

Meeting Notes
Hammond Commission's Public Policy Committee
October 22, 1998
Blue Ridge Community Services Board
Roanoke, Virginia

- Committee Members:* Louis F. Rossiter, Ph.D.
Raymond F. Burmester
The Honorable Franklin P. Hall
- Commission Members:* Catherine C. Hammond, Commission Chairman
Henry Altice
- Commission Staff and Liaison:* Julie A. Stanley, Commission Administrator
Charline Davidson, Department of Mental Health,
Mental Retardation and Substance Abuse Services
(DMHMRSAS)
- Presenters:* Nancy Roberts, Division of Legislative Services
Malcolm R. Holley, Virginia Health Quality Center
- Other Attendees:* Attachment A provides a list of individuals who
attended the Commission meeting, including
individuals who gave public comment.
- Welcome and Introductions:*

Dr. Rossiter called the meeting to order at 10:17 a.m. and welcomed committee members and others. Committee members and staff were introduced. Dr. Rossiter distributed a paper (Attachment B) that summarized comments received from various organizations related to areas the committee has been asked to examine. These comments included recommended guiding principles for public policy for mental health, mental retardation, and substance abuse services.

Discussion of Guiding Principles for Public Policy:

Dr. Rossiter suggested that it is important to look at guiding principles because the field is continuing to change. The Committee agreed to develop and present a set of guiding principles to the full Commission for action by December 1, 1998. Committee members expressed interest in reviewing the mission statements and guiding principles of the State Board, CSBs, state facilities, and advocacy groups and organizations. Charline Davidson agreed to request this information from these entities. Using this information, a draft set of guiding principles will be developed for Committee review at its next meeting.

One Committee member suggested that the difference between mental health and mental retardation services should be considered in the development of guiding principles. Mental health services focus on treatment while mental retardation services focus on long term care.

Review of House Bill 428 and House Document 77:

Charline Davidson, DMHMRSAS, provided a summary of DMHMRSAS progress in implementing the recommendations of the Joint Subcommittee Studying the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services (HJR 240, now HJR 225) contained in House Document No. 77 (1998). She presented a matrix that provided progress notes for each of the 112 recommendations as well as related requirements in budget bill language and joint resolutions (Attachment C).

A Committee member noted that the recommendations in House Document No. 77 accurately portray what the advocates asked. While he was delighted with the recommendations, he suggested that they might not have gone far enough, specifically in the areas of funds following the client. The Committee member felt that this remains as one of the most difficult unresolved problems.

The Committee discussed Recommendation #80 (page 30 of the DMHMRSAS matrix) which called on the DMHMRSAS and the Department of Medical Assistance (DMAS) Services to review and expand Medicaid-covered mental health, mental retardation, and substance abuse services in order to maximize the use of federal funds

available for individuals eligible for Medicaid. Members suggested that actual practice has emphasized optimizing the utilization of existing Medicaid-covered services rather than maximizing the use of these federal funds. Several members recognized that DMAS has effectively performed its cost-containment responsibilities, but that coverage of mental health, mental retardation and substance abuse services has not been its primary function. It was suggested that the Committee consider the issue of transferring responsibility for policy-making related to Medicaid-financed mental health, mental retardation, and substance abuse services to the DMHMRSAS. Under this scenario, DMAS would maintain its fiscal agent role and would continue to be accountable for regulations compliance. This issue also is being addressed by the HJR 225 Joint Subcommittee.

State Definition of Emergency Services and State Hospital Admission Procedures:

Nancy Roberts, Division of Legislative Services, provided an overview of the Commonwealth's definition of emergency services and emergency services functions. Her presentation specifically referenced:

- The *Code of Virginia* -- Section 37.1-194, requires that CSBs provide emergency services but these services are not defined in statute.
- The State Mental Health, Mental Retardation and Substance Abuse Services Board's Policy 1031(SYS)90-4 on Emergency Services (Attachment D) -- This policy defines emergency services in terms of availability and access rather than specific services. The policy references the various types of emergency services, emphasizes the provision of non-hospital-based services, and discusses pre-admission screening as a function of emergency services.
- Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services Procedures for Continuity of Care Between Community Services Boards and State Psychiatric Facilities (Attachment E) -- These procedures are intended to provide practitioner guidance on best practices. They are voluntary and are not required in statute or regulation. These procedures emphasize provision of services in the least restrictive and most normalized manner. They require that preadmission screenings be performed by qualified staff but training and

experience qualifications are not defined.

