would suggest that the team investigate the impact of Medicaid/Medicare policies regarding medication treatment for beneficiaries. The policy or procedure as currently implemented means that upon every anniversary of qualifying for services, beneficiaries receive notification that the contracted insurer for prescription benefits does not cover one or more of the medications currently prescribed. Thus the patient and provider must attempt to find equivalent drugs and begin the long process of trial and error and transition. Sometimes this works and sometimes it does not. In many cases, the coverage denied is for the most inexpensive generics available to treat the condition.

Most people living with SMI are taking multiple, very powerful drugs, many with severe side effects. The typical cocktail includes: anti psychotics, anti-anxiety, anti-depressants, sleeping pills and other prescriptions to alleviate the side effects of the anti-psychotics, anti-anxiety and anti-depressant medication.

Finding the right cocktail of drugs is typically the first and most important step in treating MI. This takes a tremendous amount of time, energy and effort on the part of the provider and patient as unfortunately, it is still a trial and error process as each individual's symptoms and reactions to medications are as individual as they are. The current policies which require

medication changes EVERY year are very disruptive to recovery and extremely time consuming for providers, whether providers are weaning patients from one drug and gradually increasing dosage of the alternative or spending time on paperwork requesting waivers for patients who would like to continue their current course of medication. The fact that most patients are taking multiple medications further complicates the entire process.

If a patient is doing well, progressing in his/her recovery, why risk regression or relapse to save pennies on the dollar? I would argue that the instability produced by this policy of tinkering with prescriptions that ARE WORKING certainly has detrimental short and long term effects on the recovery of every patient who is forced to make such changes. My daughter becomes extremely anxious upon receipt of the letter announcing the change just in anticipation of having to go through it. I would think many others have the same reaction.

I realize that Medicaid/Medicare are federal programs, however, does not the Commonwealth administer and/or contract for the administration of the program within Virginia?

Thank you for considering this most important policy that impacts the recovery of people living with MI.

From: Megan Valentine

Sent: Tuesday, May 26, 2015 9:48 AM

To: TransformationTeams (DBHDS)

Subject: ABA for a larger population

As a Licensed Behavior Analyst, I strongly urge that Applied Behavior Analysis (ABA) services be included in all offerings for persons with developmental delays or intellectual disabilities who have Medicaid. These services would integrate with many of the core themes in the recommendations. Applied Behavior Analysis is recommended by the National Standards Project for both children and adults with autism spectrum disorders. There is a large body of research regarding ABA and its beneficial outcomes for persons with developmental delays or intellectual disabilities, as well as other persons who have challenging behaviors. In the Commonwealth, ABA must be provided by a Licensed Behavior Analyst or Licensed Assistant Behavior Analyst, and as of April, there are almost 700 licensed persons. These providers are held to strict ethical guidelines and receive extensive training. Behavior Analysts routinely provide services that are tailored specifically to the individual (i.e. person-centered) and many provide trainings to other providers. ABA needs to be an available option among the array of services, not replacing other services, but in addition to them as requested by individuals. Please strongly consider including ABA as an option in any and all service offerings from the Commonwealth. Please involve

Licensed Behavior Analysts and Licensed Assistant Behavior Analysts from the Virginia Association for Behavior (VABA) in future planning endeavors.

--

Megan Valentine LBA BCBA

Connections Program Supervisor

Compass Counseling Services

10707 Spotsylvania Avenue, Ste 102

Fredericksburg, VA 22408

From: jody liesfeld

Sent: Tuesday, May 26, 2015 10:01 AM

To: TransformationTeams (DBHDS)

Subject: Applied Behavior Analysis Services

As a Licensed Behavior Analyst, I strongly urge that Applied Behavior Analysis (ABA) services be included in all offerings for persons with developmental delays or intellectual disabilities who have Medicaid. These services would integrate with many of the core themes in the recommendations. Applied Behavior Analysis is recommended by the National Standards Project for both children and adults with autism spectrum disorders. There is a large body of research regarding ABA and its beneficial outcomes for persons with developmental delays or intellectual disabilities, as well as other persons who have challenging behaviors. In the Commonwealth, ABA must be provided by a Licensed Behavior Analyst or Licensed Assistant Behavior Analyst, and as of April, there are almost 700 licensed persons. These providers are held to strict ethical guidelines and receive extensive training. Behavior Analysts routinely provide services that are tailored specifically to the individual (i.e. person-centered) and many provide trainings to other providers. ABA needs to be an available option among the array of services, not replacing other services, but in addition to them as requested by individuals. Please strongly consider including ABA as an option in any and all service offerings from the Commonwealth. Please involve Licensed Behavior Analysts and Licensed Assistant Behavior Analysts from the Virginia Association for Behavior (VABA) in future planning endeavors.

Jody E. Liesfeld, M.Ed, LBA, BCBA

Clinical Coordinator

The Founders Center of Commonwealth Autism

Sent: Tuesday, May 26, 2015 10:22 AM
Subject: Transformation Team Public Comment

I saw no specific mention of services for people who are deaf, hard of hearing or deaf-blind. Please be sure your Transformation Teams address the unique mental health needs of these populations. I work with senior adults who are deaf-blind and use sign language as their primary means of communication, as well as those who are hard of hearing and blind or visually impaired but do not use sign language. The need exists for professionals skilled in American Sign Language as well as those who know about communication modes/technology used by persons who are hard of hearing and have vision loss. The key to good mental health services is communication. Please do not overlook the needs of these populations.

Thank you!



May 20, 2015

Commissioner Ferguson,

The Virginia Ability Alliance is a coalition of Northern Virginia non-profits focused on ensuring all people with disabilities are living a full life in their home community. We are pleased that you have instructed DBHDS to consider options for system transformation in the coming years.

We were able to attend the May 12, 2015 presentation on the Transformation in Northern Virginia. There are several ideas presented that are great strides forward:

- A focus on futures planning for intellectual and developmental disability services that currently operate on a crisis-driven timeline

- Reducing the waiting list for ID and DD Waivers that presently leave families waiting for many years for critical supports
- Requiring case management, a core service, for anyone receiving state services and making this service available to anyone else
- A broad focus on housing, transportation, education, employment, community engagement, advocacy, service quality, and healthcare to ensure they are available and affordable for anyone in need
- Reiterating the state's commitment to Waiver Redesign which must happen to move us to a truly community-driven system
- Strengthening the professional workforce that serves people with I/DD across a lifespan
- Promotion of Early Intervention services that limit or eliminate the need for long term care
- A focus on educating judges, Commonwealth's Attorneys, and public defenders on diversion and risk screening when people with disabilities encounter the justice system
- Training for law enforcement to make any interactions with the I/DD community safer
- Ensuring psychotropic medications are available in jails and once people are released
- Jail-based screening for disabilities
- Training for jail staff of the I/DD population

We are concerned about some areas presented in the Transformation. The behavioral health presentations focused on co-occurring mental health and substance abuse needs, but did not address the high percentage of people with I/DD who also have a mental health diagnosis. These service realms have always been fragmented and must be better coordinated to ensure we are wrapping the right services around individuals.

No examples of how to reduce the waiting list were given, and there was information shared about managing the waiting list based upon urgency. We support an urgent needs-based system, but unless we get to a point where the waiting list is significantly diminished, we will continue to force people into crisis to receive services.

Though they may have been beyond the scope of this initial planning phase, no attention was given to the fast-approaching managed care system or the need for increased funding. We support efforts to think outside the box without starting with a predetermined price tag, but presenting a set of ideas that do not acknowledge the significant limitations on implementing a system like this felt hollow.

Overall, we are excited to see the work of the Transformation Teams and look forward to seeing these ideas implemented.

Sincerely,

The Virginia Ability Alliance

Sent: Tuesday, May 26, 2015 1:20 PM
 Subject: Transformation Team Public Comment

I have read the recommendations from the Adult Behavioral Health Team. Two of their "Recommendations to Improve Access" grabbed my attention: (1) Expand basic substance use disorder treatment capacity, and (2) Offer peer provided services and recovery supports. I also note that Blue Ridge Behavioral Healthcare's letter of May 14, 2015 endorses the first recommendation and states: "The costs to the Commonwealth of inadequate treatment resources for substance disorders is staggering." Those costs have been well documented by JLARC and others.

The Healing Place is a peer support and recovery program model which has a proven track record of successfully helping men and women with substance use disorders recover and maintain their sobriety. One year after completing the program, 65 - 70% of its graduates are still clean and sober. The Healing Place men's program in Richmond has been operating successfully for a number of years, and other programs are being developed in Hampton Roads and Southwestern Virginia. The Commonwealth would be wise to invest in programs like The Healing Place.

Sent: Tuesday, May 26, 2015 2:24 PM
Subject: Transformation Team Public Comment

I have been steadily losing my hearing. I wear hearing aids but still don't hear that well. I have been taking ASL classes but it has been slow going. I am not at the point where I could understand an interpreter. The team needs to be trained in working with hard of hearing people as well as deaf people. Things like facing the person, making sure there no other noises, like people talking nearby or a radio on, Emailing instead of phoning, etc.

Sent: Wednesday, May 27, 2015 12:09 PM
Subject: Public comment- Angie Leonard

I changed careers to provide intensive intervention for [son] and others like him through creation of ABA programs/schools in Roanoke, Lynchburg and Lexington VA. I have a personal concern that the tiered system in the waiver redesign might not support what we have worked so hard for. Due to intensive intervention, sacrifices in time, a change in career, typical family dynamics, draining of the bank account, and much more, Joshua is doing well, but is not quite ready for independent living. We fear that he will rate too high and fall between the cracks. His behavior was very tough, but due to great intensive support and education, his significant behaviors have been extinguished. Now he needs intensive work in the way of employment. Since Joshua joined up with DARS, they have been the opposite of intensive, and the supervision of his employment related activities has been by severely untrained individuals who have no interest in training or learning new things. Our experience has been most concerning.

