YSAT Inter-Agency Council Meeting
October 2nd 2019 · 10am-2pm
Minutes

Logistics

Location	Virginia Tech Richmond Center 2810 N. Parham Road, Richmond VA
Attendees	See roster below.
Scribe	Kathleen Owens, DBHDS

Name	Agency	Email
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Minutes

I. Introductions *10:00am-10:15am*

II. YSAT Overview and state of the state *10:15am-10:35am*

a. Grant focus – We are providing evidence-based practices for transition-age youth (16-25) with Substance Use Disorder and/or co-occurring mental health disorders.

b. Malcolm update (Rich) – He has been on medical leave for a few months. He is doing very well, and will be "coming back" to work part-time and remotely starting next week, and he will be back full-time once his doctor approves of him increasing his workload. Until then, Rich will continue to serve as the "head guy" in his absence.

c. Progress updates (Katy) – As of September 1 2019:
   i. 166 clients introduced to YSAT program
   ii. 56 3-month follow-ups
   iii. 15 6-month follow-ups

iv. 75 discharges (this number is even higher – we need discharge entries for any non-active clients!)

v. Our biggest goal for Year 3: to decrease discharges and reach 80% 6-month follow-up rates!

d. New GPO and change of scope (Rich) – Matthew Clune took over for Ramon Bonzon as our GPO a few months ago. He is from a provider-background, so he understands where our sites are coming from. We presented him with the GAIN over-assessment issue, and he was on board from the start regarding getting rid of the GAIN and using the DLA-20 and GPRA as our assessments. This change-of-scope was effective as of September 1st 2019. We hope this will help retention.

III. UBET, Ben Montemayor *10:35am-10:50am*

a. Materials are scanned and attached below (a).

b. We focus on trauma-exposed youth and how they turn to AOD use to manage intense flood of emotions and traumatic reminders associated with traumatic stress. The UBET (United in Building Evidence Together) Collaborative is a partnership between VCU and community partners. We are trying to create an evidence-based, trauma-informed behavioral health promotion and drug prevention program for ACEs exposed children. We are funded by the Virginia Foundation for Health Youth (VFHY) for a three-year project. We are targeting trauma-exposed youth ages 11-17.

c. We want to identify barriers and enables to successful implementation of a new trauma-informed AOD prevention program. We are doing this by connecting with community members and focus groups. Additionally, we want to develop an AOD prevention program for trauma-exposed teens and conduct a small, pilot, randomized controlled study to evaluate the impact of the program.

d. The intervention focuses on 5 cores: emotion, self-regulation, prosocial/resistant behavior, drugs, and trauma.

e. We are working on recruiting families to participate in focus groups. We want to make sure they know we will not ask them about their use or their family's use. We need help recruiting parents and/or teens. We have gone to Circle Ashland, Mercy House, a middle school in Hanover, and It Takes A Village (Henrico), but recruiting is hard.

f. *What sort of incentives are you offering for their participation?* We are offering $40 (for parents) or $30 (for children) and offering lunch.

g. *Some organizations to look into:* YMCA, Clark Hill Organization (VCU) – looks at positive, protective factors at what makes kids resilient, foster care,

h. Ben can send Kathleen a flyer and I can disperse it to the IAC so they can spread the word.

i. It would be great to focus on areas outside of Richmond (Petersburg, Hopewell, etc.).

IV. RoundTrip, brief overview (Katy and Rich) *10:50am-11:00am*

a. Rappahannock Rapidan and Mount Rogers are "live" with RoundTrip as of October 1st 2019. RoundTrip is a transportation assistance agency that facilitates rides between the provider and various transportation options. For RRCSB, RoundTrip will coordinate a ride

(Lyft, medical sedan/taxi, regular taxi) when the CSB requests a ride for a client from the options already available, taking that responsibility off the shoulders of the client or the staff. On the other hand, in MRCSB's area, RoundTrip is going to work to build transportation options from the group up. This is a pilot project (3 months), and we will assess its progress to inform the possibility of expansion to a longer timeline and/or other sites.