Dr. Rossiter asked if federal definitions of emergency services, such as those used by the Health Care Financing Administration and in the Federal HMO and Patient Bill of Rights Acts, could be obtained. These definitions, which are more comprehensive and focus on acute care, could be compared with the Commonwealth's definition of emergency services. They might be used to develop a conceptual principle statement on the standard of care for emergency services

Committee members and others attending the Committee meeting raised a number of points related to the current provision of emergency services, including:

- One of the principles of the current services system is that local CSBs determine the needs of their local citizens and provide services to the extent they can within resources. This results in differences in the level of emergency services provided across the state. It would be very difficult to mandate a single definition of emergency services statewide because of geographic differences.
- The DMHMRSAS has attempted to use policy and guidance to provide services to prevent people from experiencing crises that require hospitalization. By the time someone gets into the judicial Temporary Detention Order (TDO) process, there is little anyone can do to prevent hospitalization.
- Emergency services are rarely provided to individuals with mental retardation.
- In acute care, only physicians are able to admit an individual to a hospital. This is not the case with this system. The state needs to do something to strengthen medical involvement in this process. The issue of medical clearance is a critical one for state hospital admission.
- There are financial incentives to admit individuals to a state facility. People admitted through TDOs to a state facility tend to stay too long. A recent study by the Joint Legislative Audit and Review Commission (JLARC) concluded that clinical and financial incentives for state facility hospitalization are in conflict.

The Committee concluded that policy related to the provision of emergency services has been more aspirational than operational due to resource issues. In effect, expectations for the provision of emergency services have been defined at the TDO crisis capability for individuals who present public safety issues or who cannot care for themselves. Beyond this, CSBs do what they can and want to in the area of emergency services. To address this issue, the Committee agreed that:

- The DMHMRSAS should develop guidance outlining the minimum level of care that should be expected for emergency services.
- The DMHMRSAS should direct the CSBs to develop plans in collaboration with public and private providers in their communities outlining how these functions will be met. These plans will outline resources requirements (e.g., for local bed purchases, medications, aggressive case management, and other care requirements).
- The DMHMRSAS should include this requirement in CSB Performance Contracts with consequences to any CSBs where the minimum level of care was not provided.
- The DMHMRSAS should oversee the implementation of CSB plan to make sure they adhere to the minimum level of care expected for emergency services.

These actions assume the availability of funds to implement needed services.

The Committee agreed to continue its discussion of the definition of emergency services at future Committee meetings.

Quality of Care in Mental Health, Mental Retardation and Substance Abuse Services:

Malcolm Holley, Virginia Health Quality Center Chief Operating Officer, presented its recommended definitions of quality and quality values and guiding principles for mental health, mental retardation, and substance abuse services (Attachment F). The Virginia Health Quality Center (VHQC) was started by the Medical Society of Virginia. The Center has a contract for quality improvement for Virginia's

Medicare population. Mr. Holley stressed the need to constantly look at current knowledge and keep up with the field in order to provide effective and efficient care. He reviewed VHQC's recommended guiding principles for Virginia's mental health, mental retardation, and substance abuse services delivery system. These focused on working collaboratively so as not to replicate existing resources; communicating data about access, practices, and costs; and education so individuals can make informed, responsible decisions. Mr. Holley stressed the need for validated data. He also discussed the need for a consistent standard across the state and the importance of constantly reevaluating the system.

The Committee discussed the fact that the approach of measuring quality health care is moving from process to outcome measures. Committee members discussed the DMHMRSAS Performance and Outcomes Measurement System pilot project and asked that this be a topic on a future Committee agenda. Members discussed the need to have the correct data that support the outcome being sought and the importance of data validation. The approach used by the VHQC of trying to collaborate to improve the whole orchard rather than spending millions on a few bad apples was noted. One Committee member suggested that oversight of adult care residences was needed because care provided may not be appropriate in many circumstances. He suggested that the state needs to develop a capability to monitor this care.

