SB176/HB888 Workgroup on Placements in Virginia for People with Neurocognitive Disorders and Neurodevelopmental Disabilities

Secretary of Health and Human Resources

Thursday, August 29, 2024 | 10:00 a.m. – 12:30 p.m.

Location: DARS with Virtual Option

DRAFT MINUTES – Meeting Three

In Person	
Leah Mills, HHR Deputy Secretary	Judy Hackler, VALA
Braden Curtis, DBHDS	Catherine Harrison, DARS
Alexis Aplasca, HHR & DBHDS	Aimee Perron Seibert, VCEP
Ann Bevan, DMAS	Christine Schein, VHHA
Jae Benz, DBHDS	Dana Parsons, Leading Age
Karin Addison, Neuro Restorative Brain Injury Facility	Joshua Myers, Alzheimer's Association of Virginia
Jennifer Faison, VACSB	Byron Wine, The Faison Center
Jonathan Green, OES	Nicole Durose, DLCV
Brian Kelmar, Parent Advocate	Joran Sequeira, VCEP
Jason Young, VABIAV	
Online	
Senator Barbara Favola	Delegate Vivian Watts
Martin Mash, VOCAL	Steve Ford, VACA-VCAL
Bruce Cruzer, MHV	James Murphy, VHHA
Suzanne Mayo, DBHDS	Heather Norton, DBHDS
Keith Hare, VHCA-VCAL	Tonya Milling, ARC of VA
Meghan Cox, DARS	Deborah Dashiell, Western Tidewater CSB
Lucy Beadnell, ARC of NOVA	Nathalie Molliet-Ribet, BHC
Mark Smallcombe, VCU Health	Cimberly Ayers, Wythe County DSS
Sarah Harris, Parent Advocate	Annette Clark, DBHDS
Sarah Rexrode, Franklin County DSS	Dev Nair, DBHDS
Brian Unwin, Carilion Clinic	

Welcome – HHR Deputy Secretary Leah Mills

HHR Deputy Secretary Leah Mills welcomed and thanked all of the participating workgroup members and members of the public for volunteering their time to this critical effort. She reviewed major take aways from the last meeting and key themes discussed to guide recommendations. Deputy Secretary Mills noted the 25th anniversary of the *Olmstead* decision and emphasized choice, dignity, and least restrictive environments as guiding principles for the workgroup. She reminded the workgroup of a question posed during the previous meeting – "What does success look like?" – and emphasized the importance of continuing to keep the needs identified by individuals with lived experience and their supporters at the center of the workgroup's decisionmaking.

Stakeholder Perspective – Youth in Foster Care

Rebecca Morgan, with the Virginia League of Social Service Executives representing local departments of social services across Virginia, shared the challenges faced in finding placements for children in foster care with high acuity behavioral health needs who often have co-occurring neurodevelopmental and neurocognitive diagnoses. Ms. Morgan reviewed the success of the Safe and Sound Taskforce in decreasing the incidents of children in foster care staying in hotel rooms and offices due to lack of available placements. She noted that oftentimes these children had significant trauma associated with abuse and neglect which contributed to their behavioral challenges. She emphasized that in crisis situations it is often impossible to conclusively determine whether behaviors are rooted in trauma, mental illness, traumatic brain injury, developmental disability, or a combination. She pointed out the importance of exploring additional providers and community structures to better address the needs of children with complex diagnoses and reminded everyone of the need to ensure that the recommendations addressed the needs of youth.

Opportunities to Improve System Infrastructure – Partner Perspectives

Suzanne Mayo, Division of Facility Services, Department of Behavioral Health and Developmental Disability Services (DBHDS)

Suzanne Mayo provided the workgroup with an update on the case referenced in the stakeholder perspective shared at the previous meeting by the Brain Injury Association of Virginia (BIAV), which revealed challenges in communication and coordination between the hospital and community brain injury services. Following that meeting, the patient signed a release allowing DBHDS staff at Central State Hospital to communicate with BIAV case managers, and they are collaborating to support the patient. Ms. Mayo noted that the Code of Virginia has a provision permitting state hospitals to share patient information with Community Services Boards (CSBs) without a patient release. Patient information can also be shared with legal guardians and those under certain forms of power of attorney. She conveyed, however, that state hospitals cannot share patient information with other entities without a patient release, and if a patient is not able to identify community providers that they have received services from, the state hospital has no way of knowing which entities to request a release for. Ms. Mayo stressed the importance of improving communication barriers, particularly when individuals with disabilities cannot share their own information.