I am currently working to start quality programs for adults, which would support living and working in their own communities. I am worried that starting these programs will not be sustainable to keep the business open.

I am willing to do whatever you need to help. I will make the time to help change the systems in VA to meet the needs.

Finally, children have early intervention and IDEA. Adults have nothing if they don't have a waiver. We need to start with them. Start with the folks who have the least amount of supports. Grant waiver spots to the older population (past age 22) who have nothing!

Thank you.

From: jeanskane@comcast.net

Sent: Wednesday, May 27, 2015 12:10 PM

Subject: Comment on Transformation Teams' Mental Health Recommendations from the Justice Involved Services Team

Two years ago, the Western State Hospital (WSH) Advisory Council began examining some aspects of the impact that the commonwealth's criminal justice system had on hospital bed availability for civil patients. It is our understanding that the average length of stay in the hospital is much greater for forensic patients than for those whose commitments are civil. It also appears to be the case that placement back in the community after hospitalization is not always managed in a timely manner because of the inadequacy of Discharge Assistance Program (DAP) funding, among other reasons. The result is pressure on the hospital and the Community Service Boards (CSBs) using the hospital to serve Health Planning Region I (HPR 1) with regard to both admissions and discharges.

It is also evident to us that Not Guilty By Reason of Insanity (NGRI) pleas are responsible for some of the hospital bed usage by the criminal justice system. We understand the appropriateness of such pleas and the resulting hospitalizations in the case of violent crimes. However, we question the appropriateness for misdemeanor and other minor offenses; we believe that such use violates Olmstead since the hospital length of stay and time under court supervision on discharge can greatly exceed the sentence that a guilty plea would generate. It would also seem to violate the recovery model of mental health treatment, since no serious mental illness lies behind the behavior leading to the criminal justice charge.

I was therefore personally quite disappointed to find that the issues which concern the WSH Advisory Council were not among those on which the Justice Involved Services Team made any recommendations. We remain committed to see the NGRI plea used more appropriately than it seems to be at present. Such a limitation on NGRI pleas would take pressure off hospital bed availability, by restricting bed use to cases of genuine need for hospital treatment of mental illness. It would not confuse mental illness with inappropriate behavior; it would reduce societal costs of addressing such behavior in a way more in keeping with Olmstead.

I trust that as we seek to transform our mental health system and make it a "best practice" model for the nation, the concerns I've expressed above will be considered.

Sincerely yours,
Jean S. Kane
past president of the WSH Advisory Council

From: Kristie Melson Wells

Sent: Wednesday, May 27, 2015 6:23 PM

Subject: Transformation Team Public Comment

Good Morning!

I hope this email finds you well!!

I am writing to add to the Public Comments regarding The Department of Behavioral Health and Developmental Services (DBHDS) Transformation Process.

As a Licensed Clinical Social Worker here in Virginia and a family member of a Deaf individual, I want to emphasize the importance of expanding services for those who are Deaf (and use American Sign Language) and hard of hearing (and may or may not use signed languages).

The Need is Real- Statistics and Figures:

* 50% of deaf women and 16% of deaf men will experience domestic violence.

- <http://www.deafdawn.org/facts-stats>

* 80% of women with disabilities have been sexually assaulted.

- <http://www.deafdawn.org/facts-stats>

* A study published by the National Institute of Health found that Suicide Risk was higher in the deaf and deaf-blind populations: *"Deaf and deaf-blind individuals suffer higher rates of mental health problems than hearing individuals [3,4]. Recent reports from the UK Department of Health and non-governmental organizations [3,5] also reveal increased difficulties for deaf people in accessing mental health and social care services. These factors may put deaf individuals at greater risk of suicide than the general population."* (p. 6-7)

This study also noted that more research is needed in this area since little effort has been made to focus on this population (p. 5-6).

- <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2093933/>

A separate set of knowledge, experiences, and cultural competency is needed to successfully work with

those who are deaf or hard of hearing. Investing in clinicians who are linguistically and culturally competent will improve access to services for the deaf and hard of hearing and reduce risk to mental health, behavioral health, and domestic crises.

I urge you to consider the impact the limited access to services has on our community as a whole.

There are qualified clinicians available but more are needed as well as additional resources and supports: funding, training, expansion of services (Substance Abuse, Domestic Violence, Therapy, Day Treatment, etc.) and service providers.

Thank you for taking the time to read this and consider the points discussed above.

Kristine Melson Wells, LCSW, NIC-A

Commenter: Jennifer Faison

Affiliation: Executive Director, Virginia Association of Community Services Boards

Date of Submission: May 29, 2015

The Virginia Association of Community Services Boards (VACSB) commends the efforts of the Commissioner's Transformation Teams, specifically with regard to their continued commitment in upholding the person-centered principles of recovery, resiliency, self-determination, and wellness throughout the transformation process.

The themes present throughout the Teams' spring 2015 recommendations illustrate a keen understanding of the current pressures of our system. Themes of maximizing the effectiveness of current funding, strengthening and expanding the role of case managers, integrating healthcare systems, and harnessing available data allude to tangible recommendations that seek to improve services, supports, and outcomes across the continuum of care. Also relevant is the focus on workforce development. While the recommendations speak specifically to assessing the workforce we have now, we anticipate that the assessment process will lead future Transformation Team efforts toward workforce development efforts such as higher education incentives for those pursuing work in behavioral health and developmental disability-specific fields and tuition reimbursement programs, among others.

VACSB views recommendations regarding substance use disorder (SUD) services, peer supports, criminal justice diversion, and child psychiatry as potentially innovative solutions to complex problems present in the Commonwealth. Of note among those recommendations are:

- increasing medication assisted treatment and reevaluating current SUD Medicaid rates could immediately expand SA treatment capacities;
- establishing a rotating discretionary fund for peer-run organizations could provide additional peer support services for parents and persons with lived experience;
- designing a statewide system of navigation could improve access to coordinated care for children, including child psychiatry and telemedicine consults; and,
- diverting low-risk offenders from the criminal justice system through additional CIT programs and Judge/Law Enforcement behavioral health education.

The VACSB is concerned that adequate funding will not be available to accomplish all of the worthy goals laid forth in the recommendations and there does not appear to be, at present, a prioritization of the goals/recommendations according to severity of need from a consumer perspective or level of funding required to build capacity and improve quality from a provider perspective.

Thank you for the opportunity to provide comments.

Sent: Thursday, May 28, 2015 6:49 PM

To: TransformationTeams (DBHDS)

Subject: Transformation Team Public Comment

Thank you for the opportunity to submit comments on the recommendations of the DBHDS transformation teams.

As a former foster and now adoptive parent of children and youth with mental health needs, I reinforce the value of the recommendations offered by the Child & Adolescent Behavioral Health Transformation Team. Families formed by foster care, adoption and kinship care are three to four times more likely to experience mental illness and serious behavioral health impacts.

In particular, in our northern Virginia region, we are in need of core services including crisis response (for level 2 and level 3 intensity needs), parent support partners and youth peer-to-peer supports. Training of personnel who work with our children and youth, such as teachers, other school personnel and private and public agency behavioral case workers in trauma-informed practices could significantly reduce aggressive behaviors and resulting conflicts.

The systemic use of reliable data for decision-making as well as the need for a single coordinating entity are both paramount as well. Finally, transition from the child-serving systems to adult systems remains a major challenge.

Thank you for your efforts to improve access to and delivery of services to Virginia's children, youth and young adults with emotional and behavioral disorders.

From: OConnor, Michael (DBHDS)
Sent: Friday, May 29, 2015 12:04 PM
To: TransformationTeams (DBHDS)
Subject: Transformation Team Public Comment

The Child and Adolescent BH Transformation team has recommended strengthening the quality/credentials of in home providers. This is at the "deep end" of the continuum.

In the various VICAP evaluation meetings that have been held, a significant gap was identified between routine office based therapies and extremely intensive in home services of at least 5 hours a week limited to kids at risk of placement [current Medicaid criteria]. VICAP evaluators and private providers have made it clear that many kids do not qualify [or need] the more intensive in home service but will not adhere to/benefit from once a week in office therapy. Family and economic issues leave these kids without needed services. Many of these families do not have the personal resources to adhere to a once a week appointment with a therapist and neglected the need of these children escalate or they default to juvenile justice.

The team should consider the development of an in home therapy benefit that may be only an hour or two a week using eligibility criteria similar to outpatient therapy plus likely inability to utilize or benefit from office based therapy.



May 29, 2015

Re: Public Comment: Transformation Teams Report

Dear Commissioner Fergusson:

Thank you for the opportunity to provide feedback on your Department's Transformation Teams initial work and recommendations. Community Brain Injury Services is part of Virginia's state funded brain injury network and we are the primary community service provider in the Metro Richmond and on the Virginia Peninsula for persons with brain injury.

There are a couple facts that to me underscore the need for the brain injury community to work more closely with the Department of Behavioral Health and Developmental Services and the 40 Community Services in operations around the Commonwealth.

- Brain injury is one of the largest disability populations in Virginia with well over 200,000 Virginian's living with a brain injury related disability.
- There is high comorbidity between brain injury and mental illness and substance abuse issues.

As such, many persons with brain injury need efficient access and effective services within our state public mental health and substance abuse service system.