Authorizing Legislation for Virginia Health Information:

Nancy Roberts, Division of Legislative Services, summarized Virginia's statute on Health Care Data Reporting (Attachment G). This act will need reauthorization on July 1, 1999. Its provisions currently pertain to licensed facilities. The Committee reviewed the patient level data system reporting requirements outlined in the statute and discussed the relationship between these items and the items included in POMS.

The question was raised as to whether the patient level data base should include patients served in state psychiatric facilities. All licensed hospitals submit UB 92 standard claim forms to the Virginia Health Information program. This is a not-for-profit entity with a volunteer board of directors that processes efficiency and productivity reports under contract with the Department of Health. The patient level data base also includes some data on outpatient care provided under Medicaid and the state employees contract.

The Committee discussed whether CSB services also should be included. Committee members recognized that this would require a statutory change and additional funding. The goal of including state facilities and CSBs would be to have a snapshot of health services provided in the Commonwealth. Within this snapshot, comparisons could be made among health care providers.

Agenda Items for the Next Committee Meeting:

The Committee discussed the following agenda items for the November 5, 1998 Committee Meeting:

- Public policy recommendations from Dr. Geller
- Implications of Virginia Health Information collection for data from state mental hospitals and CSBs -- Michael Lundberg
- Overview of the DMHMRSAS Performance and Outcomes Measurement System Pilot Project -- Randy Koch
- Review of the Committee's draft Guiding Principles for the Mental Health, Mental Retardation, and Substance Abuse Services System
- Continued discussion of the definition of emergency services

It was suggested that facility employees be invited to the public comment period at the Committee's November 5, 1998 meeting. Other potential items raised for future Committee meeting included: public policy related to substance abuse, the Medicaid match issue, and parity in insurance coverage for mental health services.

What Is Right With the Current Services System?

Catherine Hammond asked the Committee members and others attending the meeting to share their ideas about what works well in the current services system. The following responses were provided:

- Individualized services are provided through the Mental Retardation Home and Community-Based Waiver. Mental retardation is a family-focused system.
- The Blue Ridge CSB has a comprehensive continuum of substance abuse services, including good relationships with the courts and probation and parole.
- The majority of services are planned, coordinated, and administered by local CSBs with representation by service recipients and family members on that Board. CSBs have a sense of accountability to their citizen boards and to local government. For those CSBs that are part of local government, consumers, family members, and advocates are empowered to raise issues directly with their city councils or county board of supervisors. Local government officials have ownership in the system, which is reflected in the provision of local resources. The question is whether this local government attention and involvement will continue over the long term.
- In the current system, many people are well served with a remarkable network of services. Virginia's system has avoided some of the mistakes other states have made with managed care and has steered a middle course. The current system has elements of a managed system of care, with CSBs triaging individuals for facility admission and managing budgets.
- Mental health, mental retardation, and substance abuse services are integrated within one Department. These populations are closely related and many individuals have co-occurring diagnoses.
- The state-local partnership has served Virginia well.
- There is ongoing collaboration among and between CSBs and state facilities. For example, CSBs in Northern Virginia meet monthly and collaborate on a number of projects.
- The child-adolescent system of care emphasizes collaboration. Medicaid funding is available for a number of services.

- New funding was provided to establish mental health Programs of Assertive Community Treatment (PACT) programs.
- CSBs are able to access a variety of grants.

Public Comment Period:

1. *Dan Harrington, Carilion Health System, Director of Psychiatric Education and Medical Director with Carilion Behavioral Health* (Written comments attached)

Dr. Harrington spoke to Carilion's private-public partnership with the Blue Ridge CSB and Catawba Hospital. This partnership provides brief hospitalization for crisis stabilization and has enabled hundreds of patients to be diverted from state facilities. He also noted other partnerships such as PACT.