V. Jerome VHI and APCD update – full presentation (b) *11:00am-11:20am*

a. We got our first extract from the APCD a month ago regarding YSAT age youth in terms of services, claims, diagnoses, dates, demographics, and other information.
b. We are looking at patterns and trends, at policy and process evaluation (YSAT, STEP-VA, and others), prescription patterns that don't make sense or are cause for alarm, and engaging in patient forecasting for required services in our 4 areas.
c. STEP-VA: all CSBs will be providing the same services. It takes about 9 or 10 steps to coordinate this. The idea is that *need* will dictate what service you get, not your zip code. This all happens in phases, so the first phase was implementing Same-Day Access everywhere. Now there is a workgroup on FFT and PACT and crisis.
d. Jerome told them what he was looking for and they help build the query and then drop the extract into box.
e. SPARS – we want to continue to reduce the amount of stuff being submitted through local EHRs. Jerome is looking at CCS3 text-similarity with what is coming in through the EHR. Slides are attached below.

VI. CSB Presentations *11:30am-12:00pm*

a. MRCSB

Staff: Morgan Greer (took over KJ's role), Andrew Peddy (took over Jason's role), Opal Currico (clinician), Michelle Cantrell (clinician), Darlene Vaughan (clinician), Carla Mullis (System Navigator), Debbie Vaughan (System Navigator)
CSB Information: You could drive almost 2.5 hours across the catchment area. There are two "sides" of the mountain, each with its own team. We are at the cross-section of two major interstates, so there is a lot of drug trafficking. Galax has the Life Center (a private treatment center). Some people get pulled over on the interstate, their kids go into the foster system, and then they'll stay in the area. Several of our counties are double the average poverty rate. Galax is probably the highest because it attracts more people because of affordable housing and actually has public transit (though it is minimal). Our biggest employers are: factories, hospital, prison, and MRCSB.
Barriers: We have had a lot of YSAT staffing changes as well as agency staff changes – it has been difficult to communicate that we can serve the 16-25 year old population when we are so broadly located because it is hard to stay connected. With the Medicaid expansion we have more individuals with funding but a lot of open job postings, and it's very difficult to recruit staff. Transportation has always been a huge barrier for us, but we are hoping the RoundTrip pilot project will help with that. It has been hard to engage individuals who are mandated into services. We have seen a lack of family supports which may stem from a lot of generational use and it being difficult to change the whole system in the family. There is a normalization of drug

use in our area, including seeing marijuana as not a big problem. We see different drugs on either side of the mountain.
Successes and strengths: We have seen individuals get sober and reach remission. We have had clients get closed to probation or DSS or keep custody of their kids. We have had some kids in foster care do really well and are doing fostering futures or returning to families rather than drop out of the program. Many clients are seeking jobs/obtaining jobs. The incentives are helping maintain sobriety (e.g., art supplies for one client) and prosocial skills. Clients have better coping skills and we have seen a reduction in cutting. Our bowling night allowed entire families to come and was really successful (over 150 people attended). We have made a lot of connections with community partners including a newly opened recovery court. We are working on staff training and development.
Year 3 service goals: maintain caseload of about 70 but really keeping schedule full; want to increase the SN's caseload (right now she's doing a lot of outreach)
Other goals: retain those staff and help them continue to develop training and certifications; both SN's seeking CSAC's so want to build programs where they can use that; increase engagement of 18-25 year olds
Sustainability plan: keep agency aware and updated; continue networking

b. RBHA

Staff: Kate Faina (program manager and supervisor), Rebecca Cohen (clinician), Cliff Jones (CPRS)
It has been a little difficult integrating Cliff in with young adults because many of our kids "don't have a drug problem," so it has been hard to connect with the adolescents. We want him to do more of a therapeutic mentor-style with them, but we are still working on that.
CSB Information: RBHA is in an urban setting with a big minority population in the city of Richmond. Almost all of our clients are uninsured or under-insured. We are located one block away from a housing project and half a block from juvenile court and close to other housing projects.
Barriers: We are seeing that POs are less involved than they used to be/than we'd like. When they are more involved engagement tends to be higher. Referrals have been slow over the summer. Parental engagement has been really difficult even for just getting families there for the minimal requirements for the program. When Cliff picks them up at home, it's good to go into the home and meet the family, and maybe do some things at home and slowly draw them out and engage them (we did this more frequently when we had our contact with probation).
Successes and strengths: Cliff has been really good with transportation, working on job-seeking skills, and getting families to reapply to Medicaid. We have had 9 completions with 7/9 continuing after completing, 7/9 getting off probation and/or employed, 4 still engaged, and 2 with over one year of engagement. When we were going through the certification process we took on any clients from our residential facility to get certified, but a few of those adults are still seeing our clinician! We served 35 this year (our goal was 20). Both Kate and Rebeca are certified trauma treatment professionals (earned CCTP credential).
Year 3 service and other goals: Our goal is to serve another 20 individuals. We are about to add adolescent IOP using ACRA as one of the curricula. We are looking to implement CRA skills and procedures in adult IOP, so we may be taking on another clinician to get involved in YSAT. Additionally, our clinician is trained in CRAFT and pursuing certification.