Over our 15 years of services, CBIS has developed strong working relationships with most of the local Community Services Boards within our service areas. For the most part, these working relationships have been positive and have been solution focused to ensure that clients with a dual diagnosis of a brain injury and mental illness and/or substance abuse issue receives access to the services they need. For instance, we developed a collaborative substance abuse group with Henrico County Community Services Board, specifically for survivors of brain injury. We have also worked with many CSB's in collaborating with them to meet a client's specific issues, where our organization handles the brain injury aspects of the case and the CSB collaborates with us to work on the mental health aspects of the case.

However, we have also had instances where persons with brain injury have been denied access to behavioral health services, including instances where we have had people in crisis situations and we could not access prompt crisis services from our local community service board. We have also had persons with a dual diagnosis who were being served by one Community Service Board, move to another locality and then not be able to access services at their new Community Service Board.

I served on the Governor's Mental Health Task Force, Crisis Response Workgroup, last year as a brain injury representative to this group. We were pleased to be considered a stakeholder in these important mental health reforms and added unique perspective to ensure that the recommendations were inclusive for all Virginians, specifically persons with brain injury.

The brain injury community stands ready and willing to add value to the transformation processes now ongoing at DBHDS. We did not have representation on the initial transformation team process and I personally feel that was very much a missed opportunity.

My main recommendation to the transformation teams at this juncture would be to include brain injury representative(s) on these teams. Brain injury needs to be seen as a vested stakeholder at the Department of Behavioral Health to ensure that our population has appropriate and timely access to behavioral health and substance abuse services overseen by the department. The brain injury community is dealing with many of the same issues being addressed by the transformation teams and we have numerous representatives in our community that would add great value to this ongoing process. I would specifically recommend a representative from the Brain Injury Association of Virginia and a representative from Virginia's state funded brain injury provider network be included on the transformation teams.

Additionally, during the most recent General Assembly session, several new directives were passed regarding persons with brain injury and DBHDS, including a directive to fully include persons with brain injury in the Medicaid Waiver redesign process and a directive that persons with brain injury have access to crisis, substance abuse and behavioral health services overseen by DBHDS. This is but one more reason that it is extremely timely for the Department of Behavioral Health and Developmental Services and the brain injury community to begin meaningful dialogue.

Thank you again for the opportunity to provide input into the transformation team work. I stand ready and look forward to a continued dialogue with DBHDS.

Sincerely,



Jason Young, MSW, Executive Director
Community Brain Injury Services
7812 Shrader Road
Richmond Va. 23294
Phone: (804) 261-7050
E-mail: Jason@communitybraininjury.org

dd



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www.bia.vnet

THE VOICE OF BRAIN INJURY

Public Comment: Transformation Teams Report

Sheela Nimishakavi, Director of Operations

Brain Injury Association of Virginia
1506 Willow Lawn Drive, Ste 212
Richmond, VA 23230

Service Area: Commonwealth of Virginia

May 29, 2015

On behalf of the Brain Injury Association of Virginia, thank you for taking the time to thoroughly evaluate the current state of behavioral health services offered in the Commonwealth of Virginia and for developing these recommendations. BIAV has a thirty-year history of working with people with brain injury. As the only nonprofit in the state solely dedicated to providing information and referral services for people with brain injury and their loved ones, we serve over 10,000 individuals annually and have witnessed firsthand the incredible need for neurobehavioral services for people with brain injury. The recommendations put forth by the transformation teams correspond with BIAV's goal to increase access to "the right services and the right place at the right time."

As such, BIAV would like to offer the following comments for your consideration:

- Current statistics indicate that more than 28,000 Virginians sustain a brain injury each year. Furthermore, over 40% of people with brain injury have at least one comorbid mental health issue. As such, behavioral health providers likely serve people with brain injury and need a comprehensive understanding of brain injury to be able to best serve this population. For instance, some symptoms such as memory loss can present as a psychiatric issue, when in fact it is due to cognitive deficits that will not respond to psychiatric treatment. On the other hand, over 50% of people with brain injury are affected by depression post-injury and do require behavioral health intervention. Mandated brain injury training for behavioral health providers by brain injury specialists would ensure the appropriate care, the "right service," is provided.

- More communication and coordination is needed between the Community Services Boards and brain injury service providers. While both the CSB's and brain injury service providers independently offer case management services, some cases of brain injury absolutely require collaboration and coordination between behavioral health and rehabilitative case managers. Coordination between these two systems through dedicated representatives is necessary to ensure care is provided by the "right place."
- In terms of crisis response services, adding brain injury service providers to the coalition of stakeholders that advise the Crisis Intervention Teams and adding brain injury information to training for CIT personnel could prevent people with brain injury from being turned away from providers in their moment of need, ensuring care is provided at the "right time." BIAV's own study on brain injury in the corrections population indicated that over 40% of adolescents involved in the juvenile justice system sustained a brain injury at some point prior to being detained. Thus we see a clear relationship and an imminent need for crisis intervention.

Lastly, I would like to emphasize that people with brain injury are an important constituent of our population with behavioral health issues. That being said, brain injury service providers have a vested interest in the future of mental health services in Virginia. We bring important information to the table and need to be regularly included in these mental health discussions. Brain injury service providers are ready and willing to work with behavioral health professionals to ensure that the needs of all Virginians facing mental health issues are able to access the care they need in the most effective and efficient manner possible.

Again, thank you for the opportunity to comment on the transformation team recommendations.

Comments on Transformation Team Recommendation Matrix Spring 2015

Submitted by

The Arc of Virginia

May 29, 2015

Transformation Team Recommendation Themes: (comments in blue)

1. *Formalize and fund core services and supports across a continuum of care – focus on the Right Services and the Right Place at the Right Time*

What services are considered to be 'core services and supports' in the I/DD service system? How do we ensure person centered planning when formalizing a list of core services and supports for

the I/DD population across the lifespan?

How do you set standards for any program or service and enforce those standards? With the present reimbursement rates and funding streams, who will provide them? Are some services available under regular Medicaid for those who are on the waitlist?

Additional services should be available to support individuals and their families who do not qualify for the I/DD Waiver program or are on the waiting list for the I/DD Waiver.

2. Require reimbursement for case management services

3. Strengthen the community-based system of services and supports statewide

Build an infrastructure to expand self-directed service options available to waiver participants and their families. What actions are planned to assist individuals and families to self-direct their services and supports (e.g., expanded access to support brokerage and service facilitation services)?

Make technical assistance and funds available to service providers to support the transition away from segregated congregate models and towards integrated, community-based services and supports.

There should be a continuum of community based options that meet the individual's and family's needs at any given time. If an individual or family chooses to direct their services, then they should have that option available. If an individual or family chooses to have a provider coordinate their services, they should have a quality option available to them.

4. Standardize quality of care expectations statewide

Improve quality of care and oversight of services, while minimizing paperwork for providers and families managing community directed services. Utilize/streamline existing opportunities to strengthen compliance with CMS settings rule and the DOJ settlement agreement. Ensure people with I/DD and families are involved, not just informed, in quality improvement.

5. Align and maximize effectiveness of available funding streams

Develop a plan and pursue options for generating additional Medicaid matching funds and using existing funding sources more efficiently.

6. Harness the power of data across agencies in the Secretariat to utilize and improve health outcomes

Utilize data to improve community integration of individuals with disabilities to ensure the right services are being accessed consistent with an individual's needs and preferences and in the least restrictive setting.

Collect and review available data for individuals on the ID/DD waiting lists who are served by waiver programs (EDCD, Day Support, Tech), as a starting point to project cost of providing care under ID/DD waivers.

7. Integrate behavioral health with physical health and social services

8. Strengthen the workforce to ensure access to services

Strengthening the workforce should include building community capacity, training providers on integration and new services, and providing funding to provider agencies to enable the transitioning of current services models into more integrated settings. There should be a greater focus on expanding the pool of consumer directed employees to ensure families have choice among service providers.

9. Promote through policy and reimbursement a person-centered approach to care, merging the activities and processes of mental health, substance abuse, and DD/ID with those of child welfare, juvenile justice, educational, and health services

10. Develop and conduct customized trainings to organizations who interact with populations – Employers, Schools, Jails, etc.

Develop trainings for teachers and first responders on recognizing behavior that may suggest a need for an individualized approach, positive behavioral supports, and crisis intervention. Develop trainings for employers to understand the strengths of individuals with disabilities and promote hiring persons with disabilities in naturally occurring competitive employment.

Current practices within our educational systems and funding streams, such as the Comprehensive Services Act program, should be evaluated to ensure they do not result in inappropriate and unnecessary segregated placements for school age children with disabilities.

Developmental Disability Matrix Comments: (comments in blue)

Crisis Response Services and Criminal Justice Diversion

Strengthen existing services to address the crisis needs of individuals receiving waiver services and those on the waiting lists. This should include collaboration with local first responders to recognize and support the unique needs of individuals with I/DD, to reduce unnecessary involvement in the criminal justice system by utilizing existing services. Training should be required of congregate care staff in crisis intervention, positive behavior supports, and available crisis services and supports available through programs funded by DBHDS.

Prevention and Treatment Services

An array of prevention services should include family support services and increasing public awareness.

Case Management

Ensure that CSBs and private providers of case management services are furnishing such services on a conflict-free basis. This is a fundamental issues within the current I/DD service system, and should be addressed by transformation efforts.

Case managers should receive training on best practices in person-centered planning, supported decision making, and about services and supports available to clients in the community. Training on key services should be made mandatory for case managers, such as Waiver, REACH, IFSP, and other DOJ-related goals of employment first and supported living.

Further, an array of service options should be presented to individuals when developing ISP's; and to the maximum extent possible, services should be provided in communities where the greatest level of natural supports are available.