Ms. Mayo then reviewed recommendations from a recent study conducted by Berry Dunn to support implementation of rates for the Discharge Assistance Program (DAP). One requirement of the study was to recommend training for assisted living facilities (ALFs), skilled nursing facilities, and nursing homes accepting patients from state facilities. The main finding of the study was that there was a need for training in best practices for deescalating behaviors (ex: therapeutic options, crisis prevention, the Mandt System) to support patients, especially when they are first transitioning to the new service. The study also recommended training in Mental Health First Aid, Positive Approach to Care, or best practice in Dementia Care, and patient specific training.

Workgroup Discussion:

Jeannine Rosado shared her positive experience supporting her adult son with Autism receiving care from Central State Hospital. Workgroup members emphasized the importance of supporters and community providers communicating with clinicians in the emergency room before entering the hospital and recommended that the workgroup consider means of supporting this communication. Members noted the difficulty of identifying community providers serving the patient when the patient is unable to provide that information. Brian Kelmar noted that there are “code blues” for stroke patients and suggested a similar notification for individuals in crisis. This could be a way to flag an individual before they are at hospital so that appropriate personnel arrive for the initial incident, not after. Ms. Rosado added that police have responded four different times for her autistic son but that, even after telling them that her son had Autism, they would still go to a punitive solution instead of facilitating help appropriate to Autism.

Jae Benz, Office of Licensing, DBHDS

Jae Benz provided the workgroup with an overview of services licensed by DBHDS. She shared that DBHDS is working to ensure that licenses align with the type of services/supports provided rather than primary diagnosis of the individuals receiving the service. She also provided an update on the regulatory overhaul which will re-organize DBHDS licensing regulations to support the shift from a diagnosis-driven licensing structure to a service driven structure.

Ms. Benz then reviewed DBHDS support of the buildout of a comprehensive crisis continuum as the alternative to inpatient psychiatric care based on the “no-wrong door” model, which can address the needs of anyone experiencing a mental health crisis regardless of primary diagnosis. She also provided information on how the REACH program is being incorporated into the comprehensive crisis continuum. REACH is designed to meet the crisis support needs of individuals with developmental disabilities who are experiencing behavioral health or behavior-related crisis events.

Ms. Benz also reviewed how private inpatient psychiatric services are licensed. She emphasized that if an individual with a neurodevelopmental disability or neurocognitive disorder is experiencing a mental health crisis there is no prohibition against their admission into inpatient services and this should not be a basis for exclusionary criteria. Finally, Ms. Benz reviewed existing regulations providing for the licensing of specialty services including gero-psychiatric residential services, usually for individuals 65 and older. She noted that there are no existing active licenses for the provision of gero-psychiatric residential services. Ms. Benz identified possible barriers to providers starting this service including requirements for staff qualifications and funding sources.

Workgroup Discussion:

Workgroup members emphasized that REACH services are often at capacity and cannot always admit individuals with aggressive behaviors. It was noted that efforts are being made to cross train all REACH service providers and crisis service providers to increase their capacity to support individuals with co-occurring neurodevelopmental disabilities across the continuum. Jae Benz noted that REACH is specialized for DD but that anyone can go to a CSU. Ms. Benz also noted that all providers are required to be trained in behavioral issues and that CSUs can now provide seclusion, with strict requirements. Jeannine Rosado replied that the only protocol in place was for REACH and that she had not looked into a CRC.

Workgroup members participating virtually in the chat noted that oftentimes for older adults experiencing behavioral and psychological symptoms of dementia (BPSD), the mental health crisis is linked to co-morbidities and medical factors requiring a combined “medical” and “mental health” intervention. Co-occurring medical conditions may also contribute to behavioral crisis experienced by younger individuals with neurodevelopmental disorders.

Dr. James Murphy, Virginia Hospital and Healthcare Association

Dr. James Murphy presented an overview of barriers and recommendations for supporting individuals with neurodevelopmental and neurocognitive disorders and significant behavioral challenges. He noted these disorders are extremely broad diagnostic categories, and individuals require specialized treatment that is typically different than what is provided on acute inpatient hospital units. Identifying care needs requires consideration of verbal skills and cognitive functioning and how it has changed over time as well as behaviors and potential safety risks. Individuals within these populations may need behavioral focused treatments. He noted that occupational therapy plays a key role in addressing ADLs, and staff support ratios of 2:1 or 1:1 are essential to meet both behavioral and ADL requirements; coverage for these costs, however, is challenging for insurance providers.

Because of staffing needs to ensure safety, supporting individuals in these populations with high acuity needs can increase staff burnout especially if a facility is already understaffed. These populations also have increased lengths of stay due in part to the lack of appropriate discharge placements. REACH services play an essential role in supporting those with neurodevelopmental disabilities; however, these services are often at capacity and are not always appropriate step-down placements, and there is a clear need for more comprehensive therapeutic interventions in addition to REACH. There are also often additional requirements for discharge planning that contribute to the extended length of stay (ex: Uniform Assessment Instrument (UAI), guardianship). When an individual has a primary diagnosis of neurodevelopmental disability or neurocognitive disorder it can also be challenging to prove that behavior has changed enough from baseline to get an insurer to cover the cost of treatment especially if changes have occurred over a more extended period of time.