More information on adolescent IOP: We got licensed in May but haven't started yet. Our start date is scheduled for Nov. 4th, and we are planning to have 3 sessions (M/T/Th nights) for 2 hours with classes. We will be engaging the peer on M/T for transportation assistance, while Th will be more family focused with caregiver sessions. Our office associate is trained in Medicaid transportation and that sort of thing. We need 6/9 hours to bill. We've been giving them bus tickets because we don't have an agency vehicle onsite or else she would just bring them home.
Sustainability plan: We would like to continue to help with Medicaid applications and assisting with transportation. We plan to absorb positions into our SUD Outpatient team. We want to increase adolescent SUD services provided by the agency.

VII. Lunch *12:00pm-12:30pm*

VIII. CSB Presentations – continued *12:30pm-1:00pm*

a. RRCSB

Staff: Ashley Clark (supervisor) – currently training ***all*** counselors in ACRA, although we have 3 main ones that will be working with the YSAT clients.
Amanda Loeffler and Kaitlin Nixon (Support Coordinators)
CSB Information: We have 5 counties that are all very different – 3 very rural, Faulkier thinks they're NOVA so they don't want to be served by a CSB. We have limited transportation resources. Most of our services are provided to individuals with limited income (Medicaid and self-pay).
Barriers: We have to compete with free clinics. We are seeing high co-pays because of high deductibles. We lost trained A-CRA staff, and it has been very hard to recruit staff. We have had 6 empty counselor positions for over 2 years. License-eligible staff get licensed and then move up to NOVA to get paid up to 50% more. We saw a lot of client drop out due to data collection. Clients are terminating early due to probation ending early (referrals were really late in the timeline). Training all of our staff has taken a lot of time and resources. We are struggling to develop strong relationships with referrals sources and are having some issues with probation miscommunicating with our clients (e.g., telling clients that all services are free or open late hours when that isn't true).

We are part of the National Health Service core for loan reimbursement but we haven't had anyone successful in getting that. They want you available to see clients 80% of the time even if they no-show or something comes up where you don't actually see clients that often. MR has tried to partner with the schools (VT and RU) for internships, and RR has done that too, but as soon as they finish or reach whatever goal they move to the higher-paid areas.

Successes and strengths: We are getting all of our counselors trained in the A-CRA. We have utilized incentives and are putting together a kids' room. Ashley also did the trauma training. We are excited about using RoundTrip soon.
Year 3 service goals: We want to provide services to 48 individuals (average of 4 new clients per month). We want to complete the training of all out-patient staff to be able to provide ACRA interventions (and maybe certify them). We want to engage with referral sources. We want to

integrate additional trauma informed trainings for all staff. We will utilize RoundTrip to improve access.
Sustainability plan: We will absorb YSAT staff into the agency so they can continue to provide those services.

