YSAT Interagency Council Meeting
June 11th 2019 • 10am-2pm
Minutes

Logistics

Location 2810 N Parham Road #300, Henrico VA 23294

Scribe Kathleen Owens

Attendees

Name	Affiliation	Email
Kathleen Owens	DBHDS	Kathleen.owens@dbhds.virginia.gov
Rich Firth	DBHDS	Richard.firth@dbhds.virginia.gov
Malcolm King	DBHDS	Malcolm.king@dbhds.virginia.gov
Jeffrey VanArnam	DBHDS	Jeffrey.vanarnam@dbhds.virginia.gov
Trish Mullen	Chesterfield CSB	mullenp@chesterfield.gov
Jimmy Price	VEC	Jimmy.price@vec.virginia.gov
Kristen Tully	Youth Move	tullyke@vcu.edu
Fabrienne Dorsey	Parent	Dorseyf6@gmail.com
Valerie Petrey	Parent	vpetrey@gmail.com
Rachel Stallings	VDH	Rachel.stallings@vdh.virginia.gov
Andriea Ukrop	VHDA	Adriea.ukrop@dhcd.virginia.gov
Anna Antell	OCS	Anna.antell@csa.virginia.gov
Keshawn Harper	DMAS	Keshawn.harper@dmas.virginia.gov

Agenda

I. State of YSAT-I Update
II. Malcolm King
III. Sustainability—Expansion and Replication
IV. Workforce Development
V. Roundtrip
VI. Senate Bill 1440
VII. Topics for TA Phone Calls
VIII. Summer Site Visits
IX. Higher ED Curriculum Development
X. Updating Work Plan
XI. Retention/Recruitment Breakouts
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Minutes

I. State of YSAT-I Update

We are in the middle of year 2 of implementation. We are at 4 sites (Western Tidewater CSB, Richmond Behavioral Health Authority, Rappahannock Rapidan CSB, Mount Rogers CSB)—4 geographically diverse locations.

All four sites are up-and-running, and we believe we are track to hit our initial goal of intake numbers—even with the caveat of WTCSB being shut down because of their complete turnover of YSAT staff. We think we will even surpass our target goals, and they are actually adhering to the process and seeing positive things working with folks. Three out of 4 sites have actually have had some sort of staff turnover, but we are still happy with progress in general.

Jerome is looking at big data things, while Katy looks at process data. She sends out monthly data reports to check-in on data entry and reporting, and also conducts monthly technical assistance phone calls with all the sites. Additionally, we do quarterly site visits with the entire DBHDS team, and Katy also does quarterly independent site visits in between the team visits. These site visits have turned into brainstorming sessions in addition to technical assistance, and some really great ideas come out of these invaluable meetings.

MRCSB held an awesome bowling event where they invited YSAT clients (6 came) and other CSB clients and community members to come to the local bowling alley to engage in a fun night of mingling and prosocial activities! They got a great turnout (150 people total), were able to share information regarding CSB services (including YSAT), and great feedback from attendees. Finally, the bowling alley was so happy with the event that they offered to let MR use it again for the same thing in July for free! Katy shared this information with WTCSB, and although they are a very different geographical location, they liked the idea so much that they are going to modify it to fit their needs and replicate it in their area.

Almost all of the sites are now in the process of training non-counselors in the ACRA program so that the clinicians can focus on the deeper, more clinical-based needs (e.g., trauma, problem solving, conflict resolution, SA, etc.) and other staff (e.g., Peers, Case Managers, etc.) can focus on the other procedures (e.g., job-seeking skills, communication, etc.). This allows the counselors to free up some of their time to focus on the things that the ACRA brings up but doesn't necessarily address.

The state of Virginia finally standardized something and now requires all CSBs to utilize the DLA20 assessment. Our YSAT programs currently required the GAIN-Q3 (an evidence-based assessment tool) because the DLA20 roll out happened after the beginning of our implementation. What this means then is that a client comes for help, does the CSB-specific assessment, the DLA20, the GAIN, and the GPRA assessments before they even begin the actual treatment process.

Then he discussed the current process a client goes through. Then he talked about the duplicative nature of assessments, the time it takes to complete all the assessments and

finally get access to real treatment, etc. Then he talked about the initiative we are working on to get rid of the GAIN and only use the DLA20, and also Jerome's project of figuring out if we can map the data from one assessment (e.g., the DLA20) to other required assessments (e.g., GPRA) to not have to ask the same questions more than once and reduce the amount of time.