Coordination of Services

Improve the coordination of services for individuals transitioning out of special education and into long-term support services. Take actions to collaborate with the Board of Education in cooperation with local school districts and DARS on transition related issues.

Planning for a student's transition from school-based to community-based services should begin well before the student ages out of the education system, and a plan should be in place immediately upon completion of school. CSBs should be required to participate in transition to ensure supports are in place as the individual ages out of the school system.

Adopt Best Practice Standards

Use Data to Drive Care and Policy Decisions

The Arc of Virginia supports a robust waiting list management system to help in planning and prioritizing of needs on the waiting list. Solicit stakeholder input in the development of the new management system, including, advocacy organizations, self-advocates, families, providers, and CSBs.

The waiting list management system should include assessment of needs to more effectively project costs and build capacity for community-based services.

Work to Appropriately Fund Services

Adequate funding drives quality of services and options. Service providers may require funds to shift congregate care models to individualized, integrated supports and services. In order to adequately meet the needs of individuals in the community, it may become necessary to provide grants or other one-time funds to support compliance with the CMS HCBS Rule. Similarly, adequate funds should be made available to support transition of individuals with intense medical needs from institutional placements to community-based settings.

Strengthen the Workforce

Additional comments:

How does the Developmental Disability Transformation Team recommendations and work plan coincide with the Waiver Design Advisory Committee and its related workgroups, The DOJ Settlement Agreement activities, and the Statewide Transition Plan for the CMS Home and Community Based Rule?

Many recommendations in this document mirror discussions and recommendations said in other work groups (ie. Waiver redesign, SELN, etc.) but this group was charged to explore bigger issues such as conflicts in the service system and funding strategies. Will this team take on more transformative issues? The origin of the problem is the decision to ask all five study teams to respond to a parallel set of DBHDS-generated questions, rather than having each team identify and explore key topics that it felt would shape future policies and practices in their respective focus areas. How will future work by the developmental disability team be decided?

It appears The Developmental Disability Transformation Team attempted to delineate elements of a comprehensive service system. Rather than start from scratch, the team should build on similar efforts that are underway across the country and figure out the steps necessary to apply those approaches to the existing situation in Virginia.

The Developmental Disability Transformation team should examine states delivering top ranked I/DD services and promoting inclusion to help the team explore ways the current I/DD service system in Virginia can transform. For states that have closed their institutions or in the process of closing institutions, the transformation team should identify effect strategies that helped to facilitate institution closures and build community capacity.

From: Greg Czyszczon, Ph.D., LPC
Sent: Friday, May 29, 2015 11:04 PM
Subject: Transformation Team Public Comment

Dear Transformation Team,

I read with great interest your recommendations and would like to offer any assistance I can provide as a counselor and author of a recent dissertation on in-home services in Virginia. I am attaching it here for your review. I think you will find useful themes that match many of the goals of systems transformation.

It is not enough, however, to talk about providing in-home services. It is really the quality of those services that is at issue. In-home in Virginia is, quite frankly, a mess.

I am including another article in addition to my dissertation that can shed some light on the challenges of in-home in Virginia. It is my hope to be of service to the process of transformation of Virginia's systems of care for children and families.

Sincerely,

Dr. Gregory John Czyszczon, Ph.D., LPC
Licensed Professional Counselor
Executive and Clinical Director

Sent: Sunday, May 31, 2015 8:34 AM
Subject: Transformation Team Public Comment

I think that this is excellent work. My comments are:

1. Adult Behavioral Health

-Evidence based practices are clearly important but outcomes measurement and analysis is a critical.
-A big problem is that under the current system individuals must, for the most part be well enough to come in for services and treatment.

The greatest need however is among those who are not able or willing to come to CSB offices. This has huge unmeasured impact on the community, families and the individual.

More resources for PAC Teams and Mobile Crisis Units might help. As well as a general shift in CSB/Behavioral Health culture toward treatment in the community rather than in "the office".

2. Developmental Services.

- There is a severe shortage of qualified clinicians who effectively treat mental illness and SUD issues in this community. They appear to be almost non-existent, even though the rate of mental illness among ID/DD is significantly higher than it is in the general population.

3. Youth and Children.

- As noted, Transitional services need to be established. It makes not sense for a person to fall off the map when they turn 18.

- The schools need to be enlisted as a robust player in access to services for children.

An important statistic is that 50% of those with mental illness in adulthood are showing symptoms by the time they are 14. This cannot continue to be ignored by school systems.

-Most school systems have 0 information on their websites on how a family can proceed when symptoms of serious mental illness start surfacing.

4. Criminal Justice. At least 25% of the individuals in jails have a significant mental illness.

-Serious Mental Health Assessments need to be an integral part of the judicial system. Starting with the Magistrates, once an individual is "in jail" it is much more difficult to access treatment or to be diverted to a more appropriate setting.

- Superficial assessments exist but are completely inadequate.

- Diversion and a streamlined system for the transfer to mental health facilities are critical.

General Comment:

Behavioral Health Services need to become more flexible and mobile. The emphasis on "programs" and "in office" appointments should be changed to a focus on the individual.

Hospitals need to be engaged and strong persuasion used to remove the practice of picking and choosing patients.



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I appreciate the opportunity to make comments today on this first round of recommendations from Transformation Teams. I serve on the Adult Developmental Services Team and have found the process to be very positive as we have been given the opportunity to envision an ideal system of care for those we serve.

All Teams seem to have established similar core principles for the task of transformation. This is a good place to start. The funding of core services and supports within a statewide continuum of care is essential in order to enhance the health and wellness of the individuals we serve.

Integrating care with primary care services is critical for all individuals and should be a clear and funded service goal for our community based system. This principle represents a commitment to prevention and health and wellness. An available and well qualified workforce is essential and fundamental advances in policy, practices and funding will be required to support the goal of attracting and retaining such a workforce for the future.

A system that embraces person-centeredness in all aspects of service delivery and decision making – including regulatory, financial, human resources management and quality assurance will place Virginia in good standing to meet the challenges of the future.

Relationship is one of the most powerful elements of recovery and person centeredness. The most valuable and sustaining relationships involve both service providers and families and communities working together. It is critical that we understand that an individual's stability frequently relies on all of these relationships. The attainment of this stability is something to be celebrated and should not be the reason for discontinuing the service provider relationships that are the foundation of recovery. Funding decisions must embrace this concept and realize that therapeutic relationships are a prevention tool to ensure optimal levels of wellness and recovery.

A transformed system must be comprehensive, available, accessible, and accountable and must be sustainable over time, while striving for the highest standards of care. I look forward to the next questions to come before Transformation Teams as we strive to transform the system.

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May 29, 2015

Debra Ferguson, PhD
Commissioner
Department of Behavioral Health and Developmental Services
PO Box 1797
Richmond, Virginia 23218-1797

Dear Commissioner Ferguson:

Thank you for the opportunity to comment on the Department's Spring 2015 Transformation Team recommendations. It is clear from the questions posed and the work of each team that participants invested significant time, energy, and thought in developing recommendations in each area.

Family Preservation Services, Inc. (FPS) is Virginia's largest community-based behavioral health services provider, supporting over 3,000 children and adults across the Commonwealth. We are pleased that DBHDS is taking the lead in addressing many of the issues that limit individuals' access to high quality care and is taking the time to involve stakeholders and gather input. Below are our comments for your consideration:

General

- ***Core Services and Supports.*** We support each of the ten core themes that arose out of Transformation Team process, particularly the delivery of the "Right Services at the Right Place at the Right Time." It is essential that Virginia continue to focus on person-centered, recovery oriented care in order to deliver services when and where they are needed.
- ***Case Management.*** We support reimbursement for case management services. However, tied to any mandate or requirement for reimbursement should be adequate training and/or certification for case managers to ensure they are offering the best possible support to individuals and their families. In addition, the reimbursement for case management services should accurately reflect the level of service provided, with some individuals requiring less intensive assistance and others more intensity. Finally, the Transformation Teams should take a hard look at the how case management is currently delivered and determine how it can better promote individual choice in case managers and limit conflict of interests that currently arise when case managers and providers operate in the same organization.
- ***Quality Care.*** FPS supports standardized quality of care expectations statewide. DBHDS and the Department of Medical Assistance Services (DMAS) should develop and set these expectations in collaborative manner with all public and private providers. The Department

should also closely examine the value of requiring national accreditation for services where practicable.

Adult Behavioral Health

- *Crisis Response Services.* There have been significant investments in recent years to make the emergency services/crisis services system more robust and comprehensive. These investments have been essential and the Commonwealth must continue to cultivate and advance this system. However, there are critical and significant gaps in prevention and on-going community supports for adults that must be addressed. Without additional investments in the prevention and on-going support, adults and families will continue to find themselves only able to access services when they are in crisis, not before. Virginia must find a way to develop more outpatient and community services such as psychiatry, medication assisted treatment, mental health supports, employment services, and supportive housing. We are hopeful the Adult Behavioral Health Transformation Team will address this array of services during its next series of meetings.
- *Case Management.* As stated earlier, case managers should be trained so they have the skills to understand and coordinate care for individuals. In addition, if the Commonwealth were to mandate case management caseloads, the Department must ensure there are sufficient case managers to meet consumer needs. We are hopeful that the Department would consider private sector case management as an option to meet unmet needs.
- *Coordination of Services Across the System.* DBHDS should consider how private entities could also become health homes for persons with serious mental illness and chronic co-morbid physical health conditions. In addition, any workgroups developing strategies to assist individuals with co-morbid conditions should include providers who offer ongoing support for adults with mental illness.
- *Work to Appropriately Fund Services.* DBHDS and DMAS should ensure Medicaid reimbursement is available for peer services. This action is long overdue and would significantly advance Virginia's committed to supporting individuals in their recoveries.