b. WTCSB

Staff: Latril Mariano (program supervisor), Damara Beckett (clinical supervisor), Anthony Hoskins (clinician), Brittany Sesek (clinician), Madeline Knerr (data coordinator)
CSB Information: We have a large catchment area with a few cities but also some rural areas. We are incredibly diverse (especially in SES).
Barriers: When we are doing the ACRA the clients will come for individual appointments but then for the caregiver only sessions or family sessions they don't show up. We are seeing low family engagement. We are experiencing poor follow-up with clients because of incarceration or inpatient treatment. The court will give a referral for YSAT but with pending charges so the client doesn't stay in the program for very long. We initially implemented the mentoring program to begin after treatment but that wasn't working well so we started to do mentoring during treatment.
Successes and strengths: The mentoring program implementation has increased client successes and engagement. We have seen enhanced client engagement with the incentives programs. We have made several community partners (ASAP, probation and parole, FAPT, Suffolk CPS). We started pushing internal referrals (FEP, SDA, case management, court services).
Year 3 service goals: We want to enroll at least 35 clients during the year.
Other goals: We want to engage at least half of our YSAT caseload in the mentoring program; however, some individuals don't like mentoring, especially the older ones. We want to see increased enrollment and successful discharges. We want more community partners/relationships. We want to strengthen our follow-up procedures, decrease readmits, increase family engagement, increase community involvement with events, visibility, and marketing (promotional materials for WTCSB community events), and to complete clinician trainings/certifications.
Sustainability plan: In terms of billing we will bill Medicaid and other private providers. We received 2 AMI (the funding source through DJJ) referrals and several FAPT team referrals. ASAP has an income based sliding scale.

IX. CARITAS presentation and discussion *1:00pm-1:45pm*

a. Karen O'Brien and Karen Stanley
b. www.caritasva.org for more information
c. Slides and materials attached to email.

X. Site visits and brining IAC members *1:45pm-2:00pm*

a. October 15th RBHA @ 2pm
b. October 17th RRCSB @ 10am
c. October 22nd MRCSB @ 2pm
d. November 7th WTCSB @ 2pm

(a) UBET materials

ABOUT US

OUR MISSION

The Innovative Wellness research group seeks to prevent adverse childhood experiences and promote family well-being through innovative research that informs interventions in practice and policy.

The research group consists of faculty, research staff, and students who act as agents for social change through the development and dissemination of empirically based knowledge.

Ultimately, the Innovative Wellness research group intends to increase the field's understanding of children, adolescents, and families in order to better meet the needs of our community.

CURRENT PROJECTS

L.I.F.E. STUDY

The Longitudinal Infant and Family Environment (LIFE) Study is a comprehensive intervention study designed to **decrease unsafe sleep practices among caregivers of infants** in Richmond, VA. Unsafe sleep practices and environments, such as placing babies on their stomach to sleep or bed sharing, pose a risk for Sudden Unexpected Infant Death (SUID). The caregivers participating in the LIFE study watch an educational video, take home a baby box, and receive a home visit from a pediatric nurse. The caregivers are then followed-up with at 3- and 6-months, post-intervention.

PATHWAYS TO THE PRESENT

The Pathways to the Present (P2P) Study aims to examine the **developmental processes linking childhood experiences and risky health behaviors in emerging adulthood**, a period of the life course covering ages 18 to 25. Currently, minimal understanding of how childhood experiences influence risky health behaviors in emerging adulthood limits the success of prevention and intervention efforts. The P2P study advances the mission of VCU to provide the scientific basis for the prevention and treatment of risky health behaviors in urban settings and diverse communities.

U-BET! COLLABORAT

The United in Building Evidence Tog BET!) Collaborative is a longitudinal rooted in community-based research. of U-BET is to develop and imple effective **substance-use prevention aimed at youth exposed to childhood experiences (ACES)**. Exp ACEs increases the risk of behavior problems during adolescence. The dev of the program will involve direct in ACEs-exposed youth, their caregive welfare staff, treatment provide prevention experts. Their input will be generate valuable knowledge about development, including barriers and en effective implementation of health p and drug prevention for ACEs-exposed

WHO WE ARE

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Jenny Chelmow
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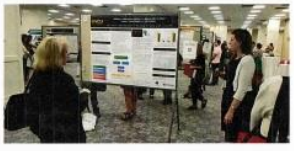
Ashley Stewart

RECENT PUBLICATIONS

Impact of a comprehensive hospital-based program to remove unsafe items from infant's sleeping area: A prospective longitudinal study. Shin, S. H., Ksinan Jiskrova G., Kimbrough, T., Trowbridge, K., Lee, E., & Ayers, C. E. (2019). Clinical Pediatrics.

Adverse childhood experiences and e-cigarette use during young adulthood. Shin, S. H., Conley, D., Ksinan Jiskrova G., & Wills, T. (2019). American Journal on Addictions, 28(4), 303–310.