Dr. Harrington also referenced the development of a Mental Health Collaborative free clinic to provide services to patients who do not meet the criteria for serious mental illness, who are not eligible for Medicaid, or who are underserved from an insurance standpoint. These individuals are at high risk for hospitalization in state facilities if they do not receive care. This is a growing unmet need.

Dr. Harrington stated that he is an attending physician at Catawba Hospital, which he described as one of the finest hospitals in the state.

2. *Jim Tobin, Piedmont Regional CSB Executive Director, representing the Virginia Association of Community Services Boards* (VACSB Principles attached)

Mr. Tobin distributed the VACSB Guiding Principles and noted that these were the result of a collaborative process with consumer and advocacy organizations. These guiding principles also including operational concepts. He expressed concern that match for Medicaid-covered mental health and mental retardation services is different from all other health care services in Virginia. CSBs have to create this match before a unit of service can be delivered. This is not the case with other hospital and physician services in Virginia. This difference has multiple implications as well as moral and ethical issues. People who are totally

appropriate for services cannot get them because match is not available.

3. *Harriette H. Shivers, Counselor and Attorney at Law, Board of Directors of the Virginia Guardianship Association (Written comments attached)*

Ms. Shivers raised the issue of guardianship for persons who do not have the mental capacity for personal decision making. Currently, state facility directors serve as the authorized representative for residents of hospitals and facilities who have seriously impaired decision making ability. Authorized representatives have no legal authority for a person who is not a patient or resident of a state facility. Many times patients in a state hospital cannot be discharged to a more appropriate community based placement because they do not have a guardian or other legal surrogate decision maker. The need for guardians and surrogate decision makers should be considered when decision about facility downsizing are made.

Ms. Shivers described the newly established Virginia Public Guardians and Conservator Program. Under this program, the cost of a public guardian for each client is anticipated to be about \$200 per month. The program, as it is currently authorized, cannot absorb a major influx of additional clients. In its initial phase, the program can serve 200 people. There are more than 200 people in state facilities who are in need of guardians. Funding for additional local/regional programs should be made a part of the overall cost of mental health restructuring. Ms. Shivers urged the Commission to commit, as a matter of policy, that patients and residents who are found to lack capacity to make an informed decision about their personal lives be assured a legally authorized decision maker.

4. *Jessica Burmester, Fairfax-Falls Church CSB Board of Directors, Past President of the Northern Virginia Arc*

Mrs. Burmester noted that Virginia's mental retardation system is largely funded through Medicaid. The state is 49th among the states in funding for residential services. There are a growing number of individuals with mental retardation who have aging care givers. Virginia is serving only the tip of the iceberg. Ms. Burmester recommended that the state appropriate Medicaid match for mental retardation separately. Current practice takes services away from people so CSBs

can get matching funds.

Ms. Burmester cautioned that as the Commission develops its guiding principles, there is a tendency to use terms that are patient and treatment focused. These terms do not recognize that mental retardation is a life-span issue and is habilitation-based rather than treatment-based.

5. *Richard Dickson, Executive Director of the Arc of Roanoke*

Mr. Dickson stated that over the past 50 years, his members have provided extensive testimony concerning the needs of people with mental retardation and other developmental disabilities. He noted that services for people with mental retardation and developmental disabilities are woefully underfunded and the system must have more money.

6. *Helen Harrah for Jim Sikkema, Director of Mental Health for Blue Ridge Community Services* (Written comments attached)

Ms. Harrah, for Jim Sikkema, stated that it is important that policy recommendations be guided by the value of providing care in the least restrictive, most normalizing environment. By definition, that environment can only exist in the community. She stated that any further deinstitutionalization without comprehensive capacity building in the community cannot take place. Ms. Harrah noted that policy recommendations regarding the future of the state hospital system must assure that this capacity is available and accessible. Beds must be available in sufficient number and be geographically distributed so that hospital can be an integral part of continuums of care in each community. Ms. Harrah recommended that this can also be achieved by public-private partnerships where private inpatient capacity is available.

Catawba Hospital is the only provider of psychogeriatric care. It also has a short term acute unit for citizens of the Roanoke Valley. Ms. Harrah suggested that the state mental health system would best be served by expanding the adult capacity at Catawba and shared a proposal to accomplish this.