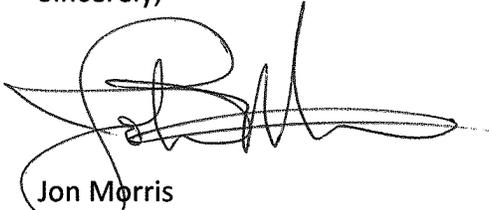
Children and Adolescent Behavioral Health

- *Prevention and Treatment Services.* FPS supports prevention and treatment services and school-based and outpatient services are critical for children and adolescents to remain in their communities. The Transformation Team should consider these services in addition to in-home services when considers "core" or mandated services.
- *Adopt Best Practice Standards.* FPS fully supports quality standards for each core services. Any evaluation of quality standards should consider the value of using national accreditation status in lieu of inventing a separate state system.

- *Adopt Industry Standards.* FPS is encouraged by the Transformation Team's recommendation to identify one entity that has the authority and accountability for children's behavioral health needs, a statewide navigation system for families, and creating local system of care for core mandated services. If the DBHDS elects to move forward with these three recommendations, we strongly encourage the Department to involve a much wider array of stakeholders in the discussion and development of these concepts. State and local government officials, local department of social services, public and private providers, schools, juvenile justice entities, and others. These recommendations represent a significant change for Virginia and stakeholder input and understanding will ensure, if implemented, they are successful for children, their families, localities, and the Commonwealth.

Thank you again for the opportunity to review and comment on the Transformation Team recommendations. FPS is available to assist in any way and discuss any of our comments. Should have any questions, please contact me at JDMorris@fpscorp.com.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jon Morris', with a large, stylized initial 'J' and 'M'.

Jon Morris
Chief Executive Officer

Issue Brief

The Public Sector, Master Data Management and the Elusive Golden Record

Boost Efficiency and Service Delivery with a Single Version of the Truth

Introduction

The digitization of government is having a dramatic impact on how agencies approach data, resulting in mountains of constituent data, which is in turn fed back into government systems. If government agencies are to provide consistent and efficient citizen services, this continuous feedback loop requires data quality, accuracy and consistency.

Yet many government agencies operate without the benefit of a golden record — a single version of the truth that provides a holistic view of each citizen with which it works, whether the citizen plays the role of beneficiary, student, patient, taxpayer or even criminal, according to the mission of the agency.

The inability of the government data management process to create a golden constituent record negatively impacts agency performance across the government enterprise.

This includes:

- Missed opportunities to coordinate or improve service delivery
- Decision- and policy-making in a vacuum
- Failure to detect fraudulent payments
- Failure to identify tax cheats
- Lack of access to complete criminal records
- Frustrating workflow inefficiencies for government workers and citizens
- Wasted taxpayer dollars

This issue brief from the Center for Digital Government will explore how a golden record can be used to improve agency efficiency and service delivery. It will examine the negative impact of inaccurate, inconsistent citizen data on the government enterprise, and propose the use of master data management (MDM) technologies to develop a golden record that overcomes these challenges and serves as a single, uniform version of the truth across all government agencies. This capability is key in enabling them to deliver relevant, insight-driven and cost-efficient constituent services.

Multiple Versions of the Truth: Charting the Negative Impact

Data can be a strategic asset, but only reaches its highest value when shared across the government enterprise. In government agencies, separate departmental IT budgets, procurement staff and deployment processes often make information sharing a challenge.

In the typical modern agency, each line of business relies on separate (and sometimes redundant) budgets, processes, applications, databases and systems. In addition, IT deployment models for data projects emphasize investment in strategic aspects of infrastructure and application development. Because data is often viewed as a non-strategic commodity, data integration is susceptible to budgeting shortfalls or scheduling problems. And in many agencies, data sharing is discouraged because it's perceived as a threat to compliance mandates and constituent privacy.

When agency cultures and processes segregate data, it's collected, managed and stored in disconnected silos. Agencies purchase standalone data analytics packages, plug them into their data applications or systems and assume they are on the path to achieving the results they intended. But there's a problem: Data is inconsistent across multiple agencies, suffering from duplications, errors and incomplete entries — there is no authoritative source.

Many government agencies operate without a single version of the truth that provides a holistic view of a citizen. With master data management, agencies can:

- Coordinate and improve service delivery
- Gain insights for better decision-making
- Detect and reduce fraudulent payments
- Improve workflows

The lack of a consistent citizen record reverberates across the government enterprise, hindering initiatives in a wide range of agencies and programs, including state health insurance exchanges, Medicaid expansion, unemployment insurance extension, health and human services (HHS) benefits, public safety and courts, educational data collecting, tax departments and workers' compensation, among others.

The negative repercussions for the government, its employees and its constituents include:

- Fractured citizen view
- Unchecked fraud, waste and abuse
- Missed opportunities to collaborate on decision- and policy-making
- Flawed service delivery
- Inefficient compliance efforts
- Lack of transparency and accountability

Let's examine each of these impacts in greater detail.

Fractured citizen view. In the absence of cross-agency/ cross-program data integration and sharing, each agency and program manages its own constituent records, leading to a fractured view of individual citizens. When each entity has a different and separate version of the truth for every constituent, the government as an enterprise doesn't have an accurate, holistic understanding of the citizen. For example, when databases from courts, prisons, and law enforcement and criminal justice agencies are not integrated, John Doe's probation violation isn't visible to the state trooper that pulls him over for speeding, and Doe gets away with only a warning.

Unchecked fraud, waste and abuse. Without a golden citizen record, the government misses the opportunity to catch inconsistencies that prevent fraud, waste and abuse in tax, unemployment insurance, workers compensation and HHS agencies. For example, when data from the state's unemployment agency is inaccessible to other agencies, jobless benefits payments might be made to ineligible citizens, including jailed felons, deceased constituents and even state employees.

Missed opportunities to collaborate on decision- and policy-making. Without shared, accurate constituent data, governments are challenged by ineffective and incomplete decision- and policy-making processes. Programs and initiatives from a single department are developed in a vacuum, without the benefit of the intelligence and insights derived from other agencies' data.

Flawed service delivery. When agencies don't have a holistic view of citizen records, they're unable to identify relationships among data that can improve service delivery and save tax dollars. Citizens miss the opportunity to benefit from coordinated services. For example, when Jane Doe's records with the agencies that manage and maintain Medicaid and Supplemental Nutrition Assistance Program (SNAP) benefits are not integrated, her caseworkers

The lack of a consistent citizen record reverberates across the government enterprise, hindering initiatives in a wide range of agencies and programs, including state health insurance exchanges, Medicaid expansion, unemployment insurance extension, health and human services benefits, public safety and courts, educational data collecting, tax departments and workers' compensation, among others.

cannot determine if she is eligible for additional benefits. Citizens become frustrated because of the time they waste interacting with multiple websites, paper forms, processes and databases. Employees, too, are discouraged by the disorganized workflow and wasted tax dollars that result from checking multiple versions of the truth.

Inefficient compliance efforts. Ensuring the privacy of non-integrated government data is complicated because security is compromised as data moves among multiple applications, databases and systems, hindering agency efforts to comply with federal mandates such as the Patient Protection and Affordable Care Act (PPACA), the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA). When compliance mandates change, upgrading and deploying them across multiple data sources, applications and system interfaces is a costly and time-consuming IT project.

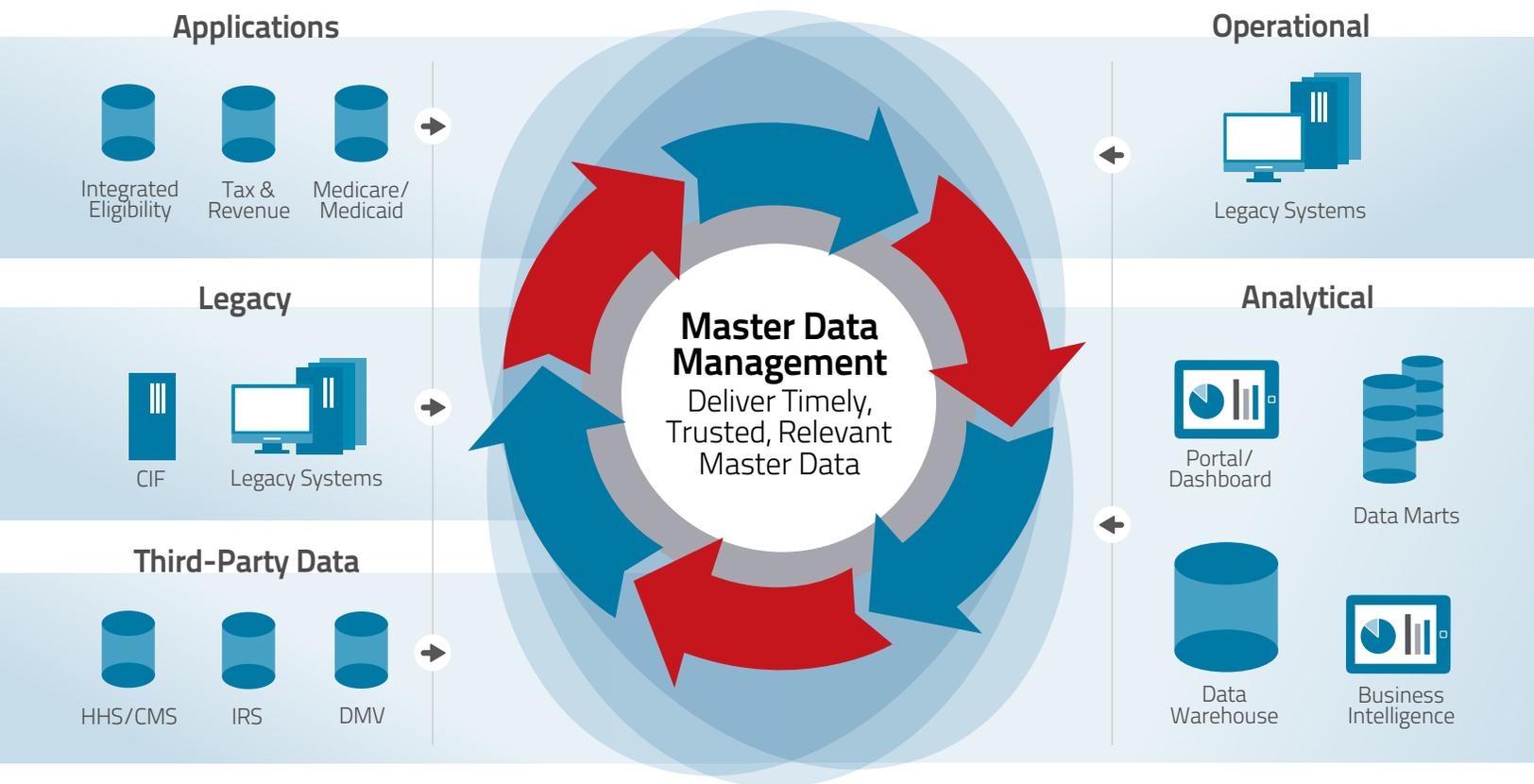
Lack of transparency and accountability. The public sector has embraced open data initiatives to provide higher levels of transparency to citizens and the press, thereby improving accountability and efficiency. Open data provides visibility into spending, vendor contracts, salaries and program performance measures. But when data is inconsistent across departments and agencies, it's impossible for the public and the media to interpret it correctly. Without precise data, governments are vulnerable to issues related to transparency and accountability.