The YSAT program has been accepted on executive level. We are doing a very good job of integrating YSAT into other grants we have at DBHDS. We have 11 grants at DBHDS. All of our SA funding is through grants, and most of them are discretionary funding. We do have a behavioral health grant which is a combination of MH and SA, but other than that everything is coming through discretionary funds. We are working well with two opioid grants (one of which the STR grant), and we have leveraged that to do some training on adolescent services. We are very happy with how it has been received by executive level staff. We are awaiting our notice of award for year 3, but our Grant Program Officer has not said to us that we should expect anything different.

II. Malcolm King

Policy Academy – Rockville, MD.

Malcolm King, Keshawn Harper, Kathleen Owens, and Mellie Randall attended this conference. Malcolm felt that the YSAT grant is doing very well in comparison to other grants in the Youth Treatment Implementation discretionary funding cohort. All the other grants from around the country were represented there. One of the things that Malcolm felt good about was that our GPO was very happy and friendly, and it was a good interaction which is always a good sign.

Two things he took away: 1) we are doing a good job of integrating our program into the other programs around the state (Medicaid expansion, Medicaid waivers, etc.); and 2) we will be utilizing the Virginia Health Information data base to begin to extract data and plot that on our provider sites and be more informed with better, more accurate data.

Jeff VanArnam – Coordinated Specialty Care for Transition Age Youth, Treatment for First Episode Psychosis Grant

8 CSBs: Henrico, Fairfax, Alexandria, Loudon, Prince William, Rappahannock Rapidan, Western Tidewater, and Highlands

10% of state money from block grant goes to this service plus some additional funding

Services = psychiatric rehabilitation model targeting TAY experiencing their FEP

Supported employment and education, family outreach, mental health services, etc.

Data suggest the sooner they receive services after FEP, the lesser the severity of impact of MH will be

Folks who might be in the category of meeting their FEP often will be from a population that also falls under YSAT. As we know, a lot of people with MH issues self-medicate and therefore meet our criteria. We do know SA and MH issues are related. We believe that we may be serving some of the same folks or at least we should be—trying pool our energies to serve this population better.

Department level – organization out of Boston called centers for social innovation, doing national study using an online training tool for coordinated specialty care, all 8 of ours are in, $25k worth of free training for all of our teams. Also, VA has applied for SAMHSA grant for supported employment and IPS and vocational skills that we wrote into our grant

III. Sustainability—Expansion and Replication

What Rich means by these terms:

Sustainability: how do we keep these programs going beyond the 4-year implementation process?

Expansion: internal – how do they go deeper and wider in their communities?

We want to challenge the IAC to figure out if there are other ways we can partner/dig deeper to support these two things without a large federal allocation.

Ideas:

-getting rid of GAIN cuts costs down dramatically

-annual cost for ACRA is only about $2500/site for up to 4 people, initial trainings are a bit more expensive

-Katy becoming the state ACRA trainer

-we funded some positions, so to keep doing that we need to find another pocket of money or they will need to figure out how to take on those salaries. Good thing is that almost all sites hired more people so they are clearly finding this helpful and are starting to take these on

-has any thought gone into making this a demonstration grant so that other agencies can look to take over pieces? We do consider this a pilot, so our hope is that we will have some compelling data to tell a story with that will make other agencies want to sustain this

-do you know if there is going to be any additional funds to apply for/opportunities after this? Other implementation states – we are not sure. Our GPO should know that. A bunch of grantee meetings have been cancelled. We need to talk to our GPO. Opioid task force – used to be more linked with that and we need to get back. Federal perspective – MAT efforts are coming out, opioid crisis continues to get a lot of support from the feds so definitely a good area to look into

-community event – get STAR person from DMAS to go out and be there to help people sign up for Medicaid?? Ke'Shawn said this is definitely something that could happen she just isn't sure how that would look

-comprehensive reduction harm locations/syringe exchange sites in MR and Richmond? We need to make sure at least the information is there for that referral relationship

-how do we start to connect the YSAT folks with their local health departments? Higher level people are mandated to talk, how do we connect lower level people? They're having their first provider training June 20th to discuss what providers need to feel comfortable treating patients with uncomplicated Hep C, so that may be a great time at the second training to have a block for us to talk about CSB services/YSAT to provide overview, contact information, what this group is trying to accomplish, etc. We are (or should be) serving the same clients. Thinking about September for 2nd training.

Social marketing plan
-in partnership with SOC (website)
-can't easily google YSAT or CSB services right now
-how can we make it easier to find information on these services?

If you all have work groups or anything similar where YSAT could maybe connect with please let us know and we will do our best to get a representative on them!

IV. Workforce Development

How can we help our folks develop the skills they need to compete in the workforce and sustain long-term wellness and recovery?