Ms. Harrah expressed concern about the proposal in the draft master plan to consolidate adolescent services at DeJarnette and to no longer provide inpatient care for pre-adolescent and urged the Committee not to consider this proposal.

7. *Nancy Canova, Alliance for the Mentally Ill - Ronaoke Valley (VAMI Principles attached)*

Ms. Canova shared a copy of the Virginia Alliance for the Mentally Ill *Principles Regarding Public Mental Health System Reform*, adopted by the VAMI Board of Directors on August 9, 1997. She noted that emergency services were the only services manadated in the Virginia Code and recommended all core services need to be mandated. She especially mentioned the importance of services that allow for an earlier intervention, such as wrap-around case management. Ms. Canova stated that it is about time for the state to accept responsibility for what services are needed and to put these services in place.

Ms. Canova also raised the issue of the number of perople who need services but who are non-Medicaid eligible. This is an important issue for our system because the services system is so Medicaid-driven and it ignores individuals who do not meet that criteria.

8. *Gail Burrus, Director of Substance Abuse Services for Blue Ridge Community Services* (Written comments attached)

Ms. Burrus raised concerns about the emphasis in talk about priority populations on individuals who are most in need. She felt that this does not make sense for substance abuse because of the benefits of early intervention before an individual is severely impaired. This is especially true for adolescent substance abuse.

Ms. Burrus noted that adolescent substance abusers are currently underprioritized. She spoke to the role of prevention and recognized the vast number of children who are at risk. She stated that Virginia does not put any state funds in substance abuse prevention services.

Ms. Burrus suggested that more attention be paid to individuals with substance abuse disorders and co-occurring mental illness diagnoses when they are in crisis. She expressed concern that current proposals would close state hospital beds to these individuals if substance abuse is their primary diagnosis. She suggested that the Code might be reviewed to determine if this issue needed legislative action.

Ms. Burrus stated that some substance abusers need to be in secure beds because they are at risk to themselves or others. This population has created a major revolving door situation at state hospitals because there have not been the resources to develop sufficient community residential and detox capacity. In order to develop this capacity, CSBs have had to stop serving others. Private providers may have empty beds but CSBs do not have the resources to purchase services.

9. *Shauna Allen, Alliance for the Mentally Ill - Roanoke Valley*

Ms. Allen stated that she does not want to see Catawba Hospital closed. She recounted a situation in which an individual was admitted to Southwestern Virginia Mental Health Institute because the beds at Catawba were full. This placed a burden on his family.

Ms. Allen expressed concern that Medicare does not pay for prescription medications. She talked about her problems with the Department of Social

Services in obtaining Medicaid coverage because her family member's disability benefit is too high. However, the cost of required medications is more than the entire disability check. Ms. Allen stated that she has received some free medication samples from the CSB and stressed that this medication is the key to keeping her family member out of the hospital.

Attachment A
Hammond Commission Public Policy Committee Meeting Attendees
October 22, 1998

Lou Rossiter	Hammond Commission
Catherine Hammond	Hammond Commission
Ray Burmester	Hammond Commission
Del. Frank Hall	Hammond Commission
Henry Altice	Hammond Commission
Julie A. Stanley	DMHMRSAS
Charline Davidson	DMHMRSAS
Malcolm Holley	Virginia Health Quality Center
Jim Tobin	Piedmont CSB
Jessica Burmester	
Nancy Canova	AMI-RV
Jim Martinez	DMHMRSAS
Jim Sikkema	Blue Ridge Community Services
Dan Harrington, M.D.	Carilion Health System
Nancy Roberts	Division of Legislative Services
Melissa Hays-Smith, LCSW	Blue Ridge Community Services
Helen Harrah	Blue Ridge Community Services
Harriette Shivers	VA Guardianship Association
Richard Dickson	Roanoke Acr
Gail Burrus	Blue Ridge Community Services
Shauna Alllen	AMI-RV
Reed Boatwright	DMHMRSAS
Chris Spanos	

Written Public Comments