Master Data Management: One Citizen, One Golden Record

The solution to these challenges is to consolidate data from multiple departments, systems and agencies to create a golden record — a single, reliable and trusted view of each citizen that can be used by all participating agencies.

A cross-agency, enterprise-wide MDM platform facilitates this model, augmenting — not replacing — data infrastructure and applications that are already in place, and allowing agencies to extract the most value not only from the data itself, but also from the technology and application infrastructures that support data collection, analysis and outcomes.

MDM technologies enable organizations to create a golden record (also called a master record) from existing data, while preserving agency investments in individual applications, systems and databases. Think of the MDM platform as a



shared layer that sits between existing multi-departmental data infrastructures and their respective analytics and business intelligence tools, creating an enterprise-wide data platform that's accessible to all relevant or contributing agencies.

MDM relies on sophisticated match algorithms and data management processes to manage data, irrespective of its source, format or application into a master data output. It can be used to develop and apply common data governance and lifecycle management rules across the enterprise. MDM platforms execute the following tasks:

- Inspect each data source, i.e., departmental database, application, etc.
- Clarify the rules and structures of each source
- Determine relationships among data types
- Recognize duplicate records and de-duplicate if needed
- Find and solve identity problems
- Cleanse and standardize data
- Identify and repair data quality issues
- Identify and resolve any other anomalies
- Apply security protocols and encrypt data according to privacy mandates
- Consolidate data into a master data record

Benefits of Data as a Cross-Organizational Asset

By leveraging a master data record that contains a treasure trove of golden records, MDM helps to ensure data accuracy and quality. Data becomes a cross-organizational asset

that yields more meaningful insights because it's based on an integrated view of the constituent's relationship with the government as a whole.

Benefits include:

- Holistic view and improved citizen understanding
- Reduced fraud, waste and abuse
- Cross-enterprise data for decision- and policy-making and analysis
- More efficient service delivery
- Improved compliance
- Improved accountability and transparency

Holistic view and improved citizen understanding.

In approaching service delivery using this model, a single, accurate and authoritative constituent record replaces multiple versions derived from disparate, duplicate and conflicting information. Data analysts can develop business rules that identify relationships among data, even when it's stored in different systems and formats. This allows for a more comprehensive, holistic understanding of constituents or program participants and their interactions with each other and participating agencies. Robert Smith, Bob Smith and Bobby Smith become the same person across all agencies, and his interactions with the government as a whole become clear.

Reduced fraud, waste and abuse. MDM helps HHS and tax and revenue departments save money and operate

more efficiently. Working from the identical, accurate citizen record, for example, multiple HHS agencies are able to more accurately determine eligibility, eliminate duplicate transactions and fraudulent claims, and decrease the amount of improper payments. Tax and revenue agencies are able to more easily flag fictitious employers and employees, tax noncompliance and suspicious returns. With the ability to access data from multiple departments, it's possible to identify and investigate unusual behaviors, patterns and trends among enrollees, claims and transactions that may signify fraud.

Cross-enterprise data for decision- and policy-making. The master data record becomes a foundation for proactive research and analysis to address key policy questions, identify and develop more effective and targeted initiatives and programs, and make insight-driven decisions. For example, public health, healthcare and transportation departments can use data from across multiple organizations to more accurately identify geographic and demographic trends, forecast problems, allocate resources more appropriately and model scenarios for better planning.

More efficient service delivery. Service delivery is more efficient when government workers aren't required to log in to multiple systems to examine records from different sources. It reduces data entry and data processing errors, ultimately leading to smoother service delivery, more satisfied citizens, more productive employees and lower operational costs. For example, public safety organizations such as law enforcement agencies, corrections institutions and court systems can use MDM solutions to unite disparate public safety systems and databases to deliver a golden record for criminal offenders. Police detectives don't have to log in to multiple databases to investigate a suspect, allowing them to respond more quickly and accurately to public safety threats, and improving coordination and communication among law enforcers.

Improved compliance. A master data record allows compliance rules to be applied across the enterprise, eliminating the headaches of administering compliance for individual systems, applications or departments. Changes to compliance mandates require IT staff to apply the new rules

only to the master data record, which conserves valuable IT resources.

Improved program transparency. With more accurate data as the foundation of open data initiatives, the public sector provides citizens and the media with better visibility into government initiatives and expands internal accountability, which lead to increased program efficiency. By providing holistic, data-driven insight into its programs, governments lower their risk of transparency-driven public relations issues.

Conclusion

The benefits of using data to make decisions is indisputable. However, data-driven decisions and outcomes are only as useful as the data that produces them. To take full advantage of the benefits of data, government organizations must shift towards a more collaborative data management process, ensuring their individual departmental systems, databases and applications have access to a single version of truth – the golden citizen record.

MDM enables the public sector to resolve data errors to develop an accurate and definitive citizen record that includes all citizen-government interactions and drives consistency across multiple government departments and agencies. Besides providing a holistic understanding of each citizen, a golden record allows agencies to reduce fraud, waste and abuse; improve cross-enterprise decision- and policy-making and analysis; deliver services more efficiently and cost effectively; and improve their efforts to achieve compliance with multiple government privacy and security mandates.

MDM does not require agencies to “rip and replace” data infrastructure and applications that are already in place. Analysts can continue to use the same back-end data collection and archiving tools and front-end data analytics and business intelligence platforms. By integrating data – regardless of source, format or application – into an accurate master data output that's accessible to all relevant or contributing agencies, MDM delivers the key to better decisions and better outcomes.

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Public Commentary by
Michael J. Carrasco, Parent Advocate

May 27, 2015

Debra Ferguson
Commissioner
Virginia Department of Behavioral Health and Developmental Services
1220 Bank Street
Richmond, VA 23219

Dear Commissioner:

I am writing to provide comments regarding the Virginia Department of Behavioral Health and Developmental Services Transformation Teams recommendations. I appreciate this opportunity to provide additional comments and suggestions. Since 1997, I served on a variety of local and state civic boards and commissions, including the City of Alexandria's Community Service Board (2005-2006), Virginia's Developmental Disability Council (2007-2010), Virginia's Behavioral Health Advisory Council (2008-2009), and most recently on Virginia's Board of Education State Special Education Advisory Committee (2011-2013). Each panel has provided me an up close look at Virginia educational, public mental health, intellectual disability and substance abuse services systems. From this vantage point, I have worked to move systems forward on behalf of the children and adults who have or who are at risk of mental illness, serious emotional illness, intellectual disabilities or substance abuse.

In reviewing your "Ten Core Themes," I support the approach of the Department of Behavioral Health and Developmental Services to partner with other state agencies to improve the workforce and the quality and availability of services across the Commonwealth which will improve the quality of life for the Virginians who need your services.

I would urge you to take an enterprise-wide look at how priorities, processes, people and systems to work together to design and implement the changes needed in Virginia's mental health care delivery system.

Virginia as a Multicultural Society

One concern that I do not see addressed is how to tackle the barrier of access due to lack of cultural understanding.

We are a collection of people built of different nationalities and ethnicities. People from all over the world immigrate to our shores for a variety of reasons and encounter barriers to assistance during what is a very traumatic time for them. As a result there are many communities all over Virginia that need to be served by a culturally and linguistically competent staff that utilizes skills, attitudes and policies to cultural and language barriers, social stigma, fear of lack of confidentiality, feelings of loneliness and isolation and being uninsured. Whether they come voluntarily or are displaced, as a result, immigrants will not access much – if any- needed mental health care from providers who are able to engage them culturally and linguistically.

This is why it is extremely important to consider creating an additional transformation team to provide the Department of Behavioral Health and Developmental Services recommendations how to eliminate access barriers related to race, ethnicity, cultural and language, which does not currently exist in the present framework of the current transformation teams.