-CPRS opens an avenue for job opportunities

-Rams in Recovery, Tom Bannard did the train-the-trainer and trains people for free

-Connect with Pam or Christie Corbin (using grant dollars), doing training for peers, maybe we can get some of our folks in that class (September/October, date and location not yet decided)

-12 step recovery – group that reaches out to professionals; once you're part of a 12-step community you're surrounded by people in long term recovery that are willing to sponsor and hire people in recovery and it's a great networking source

-Jimmy: mentorship is critical; career centers (at community colleges) throughout the state that put on meetings, provide mentorship, etc. He can look at our areas to figure out which centers are the closest to our locations

-CARITAS Works – currently only Men's Healing Place, they do job connections and soft skill work; maybe we can take that idea and replicate it outside of Richmond

-getting Karen O'Brien and other staff to join IAC and figure out ways we can partner with them soon

-Open Table movement--Sheryl Wilkinson at Blue Ridge CSB working with Craig Co. (very tiny community) to start a table

How do we improve the professional workforce such that there are qualified people to work in substance use/transition age youth/mental health areas?

Curriculum development

-EVMS providing more education on mental health/substance abuse for physicians

-where they are in the state of development we do not know

-this was Mellie Randall but she just retired but we do not know who is taking over

-if someone comes into a hospital and a contributing factor is SU hospitals have information so that they can get someone in the recovery community can come to the hospital; if this does not happen, you can see if you can get CSBs to help make that connection; look into hospital connections

-look into doing continuing education (CEUs) for current professionals

-VCU does this through their office of continuing and professional education in partnership with rehab counseling department (online CEUs can be taken remotely) you get a certificate once you take the courses and earn the CEUs

-locally talking to DARS and not just in the IAC? Probably, but probably not enough

V. Roundtrip

Katy and Rich had an introduction phone call with them yesterday to discuss a potential partnership. The idea is that the treatment providers would request transportation, and then Roundtrip would coordinate the ride for the client.

In areas where there are no transportation companies, Roundtrip is interested in helping build up transportation options.

Either clients can pay the bill themselves, organizations can take the cost, or they can set up a plan where the clients pays X and the organization covers the rest. We can make accounts so that we can just put a lump sum into an account for a particular person or organization.

VI. Senate Bill 1440

At DOE right now
Bill went through GA mandating MH counseling be available in schools
We think an alignment with DOE would be beneficial
Medicaid will be required to cover Medicaid services through this as well

VII. Topics for TA Phone Calls

-other ideas?

-Keshawn did a monthly call and never got anyone to give her topics so she stopped it

-survey of things Andriea has heard them say and then a place for them to write in other information for what they would like to talk about

-focus on family/individual, not using word client, how do you continue to engage/keep getting buy-in from individuals and families

-when Rachel struggles with ideas they present case studies whether it is one of the sites doing something that really works or a big barrier/struggle

-maybe putting the sites in charge of a call or require them to present on something

-topic of challenges, topic of successes/celebrations

-send out topic(s) a week ahead of time so that they can prepare for the call/put questions together/ask them questions beforehand so that they can prepare appropriately

-dig deeper into monthly reports and figure out if there are any patterns or areas for discussion there

-do more to celebrate successes/allow other sites to replicate successes

-how to keep hold of people as a resource/future mentor/future peer/etc.

-how to get the youth involved in the process (e.g., running groups, being in charge of their own treatment plan, mentoring other youth or getting a mentor themselves, etc.)

VIII. Summer Site Visits

-telehealth initiative

-medicaid billable service (Keshawn)

-they're working on informing providers on how to bill for telehealth and how to go about this type of service

-prosocial activities

-fishing rod and license

-art supplies

-yoga at the CSB

-getting IAC members on visits—Katy will send out a survey to gauge interest for each of the next round of team visits for the fall

IX. Updating Work Plan – next meeting focus

X. Retention/Recruitment Breakouts

We want to help our sites get a constant flow of clients.

-jails and schools

-even in these places, we miss so much

-ex: information nights at schools

-hospitals

-building an advertising community

-12 steps so successful because it builds community

-would also help with prosocial activities because you make likeminded friendships, and allows them to have fun with each other

-alumni program – build on successes and build network and don't disregard family aspect

-governor's initiative for under-served populations – looking at religious organizations to serve clients that CSBs maybe can't reach (Jimmy)

-why aren't we going through NAMI? Youth Move?

-we can change who we work with and write in private providers and faith-based community

XI. Closing Remarks

ACRA – are there referrals to individuals for resources within the community to help with their recovery after their treatment is over? I am not sure regarding aftercare and maintenance of recovery other than the wraparound components (e.g., prosocial, family, jobs, etc.)

Thanks,

Kathleen
Kathleen.owens@dbhds.virginia.gov