Childhood maltreatment and alcohol use in young adulthood: The role of self-regulation processes. Shin, S. H., Ksinan Jiskrova, G., & Wills, T. (2019). Addictive Behaviors, 90, 241-249.



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THE INNOVAT WELLNESS GR

Building healthy communities toget

VCU
School of Social Wo

BE THE VOICE OF YOUR COMMUNITY

Join us for a U-BET focus group

Calling all **teens and parents** who are interested in making a difference within their community!

What is U-BET?

The United in Building Evidence Together (U-BET!) Collaborative is a longitudinal project rooted in community-based research. The goal of U-BET is to develop and implement an effective substance-use prevention program for youth.

How can you help?

To ensure the effectiveness of our program, we need as much community input as possible. Our **anonymous** focus groups discuss program development and potential barriers to drug prevention for Virginian youth.

Earn a $40 E-gift card*

Contact ubet@vcu.edu or (804) 828-1692 for more information!

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*Teens compensated $30

(b) All Payers Claim Database (APCD) – presentation

Virginia Department of Behavioral Health & Developmental Services

All Payers Claim Database (APCD)

What is it

- In April 2012, the Virginia General Assembly enacted legislation to create a statewide APCD.
- Virginia's APCD is a voluntary program with specific requirements of participating data submitters and certain restrictions on how the de-identified data may be used.
- Virginia's APCD was created under the authority of the Virginia Department of Health.

Virginia Department of Behavioral Health & Developmental Services

What is it..

- The program is operated by VHI as a collaborative effort with health care stakeholders who provide input through the Virginia APCD Advisory Committee.
- The Virginia APCD was established to facilitate data-driven, evidence-based improvements in the access, quality and cost of health care and to promote and improve public health through the understanding of both health care spending patterns and performance outcomes

Virginia Department of Behavioral Health & Developmental Services

Quick Overview

- The Virginia APCD currently includes paid claims data for approximately 3.5 million lives.
- VHI estimates that approximately 60-65% of the Commonwealth's commercially insured residents are represented in the Virginia APCD.
- Analysis shows that anywhere from 20 to 70% of commercially-covered lives in any particular county in Virginia are included.

Data

- Records about individual plan members (e.g., demographics and enrollment), providers and insurance products (e.g., product type and coverage type).

- Data on coverage and services for the majority of commercially-insured Virginia residents as well as those with public or private Medicaid insurance. Both health insurance carriers and third-party administrators

- The following information is excluded at this time: 'Workers' Compensation, Medicare Fee For Service, TRICARE, Veterans Health Administration, and Federal Employees Health Benefit Plan

Data Submitters

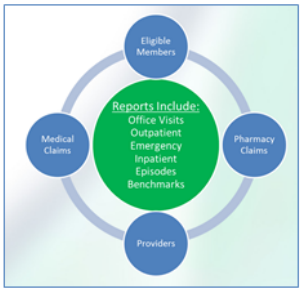
Currently, the Department of Medical Assistance Services and the following nine commercial insurance carriers submit data to the Virginia APCD: Aetna, Anthem Blue Cross and Blue Shield, Carefirst, CIGNA, INTotal Health, Kaiser Permanente, Optima Health, United Health Care and Virginia Premier.

Data..

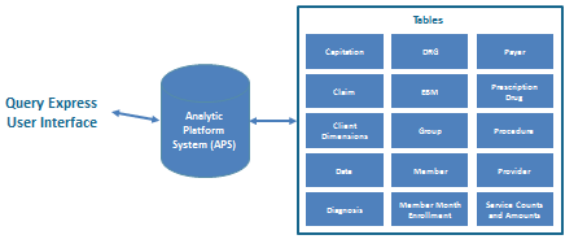
- Medical and pharmacy claims submitted by commercial and public insurance carriers.

- Includes paid claims from institutional encounters (hospital, surgery centers, etc.), medical professional services (such as doctor visits and imaging), pharmacy and other services.

- Data submitted to the Virginia APCD by medical insurance carriers includes claims from administrators of "carved-out" services such as pharmacy and mental health/chemical dependency.



Tables in the MedInsight Database



Next steps

- We have an extract. Getting familiar with navigation and data format
- Data validity check with DMAS
- Patient forecasting for required services in our four CSB catchment areas
- Process and policy evaluation. YSAT, STEP-VA, Others