I cannot tell if any of the representatives who are currently serving on your teams represent multi-cultural communities or organizations that are concerned about (1) issues of disparities in services or (2) speak other languages on these teams. It would be extremely beneficial if you had on these teams, multi-lingual members, including those who understand and communicate in sign language.

People who are multi-cultural, and can function proficiently in them, can cross boundaries and differences that may limit an individual's understanding of people from a different cultural background. Learning to function comfortably in different cultures, allows you the ability to cross these barriers and reach the people who need your services. This conclusion is not new. In 2001, the United States Surgeon General issued a report entitled "*Mental Health: Culture, Race and Ethnicity*," which focused on how important culture was when it came to providing mental health services to racial and ethnic minorities since they had less access to healthcare, in general, and if they did receive care, it is generally poorer quality.

Hispanics in Virginia

Hispanics can be of any origin¹ or race² and are Virginia's largest minority community outside of African Americans.

The 2010 Census results showed that Virginia is increasingly becoming more racially diverse with rapid growth in Hispanics and Asian populations across the state with 132 of the 134 localities in Virginia experiencing growth in their Hispanic population, and according to one source³, most of Virginia's foreign-born Hispanics being born in El Salvador, Mexico, Peru, Bolivia and Guatemala. The Pew Research Center tracks Hispanic trends and in 2011, and concluded that as many as 53% of foreign-born Hispanics were uninsured⁴. For many who make the journey to live in another country, the mental stress is significant – sleep deprivation, loss of family, anxiety, and in some case, fleeing from violence with existing psychological wounds that have not yet been diagnosed and are being worsened by the entire experience.

¹ See US Census 2010 [data briefs](#): A change to the Hispanic origin question for the 2010 Census where respondents were provided examples of six Hispanic origin groups (Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, and so on) as well as Mexican, Puerto Rican and Cuban.

² See US Census 2010 [data briefs](#): Federal agencies have traditionally tracked five race categories: White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander. In the 2000 Census the inclusion of a new category - Some Other Race - was created for respondents unable to identify with any of these five race categories. According to the Census Bureau there are 57 possible multiple race combinations involving the original five race categories and Some Other Race.

³ University of Virginia Weldon Cooper Center for Public Service 2010 Census Data Information Sheet, February 2011.

⁴ See Pew Center website: <http://www.pewhispanic.org/states/state/va/>

No one is ever prepared for the loneliness and isolation of starting over in an unfamiliar place and for some, there is a constant level of stress due to living in fear of being deported for not having proper documentation. Therefore, it is extremely important that Virginia work hard at (1) improving geographic availability of mental health services, (2) improving language access, and (3) coordinating care to vulnerable, high-need groups such as people who have immigrated to this country.

This is why adding a transformation team to focus how to eliminate access barriers related to race, ethnicity, cultural and language, which does not currently exist in the present framework makes sense. You should make sure to appoint to this team Hispanics of various origin and race as well as providers who understand the specific issues that arise with refugees and their unique needs in mental health and developmental disabilities.

This specific team can help Virginia's mental health system lay the foundation to improve the quality of its services. Cultural and linguistic competence has a significant impact on both outcomes and cost. This team can help assess the diversity and needs of the communities that it serves, which can further develop a formalized, written cultural and linguistic competency plan, which can be updated periodically as the cultural composition of communities shift over time. You may also want to consider reviewing the membership of the advisory and governing boards of the Department of Behavioral Health and Developmental Services to ensure that they are reflective and respectful of the communities they serve.

Words Matter

More broadly, I **would urge** the Department of Behavioral Health and Developmental Services to work with other key agencies serving at-risk populations to develop and implement a promotional campaign to address and combat how those living with mental health issues are portrayed, which many times are shown stereotypically violent and unpredictable further contributing to the belief that they should be shunned from society not realizing that there are those with mental health issues who are able to function normally in society but they can also lead highly successful jobs and careers, as well contribute to society.

I **strongly urge** the Department of Behavioral Health and Developmental Services to incorporate as part of any cultural and linguistic plan, language that can be utilized that is more appropriate. Words make a difference and using people first phrases and vocabulary will acknowledge a person's humanity. The Department of Behavioral Health and Developmental Services should not use language that dehumanizes those it serves and should encourage other agencies that it partners with, including law enforcement, on key points when it comes helping those with mental health issues:

- People with mental health issues are not naturally violent, unable to work or unable to get well;
- Most people living with mental health issues are able to recover with treatment and support;
- Labeling someone impacts how that person is viewed.

Autism and the Community Service Boards

I am glad to see that one of your teams focused on adult developmental services, an issue important to me, as I am the parent of an adult with autism and other cognitive and developmental disabilities. I applaud that person centered thinking and moving from service life to a community life was part of their discussions. I agree with the necessity for organizational simplification of structures and processes, since there has not been coordination of the multiple programs and agencies that serve Virginia since 2009.

However, I did not see anything about how to integrate mental health services for those with autism and developmental and intellectual disabilities, as this has been an on-going issue that unfortunately, was not addressed when the first state plan on Autism was developed and the Department of Behavioral Health and Developmental Services needs to come up with a plan for families to access mental health services for those with autism, developmental and intellectual disabilities. It is difficult for someone with autism to get mental health services, as requirements keep the local Community Service Boards *"boxed in"* as to who they can serve, since in order to access any necessary services through the Community Service Boards, autism cannot be a primary diagnosis, which is disappointing.

I **strongly urge** your teams to resolve, if they can, the issue of how Community Service Boards can serve those whose diagnosis is Autism, and not intellectual disabilities, and who may not have waiver services, but need some type of basic level of supports in order to be successful in the community living on their own. The Community Services Boards need to be allowed to provide some support for those with autism and there is a need for more BCBA professionals in the Community Services Board system and training programs would be a huge step forward for both Community Service Boards and hospitals where you can cross train behavioral supports. Additionally, the Community Service Boards should be allowed to provide training, support and supervision services to adults with autism which would help them with their functional self-help and daily living skill development, community integration skill development, work environment skill development, social and interpersonal skill development, and travel training development. Allowing Community Services Boards to provide service programs to those with Autism provides equity in a much needed area.

I **strongly urge** the Department of Behavioral Health and Developmental Services to consider commissioning an administrative census of the number of individuals with autism receiving services in Virginia. This data will be especially helpful to the Department of Behavioral Health and Developmental Services in terms of program planning and better coordination of services among various state agency partners including education, law enforcement, and children and families.

I **also strongly urge** the Department of Behavioral Health and Developmental Services also to convene a statewide professional learning group for mental health/autism issues and that the membership of this group consist of mental health providers, school personnel, law enforcement, individuals with mental health issues and autism, and citizens of different backgrounds and cultures.

Justice Involved Services

Virginia's criminal justice system is becoming increasingly responsible for providing mental health services. Americans with Disabilities Act prevents States and municipalities from discriminating against those with disabilities, *including those in prison facilities*⁵, and efforts must be made to make reasonable accommodations in their programs and services. Those with disabilities face some of the toughest conditions in prisons since these facilities control every aspect of the person inhabiting them. When someone becomes involved with the criminal justice system, it can be very traumatic, doubly so for someone with mental health issues and the resulting impact of a criminal record. Under the Americans with Disabilities Act, localities cannot discriminate and must make reasonable accommodations in their programs and services, these obligations apply to the judiciary, and can include fingerprinting, drug treatment, confinement level, housing and cell assignment, medical and mental health services, and access to food, recreation and personal hygiene.

In review your team's recommendations, I would strongly urge you to be more inclusive of individuals with autism, developmental and intellectual disabilities in service planning regarding criminal justice issues, especially application of the identified diversion strategies to prevent incarceration of individuals with intellectual or developmental disabilities with challenging behaviors or poor communication and social skills, as it seems as that your teams focus appears to be solely on individuals with psychiatric or substance abuse disorders.

A person with serious mental health issues in the criminal justice system is a great problem. There are a number of reasons why this has been occurring, including lack of adequate support systems, such as housing for people with mental health issues in the community and the stereotypes that people with mental health issues are more dangerous than others. Every effort should be made to assist people with serious mental health issues before the criminal justice system has to get involved and become another statistic.

I **strongly urge** the Department of Behavioral Health and Developmental Services to work with all state and local law enforcement agencies on training on de-escalation techniques when coming into contact with individuals with intellectual or developmental disabilities in a crisis situation, and that you include people with autism in that training as well. If such training is not mandatory already, I would urge the Department of Behavioral Health and Developmental Services to use whatever influence it has to make this type of training mandatory.

I **strongly urge** the Department of Behavioral Health and Developmental Services to reach out to Virginia's Judiciary as well as law enforcement partners and focus on developing mental health dockets as well as a statute in Virginia's code to allow judges to order pre-trial mental health evaluations to aid judges in making bail/bond determinations. I would also consider assisting with the education of judges to better understand the screening process and in determining the level of supervision needed for low risk offenders.

⁵ See Title 2 of the Americans with Disabilities Act and the Supreme Court case, *Pennsylvania Dept. of Corrections v. Yeskey*, 524 U.S. 206 (1998) where the U.S. Supreme Court held that the Americans with Disabilities Act applies to prisons and jails.