Dr. Murphy's recommendations to support included increased reimbursement rates for providers to cover increased staffing needed for these populations; funds for additional community-based providers including group homes, assisted living facilities, and nursing homes that specialize in working with these populations; grant funds to private providers/hospitals to open specialty units for each of these distinct populations; development of additional respite care and crisis service capacity including specially trained mobile crisis teams; additional resources and support for nursing and group home staff to better support patients to reduce the need for hospitalization; and development and implementation of a program modeled after VMAP to assist primary care providers in learning best practices and medication management.

Keith Hare and Steve Ford, Virginia Health Care Association (VHCA)

Keith Hare and Steve Ford presented on behalf of the VHCA. Mr. Hare emphasized the need for expanding capacity of specialized placements for individuals with neurodevelopmental disabilities noting that they are sometimes placed in assisted living facilities and nursing homes and this may not be appropriate to their needs. He emphasized the importance of supporting and expanding current pilot programs and public-private partnerships. These partnerships between CSBs and private providers include the creation of specialized units for people with high acuity needs and training for staff to support people remaining in their current treatment setting. Mr. Hare noted that unlike many other states, Virginia does not have a rate add-on to help support training staff and build the infrastructure needed to support patients with high acuity behavioral health support needs. The current pilots receive standard Medicaid reimbursement rates, and CSB provide additional staff augmentation in kind.

Mr. Ford reviewed how periodic needs assessments inform the care plan and identify resource needs which in part determine reimbursement. He stated that the current Resource Utilization Groups (RUG) in the Medicaid assessment used to determine rates do not adequately reflect behavioral health needs. As a result, facilities face lower reimbursement rates despite significant needs and costs, as Medicaid scales fail to account for these complexities. Virginia Medicaid is currently modifying the payment methodology due to federal changes with a target date of implementation in approximately 15 months. He relayed VHCA's concerned that, while the proposed changes would be an improvement, they still will not fully account for the behavioral support needs of the patients.

Mr. Hare and Mr. Ford noted that the Valley Health Care Center in Chilhowie has been successful despite the lack of Medicaid enhancements. They recommended standing up regional hubs to support public-private partnerships for creating and expanding specialized placements for individuals with neurocognitive disorders and high acuity behavioral challenges. Organizing administration at the regional level would support consolidation of resources and achieve economies of scale. In order to be sustainable, the specialization of these programs needs to be reflected in the reimbursements they receive.

Jonathan Green, Department of Magistrate Services, Office of the Executive Secretary

Jonathan Green, speaking on behalf of the Office of the Executive Secretary, discussed the statutory requirements of the TDO process noting that the TDO process is the last part of the involuntary commitment process that the magistrate is involved in. Mr. Green emphasized that the TDO process is significantly different than the involuntary commitment hearing process. Involuntary commitment hearings are scheduled in advance and respondents have a right to legal council, but TDO hearings are held as the need arise. He noted that magistrates seldom have direct contact with the individual in crisis and rely on the information provided by other sources to make this judgment. Sources of information are most commonly CSB staff but also family, treating physicians, and medical records if they are available. The availability of medical records depends on timing.

The language proposed in HB888/SB176 would prevent magistrates from issuing a TDO if they determine that there is probable cause to believe that behaviors are solely the manifestations of neurocognitive or neurodevelopmental disorders. Mr. Green reminded the workgroup that magistrates are not clinicians or diagnosticians and there is an opportunity to train magistrates to understand that ND and NC do not equate to mental illness under the law. He also noted that magistrates evaluate evidence presented to them and apply the law to the evidence; a primary challenge is obtaining sufficient information to determine whether the symptoms or behaviors are exclusively caused by ND/NC conditions. Mr. Green noted that if the legislation is reenacted there will likely be significant challenges for magistrates to receive sufficient information to determine whether there is probable cause to believe that the behavior is solely the manifestation of a ND or NC disorder. This determination will be challenging for magistrates to make and there oftentimes may not be a clear right answer.

Workgroup Discussion:

Workgroup members emphasized that oftentimes prescreeners do not have placement options for people with co-occuring neurodevelopmental or neurocognitive disorders and high acuity behavioral challenges. Members shared that REACH has significant capacity limitations and is only for voluntary patients. It was noted that the TDO process is currently the only tool that prescreeners have to support individuals in these populations who are determined to be a significant danger to themselves and/or others. Members participating virtually noted in the chat the importance of identifying how to create opportunities for better information exchange from family members and assessments.

Jennifer Faison, Virginia Association of Community Services Boards (VACSB)

Jennifer Faison spoke on behalf of VACSB. She reviewed potential implications of reenacting the bill language without amending. Ms. Faison noted most private facilities have exclusionary criteria prohibiting admission of these individuals. As written, the bill will not allow these individuals to be admitted to state hospitals regardless of whether they are an active danger to themselves and/or others and no alternative safe setting exists to care for them. Ms. Faison noted that, in a moment of crisis, there may not be strong evidence indicating whether behaviors are due to mental illness or solely a neurodevelopmental or neurocognitive disorder. Individuals may not be known to the CSB prior to their prescreen, and if the individual is not able to speak to their medical history and previous diagnosis during a crisis, it is unknown how this determination will be made.

Ms. Faison noted the expansion of mobile crisis will mitigate some of the issues identified by the workgroup. Mobile crisis teams are being cross-trained: REACH mobile teams are being trained to support individuals with primarily behavioral health needs, and mobile crisis teams are being trained to support individuals with developmental disabilities and co-occurring behavioral health challenges. Continuing to enhance REACH capacity as a specialized service is essential, as well as supporting collaboration between REACH and CRCs.

Ms. Faison emphasized that the criminal justice involvement of individuals and need for expanding diversion programs is also important to consider in developing recommendations. The state engaged in sequential intercept model cross systems mapping a number of years ago. This initiative supported the implementation and expansion of REACH and CITACs. Additionally, she pointed out the necessity of proximity for assessment centers that facilitate law enforcement drop-offs and the importance of a dedicated workforce and providers to support these efforts. Ms. Faison also addressed the need for increased funding to match the capacity and current demands of divergent programs like REACH and CRCs, which have not seen funding adjustments since they were first established 15 years ago. Finally, Ms. Faison noted that years ago there was discussion of a pilot for a CSB to work with a private hospital to develop a specialized in-patient unit for treating individuals with neurodevelopmental disabilities. She stated that CSBs are open to these kinds of partnerships but we need to figure out how to expand them to scale and make them sustainable.

Workgroup Discussion:

The workgroup expressed concern about events when an individual is experiencing a behavioral crisis and is an active danger to themselves or others but there are no safe alternatives available outside of an inpatient setting. Access to such placements is needed as a last resort.

Brian Kelmar noted the need to divert individuals before they are brought to a magistrate is crucial, as TDOs are often not the appropriate solution for many members of this population. The focus should be on finding alternative interventions to address their needs prior to the point of magistrate involvement. This would help ensure that individuals receive appropriate care and are not diverted into the criminal justice system.

Public Comment:

Lucy Beadnell, Arc of Virginia – Ms. Beadnell noted that there are times when people have a developmental disability but have never been formally diagnosed. Such individuals may get caught in the criminal justice system without access to needed services because the screenings used to identify mental health needs are not designed to and do not identify developmental disabilities.

Theresa Champion, Virginia Autism Project – Ms. Champion highlighted that inpatient treatment in state hospitals can be traumatic and is not the appropriate placement for some individuals with NDD and there are insufficient community-based services. Ms. Champion suggested that, when recommendations are presented, the workgroup discuss each real life case example presented throughout the meetings in light of the recommendations to determine if they meet the needs identified.

Review Preliminary Recommendation Topic Areas and Group Discussion

Deputy Secretary Mills noted themes that emerged from this meeting. Needs including:

- Improved communication to ensure effective information exchange among stakeholders
- Diversion strategies to redirect individuals from inappropriate settings to more suitable care environments
- Comprehensive training programs for those involved in managing individuals with special needs, including cross-training among professionals
- Ensuring adequate resources for individuals and the systems
- Expanding and building out the system will help to better accommodate and support those in need
- Implementing evidence-based models to guide practices and interventions
- Providing robust support for caregivers to enhance their ability to effectively manage and support individuals in their care

Workgroup members discussed the need to create and expand more state partnerships with group home providers. It was noted that group homes are legally permitted to refuse to allow individuals seeking to return to services after going to the emergency department even if the individual was not placed under a TDO. It was discussed that this typically happens because the provider does not feel that they have adequate staffing or training to provide services.

Workgroup members noted that every Medicaid recipient receiving long-term care services has a planner responsible for the coordination of their care. There may be opportunities to support these professionals in connecting members to mental health services as one of their covered benefits. Some workgroup members also recommended expanding the types of service settings covered under Medicaid, including Assisted Living Facilities (ALFs).

Adjourn

Deputy Secretary Mills provided closing remarks and shared tentative dates for the next meeting.