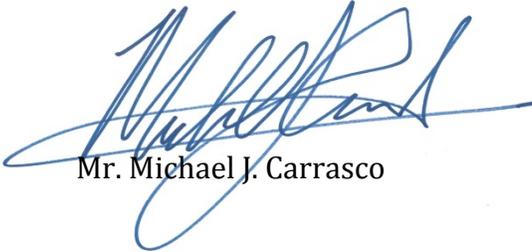
Finally, I would **strongly urge** the Department of Behavioral Health and Developmental Services to work with Virginia's law enforcement officials in developing assistance to law enforcement personnel for their own mental health needs. A career in law enforcement can be very stressful due to the nature of their work and as such are prime targets for developing post-traumatic stress disorder. However, awareness and early treatment to this disorder can have a significant positive impact.

A partnership between the Department of Behavioral Health and Developmental Services and state and local law enforcement would benefit both sides. Working together both could develop a uniform response strategy for interacting with individuals with mental health issues statewide and educate law enforcement for recognizing and understanding symptoms which is vital. When law enforcement lacks proper education about mental health, they can misinterpret actions taken by a person and respond inappropriately, resulting in trauma or even death. A partnership would foster education and understanding, which would lead to combatting stigma, which would lead to respect of others, which would save lives.

Conclusion

Generally speaking, I hope that the Transformation Teams will be able to serious focus on resolving issues concern gaps in service delivery and move away from a disability silo based system and more of an whole person integrated system approach.

Thank you for the opportunity to provide comments. If you have any questions you can contact me by at the following e-mail: michaeljcarrasco@gmail.com

A handwritten signature in blue ink, appearing to read "Michael J. Carrasco", written over a printed name.

Mr. Michael J. Carrasco

disABILITY LAW CENTER

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May 28, 2015

Debra Ferguson, Commissioner
DBHDS
P.O. Box 1797
Richmond, VA 23218-1797

Dear Commissioner Ferguson,

Please accept the following public comment on the DBHDS Spring 2015 Transformation Team Recommendations from the disAbility Law Center of Virginia (dLCV).

Sincerely,

A handwritten signature in blue ink, appearing to read 'Colleen Miller', is written over the word 'Sincerely,'.

Colleen Miller
Executive Director

Comments on the DBHDS Spring 2015 Transformation Team Recommendations

Submitted by the disAbility Law Center of Virginia (dLCV)
May 28, 2015

dLCV appreciates the opportunity to comment on the Transformation Teams' recommendations. The Ten Core Themes present a vision for person-centered services throughout the Commonwealth across multiple service delivery systems. The vision is for a comprehensive, integrated system where mental and physical health is closely linked. We support this vision. However, bringing it to fruition will require the collaboration and cooperation of agencies both inside and outside the Secretariat and across the Commonwealth.

Critical services and service providers are not uniformly available to all Virginians and a lack of affordable and reliable transportation provides a serious barrier to even reach the services. dLCV would like to point out a critical service excluded from your report is affordable housing. Housing is the foundation of successful community placement. A competent transformation plan must address these issues.

The Transformation Teams also stress coordination of services with primary care. Nonetheless, the recommendations do not address the compartmentalization that exists within the behavioral health and developmental services world. Many providers still refuse to serve persons with developmental disabilities saying that they lack specific expertise with these individuals. Services for those who have both developmental and behavioral issues are fragmented and frequently poorly coordinated. Educating and preparing providers should be an important part of this process.

There are several recommendations for increasing the availability of medication assisted treatment in both the community and in justice involved settings. This would help many. However, this is only one treatment option. CSBs still have waiting lists for basic services. Until it is possible to get services when needed, preferably *before* a crisis, Virginia will continue to talk about crisis response as a primary issue.

Adult Behavioral Services and Adult Developmental Services Teams

The Adult Behavioral Services Team made the recommendation "To ensure access as early as possible, increase capacity for timely access to screening, assessment, OP counseling, including psychiatry." Similarly, the Adult Developmental Services Team correctly identified prevention services as a necessary part of the service array. We would like to see more focus on early intervention and community treatment with or without medication and with less dependence on pharmacological interventions.

Child and Adolescent Behavioral Health Team

The Child and Adolescent Behavioral Health Transformation Team's recommendation for "one state entity to have authority, responsibility and accountability for the secondary and tertiary behavioral healthcare needs of children" is an excellent one. Having coordination and accountability across all systems and a uniform state system would ensure that all of the Commonwealth's children, wherever they might live, would have access to essential core services. This is another area where a broad based collaboration across agencies is key to success.

We welcome the increased focus on peer provided services and recognition of their importance. These services, when adequately funded and supported, have great potential and are a critical part of a full service array. This includes the parent peer support mentioned in the Child and Adolescent Behavioral Health Transformation Team's recommendations. Peer support can also play an important role in supporting individuals in crisis centers and CIT drop off centers.

Justice Involved Transformation Team

The Justice Involved Transformation Team provided recommendations for the top five priorities. This was no doubt a good place to start but does not reflect the scope of the existing issues. Much of the focus is on jails, admittedly an area of concern. However, the Team does not address the existing deficits in the delivery of timely restoration services. This is particularly alarming inasmuch as this not only a best practice matter, but a violation of law.

The recommendations made regarding to access to medications are consistent with those discussed for a number of years in various forensic workgroups. Standardization of a formulary and access to medications as individuals move from community to jail to hospital and back would resolve many issues. Currently, an individual may be hospitalized for restoration and stabilized on a particular medication. However, that medication may not be available when he returns to jail to await trial, resulting in loss of competence and possible re-hospitalization. A lack of medication can also destabilize individuals who have been stable in the community or in jail when they move to another environment. dLCV strongly supports the recommendations for prompt screening of individuals entering correctional settings and for setting standards for training jail and correctional staff on behavioral health and ID/DD issues.

In setting forth a vision for the future of care in Virginia, we would like to see the DBHDS include its 2010 Seclusion and Restraint Policy Statement, contained in DI 214:

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) is committed to creating an environment free of violence and coercion based on prevention strategies; assuring a safe environment for individuals receiving services and staff; focusing on the elimination of seclusion and restraint as congruent with the principles of recovery and person-centeredness; and building a trauma-informed system of care. This goal is consistent with a system that treats people with dignity, respect, and mutuality, protects their rights, provides the best care possible, and supports them in the achievement of their personal vision for their lives.

We recognize the amount of work necessary to turn visions into reality. dLCV looks forward to working with DBHDS to improve services to the citizens of the Commonwealth as the Transformation process moves forward.



**ServiceSource Response to Public Comment Period:
TRANSFORMATION TEAMS (May 31, 2015)**

Thank you for the opportunity to provide comments on the proposed DBHDS Transformation Teams recommendations. We appreciate the work of all four of the teams but wish to focus our comments on the recommendations of the Adult Developmental Services Team.

ServiceSource has been a provider of developmental services for more than 40 years and has participated in the Virginia Waiver program since its inception 24 years ago. ServiceSource is proud to have strong collaborative relationships with numerous public funding sources such as CSBs, DMAS, DARS and NVTC as well as with privately operated ICFs/ID through purchase of service contracts. ServiceSource is proud to have maintained CARF accreditation for many years and values its participation with other colleagues as members of both VNPP and VAACCSES. It is with this background and context that ServiceSource respectfully offers these comments for consideration:

- 1) Providers are the catalyst for a successful transformation. As a service provider, we are committed to high quality services and are willing to collaborate on transformation. As a provider managing a business, we need secure and adequate compensation.
- 2) The recommendations need to offer more strategic suggestions to strengthen and maintain our provider workforce. In order to implement best practices and maintain quality standards while providing required documentation, providers need economic support.
- 3) In addition to economic support, providers need a fully participatory and transparent relationship with public agencies to review the regulatory and documentation requirements in order to ensure that these regulations strengthen rather than inhibit quality service delivery.
- 4) As a day and employment provider, we are acutely aware of transportation support needs and we offer that this support need did not receive adequate attention in the team report. We need reliable and responsive transportation in order to help providers deliver high quality services in a health safe environment.
- 5) We are concerned that some efforts to reform may lose sight of the basic tenets of health, safety and community access. We respectfully offer that the measure of success should not be measured exclusively through details of documentation in paperwork but rather as the essence of “doing the right thing” based on an individual’s choices and needs. Rather than cultivate an atmosphere where providers live in fear of economic consequences for documentation errors, we need a system where providers collect relevant data and are reimbursed for implementing person centered supports that enable our most vulnerable and medically fragile individuals to maximize their community life and ensure health and safety.
- 6) As a continuation of that concern, we also offer that more attention is needed in these recommendations to allow our program participants to “age in place” and continue to enjoy their

communities with the increasing medical, physical, personal care and behavioral supports that are required as our population continues to age.

- 7) The most recently published ID Waiver Wait List (4/1/2015) indicates that nearly 8,000 individuals are awaiting Waiver supports and of these, nearly 5,000 are in urgent need. At the public hearing, it was also reported that over 1,000 individuals are awaiting supports through the “DD” Waiver. As a provider to many of these individuals who are waiting, we strongly request an emphasis in the Transformation Recommendations for these individuals.
- 8) Additionally, ServiceSource provides services to many “locally-funded’ individuals who do not qualify for a Waiver due to reasons of economics, clinical assessment or citizenship and we also strongly recommend that the needs of these individuals not be overlooked by promoting a system that exclusively relies on Medicaid as the primary funding source. Our system also needs general dollars so that services are in fact available, affordable and accessible.
- 9) Finally, we express our concerns that while we support the implementation of these Transformation Recommendations, we must also be attentive to the reality of the legislative cycle so that providers are not expected to receive additional service mandates or regulatory requirements without the corollary economic support legislated by the Governor and General Assembly. We share the concerns expressed in other forums that there must be a logical and strategic transformation plan that “fits” within the existing legislative cycle so that economic support coincides with implementation steps.

We thank you again for the opportunity to comment on the DBHDS Transformation Plan.